NHS
Gloucestershire
Clinical Commissioning Group

Governing Body

Meeting to be held at 2pm on Thursday 25th July 2013 in the Board Room, Sanger House, Brockworth, Gloucester GL3 4FE

No.	Item	Lead	Recommendation
1	Apologies for Absence	Chair	
2	Declarations of Interest	Chair	
3	Minutes of the Meeting held on Thursday 30th May 2013 and Extraordinary Meeting held on 18th July 2013	Chair	Approval
4	Matters Arising	Chair	
5	Chair's Update	Chair	Information
6	Accountable Officer Update	Mary Hutton	Information
7	Assurance Framework	Cath Leech	Information
8	Your NHS: Maintaining High Quality Specialist Services Verbal Update Outcome of Consultation and implementation of service changes at GHNHSFT	Mary Hutton	Information
9	Academic Health Science Network (AHSN)	Mary Hutton	Approval
10	Locality Development Plans	Helen Goodey	Information
11	Integrated Performance Report	Cath Leech	Information
11a	Performance Management Framework update	Cath Leech	Information
12	NHS 111 Update	Simon Sethi	Approval

13	Joint Case for Change and initial provider response for the strengthening of adult health and social care Integrated Community Teams	Mary Hutton	Approval
14	Winchcombe Outpatient Physiotherapy Services and Development of Extended Scope Physiotherapy Services plus proposed accommodation solutions	Mary Hutton	Approval
15	Integrated Governance Committee Minutes	Julie Clatworthy	Information
16	Audit Committee Minutes	Colin Greaves	Information
17	Any Other Business (AOB)	Chair	
18	Public Questions	Chair	
Date and time of next meeting: Thursday 26th September 2013 at 2pm in Board Room at Sanger House			

Questions should be sent in advance to the Associate Director of Corporate Governance: alan.potter1@nhs.net by 12 noon on Monday 22nd July 2013. Questions must relate to items on the agenda.

Please note: there is very limited parking available at Sanger House and all spaces must be booked in advance. If parking is required by members of the public, please e-mail Alan Potter (as above) to establish if there are any visitor spaces available.

Gloucestershire Clinical Commissioning Group (CCG)
Governing Body

Minutes of the Meeting held on Thursday 30th May 2013
in the Board Room, Sanger House, Gloucester GL3 4FE

Present:		
Dr Andy Seymour	AS	Deputy Clinical Chair (Chair)
Dr Steve Allder	SA	Secondary Care Specialist
Dr Caroline Bennett	CBe	GP Liaison Lead
Dr Charles Buckley	CBu	GP Liaison Lead
Julie Clatworthy	JC	Registered Nurse
Marion Andrews-Evans	MAE	Executive Nurse & Quality Lead
Dr Malcolm Gerald	MGe	GP Liaison Lead
Dr Martin Gibbs	MGi	GP Liaison Lead
Colin Greaves	CG	Lay Member - Governance
Dr William Haynes	WH	GP Liaison Lead
Mary Hutton	MH	Accountable Officer
Cath Leech	CL	Chief Finance Officer
Dr Hein le Roux	HLR	GP Liaison Lead
Rob Rees	RR	Lay Member – Patient and Public Engagement
Simon Sethi	SS	Deputy Director of Commissioning Implementation Deputising for the Director of Commissioning Implementation
Alice Walsh	AW	Interim Director of Public Health
Dr Jeremy Welch	JW	GP Liaison Lead
Margaret Willcox	MW	Director of Adult Social Care
In attendance:		
Kelly Matthews	KM	Associate Director of Strategic Planning (Items 7 & 13)
Teresa Middleton	TM	Head of Medicines Management (Item 9)
Alan Potter	AP	Associate Director Corporate Governance
Emma Simpson	ES	Board Administrator
There were 10 members of the public present.		

1 Apologies for Absence

Alan Elkin, Dr Helen Miller, Mark Walkingshaw, Valerie Webb.

2 Declarations of Interest

2.1 CBu declared an interest in relation to 3 areas; dispensing medicines, attendance of post graduate education meetings sponsored by pharmaceutical companies and provision of educational materials by pharmaceutical companies. Further details relating to the 3 declarations are held by the Company Secretariat and can be supplied on request.

3 Minutes of the Inaugural Meeting held on Tuesday 2nd April 2013

3.1 The minutes were approved subject to 2 amendments;

1. Page 3 – the recommendation under 5.3 should read "approved the attached policies".
2. Page 4 – under 7.2 it should read planned surplus of £6.7m.

4 Matters Arising

4.1 There were no matters arising from previous meetings.

5 Gloucestershire Clinical Commissioning Group (CCG) Clinical Chair's Update

5.1 The Deputy Clinical Chair highlighted a number of key issues to the Governing Body.

5.2 Cross Border Patients – it was noted that high level discussions are taking place at a national level but the CCG is sympathetic to the concerns of residents which are outlined under section 2 of the paper.

5.3 MAE clarified section 2.1 of the paper which explains the Aneurin Bevan Health Board (ABHB) policy.

5.4 Other discussion points included:

- The Governing Body was briefed on reablement as per section 3 of the paper.
- Strengthening of locality management structure.
- GP practice visits.
- Emergency Care Recovery Plan.
- Advice and Guidance Service extended to diabetes.

5.5 <u>RESOLUTION:</u> The CCG noted the report.

6 Gloucestershire Clinical Commissioning Group Accountable Officer's Report

6.1 The Accountable Officer introduced the paper which summarises the key issues arising during April and early May.

6.2 These included:

- Unscheduled Care Performance – significant pressures on the system in common with other parts of the South West.
- NHS 111 – CCG will not proceed to full public launch until a sustained period of high performance has been delivered.
- Your NHS: Right Care, Right Time, Right Place, 2013 Proposals for change: maintaining high quality, specialist services.
- Gloucestershire recognised for making a difference in dementia services.
- Academic Health Science Network (AHSN) – the CCG has expressed an interest in becoming a voting member of the AHSN. A paper will be presented to the Governing Body for decision in July.

6.3 Following a concern raised by JC it was noted that further discussion on Your NHS: Right Care, Right Time, Right Place 2013 would take place in the confidential part of the meeting.

6.4 **<u>RESOLUTION:</u> The Governing Body noted the content of this paper.**

7 Annual Operating Plan : 2013/14

7.1 KM introduced the report which provides an outline of the key components of the CCG 2013/14 Annual Operating Plan (AOP).

7.2 It was noted that the AOP will form the business plan for the current financial year and sets out priorities for change.

7.3 Questions included:

- Is the programme budgeting approach successful? Concerns were raised that using programme budgeting as a benchmarking tool has limited scope. Clinicians in particular recognised the impact on their own services if the programme is not within budget.
- Are areas of inequality within localities being tackled? It was noted that work is underway with the Health & Wellbeing Board on interventions.
- Local quality premiums – it was felt useful to refer back to one of the objectives in order to explain the detail.
- Section 6.3 – it was requested that a sentence be added to this section relating to the IGC reviewing the risk register. KM
- Request for further clarity regarding funding of locality initiatives and how the CCG is prioritising.
- It was noted that the AOP is an overarching plan which would evolve during the year.

7.4 **<u>RESOLUTION:</u> The Governing Body approved the final Annual Operating Plan.**

8 2013-14 CCG Budget Update

8.1 The report presents an update on the 2013/14 budgets since the draft budgets were presented in April 2013 at which point several contracts for providers were outstanding.

8.2 It was noted that heads of terms have now been signed with major providers, however baseline adjustments between commissioners to reflect services transferred, notably specialist commissioning, have not yet been resolved.

8.3 Risks were outlined as set out in Appendix 4.

8.4 A brief update was given on the issue of retrospective Continuing Healthcare (CHC) funding.

8.5 It was agreed that clearer presentation of appendices will take place going forward in relation to Section 75 partnership agreements. CL

8.6 RESOLUTION: The Board approved the budgets and the risks inherent within the plan.

9 The Independent Inquiry Into Care Provided by Mid-Staffordshire NHS Foundation Trust (The Francis Report 2013)

9.1 TM presented the paper which gives an overview of the Francis Report and highlights the key areas and 290 recommendations of the report.

9.2 It was noted that the overarching theme of the Francis Report is the importance of quality and that the report found a lack of clarity in monitoring organisations.

9.3 The Governing Body was reminded that there is a Clinical Quality Review Group for each provider within Gloucestershire CCG which meets every 2 months to robustly review the service. This then reports to the IGC.

9.4 No specific concerns have been raised in relation to the CCG but the message is that quality must percolate through everything and be present at all times.

9.5 Concerns and questions included:

- How do we measure the 'culture' of the organisation? It was noted that this is challenging because the culture of an organisation is intangible. MAE gave reassurance to the Governing Body that the staff/service user surveys are being scrutinised in order to illicit valuable information.
- How are the 6C's being monitored? A Professional Nurses Forum has been established within the CCG. The first agenda item on the next meeting of this body is how to take forward the 6C's.
- It was felt that providers should be encouraged to be transparent about challenges i.e 'enshrining a duty of candour'.
- Need for a specific timetable to hold providers to account.
- Need to look at wider provider landscape not just focus on specific recommendations.
- Need to look at assurance within independent sector.
- A more detailed piece of work will come before the Governing Body in the future. MAE

9.6 <u>RESOLUTION:</u> The Governing Body noted the report and agreed the recommendations set out in section 6 of the report.

10 <u>NHS Gloucestershire Quality Handover Document</u>

10.1 The paper presented the above document to the Governing Body. MAE explained that it was a national requirement that this document is presented to Governing Bodies of CCGs.

10.2 **<u>RESOLUTION:</u> The Governing Body formally reviewed the document and agreed to its publication on the CCG website.**

11 Performance Report

11.1 CL presented the report which provides a year end update on NHS Gloucestershire performance for the period up to 31/03/2013.

11.2 A number of concerns/achievements set out in the report were highlighted to the Governing Body including:

- A&E performance turning from amber to red. Recovery plans from Gloucestershire Hospitals NHS Foundation Trust (GHT) are being currently reviewed.
- Trauma & Orthopaedic (T&O) Referral to Treatment (RTT) performance has been achieved since November 2012.
- Achievement of 60 day cancer wait time action plan.

11.3 It was noted that a message regarding C. difficile infections is due to be printed in the e-bulletin and will cover such things as care over antibiotic and Proton Pump Inhibitor (PPI) prescribing.

11.4 **<u>RESOLUTION:</u> The Governing Body noted the performance against national targets and the actions taken to ensure that performance is at a high standard.**

11a Proposed Performance Management Framework and Update on National Indicators

11a.1 CL presented the paper which introduces the proposed CCG Performance Framework and sets out a draft framework for debate and consideration.

11a.2 Brief discussion took place on the strategic process as set out in Appendix 1.

11a.3 It was noted that the report is a starting point and this level of detail may not come to the Governing Body (but the appropriate committees) in the future.

11a.4 <u>RESOLUTION:</u> The Governing Body adopted the approach and noted the update on national indicators.

12 Gloucestershire Urgent Care Recovery Plan

12.1 SS presented the paper which summarises the context within which the urgent care system functions in Gloucestershire, outlines key recovery projects, assigns responsibility for the delivery of these projects and proposes a revised and strengthened governance system to oversee recovery.

12.2 It was noted that there has been 5.9% higher A&E attendances this winter which is having an impact on services (relating mainly to over 65/75 year olds).

12.3 The importance on focussing on admissions as much as discharges was highlighted, as well as looking at care packages because a certain group of people still attend A&E despite health and social care packages.

12.4 Further information was requested in relation to the first sentence of the second paragraph in section 1 on page 4. SS

12.5 It was agreed that further analysis needs to take place in relation to regular patients. SS

12.6 <u>RESOLUTION:</u> The Governing Body noted the report.

13 QIPP Programme

13.1 KM presented the report which provides the Governing Body with an overview of the 2013/14 QIPP Programme.

13.2 It was noted that the CCG has planned to deliver a surplus of £6.8m for the year 2013/14.

13.3 <u>RESOLUTION:</u> The Governing Body:

- **Noted the 2013/14 QIPP programme including the planned savings delivery and supporting work programme.**
- **Noted the QIPP governance and performance management structure to be delivered by the Programme Management Office.**

14 <u>Any Other Business</u>

14.1 MW gave a briefing in relation to Child and Adolescent Mental Health Services (CAMHS). It was noted that since February there have been 6 admissions for which there were no beds within county.

The Governing Body felt sending children miles away from home was not a sensible solution.

14.2 MGi informed the meeting he would attend the Local Area Network Mental Health Meeting on July 11th 2013.

14.3 MAE outlined the actions being taken to address the concerns of cross-border patients.

15 The meeting closed at 15:25.

16 Date & Time of next meeting: Thursday 25th July 2013 at 2pm in the Board Room at Sanger House.

Minutes Approved by Gloucestershire Clinical Commissioning Group Governing Body:

Signed (Chair):_____ Date:_____

Matters arising from previous Governing Body Meetings May 2013

Item	Description	Response	Action with
30.05.13 Agenda Item 7.3	Annual Operating Plan	• Local quality premiums – it was felt useful to refer back to one of the objectives in order to explain the detail. • Section 6.3 – it was requested that a sentence be added to this section relating to the IGC reviewing the risk register. • Request for further clarity regarding funding of locality initiatives and how the CCG is prioritising.	**KM**
30.05.13 Agenda Item 8.5	2013-14 CCG Budget Update	It was agreed that clearer presentation of appendices will be made going forward in relation to Section 75 partnership agreements.	**CL**
30.05.13 Agenda Item 9.5	Francis Report	A more detailed piece of work will come before the Governing Body in the future.	**MAE**
30.05.13 Agenda Item 12.4	Gloucestershire Urgent Care Recovery Plan	Further information was requested in relation to the first sentence of the second paragraph in section 1 on page 4.	**SS**
30.05.13 Agenda Item 12.5	Gloucestershire Urgent Care Recovery Plan	It was agreed that further analysis needs to take place in relation to regular patients.	**SS**

NHS
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Clinical Commissioning Group

Agenda Item 5

Gloucestershire Clinical Commissioning Group

Board Meeting Date	**Thursday 25th July 2013**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during June and early July 2013
Key Issues	The key issues arising include: • Dementia Care Rates Improve • Support for Carers • Systems Leadership
Risk Issues	None
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable Development	None
Patient and Public Involvement	
Recommendation	This report is provided for information and the Board is requested to note the contents.
Author	Helen Miller
Designation	Gloucestershire CCG Chair
Sponsoring Director (if not author)	

Gloucestershire Clinical Commissioning (GCCG)
Clinical Chair's Report

1 Introduction

1.1 This report provides a summary of key issues arising during June and early July 2013.

2 Dementia Diagnosis Rates Improve

2.1 A recent study by Gloucestershire CCG PCCAG (Primary Care Clinical Audit Group) found that formal diagnosis rates of people with dementia are improving. All 85 of the county's GP practices participated in the assessment, which revealed that formal dementia diagnosis rates are well above the national average.
They have risen from 36% to 53% over the past two years against the expected prevalence for the county (8,260 people). There are currently 4,389 patients diagnosed with dementia in Gloucestershire.

2.2 The audit also found a very positive reduction in the use of antipsychotic drugs for patients with dementia. In 2010, 14.26% of diagnosed dementia patients in Gloucestershire were prescribed anti-psychotic drugs. This has now reduced to 8.36%
An independent report commissioned by the Department of Health found that prolonged use of anti-psychotic drugs has been shown to increase the risk of strokes and mortality.

PCCAG plans to re-audit in January 2014.

3 Support for Carers

3.1 A number of organisations have been selected to support carers on behalf of Gloucestershire County Council and NHS Gloucestershire Clinical Commissioning Group (CCG), bringing together a wealth of experience in the field.

3.2 Carers Gloucestershire, working with Gloucestershire Young Carers, was selected to deliver a wide range of services. The services are carers voice; information, advice and guidance; support planning and carers assessments; and emotional support

for carers. Guideposts, working with Crossroads, will provide carers breaks.

3.3 Carers will be invited to help to shape and influence services through the creation of a carers voice organisation which will be supported by Carers Gloucestershire. The organisations were selected by the council and CCG through a commissioning process to deliver these services to carers throughout the county. Carers have been involved throughout the process, with a group of 26 carers taking part in the evaluation of the tenders.

3.4 The CCG recognise the dedication of carers and the vital role they play in supporting people within our communities. The design of these new contracts is intended to provide carers with the best possible support to help them in their caring roles.

3.5 The new contracts will start 1st October 2013 and will run until 31st March 2016.

3.6 Carers support in Gloucestershire is jointly funded and commissioned by Gloucestershire County Council and NHS Gloucestershire Clinical Commissioning Group.

4 Systems Leadership

4.1 Gloucestershire Health and Wellbeing Board have signed up to take part in a new Systems Leadership Programme. This programme is designed to support development of the Board using a specific issue – an approach that has been tested in 8 areas. It is hoped it will support Health and Well Being Boards to respond to the challenges and opportunities offered by the new organisational responsibilities. Gloucestershire has chosen to focus on Reducing Obesity for this programme, one of the key priority areas locally. The focus will be on the intergenerational aspects of obesity and the particular issues within Gloucester City (urban) and Forest of Dean (rural). The programme has the involvement of 18-20 areas in addition to the 8 that are already underway.

4.2 The programme is sponsored by Public Health England, the NHS Leadership Academy, the Kings Fund, The Local Government Association and the National Skills Academy (social care). The emphasis is on:

- Bringing partners together to deliver a place based approach with similarities and links to Total Place and Troubled Families Programmes
- Focussing on the role of leadership at all levels – aiming to develop citizens and communities as leaders and use of asset based approaches and co-production
- Working in different ways across partnerships to achieve common outcomes

4.3 The next steps are for Gloucestershire leaders to meet with the programme director and agree the scope of our programme; the support we require from the programme (this includes training and an "enabler" to work with us directly) and the outcomes we wish to achieve as a health and social care community.

4.4 This is an exciting opportunity to support high quality leadership within our Health and Well Being Board which has a vital role going forward and to ensure we work jointly to promote delivery of the best outcomes for the people of Gloucestershire. Further details are available from Justine Rawlings justine.rawlings@nhs.net.

5 Update on Meeting with Homeless Healthcare Team

5.1 The Clinical Chair met with The Homeless Healthcare Team who have put in a bid to CCG for extra nursing staff to assist with this and also requesting that there is cover for 7 days a week instead of the 5 days currently in operation at the Vaughan Centre. It was acknowledged that this should be made a priority.

6 Update on Meeting with GAVCA

6.1 The Clinical Chair met with a representative from Gloucestershire Association for Voluntary and Community Action (GAVCA) who are enquiring if there is a level of support that can be offered to the locality teams. This is being taken forward within the CCG.

7 Meetings Attended

7.1 SW HWB Chairs/Vice Chairs Network in Taunton.

7.2 NHS Commissioning Assembly CCG Development Working Group in London.

8 Recommendation

This report is provided for information and the Governing Body is requested to note the contents.

NHS
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Agenda Item 6

Gloucestershire Clinical Commissioning Group

Board Meeting Date	**Thursday 25th July 2013**
Title	**Gloucestershire Clinical Commissioning Group Accountable Officer's Report**
Executive Summary	This report provides a summary of key issues arising during June and July 2013.
Key Issues	The key issues arising include: • Strengthening Health & Social Care Integrated Community Teams • Non-Emergency Patient Transport Services • GP Out of Hours Services • NHS111 • Urgent Care/Winter Plan
Risk Issues	None
Financial Impact	None
Legal Issues (including NHS Constitution issues)	None
Impact on Equality and Diversity	None
Impact on Health Inequalities	None
Impact on Sustainable	

Development	None
Patient and Public Involvement	
Recommendation	**This report is provided for information and the Board is requested to note the contents.**
Author	Mary Hutton
Designation	Gloucestershire CCG Accountable Officer
Sponsoring Director **(if not author)**	

Gloucestershire Clinical Commissioning (GCCG)
Accountable Officer's Report

1. Introduction

This report provides a summary of key issues arising during June and July 2013

2. Strengthening Health & Social Care Integrated Community Teams

As members are aware, there is a joint programme between Health & Social Care Commissioners and Providers of health and wellbeing services to develop the county wide service requirements for Integrated Community Teams. Subject to approval this will be implemented, through a phased roll out commencing at the end of September 2013. The business case will be presented today to the Governing Body.

Good progress has been made over the last couple of months and includes the following:

- Core priorities identified around tackling preventable admissions /early deterioration, safeguarding and preventable care;
- Programme arrangements strengthened and programme plan/ milestones updated;
- Strategic service model agreed;
- Gloucestershire Community Services accelerated learning events completed across all team areas with CCG input;
- Rapid Response elements confirmed including the connectivity with High Intensity;
- ICT model shared with a number of key groups and stakeholders (e.g. GCS staff, primary care Protected Learning Time events, Joint Commissioning Board);

- Wave 1 roll out agreed with Gloucester, Cheltenham and Cotswold localities;

- Integrated Care Pioneer application submitted to NHS England.

3. Non-Emergency Patient Transport Services

Last month, following a rigorous procurement process led by the Peninsula Purchasing and Supply Alliance on behalf of Gloucestershire, Wiltshire, Swindon and Bath & North East Somerset CCGs, Arriva Transport Solutions Ltd. (ATSL) was announced as Preferred Bidder.

Commissioning Leads for the four CCGs are now working together to finalise the contract with ATSL and agree a four month mobilisation plan which will cover all the elements required to deliver the new service. Contract negotiations are still on-going to ensure that a suite of robust performance measures will be reported, monitored and performance managed - with appropriate penalties where performance fails to reach the agreed standard. We will be assessing the impact of change on the healthcare providers and patients of Gloucestershire, and will identify and mitigate risks to successful delivery throughout the mobilisation period. Working to an agreed communications strategy we will also engage and communicate with all stakeholders.

4. GP Out of Hours services

At an Extraordinary Meeting on 20/06/13 of Gloucestershire CCG's Governing Body we took the decision to cancel the current procurement process for the GP OOH service and have advised all bidding organisations accordingly. This decision was reached following the receipt of new data that showed a significant impact on OOH activity as a result of the soft launch of the new NHS111 system. The CCG wishes to continue to monitor activity data over the next few months and the CCG anticipates re-procuring OOH services with a revised service specification during 2014.

In taking this decision, the Governing Body also considered the benefits of not completing this process in late autumn as we

address current significant pressures within our system and the need to work through the wider system changes we need to make.

5. NHS111

An update on the NHS111 service will be presented to the Governing Body today including next steps.

6. Urgent Care/Winter Plan

The Gloucestershire Urgent Care Recovery plan was produced in response to local and national concerns about pressures experienced within the Urgent Care system over the winter period. Gloucestershire's plan was compiled in partnership with all key providers from across Health and Social Care, ensuring all critical phases of the system were reviewed.

The plan captures 34 component schemes which will have a positive impact on diverting and reducing demand within the urgent care system. In recognition of the urgency to deliver results it was agreed that 8 schemes would be prioritised and monitored via a Task and Finish Group. The remaining schemes continue to be driven and monitored to agreed timescales.

In addition we are also in the process of developing our 2013/14 winter plan. This work is taking place across three work streams:

- prior to A&E;
- flow through the hospital;
- discharge from hospital and community care.

The process will include clinicians and managers from across Health and Social care. This will include the triangulation of data in order to understand aspects that affect demand, performance and quality within the system. The outcome will be the agreement of schemes which will improve pathways across the system in time for winter. This will include the production of effective escalation plans.

7. Recommendation

This report is provided for information and the Governing Body is requested to note the contents

NHS
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Agenda Item 7

Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	Assurance Framework
Executive Summary	The attached Assurance Framework for 2013/14 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the CCG's Annual Objectives. The Assurance Framework identifies gaps in assurances and controls regarding the objectives along with details of the principal risks that have been identified by lead managers. The attached document was presented to the meeting of the Integrated Governance Committee, held on the 20th June 2013. Updates will be provided to future meetings of both the Committee and the Governing Body in order to demonstrate the progress made against the action plans identified to address risks and the gaps in assurances or control.
Key Issues	A number of risks have been identified which could adversely affect achievement of the objectives. Action plans have, however, been devised are being implemented to minimise the effect of these risks.
Risk Issues:	The absence of a fit for purpose Assurance Framework could result in gaps in control or assurances not being

Original Risk **Residual Risk**	identified and addressed. 8 (2x4) 4 (1x4)
Financial Impact	Not applicable
Legal Issues (including NHS Constitution)	Not applicable
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note this paper which is provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Cath Leech Chief Finance Officer

NHS
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Clinical Commissioning Group

Agenda Item 7

Governing Body

Thursday 25th July 2013

Assurance Framework

1. Introduction

1.1 The Assurance Framework provides the Governing Body with a structure and process that enables the organisation to:

- focus on those risks that might compromise achievement of the annual objectives;
- map out the key controls in place to manage the objectives;
- identify the assurances that will be received by the Governing Body regarding the effectiveness of those controls.

1.2 The Assurance Framework is also a key source of evidence for the Annual Governance Statement.

1.3 The primary benefit of the Assurance Framework is that it provides a structure for individuals within the CCG to consider and plan for the achievement of the organisation's objectives in a proactive manner.

2. The Assurance Framework

2.1 The Assurance Framework is based upon the summary objectives detailed in the Annual Operating Plan that was approved at the meeting of the Governing Body held on the 30th May 2013.

2.2 The document outlines the principal risks, control systems and assurances that will be provided to the Governing Body regarding the achievement of each summary objective. Details of the action plans to address the risks, gaps in

controls or gaps in assurance are also provided for each objective.

2.3 The initial Assurance Framework was presented to the inaugural meeting of the Integrated Governance Committee (IGC) on the 9th May 2013. The attached document, which was presented to the 20th June meeting of the IGC, incorporates updates received from the lead managers responsible for each area of activity.

2.4 Progress regarding the achievement of each annual objective is monitored separately through the performance management process.

3. Monitoring

3.1 Updates of the Assurance Framework, outlining the progress made in relation to the action plans, will be reviewed at each meetings of the Integrated Governance Committee. In addition, the document will also be presented to the Governing Body for information.

4. Recommendation

4.1 The Committee is invited to note this paper and the attached Assurance Framework.

5. Appendix

- Assurance Framework

NHS
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Agenda Item 9

Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	Academic Health Science Network (AHSN)
Purpose	This paper presents a briefing on the development of the West of England Academic Health Science Network (AHSN) and the Articles of Association (Appendix 1) and Voting Members Agreement (Appendix 2) for approval.
Executive Summary	AHSNs are a core element of 'Innovation Health and Wealth' (2011), the NHS contribution to the Government's 'Plan for Growth'. AHSNs are intended to improve the identification, adoption and spread of innovation and best practice across the NHS. Established as membership organisations with a geographical footprint, AHSNs encompass NHS commissioning bodies and providers, universities, industry, and other organisations. AHSNs have been established through a designation process designed by NHS England that assessed whether they were 'fit for purpose'. Once designated AHSNs are granted a 5 year licence and contract with NHS England setting out the funding agreement and deliverables. The West of England AHSN covers Bristol, South Gloucestershire, North Somerset, Bath and North East Somerset, Swindon, Gloucestershire and Wiltshire, a list of members is given at appendix 3. The AHSN's prospectus sets

	out the network's business plan http://www.weahsn.org.uk/documents/ .
Key Issues	The AHSN offers an opportunity to work with key partners across the Gloucestershire and wider AHSN boundary to improve the identification, adoption and spread of best practice.
Risk Issues:	There is currently no significant risk identified as the work is at an early stage.
Financial Impact	From 2014/15 the CCG is asked to contribute an annual membership fee of £10,000. There are potential benefits to be derived from the work of the AHSN.
Legal Issues (including NHS Constitution)	Advice has been provided to members through Bevan Brittan and there are no outstanding legal issues.
Impact on Health Inequalities	There is no differential impact identified.
Impact on Equality and Diversity	No impacts have been identified.
Impact on Sustainable Development	No impact identified.
Patient and Public Involvement	There will be a subgroup set up reporting to the AHSN Steering Group.
Recommendation	The Governing Body is asked to: • Note the briefing and Articles of Association. • Agree delegated authority to the Accountable Officer to sign the Voting Members Agreement.
Author	Julie Thomas
Designation	Director of Development - AHSN
Sponsoring Director (if not author)	Mary Hutton Accountable Officer

Governance Arrangements for the West of England Academic Health Science Network

1 Purpose

This paper presents a briefing on the development of the West of England Academic Health Science Network (AHSN) and the Articles of Association (Appendix 1) and Voting Members Agreement (Appendix 2) for approval.

2 Background

AHSNs are a core element of 'Innovation Health and Wealth' (2011), the NHS contribution to the Government's 'Plan for Growth'. AHSNs are intended to improve the identification, adoption and spread of innovation and best practice across the NHS. Established as membership organisations with a geographical footprint, AHSNs encompass NHS commissioning bodies and providers, universities, industry, and other organisations.

AHSNs have been established through a designation process designed by NHS England that assessed whether they were 'fit for purpose'. Once designated AHSNs are granted a 5 year license and contract with NHS England setting out the funding agreement and deliverables.

The West of England AHSN covers Bristol, South Gloucestershire, North Somerset, Bath and North East Somerset, Swindon, Gloucestershire and Wiltshire, a list of members is given at appendix 3. The AHSN's prospectus sets out the network's business plan http://www.weahsn.org.uk/documents/ . The network has identified three strategic goals:

- To deliver measurable gains in health and wellbeing across the West of England.
- To make a meaningful contribution to the West of England and UK economies
- To build a learning and delivery network to accelerate the adoption and spread of innovation and improvement

Four priority service improvement programmes were identified during early consultation with members:

- Patient safety

- Stroke
- Frail older people – including dementia
- Mental health

The AHSN prospectus describes levers and linkages that have relevance for the different types of member organisations.

3 West of England AHSN Governance Arrangements

The development of the West of England AHSN has been overseen by a Steering Group made up of partner organisation representatives, mainly represented at CEO level. It was decided by the steering group that the network would take the form of a Company Limited by Guarantee (CLG) and the dormant CLG has been set up. As such it will be governed by the Articles of Association and Voting Members Agreement. The Voting Members Agreement sets out the rights and obligations of voting members which will come from 3 constituencies: Providers of NHS Services, Universities and Clinical Commissioning Groups. The AHSN will have affiliated, non voting, members drawn from partner organisations in industry and local government who will join members on the Members Council..

The AHSN Members Council will meet at intervals throughout the year; its purpose will be to hold the AHSN to account, receive reports from the Network Board, and facilitate connections and communications. The AHSN voting members will sit alongside non-voting affiliated partners on the Members Council.

The West of England AHSN Board will govern the activities of the AHSN, determining the strategy and priorities of the network and performance managing delivery of objectives. The Board will be responsible for ensuring both financial and corporate governance and set the Network's culture. The Board's membership will be a mix of executive directors, representatives drawn from voting members and non-voting members appointed by the Health Education South West (formerly Local Education and Training Board, 'LETB'), the National Institute for Health Research (NIHR) and CLARHRC*west* if its current bid is successful. The Board will include patient and public representation. Voting member representatives on the Board will have the right to vote at the Board.

More information on the organisation form and its implications is provided in the Frequently Asked Questions (appendix 4) which have been developed with the Articles and Voting Members Agreement with expert input from many of your organisations via meetings with our legal advisors, Bevan Brittan, as well as learning from other AHSNs

Please note the following:

- We received a number of helpful comments and queries in a teleconference attended by 6 NHS Trusts, 3 HEIs, 5 CCGs, and 3 CICs on 19 April
- We have taken on board and incorporated comments into later drafts – all under the leadership of the Steering Group.

4 Financial Implications

The AHSN explains in its prospectus that the major budgets for delivering clinical care, undertaking research and workforce education and development sit with the member organisations. The AHSN will pump prime and act as a catalyst for change. This investment will be in people and supporting wealth creation, research translation and adoption and spread. The five year financial plan within the original Prospectus, estimated a total cost of £7.8 million in year one, and approximately £7.7 million in subsequent years. The planned budget is subject to members' confirmation and it is now becoming clear will need significant revision as during the recent designation of the AHSN, national funding was confirmed for 2013/14 at £2.71m.The AHSN is a service provider to its partners which is reflected in the contribution model with income derived from national funds and member contributions. Further to significant debate on fee structure, the following differentiated fee structure was agreed by the Steering Group on 17 June 2013.

Voting Member type	**Annual Fee for Year 1 (2014/2015)**
Providers of NHS services with annual turnover greater than £70m	£20k
Providers of NHS services with annual turnover less than £70m able to club together so that their combined 'club' value exceeds the £70m threshold. • 1 organisation of the 'club' to be elected to represent the 'club' in the AHSN (Club Representative). • The Club Representative would be obliged to pay the fixed annual registration fee of £20k. • The Club Representative would seek contributions from the other club members to meet the £20k fee.	£20K
Providers of NHS services covering multiple AHSNs	£10k
Clinical Commissioning Groups	£10k
Universities	£20k

It was not agreed that small NHS Trusts with annual turnover less than £70m should be able to 'club' with a larger Trust e.g. RNHRD with RUH, given the potential for precedent setting and reintroduction of further variation in fees.

Additionally the Steering Group of 17 June agreed the below points:

Given the delays to the work of the AHSN relating to licence detail and setting up of infrastructure, it is recognised that work plans will not be properly started before September 2013.

- It was agreed that fees will not be levied for 2013/14 (Year 0).

- It was agreed that organisations' Boards should be asked to agree to the Year 1 fee rate above by end July 2013.

- It was agreed that It is not intended that year 2 or future years' fees (2015/16 and onwards) would be varied without compelling reasons and any such changes would be a matter for discussion with all member organisations before consideration by the AHSN Board.

5 Legal implications

The legal issues raised in this paper are addressed in Appendix 4, Frequently Asked Questions.

6 How have service users, carers and local people been involved?

There has been patient and public involvement throughout the development of the AHSN including a conference in January 2013 during which priorities were identified. PPI is one of the most advanced of the AHSN's work streams.

7 Recommendation(s)

The …….. is asked to:

- **Note the briefing and Articles of Association**
- **Agree delegated authority to …… to sign the Voting Members Agreement.**

Bevan Brittan
The public services law firm

Dated

THE PERSONS NAMED IN SCHEDULE 1

WEST OF ENGLAND AHSN LIMITED

VOTING MEMBERS AGREEMENT RELATING TO WEST OF ENGLAND AHSN LIMITED

FINAL FORM

Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Kings Orchard | 1 Queen Street | Bristol BS2 0HQ
T 0870 194 1000 F 0870 194 1001

Interchange Place | Edmund Street | Birmingham B3 2TA
T 0870 194 1000 F 0870 194 5001

www.bevanbrittan.com

Contents

THIS AGREEMENT is made on

BETWEEN:

(1) **THE PERSONS** named in Schedule 1 (*Voting Members*); and

(2) **WEST OF ENGLAND AHSN LIMITED** (registered number 08530712) whose registered office is at South Plaza, Marlborough Street, Bristol United Kingdom BS1 3NX (the **Company**).

BACKGROUND

The Voting Members have agreed to enter into this Agreement to record their understanding of how the Company will operate the relationship between them, and the relationship between the Voting Members and the Company.

OPERATIVE CLAUSES

1 INTERPRETATION

1.1 In this Agreement unless consistent with the context the following expressions have the following meanings:

Articles means the Articles of Association scheduled to this Agreement at Schedule 4 (*Articles*) and to be adopted by the Company on Completion, and as may be amended from time to time, and references to an **Article** shall mean a specific Article in the Articles as amended from time to time

Authorised Representative has the meaning given in clause 5.5

Authority means any competent governmental, administrative, supervisory, regulatory, judicial, determinative, disciplinary, enforcement or tax raising body, authority, agency, board, department, court or tribunal of any jurisdiction and whether supranational, national, regional or local

Board means the Directors, or such of those Directors present at a duly convened meeting of the Directors at which a quorum is present in accordance with the Articles

Business means the business as described in clause 3 and/or such other business as may from time to time be carried on by the Company and/or its subsidiary undertakings in accordance with this Agreement

Business Day means any day (other than a Saturday, Sunday or bank or public holiday in England)

Business Plan means a five year rolling business plan in a form to be prepared, adopted and updated annually pursuant to clause 7 in respect of the Company;

CCG means clinical commissioning group

CIC means a community interest company

Completion has the meaning give to it in clause 2

Confidential Information means has the meaning given to that expression in clause 13.1

Deed of Adherence means a deed in the form or substantially in the form of the document scheduled to this Agreement at Schedule 3 (*Deed of Adherence*)

Director means any duly appointed director of the Company for the time being or a duly appointed alternate of any Director

Encumbrance includes any interest or equity of any person (including, without prejudice to the generality of the foregoing, any right to acquire, option, right of pre-emption or right of conversion) or any mortgage, charge, pledge, lien or assignment or any other encumbrance, priority or security interest or arrangement of whatsoever nature over or in the relevant property

Executive Team has the meaning given in clause 6.11

Financial Year means any accounting reference period of the Company, of whatever duration

First Business Plan means the Business Plan adopted at Completion

general meeting means a meeting of the members of the Company, called in accordance with the Articles, to transact the limited business that can only be transacted by members of a company, such as amending the Articles of Association

Group means in relation to an undertaking (including a Voting Member):

(a) that undertaking;

(b) any subsidiary undertaking of that undertaking;

(c) any parent undertaking(s) of that undertaking; and

(d) any subsidiary undertaking of such parent undertaking(s),

and **member of the Group** (or similar words) shall be construed accordingly. The Company shall not be a member of the Group of any Voting Member

Guarantors means those Voting Members (and, where relevant, former Voting Members) that are from time to time members of the Company for the purposes of the Companies Act 2006

Initial Budget means an initial agreed budget to be included in the First Business Plan

Independent Chair means an independent, non-executive chair of the Board, appointed by the Board on such terms as it may determine

Intellectual Property means all intellectual and industrial property of any kind whatsoever in connection with the undertaking of the Company or its activities, whether as part of a formal secondment to the Company or in conjunction with other Voting Members or otherwise, including patents, know-how, registered trademarks, registered designs, utility models, applications for and rights to apply for any of the foregoing, unregistered design rights, unregistered trademarks, rights to prevent passing off or unfair competition and copyright, database rights, topography rights, and any other rights in any invention, discovery or process, in each case in all countries in the world and together with all renewals, extensions, continuations, divisionals, reissues, re-examinations and substitutions

Managing Director means the managing director appointed by the Board to manage the Company

the Statutes means the Companies Acts as defined in section 2 of the Companies Act 2006 and every other statute, order, regulation, instrument or other subordinate legislation for the time being in force relating to companies and affecting the Company

Vice Chair means a non-executive vice-chair of the Board, appointed by the Board on such terms as it may determine

Voting Members means the signatories to this document on the date hereof and those organisations subsequently entering into a Deed of Adherence but excluding any organisation that has ceased to be a Voting Member under this Agreement

in writing means hard copy form or, to the extent agreed (or deemed to be agreed by virtue of a provision of the Statutes) electronic form or website communication

1.2 Expressions defined in the Articles have the same meanings when used in this Agreement, unless inconsistent with the context.

1.3 References to any statute or statutory provision include a reference to that statute or statutory provision as modified, re-enacted or consolidated and in force from time to time, whether before or after the date of this Agreement and any subordinate legislation made pursuant to it whether before or after the date of this Agreement.

1.4 References to persons will be construed so as to include bodies corporate, unincorporated associations and partnerships.

1.5 All covenants, agreements, undertakings and warranties by a Voting Member to do or refrain from doing anything shall be deemed to include an obligation to procure that each member of its Group will do or refrain from doing anything which the Voting Member has agreed to do or refrain from doing.

1.6 References to clauses and the Schedules are to clauses of and the Schedules to this Agreement, and references to paragraphs are to paragraphs in the Schedules in which such references appear and references to this Agreement include the Background and Schedules.

1.7 Any phrase introduced by the term **include**, **including in particular** or any similar expression will be construed as illustrating and will not limit the sense of the words preceding that term.

1.8 The word **connected** has the meaning given to it in section 252 of the Companies Act 2006 and shall apply in relation to a Director and a Voting Member (as though a Voting Member was named in that section).

1.9 The word **address** where it appears in this Agreement includes postal address and electronic address.

1.10 The headings to the clauses of this Agreement and to the paragraphs of the Schedules will not affect its construction.

2 COMPLETION

2.1 **Completion** means completion of this Agreement. At Completion:

2.1.1 the Guarantors shall pass a written resolution of the members to adopt the Articles;

2.1.2 each of the persons named in the first column of the table in Schedule 2 (*Initial Board*) shall, if they are not already Directors, be automatically deemed appointed as initial Directors;

2.1.3 the First Business Plan shall be automatically adopted by virtue of the Voting Members signing this Agreement pursuant to clause 7.4.2; and

2.1.4 each of the Voting Members shall pay to the Company the membership fees set out against their respective names in the First Business Plan.

2.2 This Agreement (other than obligations that have been fully performed) remains in full force after Completion.

3 THE COMPANY'S MISSION AND ITS PRACTICAL IMPLEMENTATION

3.1 The mission of the Company is to bring about real, practical improvements to the quality of healthcare delivery to patients across the West of England and the health of the whole population,

principally that of the West of England but extending also to the population of the UK as a whole and beyond.

3.2 The Company will build on translating the existing research and innovation infrastructure of each of the Voting Members to strengthen the coordination and adoption of innovation, and exploit commercial opportunities arising from harnessing the expertise of leading healthcare providers. In particular, the Company will fulfil its mission by:

3.2.1 achieving population wide health benefits in the West of England and beyond through collaborative research and the more systematic dissemination of proven innovation and best practice (closing the gap between "what we know and what we do");

3.2.2 contributing to and co-ordinating the health system improvements and developments in the West of England from a provider and academic perspective;

3.2.3 participating fully in the healthcare workforce education, training and leadership development agenda through the forming of LETBs which will be responsible for setting the strategy and commissioning budget in the West of England. Whilst the exact nature of the relationship with the LETBs is yet to be defined, each LETB will have an independent chairman appointed by the chairman of Health Education England. A close working relationship will be fostered between the Company and the LETBs; and

3.2.4 exploiting commercial opportunities in the UK and beyond. The distribution of surpluses generated from such activities will be determined by the Board either to be shared among the Voting Members or to be made available for reinvestment in the Company or reduction in membership fees as set out in clause 8.7. Where the Board determines to distribute a surplus, the Guarantors shall ensure that they pay across to the other Voting Members such amount(s) as may be required to ensure that all Voting Members share such surplus in a manner which is proportionate to the annual fee contributed by each Voting Member.

3.3 With regard to all opportunities and issues that directly affect or benefit the Company, every Voting Member will endeavour to consider them in the light of what is in the best interests of the fulfilment of the Company's mission, and subject to clause 10.3, not solely in relation to the narrower interests of their own organisation.

3.4 The Voting Members commit, so far as they are permitted by law (including in relation to data protection law and patient data) and by pre-existing contractual obligations, to the following principles and arrangements to enable the Company to achieve its (and the Voting Members') objectives set out in this clause 3:

3.4.1 Sharing information and patient-related data

Voting Members commit to the principle of sharing information for the benefits of clinical research, understanding public health trends and improving the availability of patient-related information to improve clinical decision-making and patient care.

3.4.2 Information governance

Voting Members commit to harmonising information governance arrangements.

3.4.3 Performance monitoring

Voting Members commit to providing performance information on the activities which are relevant to the Company. In most cases, this will be a "quantification" type of report of information already tracked, rather than a new data collection process, although some Voting Members may need to amend performance monitoring arrangements to comply with the performance monitoring arrangements of the majority of Voting Members.

3.4.4 Sharing and adopting best practice

Voting Members accept that enforcement of best practice and related value for money questions will be via service commissioning, but that the onus will be on Voting Members to justify why they do not follow recognised national or Company best practice arrangements or recommendations.

3.4.5 Mutual recognition agreement

Voting Members commit to adopt a "mutual recognition agreement" for clinical trials once this has been agreed unanimously by the Voting Members.

4 GUARANTORS

4.1 All Guarantors shall belong to one single tier, with each guarantee being for an equal amount.

4.2 The Guarantors shall vote on any matter required to be decided by them pursuant to the Companies Act 2006 or the Articles in such manner as the Voting Members shall determine in accordance with this Agreement. For this purpose:

4.2.1 the approval of not less than 75% of the Voting Members shall be required in relation to any matter which requires a special resolution of the Guarantors; and

4.2.2 the approval of a simple majority of Voting Members shall be required in relation to any matter which requires an ordinary resolution of the Guarantors.

For the avoidance of doubt, the Guarantors shall not vote on any matter required to be decided by them pursuant to the Companies Act 2006 or the Articles (including Article 2.2 (*Members' reserve power to direct the Board*)) unless and until the Voting Members have determined such matter in accordance with this clause 4.2. However, after the Voting Members have so determined such matter, the Guarantors shall take such actions and pass such resolutions as may be required in order to give effect to the determination of the Voting Members. The Voting Members shall ensure that they provide any such determination in good time so as to enable the Guarantors to meet any deadlines set by law.

4.3 Notwithstanding Clause 4.1 and 4.2 the Guarantors shall not be prevented from taking such action and passing such resolutions as may be required by law in the event that any requisite determination of the Voting Members required in accordance with Clause 4.1 and 4.2 is not provided in time for the Guarantors' to meet their statutory obligations.

5 VOTING MEMBERS

5.1 All Voting Members shall belong to one single tier.

5.2 New candidates for Voting Membership must be proposed by one or more of the then Voting Members. Such a proposal should outline the contribution or benefits that this/these organisations might bring to the Company, and will require approval of the Board. The Board shall have an absolute discretion in determining whether to accept or reject any application for Voting Membership and shall not be bound to assign any reason for their decision. It shall be a condition of any person becoming a Voting Member (who was not previously a Voting Member) that it executes a Deed of Adherence.

5.3 All Voting Members have the following equal rights and obligations:

5.3.1 each Voting Member has one vote on matters to be decided by the Voting Members;

5.3.2 each Voting Member will be liable to make an annual financial contribution as set out in clause 8;

5.3.3 if two or more Voting Members merge their organisations together:

(a) from the date of the merger, their separate votes will become one single vote and their two separate annual financial contributions will become one contribution (equal in the Financial Year in which the merger occurs, to the aggregate of the two separate pre-merger annual financial contributions, and thereafter as set in accordance with clause 8.1); and

(b) if two or more Voting Members (pre-merger) are also Guarantors, then one Voting Member shall resign as a Guarantor to leave the post-merger Voting Member as a single Guarantor from the date of the merger;

5.3.4 all Voting Members at the date hereof commit to remain Voting Members for at least three years after the date hereof (such period being the **Lock in Period**) and Article 10.2.1 (*Termination of membership*) shall not apply during the Lock in Period. After the expiry of the Lock in Period, a Voting Member can cease to be a Voting Member:

(a) in accordance with Article 10.2.1; or

(b) if it gives not less than twelve months' notice in writing to expire at the end of each successive year thereafter.

Any outgoing Voting Member pursuant to this Clause 5.3.4 will retain its rights and obligations (including the obligation to make an annual financial contribution) during any notice period; and

5.3.5 notwithstanding clause 5.3.4, a Voting Member's membership may be terminated at any time in accordance with clause 8.9.

5.4 The provisions of Articles 11 (*General meetings*) and 12 (*Proxies*) shall apply mutatis mutandis in relation to any decision which needs to be made by the Voting Members, as though those provisions were set out in full, with necessary amendments, in this Agreement.

5.5 A Voting Member may by resolution of its directors or other governing body authorise a person to act as its representative (**Authorised Representative**). An Authorised Representative is entitled to exercise (on behalf of the Voting Member) the same powers as the Voting Member. The Board may from time to time require an Authorised Representative to provide evidence of his authorisation and may refuse to permit a person purporting to be an Authorised Representative from exercising the rights of his (purported) Voting Member appointor until such evidence is provided.

6 GOVERNANCE AND OPERATIONAL STRUCTURE

6.1 The Company will be governed by the Board. The Board has the power to take all executive decisions in relation to matters contained in the Business Plan. The Independent Chair shall account to the Voting Members on behalf of the Board for the actions of the Company.

6.2 The Board will comprise:

6.2.1 the Independent Chair;

6.2.2 the Vice Chair (non-voting);

6.2.3 the Managing Director (non-voting);

6.2.4 two Directors appointed by the PPI Advisory Group

6.2.5 three Directors appointed by those Voting Members which are NHS provider organisations;

6.2.6 two Directors appointed by those Voting Members which are CCGs;

6.2.7 one Director appointed by those Voting Members which are University organisations;

6.2.8 one Director appointed by Health Education South West (non-voting) (the **HESW Director**);

6.2.9 one Director appointed by CLARHRC (non-voting) (the **CLARHRC Director**); and

6.2.10 one Director appointed by the National Institute for Health Research (non-voting) (the **NIHR Director**).

6.3 The appointment of any Director (other than the Independent Chair, Vice Chair and Managing Director) shall be effected by notice in writing to the Company signed by or on behalf of the relevant person(s) listed above. Such notice shall:

6.3.1 state the name of the person being appointed as a Director; and

6.3.2 take effect when the notice is delivered to the Company.

The power to appoint a Director includes the power to appoint a person as a Director as a replacement for any person ceasing to be a Director pursuant to this Agreement or the Articles.

6.4 The Board may from time to time adopt a form of letter to be issued by the Company to a Director in connection with his or her appointment.

6.5 A Director (other than the Independent Chair, Vice Chair and Managing Director) may be removed by person(s) who appointed him or her. Removal shall be effected by notice in writing to the Company signed by or on behalf of the relevant person(s). Such notice shall:

6.5.1 state the name of the person being removed as a Director; and

6.5.2 take effect when the notice is delivered to the Company.

6.6 In exceptional circumstances each Director may appoint an alternate from within his or her organisation in accordance with the Articles subject to approval of such an appointment by the Independent Chair. The alternate should be comprehensively briefed by the relevant Director on the matters of the meeting. The alternate of each of the initial Directors shall initially be the person whose name appears against the name of his or her appointing Director in the third column of the table in Schedule 2 (*Initial Board*). Each of the alternates listed in that Schedule shall, by virtue of this Agreement being executed, be deemed to have been approved by the Chair.

6.7 The Board will meet monthly or as subsequently agreed by the Board.

6.8 Unless Article 3.5.3 applies, the quorum for Board meetings shall always include:

6.8.1 either the Independent Chair or Vice Chair;

6.8.2 one Director appointed by those Voting Members which are NHS provider organisations;

6.8.3 one Director appointed by those Voting Members which are CCGs; and

6.8.4 one Director appointed by a Voting Member which is a University;

6.9 Board meetings shall be chaired by:

6.9.1 the Independent Chair; or

6.9.2 failing him or her, the Vice Chair; or

6.9.3 failing him or her, another Director present at the meeting,

in accordance with Article 3.6 (*Chairing Board meetings*).

6.10 Decisions at the Board require a majority of two thirds of those Directors present and eligible to vote. None of the Independent Chair, the Vice Chair, the Managing Director, the HESW Director, the CLARHRC Director or the NIHR Director shall be entitled to vote on any matter.

6.11 The Board will be supported by an executive team run by the Managing Director (the **Executive Team**). The Executive Team will have a small number of "executive directors" appointed by the Managing Director. The "executive directors" will not have a vote on the Board. The remuneration of the Executive Team will be approved by the Board.

6.12 The management of the Company shall be vested in the Board in accordance with clause 6.1 provided that the day to day management of the Company will be the responsibility of the Managing Director. The job specifications and responsibilities of the Managing Director shall be determined by the Board from time to time. Without prejudice to the generality of the foregoing and subject to the express provisions of this Agreement, the Board will determine the general policy of the Company and the manner in which that is to be carried out and will reserve to itself all matters involving major or unusual decisions and will procure that the Company will:

6.12.1 transact its business on arm's length terms; and

6.12.2 maintain adequate insurance against all risks usually insured against by companies carrying on the same or a similar business.

6.13 The Company may set up an external "AHSN Council". Members of the AHSN Council have the opportunity to be involved in shaping the Company's priorities. Any such AHSN Council shall have terms of reference approved by the Board which stipulate any membership criteria and govern the interaction between the Company and the AHSN Council.

6.14 The Company may align its governance structure over time with other bodies such as LETBs and existing innovation bodies.

6.15 The Board will agree a corporate governance structure for the Company, which will include a formal audit committee, remuneration committee, a scheme of delegation, the terms of reference for the Board and a list of reserved matters.

6.16 Prior to the commencement of the first audit of the Company, the Board will appoint an appropriate firm as the auditors of the Company.

7 ACCOUNTING MATTERS AND BUSINESS PLANS

7.1 The Company and each of its subsidiary undertakings shall maintain accurate and complete accounting and other financial records in accordance with the requirements of all applicable laws and generally accepted accounting practices applicable in the United Kingdom.

7.2 The Company shall prepare monthly management accounts and reports in relation to the Company containing such information as the Voting Members shall agree and which shall be despatched by the Company to each Voting Member within 30 days of the end of the month concerned.

7.3 Each Voting Member and their respective Authorised Representatives shall be allowed access at all reasonable times to examine the books and records of the Company and each of its subsidiary undertakings and to discuss their affairs with their Directors and senior management.

7.4 The Company shall prepare a business plan for the Company and its subsidiary undertakings for each Financial Year in accordance with clause 7.5, which shall be:

7.4.1 approved by the Board for circulation to the Voting Members; and

7.4.2 considered and, if thought fit, approved and adopted by the Voting Members. Unanimous Voting Member approval is required to adopt a Business Plan.

7.5 Subject to clause 7.4.2, each Business Plan shall include the following or such other information as the Board considers appropriate:

7.5.1 an estimate of the working capital requirements of the Company and its subsidiary undertakings incorporated within a cashflow forecast together with an indication of the amount (if any) which it is considered prudent to retain out of the profits of the previous Financial Year to meet such working capital requirements;

7.5.2 a projected profit and loss account;

7.5.3 an operating budget (see clause 8.3) and balance sheet forecast;

7.5.4 a review of projected business;

7.5.5 a summary of business objectives;

7.5.6 a financial report which includes an analysis of the results of the Company and its subsidiary undertakings for the previous Financial Year compared with the business plan for that Financial Year, identifying variations in sales, revenues, costs and other material items; and

7.5.7 such other or additional information as the Voting Members may from time to time determine.

7.6 The First Business Plan shall be automatically adopted by virtue of the Voting Members signing this Agreement. Business Plans for subsequent Financial Years shall be submitted for approval and adoption by the Voting Members in accordance with clause 7.4 not later than 60 days before the commencement of the first Financial Year to which they relate.

8 ANNUAL MEMBERSHIP FEES AND EXCEPTIONAL CONTRIBUTIONS

8.1 Each Voting Member will pay an annual membership fee to contribute towards the infrastructure costs of the Company.

8.2 The level of the annual membership fee will be:

8.2.1 recommended by the Board in line with the operating budget (see clause 8.3); and

8.2.2 considered and, if thought fit, approved by the Voting Members. Unanimous Voting Member approval is required to approve the level of the fee.

8.3 Each operating budget (other than the initial operating budget) will be prepared by the Executive Team and presented to the Board by the Managing Director three months in advance of the start of each Financial Year. The operating budget will include all elements required to operate the Company, such as staff costs, staff-related overheads and corporate costs (such as the remuneration of auditors).

8.4 In relation to the initial operating budget, the Voting Members have agreed the following:

8.4.1 the initial operating budget has been derived in order to be sufficient to fund the Executive Team;

8.4.2 the initial operating budget for the first Financial Year has been set out in the Initial Budget (which shall be automatically adopted by virtue of the Voting Members signing this Agreement) and includes a set fee per Voting Member to reflect the expectation that recruitment of the Executive Team will take several months;

8.4.3 the Initial Budget shall be reviewed and updated by the Board within three months of the date of this Agreement to include an operating budget up to the end of the first Financial Year;

8.4.4 if the cumulative initial membership fees as set out in the Initial Budget and paid to the Company are *less* than the Company's funding requirements in the first Financial Year such that the Voting Members are required to increase their initial membership fees, any such increase shall require unanimous Voting Member approval; and

8.4.5 if the cumulative initial membership fees as set out in the Initial Budget and paid to the Company exceed the Company's funding requirements in the first Financial Year, the excess will be used to offset each Voting Member's expected fee in the second Financial Year.

8.5 The operating budget for the second and subsequent Financial Years will be subject to prior agreement by the Voting Members as part of the process to approve and adopt a Business Plan.

8.6 Given the annual financial commitment that is being made by all Voting Members, it is mandatory that all workstreams and their composite programmes have in place:

8.6.1 a clear set of objectives that are in alignment with the Company's mission;

8.6.2 a set of performance indicators that are effective in measuring progress towards these objectives; and

8.6.3 robust mechanisms to report regularly on this progress to the Board.

The Executive Team and the leaders of those workstreams have clear accountability for the achievement of these objectives.

8.7 Any surplus generated by the Company will be accumulated in a separate fund for re-investment in ongoing "pump-priming" activities but the Board has the power to use this funding to offset Voting Members' annual financial contributions.

8.8 Fees are to be paid annually in advance after the Business Plan has been agreed.

8.9 In the event that a Voting Member fails to pay its annual membership fee in accordance with this Agreement (a **Defaulting Member**), the following shall apply:

8.9.1 the Defaulting Member shall be liable to pay interest on any payment not duly made pursuant to the terms of this Agreement calculated from day to day at a rate per annum equal to 4% above the base rate from time to time of the Company's bank (or if no such bank has been appointed, HSBC Bank plc) from the day after the date on which payment was due up to and including the date of payment;

8.9.2 where the Defaulting Member has failed to make payments due under this clause 8 and such sum remains unpaid for a period of thirty days or more (the **Non Payment Period**), the Defaulting Member shall be suspended from exercising any voting rights it might otherwise have had under this Agreement for the duration of the Non Payment Period; and

8.9.3 where the Non Payment Period exceeds sixty days, the Defaulting Member's membership of the Company may be terminated provided always that:

(a) two-thirds of the remaining Voting Members (i.e. not including the Defaulting Member) vote in favour of termination; and

(b) such termination shall not affect the liabilities of the Defaulting Member accrued prior to termination of membership, including in respect of any sums due and payable under this Agreement.

9 INTELLECTUAL PROPERTY

9.1 Within six months following the date of this Agreement the Voting Members shall unanimously agree a protocol governing the ownership and use of any Intellectual Property generated or acquired by the Company.

9.2 As the Company will not otherwise be bound by the protocol referred to in clause 9.1, Voting Members agree to exercise their voting and other rights as Voting Members to ensure that the protocol is adopted and followed by the Company.

10 VOTING MEMBERS' COVENANTS

10.1 Subject to clause 10.3, each Voting Member covenants with the others that so long as this Agreement remains in full force and effect it will:

10.1.1 be just and true to, and act in good faith towards, the others;

10.1.2 promptly notify the others of any matters of which it becomes aware which may materially affect the Company, to the extent it is able to do so without breaching any legally-binding confidentiality obligation;

10.1.3 generally do all things necessary to give effect to the terms of this Agreement;

10.1.4 take all steps available to it to ensure that any meeting of the Board or any committee of the Board or any general meeting has the necessary quorum throughout;

10.1.5 exercise all voting and other rights and powers of control as are from time to time respectively available to it under this Agreement and the Articles and otherwise in relation to the Company and its beneficial holdings in it and will execute and deliver such waivers and shall take or refrain from taking all other appropriate action within its power so as to procure that the provisions of this Agreement binding on it are duly observed and complied with and given full force and effect and all actions required by it are carried out promptly;

10.1.6 without prejudice to the generality of clause 10.1.5, procure that each of the Directors appointed or deemed to be appointed by it under the Articles will execute and do all acts and things and give and confer all powers and authorities as they would have been required to execute, do, give or confer had they been a party to this Agreement and had consented in the same terms as the Voting Member which appointed them (if a Director);

10.1.7 if it shall not be possible to secure the operation of this Agreement as set out in clauses 10.1.5 and 10.1.6 by reason of any contrary provision of the Articles, exercise all voting and other rights and powers respectively available to it to procure the alteration of the Articles to the extent necessary to permit the affairs of the Company to be so operated;

10.1.8 subject to the preceding provisions of this clause 10.1, observe the provisions of the Articles.

10.2 The undertakings of each Voting Member under clause 10.1 shall in each case be several so that each Voting Member shall only be liable for its own actions or failures to act in accordance with them, and none of them shall be liable for a failure to procure anything required by this clause 10 where such failure is attributable to any action or failure to act by another Voting Member, but without prejudice to the liability of such other Voting Member.

10.3 The Company and all the Voting Members acknowledge that each Voting Member has its own distinctive sense of purpose and identity. Nothing in this Agreement shall oblige a Voting Member to do anything or refrain from doing anything which would:

10.3.1 limit the discretion of any Voting Member to act in its own interests and to conduct its own respective operations and activities as it sees fit; or

10.3.2 limit the discretion of any Voting Member to pursue its own fundamental mission or impose on any Voting Member a change in such mission (without such Voting Member's express approval); or

10.3.3 constitute an unlawful delegation of its duties or powers.

10.4 Notwithstanding any other provision of this Agreement, should any Voting Member or any other person connected with it be in dispute with or have a conflict of interest with the Company, such Voting Member shall not, and shall procure the Director or Directors appointed or deemed to be appointed by it shall not, do or omit to do anything which would or would be likely to prevent the Company from exercising or from deciding whether or not to exercise such rights as it may have against the Voting Member in dispute with it, or in respect of the matter in relation to which the conflict of interest arises. However nothing in this clause 10.4 shall prevent any Voting Member or Director from pursuing any legitimate claim in respect of goods or services it has provided to the Company.

10.5 Each Director, and each director of any subsidiary undertaking of the Company, will be entitled while he holds that office to make full disclosure to the Voting Member appointing him of any information relating to the Company or such subsidiary undertaking which that Voting Member may reasonably require.

10.6 The Company shall act in a manner consistent with the corporate governance structure referred to in clause 6.15, once agreed by the Board.

10.7 This clause 10 applies to each subsidiary undertaking of the Company to the same extent as they apply to the Company (unless inconsistent with the context).

11 NO ENCUMBRANCES OR TRANSFERS OF INTERESTS IN THIS AGREEMENT

11.1 Each of the Voting Members undertakes that it will not create or permit to exist any Encumbrance over or in respect of all or any part of its interest in this Agreement or the Company nor assign or otherwise purport to deal with its beneficial ownership in, or any right relating to, its interest in this Agreement or the Company separate from the legal ownership of such interest without the prior written consent of the Voting Members.

11.2 No Voting Member may transfer any interest in this Agreement without the prior consent of the other Voting Members.

12 TERMINATION

12.1 This Agreement shall terminate when:

12.1.1 all the Voting Members agree in writing to its termination;

12.1.2 all of the interests in this Agreement become beneficially owned by any one Voting Member;

12.1.3 the Company passes a resolution for its winding up, is subject to an order or notice issued by a court or other authority of competent jurisdiction for its winding up or striking off or has an administrator appointed in respect of it.

12.2 The following provisions of this Agreement remain in full force after termination:

12.2.1 clause 1 (*Interpretation*);

12.2.2 this clause 12;

12.2.3 clause 13 (*Confidentiality and announcements*);

12.2.4 clause 18 (*Waiver*);

12.2.5 clause 19 (*Variation*);

12.2.6 clause 21 (*Notices*);

12.2.7 clause 22 (*Severability*);

12.2.8 clause 24 (*Entire agreement*); and

12.2.9 clause 28 (*Governing law and jurisdiction*).

12.3 Termination of this Agreement shall not affect any rights or liabilities that the Voting Members have accrued under it.

12.4 Where the Company is to be wound up the Voting Members shall agree a suitable basis for dealing with the interests and assets of the Company and shall endeavour to ensure that:

12.4.1 all existing contracts of the Company are performed to the extent that there are sufficient resources;

12.4.2 the Company shall not enter into any new contractual obligations; and

12.4.3 the Company is dissolved and its assets are distributed between the Voting Members as soon as practicable. Where the Company is so dissolved, the Guarantors shall ensure that they pay across to the other Voting Members such amount(s) as may be required to ensure that all Voting Members share any such surplus in a manner which is proportionate to the annual fee contributed by each Voting Member.

12.5 If at any time a Voting Member ceases to be a Member this Agreement (save for clauses referred to in clause 12.2 above) shall terminate with respect to that Voting Member.

13 CONFIDENTIALITY AND ANNOUNCEMENTS

13.1 In this clause 13 the expression **Confidential Information** means any information:

13.1.1 which any of the Voting Members may have or acquire (whether before or after the date of this Agreement) in relation to the customers, business, assets or affairs of the Company (including any information provided pursuant to clause 7 as a consequence of the negotiations relating to this Agreement or the performance of this Agreement) or patients, staff or students of any Voting Member;

13.1.2 which any Voting Member or any member of its Group may have or acquire (whether before or after the date of this Agreement) in relation to the customers, patients, staff, students, business, assets or affairs of another Voting Member, or any member of another Voting Member's Group, as a consequence of the negotiations relating to this Agreement or the performance of this Agreement; or

13.1.3 which relates to the contents of this Agreement (or any agreement or arrangement entered into pursuant to this Agreement),

but excludes the information in clause 13.2.

13.2 Information is not Confidential Information if:

13.2.1 it is or becomes public knowledge other than as a direct or indirect result of the information being disclosed in breach of this Agreement; or

13.2.2 any Voting Member can establish to the reasonable satisfaction of the other Voting Members that it found out the information from a source not connected with the other Voting Members or members of their respective Groups and that the source was not under any obligation of confidence in respect of the information; or

13.2.3 any Voting Member can establish to the reasonable satisfaction of the other Voting Members that the information was known to it before the date of this Agreement and that it was not under any obligation of confidence in respect of the information; or

13.2.4 the affected Voting Member(s) agree in writing that it is not confidential.

13.3 Each Voting Member shall at all times keep confidential any Confidential Information and shall not use or disclose any such Confidential Information except:

13.3.1 to another member of its Group or to a Voting Member's officers, employees, agents or professional advisers where such disclosure is for a proper purpose related to the operation of this Agreement; or

13.3.2 with the consent in writing of such of the Company, its subsidiary undertakings, the Voting Members or any member of their respective Groups to which the information relates; or

13.3.3 as may be required by law or regulation, when the Voting Member concerned shall, if practicable, supply a copy of the required disclosure to the other Voting Members, in sufficient time before it is disclosed to enable the other Voting Members to consider and suggest amendments to it, and incorporate any amendments reasonably required by the others; or

13.3.4 to any tax authority to the extent required by such authority with respect to the Voting Member concerned or any member of its Group; or

13.3.5 if the information comes within the public domain (otherwise than as a result of the breach of this clause 13).

13.4 Each Voting Member shall inform (and shall use all reasonable endeavours to procure that any member of its Group and the Company shall inform) any officer, employee or agent or any professional adviser advising it in relation to the matters referred to in this Agreement, or to whom it provides Confidential Information, that such information is confidential and shall require them:

13.4.1 to keep it confidential; and

13.4.2 not to disclose it to any third party (other than those persons to whom it has already been disclosed in accordance with the terms of this Agreement).

13.5 Upon termination of this Agreement, any of the Voting Members may demand from the others and the Company the return of any documents containing Confidential Information in relation to that Voting Member or any member of its Group by notice in writing whereupon the Company or the other Voting Members shall (and shall use all reasonable endeavours to ensure that members of its Group, and the officers, employees, agents and professional advisers of it and those of members of its Group and of the Company) shall (save for any submission to or filings with any Authority):

13.5.1 return such documents; and

13.5.2 destroy any copies of such documents and any other document or other record reproducing, containing or made from or with reference to the Confidential Information.

13.6 Any return or destruction pursuant to clause 13.5 shall take place as soon as practicable after the receipt of any such notice.

13.7 The obligations of each of the Voting Members and the Company in this clause 13 shall continue without limit in time and notwithstanding termination of this Agreement for any cause.

13.8 None of the Voting Members shall make or permit or authorise the making of any press release or other public statement or disclosure concerning this Agreement or any transaction contemplated by it or its termination or cessation without the prior consent in writing of the other Voting Members (except as required by law or regulation) but before any Voting Member makes any such release, statement or disclosure it shall where practicable first supply a copy of it to the other Voting Members and shall incorporate any amendments or additions they may each reasonably require.

13.9 The Voting Members recognise that each them may be subject to The Freedom of Information Act 2000 and the Environmental Information Regulations 2004, and all Voting Members shall work together to ensure that such Act is complied with and nothing in this Agreement shall override the said Act.

14 DATA PROTECTION

In performance of their respective obligations under this Agreement and in operating the Business, each party shall comply with the Data Protection Act 1998 and any other applicable data protection legislation and must ensure that all Personal Data and Sensitive Personal Data (each as defined in that Act) is processed by its staff in accordance with the provisions and principles of the Act.

15 ANTI-CORRUPTION

Each party undertakes to each other party that:

15.1 it shall not in the course of the operation of the Business, engage in any activity, practice or conduct which would constitute an offence under sections 1, 2 or 6 of the Bribery Act 2010;

15.2 it has and shall maintain in place adequate procedures (as referred to in section 7(2) of the Bribery Act 2010 and any guidance issued by the Secretary of State under section 9 of the Bribery Act 2010) designed to prevent any person (including an employee, agent or subsidiary undertaking) who performs services for or on behalf of that party from undertaking any conduct that would give rise to an offence under section 7 of the Bribery Act 2010; and

15.3 from time to time, at the reasonable request of any other party, it shall confirm in writing that it has complied with its undertakings under clauses 15.1 and 15.2 and will provide any information reasonably requested by such other party in support of such compliance.

16 WARRANTIES

Each Voting Member warrants to the others that, at the date of this Agreement it has full power and authority, and has obtained the consent of any third party necessary, to enter into and perform this Agreement.

17 NO PARTNERSHIP OR AGENCY

17.1 Nothing in this Agreement shall constitute a partnership between the Voting Members, or refer to a partnership under the Partnership Act 1890, a limited partnership established under the Limited Partnerships Act 1907 or a limited liability partnership established under the Limited Liability Partnerships Act 2000.

17.2 Nothing in this Agreement shall constitute one party the agent of another and none of the Voting Members shall do or suffer anything to be done whereby it shall or may be represented that it is the partner or agent of another Voting Member unless such Voting Member is appointed partner or agent of that other Voting Member with the consent in writing of that Voting Member.

18 WAIVER

The waiver by any Voting Member of any default by any other Voting Member in the performance of any obligation under this Agreement shall not affect such Voting Member's rights in respect of any other default nor any subsequent default of the same or of a different kind nor shall any delay or omission of any Voting Member to exercise any right arising from any default, affect or prejudice the rights of that Voting Member as to the same or any future default.

19 VARIATION

Any variation of any term of this Agreement shall be in writing duly signed by all Voting Members and the Company.

20 CONFLICT WITH ARTICLES

Where the provisions of the Articles conflict with the provisions of this Agreement, the Voting Members agree that the provisions of this Agreement shall prevail, to the intent that they shall if necessary in any case procure the amendment of the Articles to the extent required to enable the Company and its affairs to be administered as provided in this Agreement.

21 NOTICES

21.1 Subject to the provisions of the Articles regulating certain types of notices from the Company to the Voting Members:

21.1.1 any demand, notice or other communication given or made under or in connection with this Agreement will be in writing;

21.1.2 any such demand, notice or other communication will, if given or made in accordance with this clause 21, be deemed to have been duly given or made as follows:

(a) if sent by prepaid first class post, on the second Business Day after the date of posting; or

(b) if delivered by hand, upon delivery at the address provided for in this clause 21; or

(c) if sent in electronic form, on the day of transmission;

provided however that, if it is delivered by hand or sent in electronic form on a day which is not a Business Day or after 4.00 pm on a Business Day, it will instead be deemed to have been given or made on the next Business Day.

21.2 Any such demand, notice or other communication will, in the case of service by post or delivery by hand, be addressed to the recipient at the recipient's address stated in this Agreement or at such other address as may from time to time be notified in writing by the recipient to the sender as being the recipient's address for service.

21.3 Any such demand, notice or other communication will, in the case of service in electronic form, be sent to the recipient using an electronic address then used by the recipient.

21.4 For the avoidance of doubt, where proceedings have been issued in the Courts of England and Wales, the provisions of the Civil Procedure Rules must be complied with in respect of the service of documents in connection with those proceedings.

22 SEVERABILITY

The illegality, invalidity or unenforceability of any provision of this Agreement will not affect the legality, validity or enforceability of the remainder. If any such provision is found by any competent court or authority to be illegal, invalid or unenforceable the Voting Members agree that they will substitute provisions in a form as similar to the offending provisions as is possible without rendering them illegal, invalid or unenforceable.

23 EXERCISE OF POWERS

23.1 Words denoting an obligation on a Voting Member to do any act, matter or thing include, except as otherwise specified, an obligation to use all reasonable endeavours to procure that it be done and words placing a Voting Member under a restriction include an obligation not to permit or allow so far as the same is possible infringement of that restriction.

23.2 Where any Voting Member is required under this Agreement to exercise its powers in relation to the Company to procure a particular matter or thing, such obligation shall be deemed to include an obligation to procure that any Director appointed by it shall procure such matter or thing, subject to the Director acting in accordance with his duties to the Company.

24 ENTIRE AGREEMENT

This Agreement and the Articles constitute the entire contractual relationship between the Voting Members in relation thereto and there are no representations, promises, terms, conditions or obligations between the Voting Members other than those contained or expressly referred to therein. This clause does not restrict liability of any Voting Member arising as a result of any fraud.

25 CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

This Agreement shall be binding on and enforceable by the Voting Members. The Voting Members do not intend that any of its terms will be enforceable by virtue of the Contracts (Rights of Third Parties) Act 1999 by any person not a party to it.

26 FURTHER ASSURANCE

Without prejudice to any other provision of this Agreement, each Voting Member and the Company shall promptly execute and deliver all such documents, and do all such things, as the Company or any other Voting Member may from time to time reasonably require for the purpose of giving full effect to the provisions of this Agreement.

27 COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which is an original and which together have the same effect as if each Voting Member had executed the same document.

28 GOVERNING LAW AND JURISDICTION

28.1 The formation, existence, construction, performance, validity and all aspects whatsoever of this Agreement or of any term of this Agreement will be governed by the law of England and Wales.

28.2 The courts of England and Wales will have exclusive jurisdiction to settle any dispute which arises out of or in connection with this Agreement. The Voting Members irrevocably agree to submit to that jurisdiction.

THIS AGREEMENT has been entered into by the Voting Members on the date stated at the beginning of this Agreement.

SCHEDULE 1 - VOTING MEMBERS

Voting Member	Designation	Principal address	Contact name / office
North Somerset CCG	Clinical Commissioning Group	PO Box 247 Castlewood Tickenham Road Clevedon BS21 9BH	Mary Backhouse Chief Clinical Officer
South Gloucestershire CCG	Clinical Commissioning Group	8 Brook Office Park Follybrook Road Bristol BS16 7FL	Jane Gibbs Chief Officer
Swindon CCG	Clinical Commissioning Group	Floor 3, David Murray John Building Brunel Centre Swindon SN1 1LH	Tony Ranzetta Accountable Officer
Wiltshire CCG	Clinical Commissioning Group	Wiltshire CCG Southgate House Pans Lane Devizes SN10 5EQ	Deborah Fielding Chief Officer
Gloucestershire CCG	Clinical Commissioning Group	c/o Chief Executive Office NHS Gloucestershire 5220 Valiant Court Sanger House Gloucester Business Park Gloucester GL3 4FE	Mary Hutton Accountable Officer
Bristol CCG	Clinical Commissioning Group	Fifth Floor, South Plaza Marlborough Street Bristol BS1 3NX	Jill Shepherd Chief Officer
Bath and North East Somerset CCG	Clinical Commissioning Group	St Martins Hospital Clara Cross Lane Bath BA2 5RP	Ian Orpen Chair
University of Bristol	University	Pro-Vice Chancellor's Office, Senate House Tyndall Avenue Bristol BS8 1TH	Guy Orpen Pro-Vice Chancellor
University of the West of England	University	Coldharbour Lane Frenchay Bristol BS16 1QY	Steve West Vice-Chancellor
University of Bath	University	Vice-Chancellor's Office Bath BA2 7AY	Jane Millar Pro-Vice Chancellor
South West Ambulance Service NHSFT	Provider of NHS Services	Westcountry House Abbey Court, Eagle Way Sowton Business Estate Exeter EX2 7HY	Ken Wenman Chief Executive
North Bristol NHS Trust	Provider of NHS Services	Trust Headquarters Beckspool Road	Marie-Noelle Orzel

		Frenchay Bristol BS16 1JE	Chief Executive
University Hospitals Bristol NHSFT	Provider of NHS Services	Trust Headquarters Marlborough Street Bristol BS1 3NU	Robert Woolley Chief Executive
Gloucestershire Hospitals NHSFT	Provider of NHS Services	Trust Headquarters 1 College Lawn Cheltenham GL53 7AG	Frank Harsent Chief Executive
Great Western Hospital NHSFT	Provider of NHS Services	Marlborough Road Swindon SN3 6BB	Nerissa Vaughan Chief Executive
Royal United Hospital Bath NHS Trust	Provider of NHS Services	Combe Park Bath BA1 3NG	James Scott Chief Executive
Avon and Wiltshire Partnership Mental Health NHS Trust	Provider of NHS Services	Jenner House Langley Park Chippenham SN15 1GG	Iain Tulley Chief Executive Officer
Weston Area Health NHS Trust	Provider of NHS Services	Weston General Hospital Grange Road, Uphill Weston Super Mare BS23 4TQ	Nick Wood Chief Executive
2Gether Partnership NHSFT	Provider of NHS Services	Rikenel Montpellier Gloucester GL1 1LY	Shaun Clee Chief Executive
Gloucestershire Care Services NHS Trust	Provider of NHS Services	Edward Jenner Court 1010 Pioneer Avenue Gloucester Business Park Brockworth GL3 4AW	Penny Harris Chief Executive
Representative Community Interest Company	Provider of NHS Services	TBC	TBC

SCHEDULE 2 - INITIAL BOARD

Name of Director	Designation (if any)	Alternate
	Independent Chair	
	Vice Chair	
	Managing Director	
	Representative of NHS Provider Organisation Voting Members	
	Representative of NHS Provider Organisation Voting Members	
	Representative of NHS Provider Organisation Voting Members	
	Representative of CCG Voting Members	
	Representative of CCG Voting Members	
	Representative of University Voting Member	
	Representative of PPI Advisory Group	
	Representative of PPI Advisory Group	
	CLAHRC Director	
	HESW Director	
	NIHR Director	

SCHEDULE 3 - DEED OF ADHERENCE

THIS DEED is made on 20[●] by [● full name of party, registered / principal office details and company number, if applicable] (the **New Voting Member**)

This Deed is supplemental to a Voting Members' Agreement dated [● date] (the **Agreement**). Expressions defined in the Agreement have the same meanings when used in this Deed, unless inconsistent with the context.

The New Voting Member confirms that it has been supplied with a copy of the Agreement and undertakes with each of the Voting Members on the date hereof (the **Effective Date**) that, on and from the Effective Date the New Voting Member shall observe, perform and be bound by the provisions of the Agreement that contain obligations on Voting Members as though the New Voting Member was an original party to the Agreement.

The formation, existence, construction, performance, validity and all aspects whatsoever of this Deed, or of any term of this Deed, are governed by the law of England and Wales. The courts of England and Wales will have exclusive jurisdiction to settle any dispute which arises out of or in connection with this Deed. The New Voting Member irrevocably agrees to submit to that jurisdiction.

This document has been executed as a deed and is delivered and takes effect on the date stated at the beginning of it.

[● Insert appropriate execution block]

SCHEDULE 4 – ARTICLES

Signed for and on behalf of
North Somerset CCG ……

Print name ……

Position ……

Signed for and on behalf of
South Gloucestershire CCG ……

Print name ……

Position ……

Signed for and on behalf of
Swindon CCG ……

Print name ……

Position ……

Signed for and on behalf of
Wiltshire CCG ……

Print name ……

Position ……

Signed for and on behalf of
Gloucestershire CCG ……

Print name ……

Position ……

Signed for and on behalf of
Bristol CCG ……

Print name ……

Position ……

Signed for and on behalf of
WEST OF ENGLAND AHSN LIMITED .....

Print name .....

Position .....

Signed for and on behalf of
Bath and North East Somerset CCG .....

Print name .....

Position .....

Signed for and on behalf of
University of Bristol .....

Print name .....

Position .....

Signed for and on behalf of
University of the West of England .....

Print name .....

Position .....

Signed for and on behalf of
University of Bath .....

Print name .....

Position .....

Signed for and on behalf of
South West Ambulance Service NHSFT .....

Print name .....

Position .....

Signed for and on behalf of
North Bristol NHS Trust ……

Print name ……

Position ……

Signed for and on behalf of
University Hospitals Bristol NHSFT ……

Print name ……

Position ……

Signed for and on behalf of
Gloucestershire Hospitals NHSFT ……

Print name ……

Position ……

Signed for and on behalf of
Great Western Hospital NHSFT ……

Print name ……

Position ……

Signed for and on behalf of
Royal United Hospital Bath NHS Trust ……

Print name ……

Position ……

Signed for and on behalf of
Avon and Wiltshire Partnership Mental Health NHS Trust ……

Print name ……

Position ……

Signed for and on behalf of
Weston Area Health NHS Trust .....

Print name .....

Position .....

Signed for and on behalf of
2Gether Partnership NHSFT .....

Print name .....

Position .....

Signed for and on behalf of
Gloucestershire Care Services NHS Trust .....

Print name .....

Position .....

Signed for and on behalf of
[ ] .....

Print name .....

Position .....

ARTICLES OF ASSOCIATION

OF

WEST OF ENGLAND AHSN LIMITED

Contents

PRIVATE COMPANY LIMITED BY GUARANTEE

ARTICLES OF ASSOCIATION

OF

WEST OF ENGLAND AHSN LIMITED

1 INTRODUCTORY PROVISIONS

1.1 Exclusion of model or other regulations

Neither:

1.1.1 the model articles for private companies limited by guarantee contained in Schedule 2 of the Companies (Model Articles) Regulations 2008 (SI 2009/3229); nor

1.1.2 any other regulations or model articles contained in any statute or subordinate legislation

shall apply to the Company, but the following shall be the articles of association of the Company.

1.2 Definitions

In these Articles, unless the context requires otherwise, the following words and expressions shall have the following meanings:

address has the meaning given in section 1148 of the Companies Act 2006

Articles means the Company's articles of association and a reference to a numbered **Article** is a reference to a provision of these Articles

bankruptcy includes individual insolvency proceedings in a jurisdiction other than England and Wales which have an effect similar to that of bankruptcy

Board means the Directors, or such of those Directors present at a duly convened meeting of the Directors at which a quorum is present in accordance with the Articles

Business Day means any day (other than a Saturday, Sunday or bank or public holiday in England)

Chair has the meaning given in Article 3.6 (*Chairing Board meetings*)

chair of the meeting has the meaning given in Article 11.5 (*Chairing general meetings*)

clear days, in relation to a notice, excludes the day the notice is deemed under these Articles to be given and the day on which the specified period expires

Companies Acts means the Companies Acts (as defined in section 2 of the Companies Act 2006), in so far as they apply to the Company

Company means the company which is the subject of these Articles or the members in general meeting, as the context may require

Director means a director of the Company including any person occupying the position of director, by whatever name called

document includes, unless otherwise specified, any document sent or supplied in electronic form

electronic form has the meaning given in section 1168 of the Companies Act 2006

eligible Director has the meaning given in Article 3.2 (*Unanimous decisions*)

general meeting means a formal meeting of the members convened in accordance with these Articles and the Companies Act 2006

hard copy form has the meaning given in section 1168 of the Companies Act 2006

instrument means a document in hard copy form

member has the meaning given in section 112 of the Companies Act 2006

ordinary resolution has the meaning given in section 282 of the Companies Act 2006

participate, in relation to a Board meeting, has the meaning given in Article 3.4 (*Participation in Board meetings*)

proxy notice has the meaning given in Article 12.1 (*Content of proxy notices*)

Relevant Agreement means any agreement in force from time to time regulating the business and affairs of the Company

special resolution has the meaning given in section 283 of the Companies Act 2006

writing means the representation or reproduction of words, symbols or other information in a visible form by any method or combination of methods, whether sent or supplied in electronic form or otherwise

1.3 Interpretation

1.3.1 **Subsidiary undertaking** and **parent undertaking** shall have the meanings given to those words in section 1162 of the Companies Act 2006, provided that for the purposes only of the membership requirement contained in sections 1162(1)(b) and (d) of that Act, an undertaking shall be treated as a member of another undertaking even if its shares or capital interests in that other undertaking are registered in the name of (i) another person or its nominee, by way of security or in connection with the taking of security, or (ii) its nominee.

1.3.2 Unless the context requires otherwise, other words or expressions defined in the Companies Act 2006 shall bear the same meanings when used in these Articles.

1.3.3 Except where the contrary is stated or the context requires otherwise, any reference in these Articles to a statute or statutory provision includes any order, regulation, instrument or other subordinate legislation made under it for the time being in force, and any reference to a statute, statutory provision, order, regulation, instrument or other subordinate legislation includes any amendment, extension, consolidation, re-enactment or replacement of it for the time being in force.

1.3.4 Words importing the singular number only include the plural and vice versa. Words importing the masculine gender include the feminine and neuter gender. Words importing persons include corporations.

1.4 **Liability of members is limited**

The liability of each member is limited to £1, being the amount that each member undertakes to contribute to the assets of the Company in the event of the Company being wound up while he is a member or within one year after he ceases to be a member, for:

1.4.1 payment of the Company's debts and liabilities contracted before he ceases to be a member;

1.4.2 payment of the costs, charges and expenses of winding up; and

1.4.3 adjustment of the rights of the contributories among themselves.

2 GOVERNANCE AND MANAGEMENT

2.1 **Board's general authority to manage the Company's business**

Subject to these Articles and any power reserved to the members pursuant to the Companies Act 2006, the Board is responsible for the management of the Company's business, for which purpose they may exercise all the powers of the Company. No alteration of these Articles invalidates anything which the Board has done before the alteration was made.

2.2 **Members' reserve power to direct the Board**

The members may by special resolution direct the Board to take, or refrain from taking, specified action. No such special resolution invalidates anything which the Board has done before the passing of the resolution.

2.3 **Board's power to delegate**

2.3.1 Subject to these Articles, the Board may delegate any of the powers which are conferred on it under these Articles:

(a) to such person (whether a Director or not) or committee;

(b) by such means (including by power of attorney);

(c) to such an extent;

(d) in relation to such matters or territories; and

(e) on such terms and conditions

as it thinks fit. The power to delegate shall be effective in relation to the powers, authorities and discretions of the Board generally and shall not be limited by the fact that in certain of these Articles, but not in others, express reference is made to particular powers, authorities or discretions being exercised by the Board or by a committee authorised by the Board.

2.3.2 If the Board so specifies, any such delegation may authorise further delegation of the Board's powers by any person to whom they are delegated.

2.3.3 The Directors may revoke any delegation in whole or part, or alter its terms and conditions.

2.4 **Committees**

2.4.1 Committees to which the Board delegates any of its powers must follow procedures which are based as far as they are applicable on those provisions of these Articles which govern the taking of decisions by the Board.

2.4.2 A member of a committee need not be a Director.

2.4.3 In accordance with Article 18 (*Rules*), the Board may make rules of procedure for all or any committees, which prevail over rules derived from these Articles if they are not consistent with them.

3 DIRECTORS' DECISION-MAKING

3.1 **Directors to take decisions collectively**

3.1.1 The general rule about decision-making by Directors is that any decision of the Board must be either a decision taken by two thirds of the eligible Directors at a meeting or a decision taken in accordance with Article 3.2.

3.1.2 If:

(a) the Company only has one Director; and

(b) no provision of these Articles requires it to have more than one Director,

the general rule does not apply, and the Director (for so long as he remains the sole Director) may take decisions without regard to any of the provisions of these Articles relating to Directors' decision-making.

3.2 **Unanimous decisions**

3.2.1 A decision of the Board is taken in accordance with this Article 3.2 when all eligible Directors indicate to each other by any means that they share a common view on a matter.

3.2.2 Such a decision may take the form of a resolution in writing, signed by each eligible Director (whether or not each signs the same document) or to which each eligible Director has otherwise indicated agreement in writing.

3.2.3 References in these Articles to **eligible Directors** are to Directors who would have been entitled to vote on the matter had it been proposed as a resolution at a Board meeting (but excluding any Director whose vote is not to be counted in respect of that particular matter).

3.2.4 A decision may not be taken in accordance with this Article 3.2 if the eligible Directors would not have formed a quorum at such a meeting.

3.3 **Calling a Board meeting**

3.3.1 Any Director may call a Board meeting by giving notice of the meeting to the Directors or by authorising the company secretary (if any) to give such notice.

3.3.2 Except as set out in Article 3.3.3, notice of any Board meeting must be given in writing to each Director and indicate:

(a) its proposed date and time;

(b) where it is to take place; and

(c) if it is anticipated that Directors participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

3.3.3 Notice of a Board meeting need not be given to a Director who:

(a) is absent from the United Kingdom on the date on which such notice is given if that Director has not furnished the Company with an address for sending or receiving documents or information by electronic means to or from that Director outside the United Kingdom; or

(b) waives his entitlement to notice of that meeting, by giving notice to that effect to the Company either before or after (but in any event not more than seven days after) the date on which the meeting is held. Where such notice is given by the relevant Director after the meeting has been held, that does not affect the validity of the meeting, or of any business conducted at it

3.4 **Participation in Board meetings**

3.4.1 Subject to these Articles, Directors **participate** in a Board meeting, or part of a Board meeting, when:

(a) the meeting has been called and takes place in accordance with these Articles; and

(b) they can each communicate to the others any information or opinions they have on any particular item of the business of the meeting.

3.4.2 In determining whether Directors are participating in a Board meeting, it is irrelevant where any Director is or how they communicate with each other.

3.4.3 If all the Directors participating in a meeting are not in the same place, they may decide that the meeting is to be treated as taking place wherever any of them is. For the avoidance of doubt, a meeting of the Board may be conducted via telephone, video conference or other medium as agreed by the Board.

3.5 **Quorum for Board meetings**

3.5.1 At a Board meeting, unless a quorum is participating, no proposal is to be voted on, except a proposal to call another meeting.

3.5.2 The quorum for Board meetings may be fixed from time to time by a decision of the Board and, unless otherwise fixed or Article 3.5.3 applies, the quorum shall be [four].

3.5.3

(a) If and so long as there is only one Director the quorum for that meeting shall be one.

(b) For the purposes of any meeting held pursuant to Article 7.1 (*Conflict situations*) (or part of a meeting where it is proposed) to authorise a Director's conflict, if there is only one Director besides the Director concerned and Directors with a similar interest, the quorum for that meeting (or the relevant part) shall be one.

3.5.4 If the total number of Directors for the time being is less than the quorum required, the Board must not take any decision other than a decision:

(a) to appoint further Directors; or

(b) to call a general meeting so as to enable the members to appoint further Directors.

3.6 **Chairing Board meetings**

3.6.1 Board meetings shall be chaired by:

(a) the independent chairperson (if any); or

(b) if there is no independent chairperson holding office at the time of the meeting, or he or she is unwilling or unable to chair the meeting, or is not participating in a Board meeting within ten minutes of the time at which it was to start, the vice chairperson (if any) shall chair the meeting; or

(c) if there is neither an independent chairperson nor a vice chairperson holding office at the time of the meeting, or there is an independent chairperson and vice chairperson holding office at the time of the meeting, but neither of them is willing or able to chair the meeting, or neither of them is participating in a Board meeting within ten minutes of the time at which it was to start, the participating Directors must appoint one of their number to chair it.

3.6.2 The person chairing the Board meeting is known as the **Chair**.

3.7 **Records of decisions to be kept**

The Directors must ensure that the Company keeps a record, in hard copy form, for at least 10 years from the date of the decision recorded, of every unanimous or majority decision taken by the Directors.

3.8 **Directors' discretion to make further rules**

In accordance with Article 18 (*Rules*), the Board may make any rule which they think fit about how they take decisions, and about how such rules are to be recorded or communicated to Directors.

4 THE BOARD

4.1 **Number of Directors**

The Directors shall not, unless otherwise determined by an ordinary resolution of the members, be less than two or more than fourteen.

4.2 **Directors need not be members**

A Director need not be a member of the Company.

5 APPOINTMENT OF DIRECTORS

5.1 **Power to appoint specific Directors**

5.1.1 Where a Relevant Agreement provides for the appointment of Directors, Directors shall be appointed in accordance with that agreement and these Articles.

5.1.2 If Article 5.1.1 does not apply, the Board may appoint any person who is willing to act to be a Director, either to fill a vacancy or by way of addition to their number, but so that the total number of Directors appointed in this manner shall not (when aggregated with all other Directors then in office) exceed any maximum number fixed by or in accordance with these Articles.

5.2 **Company's residual power to appoint Directors**

In any case where, as a result of death or bankruptcy, the Company has no members and no Directors, the personal representatives of the last member to have died or to have a bankruptcy order made against him has the right, by notice in writing, to appoint a person to be a Director. For the purposes of this Article 5.2, where two or more members die in circumstances rendering it uncertain who was the last to die, a younger member is deemed to have survived an older member.

6 VACATION OF OFFICE OF DIRECTOR

6.1 **Grounds for vacation of office**

The office of a Director shall be vacated if:

6.1.1 where a Director has been appointed pursuant to the terms of a Relevant Agreement, the person(s) entitled to remove that Director:

(a) so remove him in accordance with those terms; or

(b) is/are no longer a party or parties, as the case may be, to the Relevant Agreement (provided that if the Director concerned has been appointed by more than one such person and 50% or more (rounded up) of the persons originally appointing that Director continue to be parties to the Relevant Agreement, then that Director shall not be required to vacate office); or

6.1.2 that person ceases to be a Director by virtue of any provision of the Companies Act 2006 or is prohibited from being a Director by law;

6.1.3 a bankruptcy order is made against that person and/or a composition is made with that person's creditors generally in satisfaction of that person's debts;

6.1.4 a registered medical practitioner who is treating that person gives a written opinion to the Company stating that the person has become physically or mentally incapable of acting as a Director (and may remain so for more than three months);

6.1.5 by reason of that person's mental health, a court makes an order which wholly or partly prevents that person from personally exercising any powers or rights which that person would otherwise have;

6.1.6 notification is received by the Company from the Director that the Director is resigning from office, and such resignation has taken effect in accordance with its terms;

6.1.7 that person has for more than six consecutive months been absent without permission of the Board from Board meetings held during that period and the Board resolves that the person should cease to be a Director; or

6.1.8 he is removed from office by a majority of three quarters of the Board present and voting.

6.2 **No prejudice to agreement between the removed Director and the Company**

Any removal of a Director under Article 6.1 shall be without prejudice to any claim which that Director may have for damages for breach of any agreement between him and the Company.

7 DIRECTORS' DUTIES AND INTERESTS

7.1 **Conflict situations**

7.1.1 In accordance with section 175 of the Companies Act 2006, a Director must avoid a situation in which he has, or can have, a direct or indirect interest that conflicts, or

possibly may conflict, with the interests of the Company (a **conflict situation**). This applies in particular to the exploitation of any property, information or opportunity (and it is immaterial whether the Company could take advantage of the property, information or opportunity).

7.1.2 However, this duty:

(a) does not apply to a conflict of interest arising in relation to a transaction or arrangement with the Company; and

(b) is not infringed:

(i) if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

(ii) if the matter has been authorised by the Board.

7.1.3 For authorisation of a conflict situation by the Board to be effective:

(a) the matter in question must have been proposed in writing for consideration at a Board meeting in line with the normal procedures for such meetings or in any other way the Board may decide;

(b) any quorum requirement at the Board meeting when the matter is considered must be met without counting any Directors who are or could be subject to the conflict situation (**Interested Directors**); and

(c) the matter must be agreed without the Interested Directors voting, or would have been agreed if the votes of the Interested Directors had not been counted.

7.1.4 Any conflict situation authorised under this Article 7.1 will include any existing or potential conflict of interest which it is reasonable to expect will arise out of the authorised matter.

7.1.5 Any authorisation of a conflict situation under this Article 7.1 will be subject to any conditions or limitations that the Board (other than the Interested Directors) decide. The Board (other than the Interested Directors) can decide the conditions or limitations at the time authorisation is given, or later on, and can end them at any time. A Director must comply with any obligations imposed on him after a conflict situation has been authorised.

7.1.6 A Director does not have to hand over to the Company any benefit he receives (or a person connected with him receives) as a result of any conflict situation authorised under this Article 7.1. No contract, transaction or arrangement of the type described in this Article 7.1 can be set aside because of any Director's interest or benefit.

7.1.7 Notwithstanding any other provision of these Articles, any Director who is also a director, other officer or employee of:

(a) a member or any of its subsidiary undertakings; or

(b) any person (other than a member) who by virtue of a Relevant Agreement is entitled (whether on its own or jointly) to appoint a Director,

and who has a conflict situation merely by virtue of holding such office, shall be deemed to have declared the conflict situation and been authorised for the purposes of section 175 of the Companies Act 2006 and these Articles in respect of the conflict situation.

7.2 **Directors may have certain interests**

7.2.1 In this Article 7.2, each of the following is a **Relevant Entity**:

(a) the Company;

(b) a subsidiary undertaking of the Company;

(c) any parent undertaking of the Company or a subsidiary undertaking of any such parent undertaking;

(d) any undertaking promoted by the Company;

(e) any undertaking in which the Company is interested;

(f) a member;

(g) any subsidiary undertaking of a member;

(h) any person (other than a member) who by virtue of a Relevant Agreement is entitled (whether on its own or jointly) to appoint a Director; and

(i) any subsidiary undertaking of a person referred to in limb (h) above.

7.2.2 Subject to complying with Article 7.2.3, a Director can have the following interests:

(a) a Director (or a person connected with him) can be a director, officer or employee of, or have an interest (including holding shares) in any Relevant Entity.

(b) a Director (or a person connected with him) can have an interest in any Relevant Entity which the Company also has an interest in, or be a party to a contract with that Relevant Entity.

(c) a Director (or a person connected with him, or any firm the Director is a partner, employee or shareholder of) can do professional work for any Relevant Entity (other than as an auditor) whether or not they are paid for the work.

(d) a Director can have an interest if it is unreasonable to expect that it will result in a conflict of interest.

(e) a Director can have an interest, transaction or arrangement which may result in another interest which they do not know about.

(f) a Director may have an interest in any conflict situation authorised under 7.1 (*Conflict situations*).

(g) a Director may have any other interest authorised by ordinary resolution.

No further authorisation under Article 7.1 (*Conflict situations*) is required for any interests under this Article 7.2.

7.2.3 Unless Article 7.2.4 applies, the Director concerned must declare the nature and extent of any interest allowed under Article 7.2.2. The Director must do this at a Board meeting or by sending notice to other Directors in a manner permitted by these Articles. If the Director:

(a) has an interest in a Relevant Entity (other than the Company) and is interested in any transaction or arrangement with the Company; or

(b) is connected with a person and is interested in a transaction with that person,

they must declare the nature and extent of any interest and give such notice at the Board meeting.

7.2.4 A Director does not need to declare an interest:

(a) falling within Article 7.2.2(d), Article 7.2.1(e) or Article 7.2.1(f);

(b) if the other Directors already know about the interest (and for this purpose the other Directors will be treated as knowing about the interest if it is reasonable to expect they know about it); or

(c) if the interest concerns the terms of their service contract (as defined in section 227 of the Companies Act 2006) that have been or are to be considered at a Board meeting or at a meeting of a committee of the Board appointed under these Articles to consider the terms.

7.2.5 A Director does not have to hand over to the Company any benefit he or she (or a person connected with them) receives:

(a) from any contract or employment with, or interest in, any Relevant Entity; or

(b) for any payment as referred to in Article 8 (*Directors' remuneration and expenses*).

No contract, transaction or arrangement of the type described above can be set aside because of any Director's interest or benefit.

7.3 **Determining whether a Director has the right to participate for quorum and voting purposes**

7.3.1 Subject to Article 7.3.2, if a question arises at a Board meeting or of a committee of Directors as to the right of a Director to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting, be referred to the Chair, whose ruling in relation to any Director other than the Chair is to be final and conclusive.

7.3.2 If any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the Chair, the question is to be decided by a decision of the Directors at that meeting, for which purpose the Chair is not to be counted as participating in the meeting (or that part of the meeting) for voting or quorum purposes.

7.4 **Confidentiality**

7.4.1 Subject to Article 7.1 (*Conflict situations*), if a Director receives information for which he owes a duty of confidentiality to a person other than the Company, and he does not receive the information because of his position as a Director, he will not be required to:

(a) disclose the confidential information to the Board, or to any of the Directors or other officers or employees of the Company; or

(b) use or apply the confidential information in any other way in connection with their duties as a Director.

7.4.2 A duty of confidentiality may arise when a Director is, or could be subject to a conflict situation (as defined in Article 7.1.1). This Article 7.4 will apply only if the conflict situation arises out of a matter which has been authorised under Article 7.1 (*Conflict situations*) or falls within Article 7.2 (*Directors may have certain interests*).

7.4.3 This Article 7.4 does not affect any equitable principle (rules of fairness) or rule of law which may excuse or release the Director from disclosing information, in circumstances where disclosure may otherwise be required under this Article 7.4.

8 DIRECTORS' REMUNERATION AND EXPENSES

8.1 Directors' remuneration

8.1.1 Directors may undertake any services for the Company that the Board decides.

8.1.2 Directors are entitled to such remuneration as the Board determines for their services to the Company as Directors and any other service which they undertake for the Company.

8.1.3 Subject to these Articles, a Director's remuneration may take any form and include any arrangements in connection with the payment of a pension, allowance or gratuity, or any death, sickness or disability benefits, to or in respect of that Director.

8.1.4 Unless the Board decides otherwise, Directors' remuneration accrues from day to day.

8.1.5 Unless the Board decides otherwise, Directors are not accountable to the Company for any remuneration which they receive as Directors or other officers or employees of the Company's subsidiary undertakings or of any other undertakings in which the Company is interested and the receipt of such benefit shall not disqualify any person from being a Director of the Company.

8.2 Directors' expenses

The Company may pay any reasonable expenses which the Directors (and the alternate Directors and the company secretary (if any)) properly incur in connection with their attendance at:

8.2.1 meetings of Directors or committees of Directors,

8.2.2 general meetings, or

8.2.3 separate meetings of the holders of debentures of the Company,

or otherwise in connection with the exercise of their powers and the discharge of their responsibilities in relation to the Company, in accordance with any rules established by the Board from time to time.

9 NOT USED

10 BECOMING AND CEASING TO BE A MEMBER

10.1 Applications for membership

No person shall become a member of the Company unless:

10.1.1 that person has completed an application for membership in a form approved by the Board; and

10.1.2 the Board has approved the application.

The Board shall have an absolute discretion in determining whether to accept or reject any application for membership and shall not be bound to assign any reason for their decision.

10.2 Termination of membership

10.2.1 A member may only withdraw from membership of the Company by agreement with the consent of the majority of two thirds of the remaining members.

10.2.2 A member's membership terminates when that member ceases to exist.

10.2.3 Membership is not transferable.

10.3 **Board's power to establish different classes of membership**

The Board may establish different classes of membership and prescribe their respective privileges and duties in accordance with Article 18 (*Rules*).

10.4 **Membership fees**

The Board may from time to time prescribe fees for different classes of membership.

11 GENERAL MEETINGS

11.1 **Calling general meetings**

11.1.1 Subject to Articles 11.1.2 and 11.1.3, the Board *may* at any time call:

(a) a general meeting called for the passing of a special resolution on not less than 21 clear days' notice; or

(b) any other general meeting on not less than 14 clear days' notice,

unless 90% of the members having a right to attend and vote at the general meeting agree that the general meeting in question can be called on shorter notice, in which case, that general meeting may be called on that shorter period of notice.

11.1.2 Subject to Article 11.1.3, the Board *shall* call a general meeting on not less than 28 days' notice within 21 days of receiving requests to do so from at least the required percentage of members in accordance with the Companies Act 2006. For these purposes, the required percentage is members who represent at least 5% of the total voting rights of all the members having a right to vote at general meetings.

11.1.3 Where "special notice" is required for the purposes of a resolution to remove a Director pursuant to the Companies Act 2006 or to appoint somebody instead of a Director so removed at the meeting at which he is removed, at least 28 days' notice must be given prior to the date of the meeting at which the resolution is to be moved, otherwise the resolution is not effective.

11.2 **Notice of general meeting**

11.2.1 Notice of a general meeting shall be given in hard copy form, in electronic form or by means of a website, provided that the Company complies with any requirements relating to the giving of notice laid down in the Companies Act 2006.

11.2.2 Notice of a general meeting shall be sent to every member, every Director and any other person required by law to be sent such notice.

11.2.3 Notice of a general meeting shall:

(a) state the time, date and place of the meeting;

(b) specify the general nature of the business to be dealt with at the meeting and set out the text of any special resolution to be voted upon at the meeting; and

(c) be accompanied by a proxy form.

11.2.4 The accidental omission to give notice of a general meeting to, or the non-receipt of notice by, any person entitled to receive the notice; or a technical defect in the timing or manner of giving such notice of which the Board is unaware shall not invalidate the proceedings of that meeting.

11.3 **Attendance and speaking at general meetings**

11.3.1 A person is able to exercise the right to speak at a general meeting when that person is in a position to communicate to all those attending the meeting, at any time during the meeting, any information or opinions which that person has on the business of the meeting.

11.3.2 A person is able to exercise the right to vote at a general meeting when:

(a) that person is able to vote, at any time during the meeting, on resolutions put to the vote at the meeting; and

(b) that person's vote can be taken into account in determining whether or not such resolutions are passed at the same time as the votes of all the other persons attending the meeting.

11.3.3 The Directors may make whatever arrangements they consider appropriate to enable those attending a general meeting to exercise their rights to speak or vote at it.

11.3.4 In determining attendance at a general meeting, it is immaterial whether any two or more members attending it are in the same place as each other.

11.3.5 Two or more persons who are not in the same place as each other attend a general meeting if their circumstances are such that if they have (or were to have) rights to speak and vote at that meeting, they are (or would be) able to exercise them.

11.4 **Quorum for general meetings**

No business other than the appointment of the chair of the meeting is to be transacted at a general meeting if the persons attending it do not constitute a quorum. One half of the members for the time being (rounded up if this is not a whole number) present in person, by proxy or by a duly authorised representative and entitled to vote at general meetings shall constitute a quorum.

11.5 **Chairing general meetings**

11.5.1 If the Board has appointed a Chair, the Chair shall chair general meetings if present and willing to do so.

11.5.2 If the Board has not appointed a Chair, or if the Chair is unwilling to chair the general meeting or is not present within ten minutes of the time at which a meeting was due to start:

(a) the Directors present; or

(b) (if no Directors are present), the members present,

must appoint one of those present to chair the meeting, and the appointment of the chair of the meeting must be the first business of the meeting.

11.5.3 The person chairing a general meeting in accordance with this Article 11.5 is referred to as the **chair of the meeting**.

11.6 **Attendance and speaking by Directors and non-members**

Directors may attend and speak at general meetings, whether or not they are members. The chair of the meeting may also permit other persons who are not members of the Company to attend and speak at that meeting.

11.7 **Adjournment**

11.7.1 If the persons attending a general meeting within half an hour of the time at which the meeting was due to start do not constitute a quorum, or if at any time during a meeting a quorum ceases to be present, if the meeting was convened by the members, the meeting shall be dissolved and, in any other case, the chair of the meeting *must* adjourn it.

11.7.2 The chair of the meeting *must* adjourn a general meeting if directed to do so by the meeting.

11.7.3 The chair of the meeting *may* adjourn a general meeting at which a quorum is present if:

(a) the meeting consents to an adjournment, or

(b) it appears to the chair of the meeting that an adjournment is necessary to protect the safety of any person attending the meeting or ensure that the business of the meeting is conducted in an orderly manner.

11.7.4 When adjourning a general meeting, the chair of the meeting must:

(a) either specify the time and place to which it is adjourned or state that it is to continue at a time and place to be fixed by the Board; and

(b) have regard to any directions as to the time and place of any adjournment which have been given by the meeting.

11.7.5 If the continuation of an adjourned meeting is to take place more than 14 days after it was adjourned, the Company must give at least seven clear days' notice of it:

(a) to the same persons to whom notice of the Company's general meetings is required to be given; and

(b) containing the same information which such notice is required to contain.

11.7.6 No business may be transacted at an adjourned general meeting which could not properly have been transacted at the meeting if the adjournment had not taken place.

11.8 **Voting**

11.8.1 Notwithstanding the different classes of membership which may be in existence from time to time, for the purposes of any vote, all members present and entitled to vote at a general meeting shall be counted pari passu as one class for the purposes of that vote.

11.8.2 A resolution put to the vote of a general meeting must be decided on a show of hands unless a poll is duly demanded in accordance with these Articles.

11.8.3 A poll on a resolution may be demanded:

(a) in advance of the general meeting where it is to be put to the vote, or

(b) at a general meeting, either before a show of hands on that resolution or immediately after the result of a show of hands on that resolution is declared.

11.8.4 A poll may be demanded by:

(a) the chair of the meeting;

(b) the Directors;

(c) two or more persons having the right to vote on the resolution; or

(d) a person or persons representing not less than one tenth of the total voting rights of all the members having the right to vote on the resolution.

11.8.5 A demand for a poll may be withdrawn if the poll has not yet been taken and the chair of the meeting consents to the withdrawal. A demand so withdrawn shall not be taken to have invalidated the result of a show of hands declared before the demand was made.

11.8.6 Polls must be taken immediately and in such manner as the chair of the meeting directs.

11.9 **Errors and disputes**

No objection may be raised to the qualification of any person voting at a general meeting except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote not disallowed at the meeting is valid. Any such objection must be referred to the chair of the meeting whose decision is final.

11.10 **Amendments to resolutions**

11.10.1 An ordinary resolution to be proposed at a general meeting may be amended by ordinary resolution if:

(a) notice of the proposed amendment is given to the Company in writing by a person entitled to vote at the general meeting at which it is to be proposed not less than 48 hours before the meeting is to take place (or such later time as the chair of the meeting may determine), and

(b) the proposed amendment does not, in the reasonable opinion of the chair of the meeting, materially alter the scope of the resolution.

11.10.2 A special resolution to be proposed at a general meeting may be amended by ordinary resolution, if:

(a) the chair of the meeting proposes the amendment at the general meeting at which the resolution is to be proposed, and

(b) the amendment does not go beyond what is necessary to correct a grammatical or other non-substantive error in the resolution.

11.10.3 If the chair of the meeting, acting in good faith, wrongly decides that an amendment to a resolution is out of order, the chair's error does not invalidate the vote on that resolution.

12 PROXIES

12.1 **Content of proxy notices**

12.1.1 Proxies may only be validly appointed by a notice in writing (a **"proxy notice**") which:

(a) states the name and address of the member appointing the proxy;

(b) identifies the person appointed to be that member's proxy and the general meeting in relation to which that person is appointed;

(c) is signed by or on behalf of the member appointing the proxy, or is authenticated in such manner as the Board may determine; and

(d) is delivered to the Company in accordance with these Articles not less than 48 hours before the time appointed for holding the general meeting in relation to which

the proxy is appointed and in accordance with any instructions contained in the notice of the general meeting to which they relate (but notwithstanding the foregoing, an appointment of a proxy may be accepted by the Board, in its absolute discretion, at any time prior to the meeting at which the person named in the appointment proposes to vote (or, where a poll is demanded at the meeting, but not taken forthwith, at any time prior to the taking of the poll)).

12.1.2 The Company may require proxy notices to be delivered in a particular form and may specify different forms for different purposes.

12.1.3 Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions, but the Company shall not be obliged to ascertain that any proxy has complied with those or any other instructions given by the appointor and no decision on any resolution shall be vitiated by reason only that any proxy has not done so.

12.1.4 On a vote on a resolution on a show of hands or a poll at a meeting, every proxy present who has been duly appointed by one or more members entitled to vote on the resolution has one vote, except that if the proxy has been duly appointed by more than one member entitled to vote on the resolution and:

(a) has been instructed by one or more of those members to vote for the resolution and by one or more other of those members to vote against it; or

(b) has been instructed to vote the same way (either for or against) on the resolution by all of those members except those who have given the proxy discretion as to how to vote on the resolution,

the proxy is entitled to one vote for and one vote against the resolution.

12.1.5 Unless a proxy notice indicates otherwise, it must be treated as:

(a) allowing the person appointed under it as a proxy discretion as to how to vote on any ancillary or procedural resolutions put to the meeting, and

(b) appointing that person as a proxy in relation to any adjournment of the general meeting to which it relates as well as the meeting itself.

12.2 **Delivery of proxy notices**

12.2.1 A person who is entitled to attend, speak or vote (either on a show of hands or on a poll) at a general meeting remains so entitled in respect of that meeting or any adjournment of it, even though a valid proxy notice has been delivered to the Company by or on behalf of that person.

12.2.2 An appointment under a proxy notice may be revoked by delivering to the Company a notice in writing given by or on behalf of the person by whom or on whose behalf the proxy notice was given. A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

12.2.3 If a proxy notice is not executed by the person appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the appointor's behalf.

13 COMMUNICATIONS

13.1 Means of communication to be used

Subject to these Articles, any notice, document or other information (a **"communication**") sent or supplied by or to the Company under these Articles may be sent or supplied in any way in which the Companies Act 2006 provides for communications which are authorised or required by any provision of that Act to be sent or supplied by or to the Company.

13.2 Company not obliged to accept communications sent or supplied in electronic form

Except insofar as the Companies Acts require otherwise, the Company shall not be obliged to accept any communication sent or supplied to the Company in electronic form unless it satisfies such stipulations, conditions or restrictions (including, without limitation, for the purpose of authentication) as the Board thinks fit, and the Company shall be entitled to require any such communication to be sent or supplied in hard copy form instead.

13.3 Execution by members which are not natural persons

In the case of a member which is not a natural person, for all purposes, including the execution of any communication in hard copy form or electronic form which is executed or approved pursuant to any provision of these Articles, execution by any director or the company secretary of that member or any other person who appears to any officer of the Company (acting reasonably and in good faith) to have been duly authorised to execute shall be deemed to be and shall be accepted as execution by that member.

13.4 Member whose registered address is not within the United Kingdom

13.4.1 A member whose registered address is not within the United Kingdom and who notifies the Company of an address within the United Kingdom at which communications may be served on or delivered to him shall be entitled to have such things served on or delivered to him at that address (in the manner referred to in this Article 13), but otherwise no such member shall be entitled to receive any communication from the Company.

13.4.2 If the address supplied is that member's address for sending or receiving communications by electronic means the Company may at any time without prior notice (and whether or not the Company has previously sent or supplied any communications in electronic form to that address) refuse to send or supply any communications to that address.

13.5 Communications with Directors

13.5.1 Subject to these Articles, any communication to be sent or supplied to a Director in connection with the taking of decisions by Directors may also be sent or supplied by the means by which that Director has asked to be sent or supplied with such communications for the time being.

13.5.2 A Director may agree with the Company that communications sent to that Director in a particular way are to be deemed to have been received within a specified time of their being sent, and for the specified time to be less than 48 hours.

13.6 Timing of delivery of communication

13.6.1 Any communication sent or supplied by the Company shall be deemed to have been received by the intended recipient:

(a) where the communication is properly addressed and sent by first class post or other delivery service to an address in the United Kingdom, on the day (whether or not it is a Business Day) following the day (whether or not it is a Business Day) on which it was put in the post or given to the delivery agent. In proving that it was

duly sent, it shall be sufficient to prove that the communication was properly addressed, prepaid and put in the post or duly given to the delivery agent;

(b) where (without prejudice to Article 13.4) the communication is properly addressed and sent by post or other delivery service to an address outside the United Kingdom, five Business Days after it was put in the post or given to the delivery agent. In proving that it was duly sent, it shall be sufficient to prove that the communication was properly addressed, prepaid and put in the post or duly given to the delivery agent;

(c) where the communication is not sent by post or other delivery service but delivered personally or left at the intended recipient's address, on the day (whether or not a Business Day) and time that it was sent;

(d) where the communication is properly addressed and sent or supplied by electronic means, on the day (whether or not a Business Day) and time that it was sent. Proof that it was sent in accordance with guidance issued by the Institute of Chartered Secretaries and Administrators shall be conclusive evidence that it was sent;

(e) where the communication is sent or supplied by means of a website, when the material was first made available on the website or (if later) when the intended recipient received (or is deemed to have received) notice of the fact that the material was available on the website.

13.6.2 A technical defect in the timing or manner of giving of notice of which the Board is unaware at the time does not invalidate decisions taken at a meeting referred to in that notice.

13.6.3 Any communication sent or supplied to the Company shall be deemed to have been received only upon the date and at the time of actual receipt.

14 USE OF THE COMPANY SEAL AND CERTIFICATION OF DOCUMENTS

14.1 Company seal

14.1.1 Any common seal may only be used by the authority of the Board.

14.1.2 The Directors may decide by what means and in what form any common seal is to be used.

14.1.3 Unless otherwise decided by the Board, if the Company has a common seal and it is affixed to a document, the document must also be signed by at least one authorised person in the presence of a witness who attests the signature.

14.1.4 For the purposes of this Article 14.1, an authorised person is:

(a) any Director of the Company;

(b) the company secretary (if any); or

(c) any person authorised by the Board for the purpose of signing documents to which the common seal is applied.

14.2 Certification of documents

14.2.1 Any Director or the company secretary or any person appointed by the Board for the purpose shall have power to authenticate and certify as true copies of extracts from:

(a) any document comprising or affecting the constitution of the Company, whether in hard copy form or in electronic form;

(b) any resolution passed by the Company, the Board or any committee of the Board, whether in hard copy form or in electronic form; and

(c) any book, record and document relating to the business of the Company, whether in hard copy form or in electronic form (including, without limitation, the accounts).

14.2.2 If certified in this way, a document purporting to be a copy of a resolution, or the minutes of or an extract from the minutes of a meeting of the Company, the Board or a committee of the Board, whether in hard copy form or in electronic form, shall be conclusive evidence in favour of all persons dealing with the Company in reliance on it or them that the resolution was duly passed or that the minutes are, or the extract from the minutes is, a true and accurate record of proceedings at a duly constituted meeting.

15 PROVISION FOR EMPLOYEES ON CESSATION OF BUSINESS

The Board may decide to make provision for the benefit of persons employed or formerly employed by the Company or any of its subsidiary undertakings (other than a Director or former Director or shadow Director) in connection with the cessation or transfer to any person of the whole or part of the undertaking of the Company or that subsidiary undertaking.

16 COMPANY SECRETARY

Subject to the Companies Act 2006, the Board may appoint a company secretary (or two or more persons as joint secretary) for such term, at such remuneration and upon such conditions as the Board may think fit; and any company secretary (or joint secretary) so appointed may be removed by the Board. The Directors may also from time to time appoint on such terms as they think fit, and remove, one or more assistant or deputy secretaries.

17 DIRECTORS' INDEMNITY AND INSURANCE

17.1 Definitions

In this Article 17, the following words and expressions shall have the following meanings:

undertakings are **"associated"** if one is a subsidiary undertaking of the other or both are subsidiary undertakings of the same parent undertaking

relevant Director means any Director or former Director of the Company or an associated company

relevant loss means any loss or liability which has been or may be incurred by a relevant Director in connection with that Director's duties or powers in relation to the Company, any associated company or any pension fund or employees' share scheme of the Company or associated company

17.2 Indemnity

17.2.1 Subject to Article 17.2.2, a relevant Director of the Company or an associated company may be indemnified out of the Company's assets against:

(a) any liability incurred by that Director in connection with any negligence, default, breach of duty or breach of trust in relation to the Company or an associated company,

(b) any liability incurred by that Director in connection with the activities of the Company or an associated company in its capacity as a trustee of an occupational pension scheme (as defined in section 235(6) of the Companies Act 2006); and

(c) any other liability incurred by that Director as an officer of the Company or an associated company.

17.2.2 This Article 17.2 does not authorise any indemnity which would be prohibited or rendered void by any provision of the Companies Acts or by any other provision of law.

17.3 **Insurance**

The Directors may decide to purchase and maintain insurance, at the expense of the Company, for the benefit of any relevant Director in respect of any relevant loss.

18 RULES

18.1 **Board's power to make rules**

The Board may make such further rules as it considers necessary or convenient for the proper conduct and management of the Company and for the purposes of prescribing the classes of and conditions of membership. In particular, and without prejudice to the generality of the foregoing, the Board may make rules regulating:

18.1.1 the admission and classification of members of the Company, and the rights and privileges of such members, the conditions of membership and the terms on which members may resign or have their membership terminated and the entrance fees, subscriptions and other fees or payments to be made by members;

18.1.2 the conduct of members of the Company in relation to one another, and to the Company's officers and employees;

18.1.3 the setting aside of the whole or any part or parts of the Company's premises at any particular time or times or for any particular purpose or purposes;

18.1.4 the procedure at general meetings and Board meetings and committee meetings (in so far as such procedure is not governed by these Articles); and

18.1.5 any and all other matters as are commonly the subject matter of company rules.

18.2 **Board to bring rules to attention of members**

The Board must adopt such means as they consider sufficient to bring to the notice of members all rules made under Article 18.1.

18.3 **Status of rules**

18.3.1 Any rules made by the Board under Article 18.1 will be valid and binding as against all members for so long as such rules are in force.

18.3.2 The Company in general meeting may alter or repeal any rules made by the Board in accordance with Article 18.1.

18.3.3 Nothing in this Article 18 permits the Board to make any rules which are inconsistent with or affect or repeal anything in these Articles or in any resolution passed by members or agreement to which Chapter 3 of Part 3 of the Companies Act 2006 applies.

Appendix 3

Anticipated Voting Members

ORGANISATION
Providers of NHS Services
Avon and Wiltshire Mental Health Partnership NHS Foundation Trust
Gloucestershire Care Services NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
Royal United Hospital Bath NHS Foundation Trust
South West Ambulance Service NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust
2Gether Partnership NHS Foundation Trust
Representative of the CIC 'club'
Universities
University of Bath
University of Bristol
University of the West of England
Clinical Commissioning Groups
Bath and North East Somerset CCG
Bristol CCG
Gloucestershire CCG
North Somerset CCG
South Gloucestershire CCG
Swindon CCG
Wiltshire CCG

Bevan Brittan

West of England Academic Health Science Network

WEST OF ENGLAND ACADEMIC HEALTH SCIENCE NETWORK

FREQUENTLY ASKED QUESTIONS

Note – references to the **"Company"** are to the West of England AHSN

1 What are the objectives of the Company

1.1 The broad objective of the Company is to accelerate the spread of innovative, evidence-based practice to improve health and care quality. This will deliver economic benefits through increased regional investment, job creation, effective procurement and health improvement.

2 What corporate form will the Company take?

2.1 The Department of Health's guidance on AHSNs[1] states that each AHSN should be established as an incorporated body with a clear public interest. However there is no prescribed form of incorporated body and AHSN applicants are required to develop their own model, taking into account local needs.

2.2 West of England AHSN partners considered a number of potential corporate vehicles and decided that a **company limited by guarantee** (without charitable status) was the most appropriate vehicle for the Company.

3 What are the key elements of a company limited by guarantee?

Alternative to a company limited by shares

3.1 A company limited by guarantee is a common alternative corporate vehicle to a company limited by shares and is often used where the company's members (equivalent to shareholders in a company limited by shares) wish to incorporate a "not-for-profit" vehicle, or a vehicle

[1] https://www.wp.dh.gov.uk/health/files/2012/06/Academic-Health-Science-Networks-21062012-gw-17626-PDF-229K.pdf

where profit is not the principal driver of the company's business. Please note that this does not prohibit the extraction of profit – see question 16 below.

3.2 A company limited by guarantee has its own legal "personality" meaning that it may enter into contracts in its own name and be sued by and sue third parties in its own name.

3.3 A company limited by guarantee does not have a share capital. Instead, the members undertake to contribute a predetermined nominal sum (e.g. £1) to the liabilities of the company which becomes due in the event of the company being wound up (see question 5.2 below). This statement of guarantee must be provided on incorporation of the company.

3.4 A company limited by guarantee cannot be re-registered as a company limited by shares.

Governance structure

3.5 A company limited by guarantee has a governing structure of members and directors. Its governance arrangements are the same as for a company limited by shares.

Constitution

3.6 Like a company limited by shares, a company limited by guarantee is governed by its memorandum and articles of association. Sometimes a members' agreement is also entered into to further regulate the business and affairs of the company.

Regulator

3.7 A company limited by guarantee is subject to the regulation of Companies House.

4 Please can you clarify the terminology used for each party in the constitutional documentation?

4.1 **"Guarantors"**

The Guarantors are the members of the Company under the Companies Act 2006. Not all West of England partners can be Guarantors (for example, NHS Trusts will not be Guarantors). It is proposed that there are a small number of Guarantors representing each of the main "constituencies" of Voting Member (i.e. Foundation Trusts and Trusts, CICs, Universities and CCGs). As noted above, Guarantors will be liable for the nominal guaranteed sum in the event that the Company is wound up.

4.2 **"Voting Members"**

The Voting Members will be the West of England partner organisations which intend to participate in and direct the Company's business.

The rights and obligations of these partner organisations will be set out in the Voting Members' Agreement. The Voting Members' Agreement is a separate contractual arrangement between the Voting Members and the Company. The admission of any organisation as a Voting Member would require the consent of the Company's Board of Directors. Voting Members would pay an annual membership fee to towards the Company's infrastructure costs.

4.3 "Affiliates"

The Affiliates are organisations with an interest in the Company's business but which are not Voting Members. These organisations may include local authorities, smaller CICs, private companies, patient groups, etc.

The Affiliates will act as the Company's "sounding board". This affords the Affiliates the opportunity to shape the Company's priorities. The Company may therefore take into account views expressed by the Affiliates. However, it is important to note that no rights will be granted to the Affiliates in relation to the Company or its business. The Board once established has the opportunity to invite the Affiliates to attend Board meetings and/or general meetings as appropriate.

It is not currently envisaged that the Affiliates will pay any fee. However this is an option being considered by other AHSNs and it is recommended that WoE Voting Members give this consideration in year two.

5 Who can be a Guarantor of the Company and what does this mean?

5.1 Who can be a Guarantor?

Foundation Trusts can be Guarantors of the Company.

CCGs have powers to form companies where formation is for the purpose of service improvement in health or in prevention, diagnosis or treatment of illness for the people for whom they are responsible. The CCGs will therefore need to satisfy themselves that this purpose is satisfied - which we consider it should be. CCGs should therefore be capable of being Guarantors of the Company.

Our view has always been that NHS Trusts do not have the power to form companies other than for income generation purposes (which would not apply here). There is an argument that they could use their general powers, but we are sceptical about this. As a result those Voting Members which are NHS Trusts are not also Guarantors of the Company.

Community Interest Companies or "CICs" (e.g. limited companies, with special additional features, created for the use of people who want to conduct a business for community benefit) may be Guarantors of the Company. However, given the diverse natures of CICs, each CIC will need to satisfy itself that there is nothing within its constitution

which prohibits the CIC from being a Guarantor. We are able to assist with any review as required.

The WoE AHSN Shadow Steering Group considers that the appropriate number of Guarantors for the company is four – one representative from each of the four constituencies (being Universities, NHS Trusts, CCGs and the CICs).

To achieve this one Voting Member from each of the constituencies will need to volunteer for this role.

5.2 **What are the liabilities of the Guarantors?**

In the ordinary course of business, the debts and obligations of the Company are not the debts and obligations of the Guarantors, and the Guarantors' liability towards the company is limited.

The Guarantors undertake to contribute a predetermined nominal sum to the company in the event of it being wound-up while the Guarantor is a member of the company or within a year after that person ceases to be a member. The articles of association (to be adopted upon establishment) will state the amount of this guarantee. There is no statutory maximum or minimum value to the guarantee and a very low figure (e.g. £1 or £10) will be chosen.

Notwithstanding this constitutional limit of liability, there remains an outside risk that a Guarantor is found liable for the debts and obligations of the company in excess of its guarantee. In very rare cases, the courts have concluded that a member has controlled a company to such an extent that the "corporate veil" (i.e. the shareholder's or member's limited liability) is effectively a façade and should be removed.

Unless and until the company is sufficiently creditworthy in its own right, it is possible that the Guarantors may have to provide guarantees or other assurances to third parties (e.g. banks) as well as ongoing financial support to the company. This is not a current requirement of the Guarantors and will only be provided if this approach is agreed by respective Guarantors and the Voting Members more generally.

In the event of insolvency, a Guarantor may be called to honour those guarantees or assurances and/or may lose the value of any financial support given to the Company in addition to any investment value generated in the joint venture. However, we understand that any guarantees, assurances and/or ongoing financial support – to the extent the same is not provided by third parties – will be provided by all Voting Members, not just the Guarantors.

6 What are the implications for a party who is not a Guarantor?

6.1 The Voting Members' Agreement will be drafted on the basis that there should be no practical differences between the rights of the Voting Members, whether they be Guarantors or not.

6.2 Under statute there are certain actions which only Guarantors can take (e.g. adopting new articles of association). However, the Voting Members' Agreement will require that the Guarantors do not take any action unless instructed to do so by the Voting Members.

7 Who will be the Voting Members and what are their roles and responsibilities?

The proposed list of Voting Members is set out in the annex 1 to this paper. Please note that this list is currently with the WoE Shadow Steering Group for comment.

8 What are the commitments for the Voting Members in terms of finance?

The WoE Shadow Steering Group recommends that each Voting Member provide a registration fee of:

Organisation	Fee
NHS Acute, Ambulance, Community and Mental Health Trusts (annual turnover over £70m)	£20,000
NHS Acute, Ambulance, Community and Mental Health Trusts (annual turnover below £70m)	£10,000
Universities	£20,000
Community Interest Companies	£10,000
Clinical Commissioning Groups	£20,000

Each further annual fee will need to be agreed by the Voting Members (unanimously) in developing the Business Plan for the relevant year.

9 What are the commitments for West of England partners in terms of time?

9.1 At this stage in the process it is impossible to given a definitive response in respect of the amount of time each Voting Member will need to commit to the Company.

9.2 It is anticipated that the Board will meet monthly or as subsequently agreed by the Board. To the extent that a Voting Member organisation has a representative acting as a Director they will therefore need to be available on a monthly basis.

9.3 Under the Company's articles of association the Board may call a general meeting at any time giving each Voting Member at least 21 days' notice. The WoE Shadow Steering Group anticipate that in addition to any specific matter requiring a general meeting, a general meeting will be held (as a minimum) twice annually. The West of England prospectus was developed on the premise of the commitment of the Members to deliver change and the success of the Company will be in part determined by the active participation and support of the Voting Members.

10 Is it possible for new Voting Members to join the company?

The Voting Members' Agreement envisages that new Voting Members will be able to join the Company through entering into a Deed of Adherence and with the approval of the Board.

11 What will be the composition of the Board?

The Board will be composed of three distinct groups:

1) Directors appointed by the constituent groups of Voting Members

2) Directors appointed by LETB and NIHR (who will not be Voting Members)

3) Directors appointed by the Board to manage the Board and the company e.g. the Chair and Managing Director

There is also the opportunity for non-executive directors to be invited to the Board though this is not envisaged at this initial stage.

The WoE Steering Group is currently considering the composition of the Board and further details on this will be circulated to all Voting Members shortly.

12 What will be the duties of the directors and related liabilities?

12.1 Please see attached at annex 2 a supplementary paper setting out the duties of directors and related liabilities.

12.2 We would highly recommend that the Company procures appropriate insurances to mitigate against the risk of any claims against the Company or its directors. Insurance brokers are best placed to advice on what policies might be appropriate.

13 What is the "lock-in period" and what are the consequences of withdrawing during this period?

13.1 As set out above, the success of the Company will in part be determined by the commitment of the Voting Members to the Company and the Company's overriding objectives.

13.2 To assist in securing this commitment, the West of England partners consider that the initial Voting Members should be committed for a three year period beginning on the date that the Voting Members Agreement is entered into.

13.3 Although the West of England partners consider a lock-in period to be appropriate, the consequences for a Voting Member leaving the Company during this lock-in period are to be determined by the Board at the time. As a result, the Voting Members through their representative Directors will have a say on what the consequences are for a Voting Member wishing to withdraw during the "lock-in period".

14 What are the arrangements for a Voting Member withdrawing outside of the "lock-in period"

14.1 It is anticipated that once the "lock-in period" has expired a Voting Member may withdraw voluntarily in the following circumstances:

14.1.1 by agreement with the consent of the majority of two thirds of the remaining members; or

14.1.2 by giving not less than twelve months' notice in writing to expire at the end of the third year or at the end of each successive three years thereafter (i.e. at the end of the third year, the sixth year, the ninth year, etc.).

14.2 A Voting Member may also cease to be a Voting Member where the other Voting Members (by a majority of two thirds) vote to remove it if it fails to pay its membership fee when due.

15 What happens if a Voting Member is acquired by a non-Voting Member?

15.1 Where two Voting Members merge their organisations the Voting Members Agreement will set out how the merged organisation is to be treated e.g. as one Voting Member.

15.2 The concept of "non-Voting Member" does not currently exist within the Agreement – all the parties to the Voting Members Agreement are "Voting Members". It is of course possible for a Voting Member to merge with another entity who is not a party to the Agreement. In this scenario, the Voting Members will need to meet to discuss and agree what the impact of this will be on the existing Voting Member following the merger.

16 Does the choice of vehicle (a company limited by guarantee) prohibit or restrict the ability to produce (and extract) a profit?

16.1 Companies limited by guarantees are most frequently used for non-trading purposes trading purposes, especially charitable and social objectives on a not for profit basis.

16.2 This is not to say that a company limited by guarantee cannot *by its nature* distribute profits. Profits can be distributed to the members if there is nothing in the articles of association prohibiting this and there are sufficient distributable reserves available for the purpose. If the articles of association do not state anything about the distribution of profits there is an implied power to distribute dividends. The Company's articles of association will not be drafted to contain any prohibition on the distribution of profits.

16.3 Additionally, the proposed structure does not prohibit the creation of subsidiaries or entering into joint ventures which are established as companies limited by shares allowing for the easier distribution of profits in respect of specific projects or work streams.

17 What is the timeframe for the establishment of the company?

17.1 There are three key actions to be undertaken to establish the Company:

17.1.1 ***Incorporation of the Company*** (including appointing directors and registering documentation at Companies House). The company will be set up with a standard "shelf company" articles of association.

17.1.2 ***Adoption of WoE AHSN new articles of association***. These new articles of association will be the articles of association agreed by the West of England partners. The Articles of Association will bind the "Guarantors" of the Company but will also be important for the Voting Members as a whole.

17.1.3 ***Entry into the proposed Voting Members Agreement***. This will set out the commercial rights and obligations of the Voting Members and the Company.

17.2 A project timeframe detailing the timeframe for establishment of the Company and the critical dates for the project more generally is to be provided separately.

Bevan Brittan

1 May 2013

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

Governing Body Meeting	**25th July 2013**
Title	**Locality Development Plans**
Executive Summary	The CCG Locality Team has been working with the Locality Executive Groups to produce seven Locality Development Plans (LDPs) that set out the local health needs of each Locality and how each of those needs will be addressed. This paper describes the process used to develop these Plans, including engagement and next steps.
Key Issues	It is vital to have high quality LDPs in each Locality that are consistent to ensure resources are prioritised based on local need, reflecting that many issues cannot/should not be dealt with at a county-wide level.
Risk Issues: **Original Risk** **Residual Risk**	Localities will not deliver the Plans/their Work Programmes. Mitigation – a performance management framework is being developed to ensure delivery is tracked and assured. Also, there has been real enthusiasm from many GPs in having a clear plan and clear priorities they can work to, which should minimise the risk. 12 (3x4) 4 (1x4)
Financial Impact	The CCG will need to consider all the proposed Locality Work Programmes and determine which projects will be resourced and how. Therefore, the financial impact is as yet unknown in terms of resources required and any potential savings that may be made.
Legal Issues (including NHS Constitution)	None aware of.

Impact on Health Inequalities	A key driver for developing the Plans was to ensure health inequalities are identified and addressed, with key partners, at a local level. Equality Impact Assessments will need to be completed for projects within the Work Programmes.
Impact on Equality and Diversity	This will need to be determined for each project progressed.
Impact on Sustainable Development	This will need to be determined for each project progressed.
Patient and Public Involvement	This has been determined by each Locality and has varied. Some have patient representatives on their Locality Executive Groups, and some have discussed the Plans at Practice Patient Participation Groups for example.
Recommendation	Approval of the process adopted and the proposed next steps.
Author	Helen Goodey
Designation	Associate Director – Locality Development
Sponsoring Director (if not author)	Andy Seymour/Mary Hutton

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 10

Governing Body

25th July 2013

Locality Development Plans

1 Introduction

Gloucestershire CCG has seven Localities, headed by Locality Executive Groups, where groups of GP practices have agreed to work collaboratively for the benefit of the local patient population and wider NHS. The membership of the Locality Executive Groups varies; however as a minimum includes a GP Chair, CCG Liaison GP and local GPs. The Localities vary considerably in geographical size and patient population. The role of the Locality Executive Group is to support the improvement of local health services through understanding the health service needs of their Locality and use these to develop local priorities. Furthermore Localities, by their nature and geographical coverage, offer an important opportunity to ensure that countywide strategic decisions are informed by, and relevant to, the different Localities.

This paper outlines the locality development planning process that has been undertaken for 2013/14, central to which is the production of seven Locality Development Plans.

2 Background

The county of Gloucestershire covers a diverse range of populations, from the
very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area. In recognition of the need to understand and represent these differences, the Localities work alongside key partners to help determine how best to meet the needs of its population.

3 Producing the Locality Development Plan (LDP)

The LDP needs to be an evidence based document that can be easily read and understood by any audience and the framework for the Plan should be consistent across all Localities.

The benefits of a well-produced LDP include:

- ✓ Understand local health needs and develop local solutions to improve health outcomes;
- ✓ Greater clinical and professional collaboration with partnership organisations i.e. Local Authority, Public Health, Community and Acute sectors;
- ✓ Informs entire decision making process;
- ✓ Promotes the further use of local health services that already exist;
- ✓ Supports the communication between the CCG and its member practices;
- ✓ Balances local and countywide perspectives;
- ✓ Strategic decisions are informed by and relevant to the Localities;
- ✓ Opportunity to pilot and implement new service and care pathways.

Strategic Context

Two major strategies have recently been produced by the CCG (and its predecessor PCT), working with Gloucestershire County Council. The first is the Health and Wellbeing Strategy ('Fit for the Future'), which sets out the priorities for improving health and outcomes of the population of Gloucestershire over the next twenty years, focusing on supporting preventative measures and self-care.

The second major strategy, as the NHS response to the Health and Wellbeing Strategy, is 'Your Health, Your Care', which sets out the vision for health and social care services and community support in Gloucestershire for the next five years.

This Locality Development Plan must be seen in the context of these two important strategy documents – we do not intend to replicate them. The CCG has also produced an Annual Operating Plan for 2013/14, which sets out its work programme for the coming year. This Locality Development Plan therefore fits within this wider context as follows:

Understanding Local Health Needs

Three main sources of information and data have been used to support the development of the LDPs, these are:

- Public Health Intelligence (through the Joint Strategic Needs Assessment);
- Activity and financial data on the use of services, highlighting those areas where the Locality is significantly over or below 'expected' levels;
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need.

Engagement

The process has involved a number of stakeholders and in particular public health input has been significant, others include:

- CCG Lead GPs
- Chairs of Locality Executives
- Consultants for Public Health by Locality
- Local Authority - Strategic Partnership Managers
- CCG Finance and Performance
- CCG Senior Locality Managers
- Medicines Management
- Quality Representatives
- Clinical Programmes

Progress to date

To date all seven Localities have developed draft LDPs and are in the process of consultation and engagement with local stakeholders before final sign off. An example LDP is attached (*see Appendix A*). All seven LDPs have been developed following a common framework to ensure consistency of approach. The Localities will actively engage with District Councils to ensure that opportunities to align priorities are taken, this will include Strategic Partnership Plans for 13/14.

Next Steps

i. All seven LDPS will need to be signed off by each Locality Executive Group and also the CCG;
ii. Project plans developed to support delivery of local priorities (identified in the Work Programmes contained in the LDPs). These will need to evidence tangible outcomes and delivery of QIPP and H&WB priorities;
iii. Identify resources to support delivery of projects;
iv. Performance framework developed to monitor delivery of plans for 2013/14.

Locality Operating Framework (LOF)

Following a number of meetings with Locality Executive Groups it has been highlighted that the Localities would benefit from an operating framework. This will support Localities by defining their new role and responsibilities. Furthermore, it is accepted that there needs to be greater consistency across all Localities in areas such as remuneration, membership, resourcing etc. It is expected that the Operating Framework will be developed in partnership with all seven Localities and finalised by Autumn 2013.

Recommendation(s)

The Governing Body is asked to:

- Approve the process for the development of Locality Development Plans for the seven Gloucestershire localities as detailed in this paper;
- Approve the next steps outlined within the final section of the LDPs.

Appendices

- Tewkesbury, Newent and Staunton LDP

Tewkesbury, Newent & Staunton LOCALITY DEVELOPMENT PLAN 2013-15

1 PURPOSE

1.1 This Locality Development Plan has been produced to describe the specific health needs for the population of Tewkesbury, Newent and Staunton (TNS), and sets out how the Locality Executive Group will lead work to address these needs over the next two years (subject to an annual refresh).

1.2 As appropriate the locality Development Plan will refer to the priorities across the locality, in particular linked to public health and social care.

2 BACKGROUND

2.1 Gloucestershire Clinical Commissioning Group (CCG) was formally constituted in April 2013 as a requirement of the Health and Social Care Act 2012, replacing Gloucestershire Primary Care Trust (PCT) as the organisation responsible for the local NHS. A central aim of creating the CCG is to ensure a clinical focus on the commissioning of healthcare services for the county's population.

2.2 The county of Gloucestershire covers a diverse range of populations, from the very deprived to the very affluent, from people living in very rural areas to people living in one of two large urban areas where there are a significant number of immigrant populations. This leads to a countywide population with very different health and social care needs, spread over a large geographic area. In recognition of the need to understand and represent these differences, the CCG has formed seven Localities; one of these is for the Tewkesbury, Newent and Staunton area. In each Locality lead GPs work alongside key partners to help determine how best to meet the needs of its population, informing the wider work of the CCG. The two key groups to lead this locally are the TNS Locality Executive Group and TNS Reference Group (including Tewkesbury Borough Council, Patient Representatives and Health Watch)

2.3 Two major strategies have recently been produced by the CCG (and its predecessor PCT), working with Gloucestershire County Council. The first is the Health and Wellbeing Strategy ('Fit for the Future'), which sets out the priorities for improving health and outcomes of the

population of Gloucestershire over the next twenty years, focusing on supporting preventative measures and self-care. The priorities within this Strategy during 2013/14 are:

- Reducing obesity;
- Reducing the harm caused by alcohol;
- Improving mental health;
- Improving health and wellbeing into older age;
- Tackling health inequalities.

2.4 The second major strategy, as the NHS response to the Health and Wellbeing Strategy, is 'Your Health, Your Care', which sets out the vision for health and social care services and community support in Gloucestershire for the next five years.

2.5 This Locality Development Plan must be seen in the context of these two important strategy documents – we do not intend to replicate them. The CCG has also produced an Annual Operating Plan for 2013/14, which sets out its work programme for the coming year. This Locality Development Plan therefore fits within this wider context as follows:

Delivery of the actions contained within these plans will be measured in a number of ways, including against the NHS Outcomes Framework.

2.6 *Producing this Locality Development Plan* - To identify the health needs of the population of Tewkesbury, Newent and Staunton the Locality Executive Group has identified three main sources of information:

- Public Health Intelligence (through the Joint Strategic Needs Assessment);

- Activity and financial data on the use of services, highlighting those areas where the Locality is significantly over or below 'expected' levels;
- 'On the ground' intelligence – i.e. conversations with local colleagues who are working directly with patients to understand their views about need.

2.7 The Locality Executive Group will continue to work closely with key stakeholders through 2013/14 to ensure they have the opportunity to fully contribute to identifying the health and social care needs of the local population, prioritising actions, and providing ideas for how these needs could be addressed, including:

- Local GP Practices and their staff;
- Patients and their representatives;
- Tewkesbury Borough Council & FoD District Council

This will be done in collaboration with organisations supporting delivering objectives, including:

- Gloucestershire Care Services;
- Gloucestershire Hospitals NHS Foundation Trust;
- Gloucestershire County Council;
- Local voluntary organisations;
- Local MPs/councillors;

3 KEY ACHIEVEMENTS TO DATE

3.1 Whilst the CCG was only formally constituted recently, the Localities have been working in shadow form for much of 2012/13. Key achievements of the Tewkesbury, Newent and Staunton Locality during this time are as follows:

- Implementation of a local GPSI Dermatology Service
- Continued implementation of 24hr ECG Service locally
- Tewkesbury Hospital (build in progress)
- Targeted education through Protected Learning Time (PLT) Events to cover Musculoskeletal (MSK), Cancer, Social Prescribing and Exercise on Prescription.

4 LOCAL SERVICE PROVISION

4.1 The Tewkesbury, Newent and Staunton Locality is comprised of Newent, Staunton and Tewkesbury Town Centre – the total area covers approximately 41,500 people. There are 5 GP Practices in the Locality, listed with their population size as:

- Jesmond House (5,000)

- Watledge Surgery (7,000)
- Holts Health Centre (10,500)
- Staunton & Corse Surgery (6,000)
- Church Street (13,000)

4.2 In addition to the main acute hospitals in Gloucester and Cheltenham and the GP Practice sites, local NHS health services are also delivered from:

- Tewkesbury, Dilke & Lydney Community Hospitals
- Avon House
- Alongside these some health services are available within Marina Court.

5 WHAT ARE THE ISSUES WE FACE?

5.1 The NHS and Local Authority in Gloucestershire produce a Joint Strategic Needs Assessment (JSNA) – this highlights the medical conditions that particularly affect the population of the county and its Localities. It also highlights population changes over the coming 20 years.

A significant challenge for analysing the health needs is the rationale in population between Tewkesbury, Newent and Staunton Boroughs (need analysis) with the locality commissioning catchment (practice based).

The demographic profile for each practice area is shown below:

Tewkesbury CCG Demography

2011-12

Practice	Jesmond House	Watledge	Holts Cetre	Staunton & Corse	Church Street	Glous' average
Population size	4,929	7,199	10,386	6,311	12,715	7,238
Under 18	21.3%	21.2%	18%	21.2%	18.8%	20.2
Over 65	16.0%	17.7%	24.1%	19.8%	19.4%	19.2
Longstanding health condition	54%	58.2%	54.2%	51.9%	48.8%	53.5%
Ethnicity	4.4%	0.8%	0%	0.8%	1.1% (asian)	4.3%
Deprivation score	9 (2nd less deprived decile)	9 (2nd less deprived decile)	8 (3rd less deprived decile)	9 (2nd least deprived decile)	8 (3rd less deprived decile)	8 (3rd less deprived decile)

Specifically for Tewkesbury, Newent and Staunton the following areas were highlighted as concerns:

- **Incidence of Malignant Melanoma** – The area of Tewkesbury borough ranks highest in the incidence based on a rate per 100 thousand patients; and are above county and national averages. There can be various causes for this however, Tewkesbury will aim to understand the trends in more detail and identify measures to improve.
- **Alcohol Admissions**: 3 out 5 practices rank above the Gloucestershire average for alcohol related admissions to hospital
- **Health Checks**: 3 out of 5 GP practices did not offer 20% of health checks to their practice population.
- **Smoking**: 2 of the GP practices were above the Gloucestershire and England average for prevalence of smoking within their population

- **Childhood Obesity and Physical Activity**: Tewkesbury, Newent and Staunton locality ranks as the 2nd highest with children defined as obese or above, surpassing County and National averages.
- **Sexual Health**: Young people aged between 15 and 24 carry the highest burden of Sexually Transmitted Infection. With 5,500 young people within this age group registered to the 5 Tewkesbury, Newent and Staunton Locality Practices (2700 of which with the rural practices of Staunton & Corse and Newent) the locality will focus on increasing the coverage of Chlamydia Screening within the population.
- **Bullying and Self Harm**: Work to understand the burden of these risks to health and wellbeing in the younger age group and support and redesign the local provision where required.

5.2 In addition to the JSNA intelligence, the CCG information team has reviewed activity and finance data from commissioned services to assess where there are significant variances from expected levels; this has highlighted the following areas for further consideration:

- **Elective Admission**: Tewkesbury, Newent and Staunton had significant increases in spend for some specialities and/or practices (based on 11/12 outturn vs. 12/13 forecast outturn based on month10) with an overall increase noted. Within this a notable change in Paediatrics elective episodes will be reviewed.

- **Outpatients:** In 2012/13 there was an increase in outpatients for TNS compared to 11/12. Based on spend per 100k population TNS Practices rank above the CCG average spend in a number of specialities. The locality has chosen to focus on Trauma and Orthopaedics in 13/14.

- **Emergency Admission:** With increasing pressure on emergency care (and a noted over spend in 12/13) Tewkesbury, Newent and Staunton recognize the need to work to focus their attention on urgent care flows. The areas of Trauma and Respiratory System have been highlighted for focus, based on outlier spend per 100k population.

5.3 As well as the information provided through the JSNA and CCG activity data, we want to strengthen this with understanding the views of people working alongside our patients in the community/'on the ground', so we have also worked with our local colleagues (see section 2.6 above) to better understand the needs of our population, and priorities for improvement.

5.4 Critically, we face an unprecedented financial challenge over the coming years, at the same time as increased demand for our services, within the context of a fast-ageing population. At present around 17 %

of the population are aged 65 and over; this is expected to grow to 30% over the next 20 years. We will therefore need to provide services that are simple to access, integrated and cost-effective.

5.5 This Plan therefore incorporates all the intelligence we have gathered into a comprehensive statement of local health needs/issues, shown below in section 6.

6 FINANCIAL CONTEXT

6.1 In 2013/14, the scope of CCG commissioning has changed from the PCT scope of budgets in 12/13. Former PCT resources, particularly Specialised Services Commissioning, having transferred to new Commissioning Organisations in the NHS organisational structure (CCG's, NHS England and Local Authorities).

6.2 The scope of practice and locality budgets devolved in 12/13, was Acute commissioning, Community Services and Practice Prescribing.

6.3 The 2012/13 Tewkesbury, Newent and Staunton Locality allocation of the Gloucestershire PCT budgets, devolved to Localities, was 6.42%. Tewkesbury Newent and Staunton's spend on services for the year was 6.52% of this Budget. This amounted to an overspend of 1.44% or £670k.

6.4 For the financial year 2013/14, the Locality has a 6.45% share of resources based on the national fair shares toolkit. Gloucestershire CCG budgets are devolved to the Locality using this share of resources.

7 LOCAL HEALTH NEEDS

The below table will focus on Tewkesbury, Newent and Staunton's Locality health needs from a Public Health perspective with significant link to the Borough/District Councils for delivery.

NEED/ISSUE	SOURCE	ACTION LEVEL*	IDEAS/OPTIONS **	WORK ALREADY UNDERWAY?
Incidence of Malignant Melanoma	JSNA	Locality	Initially investigate the information in more detail and understand whether this is purely caused by improved referrals into Cancer services	
Alcohol Admissions	JSNA	Locality/ County	Investigate the process within Practices to identify current ways of working that are different and adopt better performance. Link in with county programmes such as Turning Point and work with the local schools.	
Health Checks	JSNA	County (GCC) / Locality	Look at methods within practices that have been able to attain the 20% offered standard and look at developing/ implementing ways of working. Work towards achieving and MECC (Making every Contact Count) registration.	
Smoking	JSNA	County (GCC)	Committing to referring patients to Gloucestershire's 'Stop Smoking Service' or directly to Practice Nurses (if available) in-house service. Explore earlier engagement in 'Stop before the op' and supporting local	Yes

NEED/ISSUE	SOURCE	ACTION LEVEL*	IDEAS/OPTIONS **	WORK ALREADY UNDERWAY?
			schools following the implementation of the ASSIST programme.	
Childhood Obesity and Physical Activity	JSNA	County	Linking in with Tewkesbury Borough Councils work to support, encourage and enable healthy, active lifestyles incl. Increase in opportunities to take part in activities, 'Exercise on Referral' and 'Active & Able'. Investigate and support schools via Gloucestershire Healthy Living and Learning programme.	Yes
Sexual Health	JSNA	County (GCC)	Support the Public Health Service to increase testing in order to halt preventable harm.	Yes
Bullying and Self Harm	JSNA	County (GCC)	Liaise with current services to understand what can be done in order to develop. Work with Tewkesbury Borough Council, in line with the Health and Wellbeing strategy, to facilitate opportunities for children and young people. Investigate and support schools via Gloucestershire Healthy Living and Learning programme.	

7.1 * We will not be working alone in addressing the needs of our population. As can be seen in the YHYC strategy, there are many actions that are already underway and are planned at a countywide level by the CCG that will help. The identified needs and issues will be addressed at a number of levels, and the amount of input required of the Locality Executive Group will vary accordingly:

LEVEL	LOCALITY INPUT
CCG/Countywide	Provide lead person(s), where relevant
Locality	Lead the identified workstream
A group of two or more Practices	Support as required
Individual Practice	Support as required

7.2 ** At the time of writing, these are the list of ideas/options generated by local clinicians and managers for how the need/issue *could* be addressed. It is vital to note though that no decisions have yet been made, they are not exhaustive and further work is now required to agree a long list of options, assess them and determine the preferred commissioning intentions.

7.3 Crucially, for patients living in any part of Gloucestershire their health issues are often closely linked to other 'social' factors, such as employment, education, and housing. Therefore, we are committed to working in partnership with the Local Authority and third sector partners to both find and implement solutions.

8 LOCALITY WORK PROGRAMME FOR 2013/14

8.1 We have set out a range of local health needs/issues in section 6 above. With our CCG, GP Practice and other colleagues, we will work hard to address these. Recognising though that we need to prioritise our work as a Locality, we have summarised what we aim to achieve in 2013/14 in the programme below:

Locality Work Programme 2013/14

Links to Work Programme		Priority action area	Proposed scheme	Lead partner (s)	Lead locality exec GP	Lead manager CCG or other agency	Expected outcomes/impact	Support /links required to develop scheme
HWB	1	Incidence of Cancer within Tewkesbury	Investigate referrals into Cancer services	CCG	Jeremy Welch	Kathryn Hall	Reduction in activity for patients with Malignant Melanoma Improved prevention methods Reduction in spend for Cancer	
HWB	2	Reduce Incidence of Chlamydia within the locality (initially to focus on working with Hartpury College)	Support the Public Health Service to increase testing in order to halt preventable harm.	GCC	Roger Whittle (Staunton)	Karen Pitney (GCC)	Liaise with colleges and colleagues, promotion of awareness and testing with Hartpury College in the locality. Increase awareness of sexual health issues	Working alongside Public Health. Links to Gloucestershire GPs as some students live outside of the locality.
HWB	3	Bullying and Self-harm support (with a focus on children with carers responsibilities)	Liaise with current services to understand what can be done in order to develop. Explore further work with Young Carers (based at Tewkesbury Comprehensive previously)	GCC	Jeremy Welch	GCC Lead	Ensure coherent multi-agency approach is available and fit for the future Reduction in reports of self-harm / bullying in Tewkesbury	Close working with Tewkesbury Borough Council (TBC)
AOP / QIPP	4	Reduction in Elective Admissions & Outpatients	Paediatrics: Evaluation of current activity flows for elective care, reviewing significant increases noted in 2012/13. MSK: Increased use of local interface services through proactive work with the local interface service and GP practices.	CCG	Jeremy Welch	Kate Liddington	Reduce activity and spend within Elective admissions Increase local attendances for MSK Interface Services.	
AOP / QIPP	5	Reduce Emergency Admissions	Understand current admissions particularly areas of significant increase Liaise with Urgent Care work stream support the development in order to impact the locality position; with a focus on living well and the role of community teams.	CCG	Jeremy Welch	Maria Metherall	Reduce activity and spend within emergency admissions Work towards more integrated care in the community.	

Links to Work Programme		Priority action area	Proposed scheme	Lead partner (s)	Lead locality exec GP	Lead manager CCG or other agency	Expected outcomes/impact	Support /links required to develop scheme
AOP / QIPP	6	COPD and emergency admissions (nb QP 4-6 says should also include asthma)	Survey, peer review and action plan aligned to the QP 4-6 for QOF and involving ALL practices (adaptation of QP 4-6)	Respiratory clinical programme	tbc	Duncan Thomas	Reduced inter practice variation in COPD admissions greater uptake of available services in the community greater uptake of available services in the community Review as approach to other LTC and reducing admissions for FoD Respiratory rehabilitation programme	Respiratory clinical programme lead and locality development lead to assure acceptable as QP
AOP	7	Care home admissions	Support the countywide care home ES	Care homes Care home support team	tbc	Helen Bown/Helen Goodey	Reduce admissions from care homes Improve completion of care plans Improve prescribing	
QIPP	8	Evaluate schemes from 2012/13	Evaluation of: • Dermatology and; • 24 hour ECG	CCG	Tbc	Zoe Riley	Identify lessons learnt and adopt improved modes of practice	
HWB	9	Living Well	Continue working within locality on Living Well approach	CCG	TBC	TBC	Continue in the two practices with evaluation to inform roll out to other practices or on a larger scale within a practice; Develop proposal alongside Integrated Community Teams (ICT).	ICT Steering Group. Living Well team locally.
YHYC	10	Utilisation of locality services	Focussed work plan to look at developing the use of community services (as required) through the role of integrated community teams, the new hospital site and the MIU facilities.	CCG	TBC	TBC	Stock-take of work to dtae and in progress. Develop proposal for further integrated working.	***NOTE: DRAFT ADDITION TO BE DISCUSSED FURTHER***

9 NEXT STEPS

9.1 Once this Plan has been approved by the CCG Board, the following will occur:

a) Through a comprehensive option appraisal process, determine how best to address each area of need included within the 2013/14 work programme, then work to formulate a detailed plan for how they will be delivered, including management resources required – **ACTION BY LOCALITY EXECUTIVE GROUP WITH CCG COLLEAGUES**

b) Develop common format finance and information briefings to support the implementation of this Plan and the Locality Work Programme – **ACTION BY CCG FINANCE AND INFORMATION TEAMS**

c) Agree a process for how progress on delivery of the work programmes (for all seven Localities) will be monitored and assured – **ACTION BY CCG PROGRAMME MANAGEMENT OFFICE**

d) Ensure this plan is reviewed at regular points and refined as appropriate, at least every 12 months – **ACTION BY LOCALITY EXECUTIVE GROUP**

[INSERT AUTHOR NAME]
[INSERT AUTHOR TITLE]
On behalf of Tewkesbury Locality
[INSERT DATE]

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Gloucestershire Clinical Commissioning Group Board

Governing Body Meeting Date	25th July 2013
Title	Integrated Performance Report
Executive Summary	The report provides the Governing Body with an update on the finance, QIPP and service performance for the period to the end of June 2013 and provides assurance on the performance of the organisation in these areas and actions being taken where performance is not on track.
Key Issues	Issues arising relate to the non-achievement of some key performance indicators and the resultant impact on the health community. Exceptions are shown for: - 4 hour A&E target - Cancer 62 day wait - Health care acquired infections - Ambulance targets The CCG is forecasting achievement of its planned surplus for the year.
Risk Issues: **Original Risk** **Residual Risk**	All risks are identified within the relevant sections of this report. Risks are reviewed and actions being taken where performance is not on track are detailed in the report L * C 3 * 4 = 12
Financial Impact	Not meeting key financial targets
Legal Issues (including NHS Constitution)	These are set out in the main body of the report

Impact on Health Inequalities	Not Applicable.
Impact on Equality and Diversity	There are no direct health and equality implications contained within this report
Impact on Sustainable Development	There are no direct sustainability implications contained within this report
Patient and Public Involvement	
Recommendation	The Board is asked to: • Note the financial position and the inherent risks outlined within the attached report • the reported financial position as at June 2013 • note the performance against national targets and the actions taken to ensure that performance is at a high standard.
Author & Designation	Andrew Beard, Deputy CFO Sarah Hammond, Head of Information & Performance Kelly Matthews, Associate Director Strategic Planning
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Governing Body

25th July 2013

Integrated Performance Report

1 Introduction

1.1 This report sets out the Finance and Commissioned Service performance including the QIPP position as at 30th June 2013. It is broken down into two sections:

Section 1 - performance relating to the key commissioning service targets.

Section 2 - a combined Finance and Efficiency report including QIPP delivery and the CCG's financial position.

Future integrated performance reports will mirror the format of CCG Performance Framework.

1.2 Only those areas of performance assessed as being at risk of failure at year end, or other issues that engender concerns throughout the year, for which the Board need to be made aware of, are included in the report. Where standards are reported on a quarterly basis, the board will be informed of updates as and when data is available or new information comes to light.

The full summary of performance is included in the relevant appendices.

1.3 The supporting appendices provide a full analysis of the CCG's Finance position, progress against individual QIPP programmes and performance against our commissioning performance targets. The 2013/14 commissioning performance dashboard (appendix 1) covers the 2013/14 Everyone counts targets, NHS Constitution commitments and key 'local offer' commitments. All sections of the scorecard have been updated with the latest available information.

2 Performance

2.1 A full overview of year end performance of GCCG against the national and key local targets is given in appendix 1 and is grouped as follows;

- Unscheduled Care
- Planned care
- Primary and Community Care
- Mental Health and Learning Disabilities
- Quality

All indicators are RAG rated, based on the 2013/14 NHS Everyone Counts Planning for Patients thresholds.

2.2 For the purposes of this report NHS 111 and planned diagnostic tests will not be RAG rated as they are currently being monitored against a recovery trajectory; however, a detailed update is provided within the table below. A summary of the year to date (YTD) position for all other indicators is also provided within the table below. Appendix 1 shows that of the total of 50 indicators reported on; 37 were rated Green, 4 Amber and 9 Red.

Breakdown of current year to date performance by RAG status of indicator

	Green	Amber	Red
Gloucestershire CCG	37	4	9
Percentage	74%	8%	18%

2.3 Areas where performance has been particularly good include:

- RTT performance has been achieved in April and May 2013
- Improved diagnostic performance has been sustained throughout April and May 2013
- Cancer 2 week wait target has been achieved consistently with the introduction of directly bookable service on choose and book.

2.4 The table below provides a more complete position statement for each of the Amber and Red rated indicators. This table outlines year to date performance, identifies the issues leading to that performance and any

mitigating actions being taken to improve performance.

3 Recommendation(s)

3.1 The Board is asked to note the performance against national targets and the actions taken to ensure that performance is at a high standard.

Ref	Indicator	Status	Issue	Mitigating Action
Unscheduled Care				
CB_B5	4-hour A&E target - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge Threshold – at least 95% of patients should be transferred, admitted or discharged within 4 hours.	**YTD: RED 92.49%** Performance in April (90.7%) & June (94.4%). May's position is currently being validated by GHT following IT issues. Target has not been achieved since November 2012.	Issues at both Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) hospitals. Both hospitals failed to achieve the 4 hour target in May. Performance at Gloucestershire Royal was also below the 95% threshold in June. GCCG modelling suggests that GHT will need to achieve 98.2% in Q2, 96.2% in Q3 and 94.4% in Q4 to achieve the overall target of 95% for 2013/14.	GHNHSFT to provide finalised May position by the 12th July 2013. GHNHSFT to provide updated recovery plan/ trajectory to recover performance. Whole system unscheduled care action plan in place; this includes a series of 35 projects covering pre-hospital, in hospital flows and discharge and community care. The top nine priority schemes are driven fortnightly at a Task and Finish Group chaired by the Director of Commissioning Implementation. Additional areas for CCG investment to increase the pace of Urgent Care recovery have now been proposed to the Urgent Care Network Board including the appointment of an interim Urgent Care Director to increase the pace of change, intensive work on

Ref	Indicator	Status	Issue	Mitigating Action
				escalation processes, and initiating a review into flow and discharge processes at GHFT. Weekly performance is monitored through a weekly call with the Director of Service Delivery at GHNHSFT, the CCG Head of Performance and the Deputy Director of Commissioning Implementation.
CB_B15_01	Cat A 8 min response - The percentage of Category A RED 1 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. Threshold – at least 75% of incidents requiring an emergency response should be arrived at within 8 minutes.	**YTD: RED 73.4%** South West Ambulance Service Trust (SWAST) North division performance in April was poor; however, improvements have been seen in May & June. Gloucestershire only performance has been below the 75% threshold throughout Q1 2013/14.	Activity has increased significantly during Q1 2013/14. SWAST have cited the impact of 111 and increased handover delays as contributing to their failure to achieve this target.	We are working with SWAST regarding the increase in demand to understand the root causes. A Contract Board scheduled for 23rd July aims to discuss what recovery actions SWAST are taking to improve performance and how GCCG can support this. Following initial high rates of 999 transfers from 111 calls these are now at between 6-8% which is significantly better than the national target of 10%. There is continued work underway to further reduce this rate.

Ref	Indicator	Status	Issue	Mitigating Action
CB_B15_02	Cat A 8 min response - The percentage of Category A RED 2 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. Threshold – at least 75% of incidents requiring an emergency response should be arrived at within 8 minutes.	**YTD: AMBER 74.4%** South West Ambulance Service Trust (SWAST) North division & Gloucestershire only performance in has deteriorated in June.	As above	As above
Planned Care				
CB_S6	Number of completed admitted pathways greater than 52 weeks	**YTD: RED 1** 1 patient in April 2013	Patient at Plymouth Hospitals NHS Trust waited over 52 weeks for treatment.	Plymouth Hospitals NHS trust submission to UNIFY2 for April suggested that a Gloucestershire CCG patient had waited over 52

Ref	Indicator	Status	Issue	Mitigating Action
	Threshold – 0		Patient was waiting for plastic surgery procedure. We are currently investigating a non-admitted pathway greater than 52 weeks at North Bristol; however, we are awaiting guidance from the Area team as this patient has not been reported as an incomplete 52 week at any point.	weeks for their first definitive treatment. Plymouth have validated and confirmed this to be a genuine breach of the 52 week maximum wait for patients. The UNIFY2 returns in previous months did not give Gloucestershire CCG any visibility of this patient on an incomplete pathway; therefore we were unable to fulfil our duties under the NHS constitution by taking reasonable steps to offer a suitable alternative provider. Letter written to Plymouth Hospitals NHS Trust confirming that GCCG will not be providing payment for patient's treatment as this was in breach of the NHS Constitution.
CB_B12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for	**YTD: AMBER 82.0%** Issues at GHNHSFT in April with 4 specialties failing to meet the required	Capacity issues within Urology & Lower GI specialties.	Lower GI issues have now resolved with the recruitment of an additional consultant (starting in July).

Ref	Indicator	Status	Issue	Mitigating Action
	suspected cancer. Threshold – at least 85% of patients should receive their first definitive treatment for cancer within 62 days of GP referral.	standard: Haematology (63.6%), Lower GI (75.9%), Upper GI (73.7%) & Urology (62.2%) Performance has improved in May with overall GCCG performance of 84.60%		Capacity within the Urology service will continue through to Q3 2013/14. GHNHSFT have recruited 2 replacement consultants; however, they do not start until September. GHNHSFT have confirmed the appointment of 2 additional trust grade doctors starting in August. GCCG & GHNHSFT have submitted a comprehensive recovery plan and trajectory by month for the remainder of the year. GCCG are working to support GHNHSFT in increasing the number of patients using available capacity at the Independent Sector Treatment Centres to enable cancer cases to be treated more promptly at GHNHSFT.
CB_B14	Percentage of patients	**YTD: RED 71.4%**	Challenging target to meet if	As above.

Ref	Indicator	Status	Issue	Mitigating Action
	receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status. Threshold – at least 85% of patients should receive their first definitive treatment for cancer within 62 days of a consultant decision to upgrade their status.	3 patients were upgraded in April with 1 breach. 4 patients upgraded in May with 1 breach. Both breaches occurred at GHNHSFT.	decision to upgrade is taken. Exception reports have highlighted delays within the patients pathways.	
Quality				
CB_A15	Number of MRSA infections (Health Community) Threshold – 0 cases	**YTD: RED 1** 1 case of MRSA at GHNHSFT in April	GHT case in April which was pre 48 hours by definition; however, attributed to trust due to recent hospital stay and discharged for 24 hours before readmission with sepsis.	GHNHSFT have completed a root cause analysis (RCA) and have reviewed with the GCCG quality team and taken forward the findings from this analysis.
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust) Threshold – 0	**YTD: RED 1** 1 case of MRSA at GHNHSFT in April		
CB_A16	Number of total C Diff	**YTD: RED 36**	Increased C diff incidence led	GCCG have requested exception

Ref	Indicator	Status	Issue	Mitigating Action
	infections (Health Community) Threshold – 162 cases		to the temporary closure of Ryeworth ward at Cheltenham General Hospital. Health community figure includes one case for 2gether NHS Foundation trust.	reports to assess the level of risk. GHNHSFT Review of C diff relapses and antibiotic ward rounds on Ryeworth ward to improve antibiotic prescribing.
	Number of post 48 hour C Diff infections (Acute Trust) Threshold – 52 cases	**YTD: AMBER 12**		
CB_B17	Eliminate mixed-sexed accommodation breaches at all providers sites Threshold – 0	**YTD: RED 15** 1 breach in April affecting 4 patients 2 breaches in May affecting a further 11 patients	GHNHSFT have cited capacity issues in ACUC and ED attendances as the root cause of increase mixed sex accommodation. May's breaches affected 10 patients – both in ACUC at CGH.	RCAs have confirmed that the 2 breaches in May were not clinical exemptions as they were due to capacity issues. Capacity of Acute Care units is being picked up as part of the Unscheduled care recovery plan. GHNHSFT are working to more accurately predict admissions and have a number of actions to improve patient flow.

Ref	Indicator	Status	Issue	Mitigating Action
Unscheduled Care				
Harmoni 111		Service continues to be in transition and has not reached full service commencement. Commissioners are working with provider on rectification plan.	Services has not achieved sustained delivery of all KPIs	Rectification plan taskforce meeting weekly with provider to monitor performance.
Planned Care				
Local	Percentage of patients who have waited 6 weeks longer than their due date for a planned diagnostic surveillance test (GHNHSFT only) Threshold – Only 1% of patients should wait 6 plus weeks past their due date.	The validated position on 1st July was 318 patients waiting over 6 weeks for planned/surveillance procedure vs. a plan of 282. Performance in the first week of July was excellent and GHNHSFT are back in line with their trajectory.	GHNHSFT have had a large backlog of patients waiting for endoscopic surveillance procedures. GHNHSFT have an action plan to reduce the number of 6 + week waiters to zero by the end of July 2013	GHNHSFT has taken a number of actions in order to enable it to both address the current backlog of endoscopy surveillance patient and to maintain diagnostic waiting times within 6 weeks. 3rd Endoscopy suite is fully open with 10 extra sessions available per week; however, capacity has been reduced due to one of the locum consultants leaving. The replacement locum is due to start on the 8th July; in addition to the locum an additional colorectal consultant will start in July and provide extra Surgical Endoscopy capacity.

Ref	Indicator	Status	Issue	Mitigating Action
				GHNHSFT have provided a trajectory to deliver a complete removal of the backlog by the end of July and have provided assurance that they remain on course to deliver this.

4 Finance and Efficiency Report

4.1 This report summarises the financial position of the CCG and performance against its QIPP programme up to and including 30 June 2013.

The CCG has to use the national finance system and the associated Integrated Single Financial Environment reporting structure. This has led to very limited flexibility in reporting the position and the CCG is working with other organisations to enable greater flexibility in the reporting structure to enable local reporting.

5 Recommendation

5.1 The Governing Body is asked to

- Note the financial position and the inherent risks outlined within the attached report

6 Resources

6.1 The CCG's current revenue resource limit for the 2013/14 financial year is £693,004k (of which £686,375k is recurrent) and includes a running cost allocation of £15,090k. Within this position, anticipated adjustments to the baseline since 1 April include the return of the 2012/13 PCT surplus (£6,629k increase) and further adjustments to Specialist Commissioning responsibilities (£4,456k decrease). Further analysis can be seen in Appendix 1.

6.2 Other non-recurrent resource limit changes of £3,331k have been assumed within the overall financial position but have yet to be adjusted by the National Commissioning Board (NCB). This sum includes expected increases on capital grants of £3,700k and a number of small deductions.

7 Income and Expenditure

7.1 At the end of the first quarter, the CCG is reporting a year to date surplus of £1,689k; which is in line with the 2013/14 plan.

7.2 Programme costs show an overspend of £184k which are offset by an equivalent underspend on running costs. This is shown in Appendix 2.

Programme costs

7.3 Due to national changes to information flows, the CCG has had restricted access to detailed contract monitoring information within the first three months of the financial year. However, summarised performance data produced by Gloucestershire Hospitals NHS FT at the end of May shows that the position was broadly in line with plan at this early stage of the year.

7.4 Out of county providers have produced limited monitoring information and, therefore, their performance has been forecast to be at planned levels based on early monitoring.

7.5 Prescribing data has been received for April 2013 and highlights that spend is on plan. However, it should be stressed that April data cannot reliably be used to predict the outturn position.

7.6 In conjunction with the County Council, further work is being done to assess the financial position on Learning Difficulties, Continuing Healthcare and Funded Nursing Care budgets.

Running costs

7.7 The CCG is reporting a year to date underspend against its running costs allocation of £184k.

7.8 The underspend primarily relates to pay costs (£183k) and is due to a combination of factors such as vacant posts, slippage on appointments and hours worked being less than those budgeted.

8 QIPP

8.1 GCCG has a requirement to deliver £18.2m recurrently from its QIPP programme, to ensure delivery of the planned surplus in 2013/14. To achieve this position commissioner QIPP schemes are being delivered in conjunction with local providers to ensure whole system reform. To this end, 2013/14 in county provider contracts include agreed financial risk shares on specific schemes.

8.2 The table in Appendix 2 shows the apportionment of the £18.2m QIPP against delivery theme; and project (as described within the May Governing body report).

8.3 In terms of financial risk associated with the QIPP programme, the shared risk agreement means that the CCG's exposure is more limited, however, the risk is still significant. Monitoring against schemes for the year to date has been limited to scheme implementation progress, even where schemes are currently underway. This is because information flows have been delayed whilst information governance issues are being resolved at a national level. Information associated with contract monitoring has now started to flow and analysis of the position based on month 2 for those schemes underway has now started.

8.4 A new project and programme governance framework has been developed by the Programme Management Office for 2013/14 that will provide a more rigorous, multi-disciplinary, assessment of schemes from initiation to implementation. The proposed governance framework will include review points and define authorisation sign off using the scheme of delegation.

9 Forecast Outturn

9.1 Based on its current reported position, the CCG continues to forecast a surplus of £6,757k in line with its Annual Operating Plan target.

9.2 Risks to the forecast position are referred to in section 10 below.

10 Working Capital

Cash

10.1 The CCG has yet to be officially notified of its 2013/14 cash limit but has assumed an allocation of £686,375k. Appendix 3 provides detail on the current position regarding drawdown against this limit.

Better Payment Practice Code

10.2 Appendix 4 highlights the CCG's performance against the Better Payment Practice Code. It is a national target to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice.

10.3 In order to improve on the current position, the CCG is working with managers both to clarify roles and responsibilities and provide training following the introduction of the new financial system on 1 April.

11 Statement of Financial Position

11.1 The CCG's current and forecast balance sheet is shown at Appendix 5. As can be seen, the net asset position contains mainly creditor, debtor and provisions balances. All property, plant and equipment were transferred to other organisations on 1 April 2013.

11.2 Work is currently in hand to review legacy balances that were reported as part of Gloucestershire PCT's 2012/13 Annual Accounts. Since April, these balances have been reduced by payments being made as "old year" invoices are presented.

11.3 National guidance suggests that this process will continue until 20 August and that any remaining balance at that point will be transferred to CCG or NCB, as appropriate.

12 Capital

12.1 Capital allocations to CCGs have yet to be confirmed by the NCB.

12.2 From a national perspective, allocations are likely to be over committed and, therefore, the NCB Area Team are currently reviewing CCG plans. Priority is being given to capital commitments which have either been approved in a prior year.

13 Financial Risk

The following risks may be material to the current financial position:

- Specialist Commissioning allocation changes
  Limited data is available to support the national changes which have been actioned to date (£103m deduction). The CCG is working with the SCG and triangulating information from other sources, where available, to validate the position. The current position assumes that transfers will be cost neutral.
- Capital Grants
  Access to capital grants has been assumed within the current plan. As is the position nationally, the CCG is awaiting confirmation from the NCB regarding such allocations and the current plan assumes receipt of the allocations.
- Detailed monitoring data
  National changes to the way that detailed information can flow to CCGs for contract monitoring have led to delays in the receipt of this information by CCGs. This has meant that contract monitoring is behind schedule and that monitoring is not yet up to date. Assumptions around financial performance against contract are therefore dependent on provider's own monitoring.
- QIPP slippage
  Due to the nature and scale of system changes within the QIPP programme along with the number of live schemes for the organisation there is a high risk of slippage to the programme.

14 Appendices

- Appendix 1 – GCCG Commissioned Performance Scorecard
- Appendix 2 – QIPP against delivery theme
- Appendix 3 – Resources
- Appendix 4 – Summary Financial Position
- Appendix 5 – Cash Performance Indicators
- Appendix 6 – Performance against better payment practice code
- Appendix 7 – Statement of Financial Position

Gloucestershire CCG 2013/14 Integrated Performance Scorecard

Target	Principal Delivery Targets		2012-13 Outturn	Apr 2013	May 2013	Jun 2013/ Q1	Jul 2013	Aug 2013	Sept 2013/ Q2	Oct 2013	Nov 2013	Dec 2013/ Q3	Jan 2014	Feb 2014	Mar 2014/ Q4	Year / Quarter to date	Year end forecast	Perf. Measured	Director	Responsible Manager
Unscheduled Care																				
Accident & Emergency																				
CB_B5	**4-hour A&E target** - Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C	Mark Walkinshaw	Maria Metherall
		GRH	94.5%	91.3%	91.7%	93.7%										92.2%				
		CGH	95.0%	89.9%	93.7%	95.4%										92.9%				
		GHNHSFT total	94.7%	90.7%	92.5%	94.4%										92.5%				
		GCS - MIU	99.9%	99.95%	99.88%	99.91%										99.91%				
CB_S9	**12 hour trolley waits** (no A&E attender should wait more than 12 hours from the decicision to admit to admission)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		GRH	0	0	0	0														
		CGH	0	0	0	0														
		GHNHSFT total	0	0	0	0														
		GCS - MIU	0	0	0	0														
Ambulance																				
CB_B15_01	**Cat A 8 min response** - The percentage of Category A RED 1 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	C	Mark Walkinshaw	Maria Metherall
		SWASFT	n/a	70.2%	74.5%	75.7%										73.4%				
		Glos only	n/a	69.9%	70.1%	73.6%										71.2%				
CB_B15_02	**Cat A 8 min response** - The percentage of Category A RED 2 incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.	Target		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%			
		SWASFT	n/a	74.7%	75.7%	73.2%										74.4%				
		Glos only	n/a	75.7%	75.2%	73.1%										74.6%				
CB_B16	**Cat A 19 min response** - The percentage of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%			
		SWASFT	95.5%	95.3%	95.2%	95.2%										95.5%				
		Glos only	95.0%	95.8%	95.9%	94.1%										95.0%				
CB_S7	Over 30 minute ambulance handover delays (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		Actual	2,473	136	87	77										300				
CB_S7	Over 1 hour ambulance handover delays (GHNHSFT)	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	731	71	10	18										99				
CB_S8	Clear up delays of over 30 minutes	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		Actual	n/a	31	14	6										51				
CB_S8	Clear up delays of over 1 hour	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual	n/a	7	3	6										16				
Delayed Transfers of Care (DTOC)																				
Local	Average number of Delayed Transfers of Care for acute patients in the month	GHNHSFT target		14	14	14	14	14	14	14	14	14	14	14	14	14	14	C	Mark Walkinshaw	Maria Metherall
		GHNHSFT actual		14.8	16.6	9.8										13.7				
Local	Reimbursable Days for Acute DTOCs (Attributable to Social Services)	GHNHSFT		0	0	0														
Local	Average number of Delayed Transfers of Care for non-acute patients in the month	GCS target		10	10	10	10	10	10	10	10	10	10	10	10	10	10	M		
		GCS actual		5.5	8	5.5										6.3				
Harmoni 111																				
Local	Calls answered within 60 seconds	Target	N/A	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	M		
		Actual		73.9%	89.5%	95.7%										86.4%				
Local	Calls abandoned after 30 seconds	Target	N/A	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%			
		Actual		4.4%	3.1%	1.3%										2.9%				
Local	Calls triaged	Target	N/A	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%			
		Actual		77.3%	75.6%	74.8%										75.9%				
Local	Calls warm transferred	Target	N/A	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%			
		Actual		-	49.3%	44.4%										46.9%				
Local	Longest wait for an answer	Target	N/A	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00	00:01:00			
		Actual		00:27:35	00:15:48	00:18:17														
Local	Longest wait for a call back	Target	N/A	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00	00:10:00			
		Actual		03:07:38	00:08:53	00:25:45														
Planned Care																				
Acute Care Referral to Treatment																				
CB_B1	Percentage of admitted pathways treated with in 18 Weeks	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	C	Mark Walkinshaw	Kate Lidington
		Actual		93.6%	92.8%															
CB_S6	Number of completed admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual		1	0															
Local	Number of specialties where admitted standard was not delivered	Actual		2	7															
CB_B2	Percentage of non - admitted pathways treated within 18 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%			
		Actual		98.0%	97.9%															
CB_S6	Number of completed non-admitted pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual		1	0															
Local	Number of specialties where non-admitted standard was not delivered	Actual		1	2															
CB_B3	Percentage of incomplete Pathways that have waited less than 18 Weeks	Target		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%			
		Actual		95.6%	95.7%															
CB_S6	Number of incomplete pathways greater than 52 weeks	Target		0	0	0	0	0	0	0	0	0	0	0	0	0	0			
		Actual		0	0															

Gloucestershire CCG 2013/14 Integrated Performance Scorecard

Target	Principal Delivery Targets		2012-13 Outturn	Apr 2013	May 2013	Jun 2013/ Q1	Jul 2013	Aug 2013	Sept 2013/ Q2	Oct 2013	Nov 2013	Dec 2013/ Q3	Jan 2014	Feb 2014	Mar 2014/ Q4	Year / Quarter to date	Year end forecast	Perf. Measured	Director	Responsible Manager
Local	Number of specialties where incomplete standard was not delivered	Actual		4	4															
Cancelled Operations																				
CB_B18	**Cancelled operations** - Number of patients who have had an operation cancelled, on or after the day of admission, for non-clinical reasons that have not been offered another binding date within 28 days	Target				0			0			0			0	0	0	C	Mark Walkinshaw	Kate Lidington
		Actual																		
CB_S10	**Urgent operations cancelled for a second time** - number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons	Target				0			0			0			0	0	0			
		Actual																		
Diagnostics																				
CB4	Percentage of patients who have waited more than 6 weeks for one of the 15 key diagnostic tests	Target		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	C	Mark Walkinshaw	Kate Lidington
		Actual breaches		68	68											136				
		Actual Perf		0.98%	0.94%											0.96%				
Local	Percentage of patients who have waited 6 weeks longer than their due date for a planned diagnostic surveilance test (GHNHSFT only)	Target		N/A	N/A	N/A	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%			
		Actual		69.9%	70.0%	68.1%														
Cancer Waits																				
CB_B6	Percentage of patients seen within 2 weeks of an urgent GP or GDP referral for suspected cancer	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C	Mark Walkinshaw	Kate Lidington
		Actual breaches		67	38											105				
		Actual Perf		93.6%	96.1%											94.9%				
CB_B7	Percentage of patients seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected	Target		93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	C		
		Actual breaches		4	5											9				
		Actual Perf		97.7%	97.7%											97.7%				
CB_B8	Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	Target		96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	C		
		Actual breaches		4	0											4				
		Actual Perf		98.2%	100.0%											99.2%				
CB_B9	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	Target		94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C		
		Actual breaches		1	1											2				
		Actual Perf		97.7%	97.9%											97.8%				
CB_B10	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is an Anti-Cancer Drug Regime	Target		98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	C		
		Actual breaches		0	0											0				
		Actual Perf		100.0%	100.0%											100.0%				
CB_B11	Percentage of patients receiving subsequent treatment for cancer within 31 days where that treatment is a Radiotherapy Treatment	Target		94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	C		
		Actual breaches		0	0											0				
		Actual Perf		100.0%	100.0%											100.0%				
CB_B12	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C		
		Actual breaches		20	18											38				
		Actual Perf		78.7%	84.6%											82.0%				
CB_B13	Percentage of patients receiving first definitive treatment for cancer within 62 days from an NHS Cancer screening service	Target		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	C		
		Actual breaches		0	1											1				
		Actual Perf		100.0%	96.4%											97.9%				
CB_B14	Percentage of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	Target		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	C		
		Actual breaches		1	1											2				
		Actual Perf		66.7%	75.0%											71.4%				
Long Term conditions																				
EC	Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	Target				80.0%			80.0%			80.0%			80.0%	80.0%	80.0%	C	Mark Walkinshaw	Maria Metherall
		Glos																		
EC	Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	Target				60.0%			60.0%			60.0%			60.0%	60.0%	60.0%			
		Glos																		
CB_A9	Dementia diagnosis rate	Target				50%			51%			53%			56%	50%	56%	C		Helen Bown
		Glos																		
Community Care Referral to Treatment (GLOUCESTERSHIRE only)																				
Paediatric																				
Local	Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Local	Percentage of patients referred to the Paediatric OccupationalTherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Local	Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		99.0%	99.0%											99.0%				
Adult																				
Local	Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Local	Percentage of patients referred to the Podiatry Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		99.0%	99.0%											99.0%				
Local	Percentage of patients referred to the Adult Occupational Therapy Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Local	Percentage of patients referred to the Adult Physiotherapy Service who	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		

Gloucestershire CCG 2013/14 Integrated Performance Scorecard

Target	Principal Delivery Targets		2012-13 Outturn	Apr 2013	May 2013	Jun 2013/ Q1	Jul 2013	Aug 2013	Sept 2013/ Q2	Oct 2013	Nov 2013	Dec 2013/ Q3	Jan 2014	Feb 2014	Mar 2014/ Q4	Year / Quarter to date	Year end forecast	Perf. Measured	Director	Responsible Manager
Local	are treated within 8 Weeks	Actual		100.0%	100.0%											100.0%		C		
Specialist Nurses																				
Local	Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Local	Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks	Target		95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	C		
		Actual		100.0%	100.0%											100.0%				
Mental Health and Learning Disabilities																				
Adults of Working Age																				
CB_B19	Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	Target				95.0%			95.0%			95.0%			95.0%	95.0%	95.0%	C	Mark Walkinshaw	Eddie O'Neill
		Glos																		
Improving Access to Psychological Therapies (IAPT)																				
CB_S5	The proportion of people who have depression and/or anxiety disorders who receive psychological therapies	Glos target															12.0%	C	Mark Walkinshaw	Eddie O'Neill
		Glos actual																		
CB_S5	The proportion of people who complete therapy who are moving towards recovery	Glos target				50.0%			50.0%			50.0%			50.0%	50.0%	50.0%	C		
		Glos actual																		
Quality																				
Quality Indicators																				
CB_B17	Eliminate mixed-sexed accommodation breaches at all providers sites	GHT		4	11											15		C	Marion Andrews-Evans	Heather Beer
		GCS		0	0											0				
		2gether		0	0											0				
	Number of Never Events	GHT		1	0													C	Marion Andrews-Evans	Heather Beer
		Care Services Actual		0	0															
		2gether		0	0															
		GWAS		0	0															
		Ramsay Healthcare		0	0															
	Percentage of all adult inpatients who have had a VTE risk assessment	Target		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	C	Marion Andrews-Evans	Heather Beer
		GHNHSFT		95.0%	95.6%															
		GCS		98.7%	97.8%															
Cleanliness and HCAIs																				
Methicillin Resistant Staphylococcus Aureus (MRSA)																				
CB_A15	Number of MRSA infections (Health Community)	Glos HC target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C	Marion Andrews-Evans	Heather Beer
		Glos HC actual		1	0											1				
	Number of post 48 hours MRSA infections post 48 hours (Acute Trust)	GHNHSFT target		0	0	0	0	0	0	0	0	0	0	0	0	0	0	C		
		GHNHSFT actual		1	0											1				
Clostridium Difficile (C.Diff)																				
CB_A16	Number of total C Diff infections (Health Community)	Glos HC target		14	14	14	14	14	14	13	13	13	13	13	13	162	162	C	Marion Andrews-Evans	Heather Beer
		Glos HC actual		16	20											36				
	Number of post 48 hour C Diff infections (Acute Trust)	GHNHSFT target		5	5	5	5	4	4	4	4	4	4	4	4	52	52	C		
		GHNHSFT actual		4	8											12				

local Priorities																				
LP1	Reduction in COPD admmission	Glos HC target	N/A			n/a			12 (1%)			24 (2%)			36 (3%)		97.0%	C		
		Glos HC actual																		
LP2	Provide an enhanced level of health service into the homes over 50% of Care homes in Gloucestershire	Glos HC target				n/a			10%			35%			50%		50.2%	C		
		Glos HC actual																		
LP3	The number of people, who are eligible to be offered a weight management intervention, who take up a weight management referral	Glos HC target				n/a			300			800			1,700		1.5%	C		
		Glos HCactual																		

Appendix 2

QIPP Project Level Summary		
Work Programme	**Component Projects**	**Gross Savings 2013/14 £'000**
Frail Elderley	OPAL	400
	Care Home ES	400
Access	ADU / AEC	300
	GP in ED	
	MIU Utilisation	200
Community Care	Integrated Commmunity Teams	500
	Living Well	400
	Rapid Response	1,500
	Community Hospitals	1,000
	IV Therapy	260
Integrated Care	Diabetes Service Re-Design	110
	Respiratory: Specialist Team	300
	IDT	400
Paediatrics	Paediatric Admissions	350
Maternity	Maternity pathways	0
MSK CPG	MSK: Interface Service	700
	MSK: Pathways	508
Opthamology CPG	Opthalmology: Wet AMD, Cataract, Lecentis & Glaucoma	100
Dermatology CPG	Dermatology: Intermediate Tier	65
Demand Management	Peer Review	131
	Advice and Guidance Roll out	150
Follow Up Care	Follow Up Care	730
Paediatric CHC	Paediatric CHC	121
Oxygen Prescribing	Oxygen Assessment	87
Primary Care	Prescribing Plan	4,000
Placements	OOC Placements	245
Liaison	Liaison Services (Acute and Community)	250
Joint Funding	Joint Funding	982
LD Community Care	LDISS	
CHC	CHC	1,756
Transactional QIPP	Transactional QIPP	1,000
	Pathology Pricing	500
	Pharmacy Homecare	500
GHFT Unidentfied	(covered by Urology One Stop & CPAP Change)	255
		18,200

Appendix 3

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Current Assumed Resource Limit Position

AS AT MONTH 3 2013/14	2013/14 R	2013/14 NR	2013/14 TOTAL	Cash Limit
	£000	£000	£000	£000
CONFIRMED				
2013/14 baseline excl growth	**660,548**		**660,548**	**660,548**
Growth	15,193		15,193	15,193
Running costs	15,090		15,090	15,090
Other confirmed adjustments				
CONFIRMED ALLOCATIONS	**690,831**		**690,831**	**690,831**
ANTICIPATED ADJUSTMENTS				
B/f surplus		6,629	6,629	
Specialised Commissioning adj (South)	(4,456)		(4,456)	(4,456)
Total Anticipated adjustments	**(4,456)**	**6,629**	**2,173**	**(4,456)**
TOTAL NATIONALLY REPORTED LIMIT	**686,375**	**6,629**	**693,004**	**686,375**

Notes to the above :-

1. Other local assumptions within current position

	Res Limit	Cash Limit
	£000	£000
Capital Grants	3,700	3,700
Other miscellaneous adjustments	(369)	(369)
	3,331	**3,331**

2. Total resource limit including locally assumed item £ **696,335**

3. Total cash limit including locally assumed items £ **689,706**

Appendix 4

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Summary Financial Position

Overall financial position as at 30th June 2013 (Month 3)

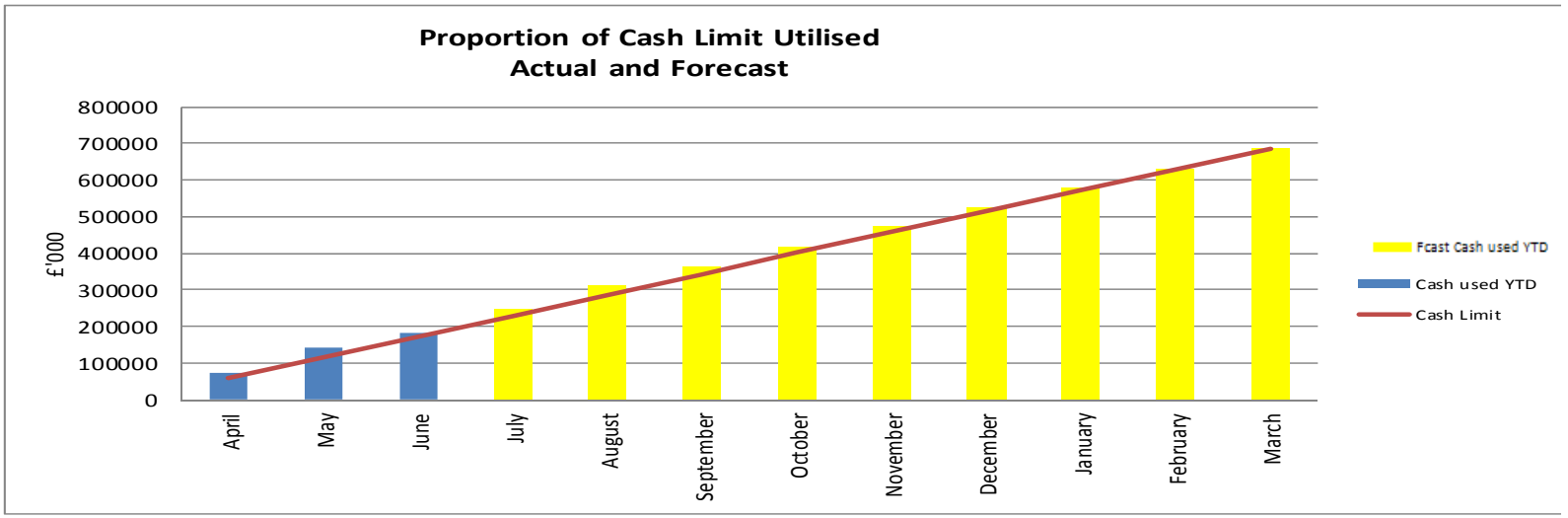
	Year to Date			Full Year		
	Budget	Actual	(Under)/Over spend	Annual Budget	Forecast Outturn	(Under)/Over spend
	£000	£000	£000	£000	£000	£000
Secondary and Community Care services						
Acute services						
Acute contracts -NHS (includes Ambulance servic	84,776	84,776	0	339,104	339,104	0
Acute contracts - Other providers	1,462	1,462	0	5,848	5,848	0
Acute - NCAs	1,343	1,343	0	5,374	5,374	0
Sub-total Acute services	87,581	87,581	0	350,325	350,325	0
Mental Health Services						
Contracts - NHS	18,821	18,795	(26)	75,285	75,285	0
Contracts - Other providers	1,942	1,963	21	7,769	7,769	0
Sub-total MH services	20,764	20,758	(5)	83,054	83,054	0
Community Health Services						
Contracts - NHS	18,066	18,066	0	72,263	72,263	0
Contracts - Other providers	1,755	1,742	(13)	7,021	7,021	0
Sub-total Community services	19,821	19,808	(13)	79,284	79,284	0
Continuing Care Services						
Continuing Care Services (All Care Groups)	2,846	2,846	0	11,364	11,364	0
Local Authority / Joint Services	39	39	0	156	156	0
Funded Nursing Care	2,242	2,242	(0)	8,970	8,970	0
Sub-total Continuing Care services	5,128	5,128	(0)	20,490	20,490	0
Primary Care services						
Prescribing	21,453	21,453	(0)	85,812	85,812	0
Enhanced services	1,110	1,110	0	4,439	4,439	0
Other	896	896	0	3,583	3,583	0
Sub-total Primary Care services	23,458	23,458	0	93,834	93,834	0
Other Programme services						
Re-ablement funding	2,012	2,012	0	8,047	8,047	0
Other	1,404	1,352	(52)	5,615	5,615	0
Sub-total Other Programme services	3,415	3,363	(52)	13,662	13,662	0
Total - Commissioned services	160,167	160,097	(70)	640,648	640,648	0
Specific Commissioning Reserves (incl headroom and contingency)	7,619	7,874	255	30,509	30,509	0
Sub-total Reserves - Programme	7,619	7,874	255	30,509	30,509	0
Total - Programme Costs (excl Surplus)	167,787	167,971	184	671,157	671,157	0
Running Costs	3,775	3,591	(184)	15,090	15,090	0
Total - Running Costs	3,775	3,591	(184)	15,090	15,090	0
Surplus	1,689	0	(1,689)	6,757	0	(6,757)
Total Application of Funds	173,251	171,562	(1,689)	693,004	686,247	(6,757)

Appendix 5

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Cash Performance Indicators

As at 30th June 2013 (Month 3)



Overview of current position

The CCG has an anticipated cash limit of £686m in 2013/14.
At the end of June £183m had been drawn down (27%) of the anticipated cash limit.
The closing bank balance was £2,067k.
This is 2% higher than a straightline profile for cash drawings due substantial prepayments being made to Gloucestershire County Council.

Appendix 6

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

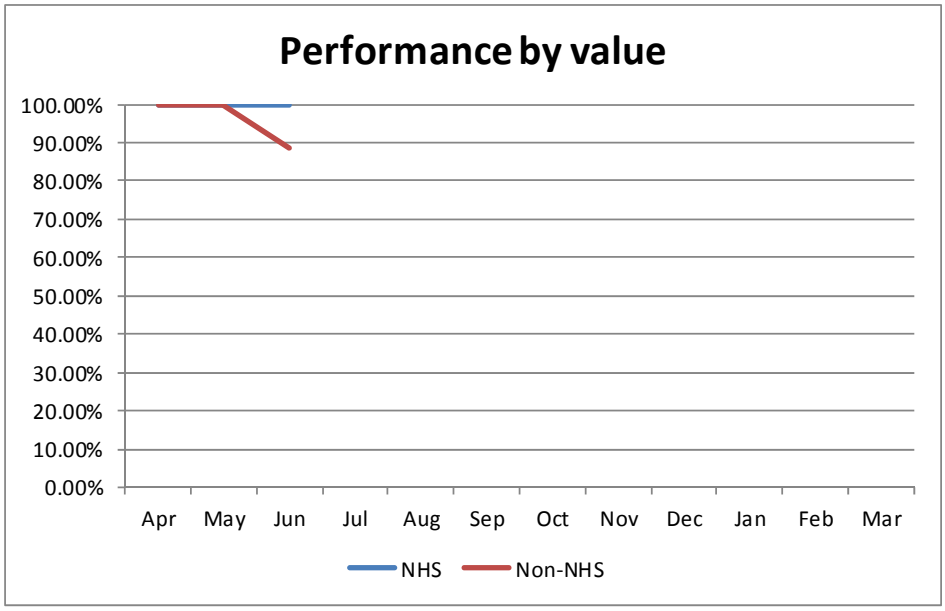
Performance against better payment practice code

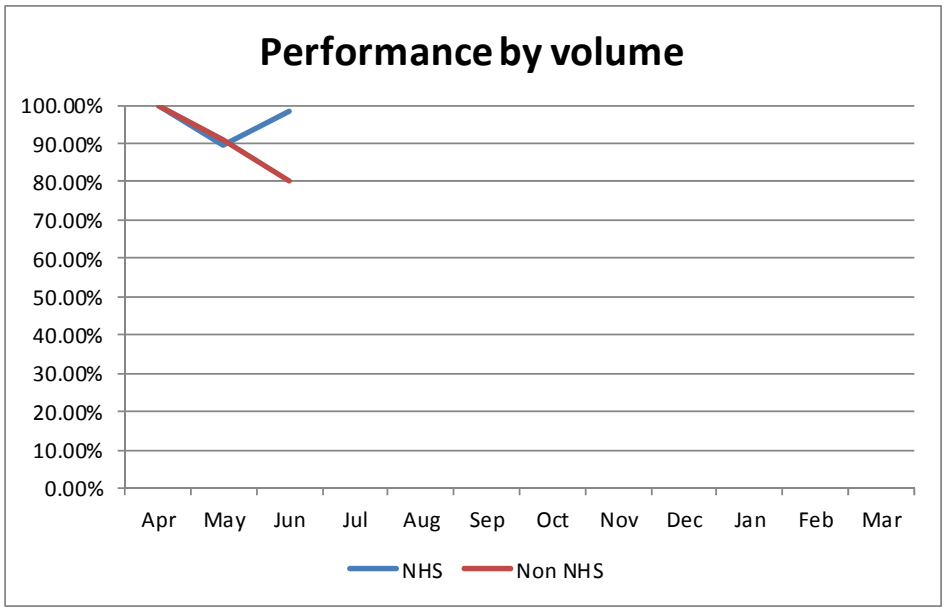
As at 30th June 2013 (Month 3)

	In Month		Year to Date	
	NHS	Non NHS	NHS	Non NHS
By volume				
Total number of invoices	65	303	111	1,088
Number paid within target	64	243	108	925
Performance	98.46%	80.20%	97.30%	85.02%
By value				
Total value of invoices (£000)	16.98	1.81	132.61	46.96
Value paid within target (£000)	16.98	1.60	132.59	46.61
Performance	100.00%	88.66%	99.99%	99.25%
The target performance level is 95%				

In the first quarter, the CCG met the BPPC target in terms of the value of invoices paid (99%). However, only 85% was paid when this metric was analysed by volume.

Appendix 6 (contd)





Appendix 7

NHS GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP

Statement of Financial Position

As at 30th June 2013 (Month 3)

	Current Month end Position £000	Forecast Position as at 31 March 2014 £000
Non current assets	0	0
Current assets:		
Inventories	0	0
Trade and other receivables	19,432	5,000
Cash and cash equivalents	2,067	1
Total current assets	21,499	6,000
Total assets	**21,499**	**6,000**
Current liabilities		
Short Term Payables	(10,129)	(22,128)
Provisions	68	(1,000)
Borrowings	0	0
Total current liabilities	(10,061)	(23,128)
Sub-total	**11,438**	**(17,128)**
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	0	0
Borrowings	0	0
Total non-current liabilities	0	0
Total Assets Employed:	**11,438**	**(17,128)**
Financed by taxpayers' equity:		
General fund	11,438	(17,128)
Revaluation reserve	0	0
Other reserves	0	0
Total taxpayers' equity:	**11,438**	**(17,128)**

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11a

Gloucestershire CCG Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	Performance Management Framework update on progress
Executive Summary	This paper provides an update on the development of the CCG Performance Framework and sets out the draft success criteria to support each objective.
Key Issues	Monitoring of performance is key to ensuring that the CCG is on track to deliver its strategic objectives and identify areas of concern at an early stage. A robust framework is required to ensure that all objectives are covered and reported on consistently.
Risk Issues: **Original Risk** **Residual Risk**	Lack of performance reporting would mean that the CCG is unable to monitor its progress against key objectives and take action where performance is not on track. L * C 2 * 5 = 10
Financial Impact	Non delivery of all key objectives has a financial impact, whilst it may not be a direct financial consequence indirect consequences impact on overall resources.
Legal Issues	Delivery of NHS constitution requirements is a legal right for patients.
Impact on Health	This report presents the CCG's

Inequalities	performance against national targets that include measures designed to tackle health inequalities. Service users, carers and local people have not been involved in the production of this report. Separate reports relating to public involvement are presented to the Board as appropriate.
Impact on Equality and Diversity	None
Impact on Sustainable Development	None
Patient and Public Involvement	None
Recommendation	The Board is asked to note the approach
Author	Sarah Hammond
Designation	Head of Information & Performance
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer (CFO)

Gloucestershire CCG Governing Body

25th July 2013

Performance Management Framework

1 Introduction

1.1 This paper provides an update on the progress of the development of the CCG Performance Framework and sets out a draft set of success criteria against the objectives.

1.2 Effective performance management will allow the CCG to identify issues and risks and make informed decisions in an open way which can be acted upon and reviewed to drive continuous improvement in performance.

The framework will allow us to:

- Monitor performance against organisational objectives and commitments.
- Define ownership and accountability for all objectives and commitments.
- Provide a robust process by which progress towards achieving those objectives and commitments will be monitored and areas of risk clearly identified through regular review and evaluation.
- Ensure that all areas of risk have robust recovery action plans to mitigate against any under-performance
- Understand how the contribution of individual members of staff, managers, directorate leads and board members relate to each other and help to deliver the objectives set for the whole organisation.

2 Development of the Performance Management Framework

2.1 In May a paper was presented to the board on the development of a performance management framework for the CCG. The paper outlined the structure of the framework and how the framework would incorporate the CCG's vision and objectives that were set out in the organisation's annual operating plan.

2.2 As part of the development of the performance framework a balanced scorecard approach has been adopted which will allow the organisation's vision/strategy to be translated into key actions.

2.3 The CCGs balanced scorecard will be based on 5 internal perspectives which are:

- Clinical Excellence (P1)
- Finance and Efficiency (P2)
- Patient Experience (P3)
- Partnerships (P4)
- Staff (P5)

Each of the internal perspectives are linked to the organisational objectives, allowing a high level view of the risks to the organisation in delivering it's performance agenda.

Below is a summary of the linkages between the balanced scorecard internal perspectives and the organisational objectives.

Internal Perspective	**Organisational Objective**
(P1) Clinical Excellence	(1) Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on clinical programme approach and developing our member localties.

(P2) Finance and Efficiency	(3) Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation. (4) Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities.
(P3) Patient Experience	(2) Work with patients, carers and the public; to inform decision making.
(P4) Partnerships	(5) Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers.
(P5) Staff	(6) Develop strong leadership as commissioners at all levels of the organisation, including localities.

2.4 **Proposed Success Criteria within the Internal Perspectives**

Each internal perspective will consist of a number of defined success criteria. These success criteria will incorporate a number of similar themed individual indicators that will be grouped and RAG (red, amber or green) rated. The indicators within each group will be developed to describe what actions must be undertaken to enable the strategic objectives to be achieved. A lead director has been nominated for each internal perspective.

The proposed success criteria for each of the internal perspectives is detailed below:

Internal Perspective	**Success Criteria**
(P1) Clinical Excellence	1. Support the work of the clinical programme groups and the localities ensuring that quality and patient safety is at the heart of their work 2. Provision of regular, robust information to provide assurance that our service providers are delivering quality, safe & clinically effective services.
(P2) Finance & Efficiency	1. Underlying recurrent surplus 2. QIPP full year forecast 3. Robust governance arrangements are in place
(P3) Patient Experience	1. Improving reporting of patient experience and the use of feedback to influence commissioning intentions 2. Understand the impact of staff experience on patient experience 3. Demonstrate that we have acted upon feedback from HealthWatch Gloucestershire
(P4) Partnerships	1. Prioritise areas we need to work in partnership with other commissioners and put in place effective partnership arrangements. 2. Ensure strong engagement with Health & Wellbeing Board. 3. Develop strong partnerships with

	Health, Care Overview and Scrutiny Committee and HealthWatch Gloucestershire. 4. Develop approach to asset based communitied and work with localities to deliver.
(P5) Staff	1. Attracting and retaining high quality staff aligned to the CCGs vision and values 2. Personal development processes that are linked to the strategic plan 3. Staff are happy and motivated

2.5 **Next phase of development**

Following agreement of the success criteria, key performance indicators and associated targets are being developed. The indicators will be made up of national commitments and the local targets deemed necessary to monitor progress towards achieving the organisation's objectives. An accountable manager will be assigned to each performance indicator which will be supported by a performance plan, this is a tool to manage the delivery of the indicator to ensure the target is met.

Performance against the performance framework will be reported to the Board. Areas of under-performance (i.e. red or amber), or that are giving cause for concern, will be highlighted to draw attention to the Board.

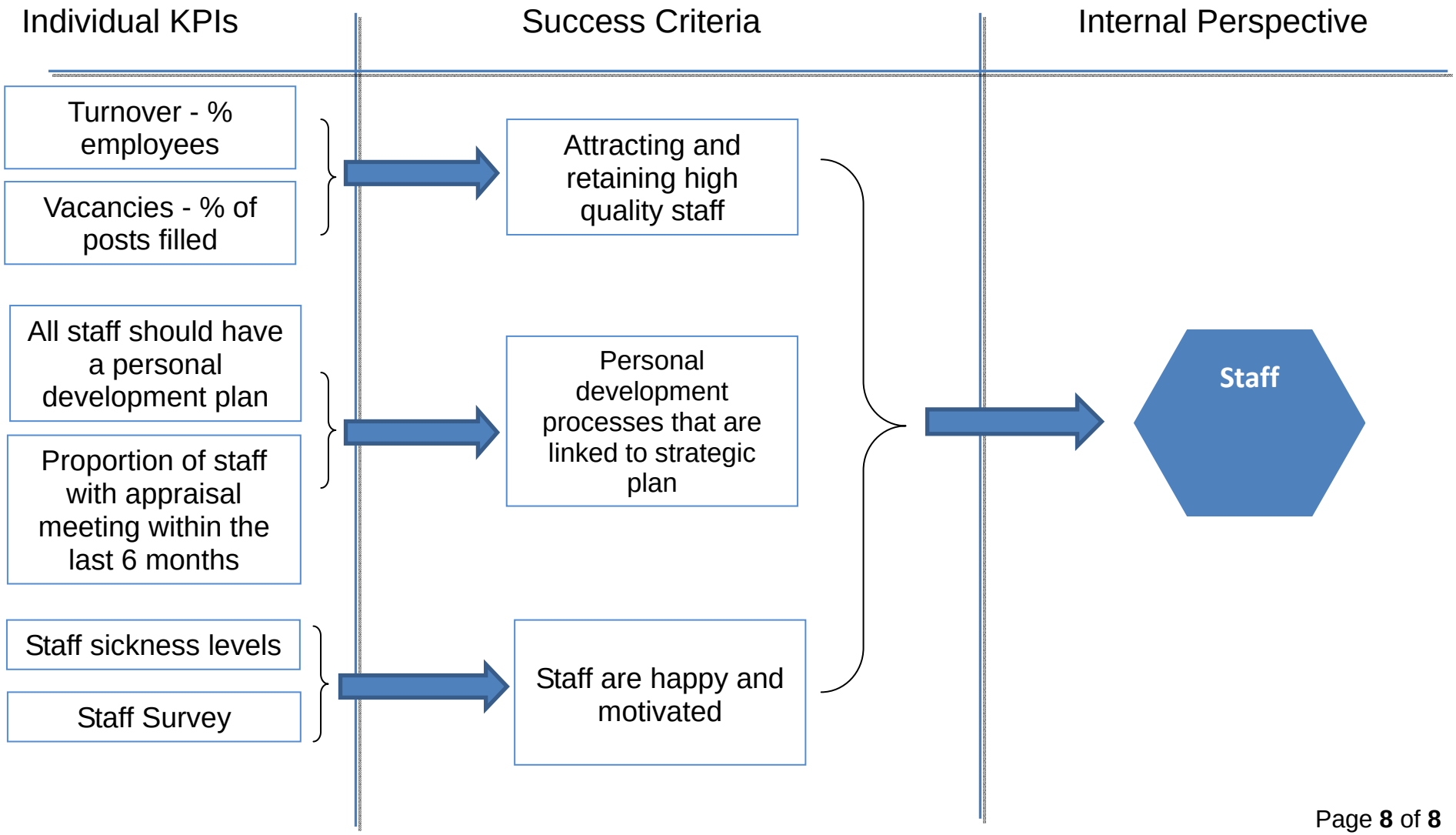
3 Recommendation(s)

3.1 The Board is asked to note the approach

Appendices

- Appendix 1 – Example of the CCG performance scorecard

Appendix 1 – Example Scorecard for the Staff Internal Perspective



NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

Governing Body Meeting Date	25th July 2013
Title	Gloucestershire NHS 111 Update
Executive Summary	This paper is intended to update the Governing Body on the current NHS 111 service in Gloucestershire. It proposes collaborative working with the Provider, Harmoni, to further improve performance and to ensure full clinical safety of the service.
Key Issues	Performance at the end of Rectification Plan 1 showed achievement of 3 of 4 Key Performance Indictors (KPIs). Further action is needed to consistently achieve the remaining KPI. Need to agree process for sign off of next steps in the gateway process.
Risk Issues: **Original Risk** **Residual Risk**	Risk of failing to provide a high quality, effective NHS 111 service and the resultant impact upon the wider urgent care system.
Financial Impact	Potential negative financial impact on wider urgent care system. Contingency costs incurred.
Legal Issues (including NHS Constitution)	Contract management process is in place, with legal advice secured (particularly in terms of contract definitions/terms).

Impact on Health Inequalities	Inequalities Impact Assessment completed as part of tender process.
Impact on Equality and Diversity	Equality and Diversity Impact Assessment completed as part of tender process.
Impact on Sustainable Development	None identified.
Patient and Public Involvement	Patient representatives at Clinical Governance forum for NHS 111 service.
Recommendation	Paper for information and decision on; - Supporting the proposed next steps set out in section 7. - To provide delegated authority to Mark Walkingshaw (Deputy Accountable Officer) and Dr Jeremy Welch (NHS 111 Clinical Lead) to agree and formally sign-off each step in the Gateway Process (in negotiation with Harmoni and NHS England).
Author	Kate Liddington
Designation	Senior Commissioning Manager
Sponsoring Director (if not author)	Mark Walkingshaw Deputy Accountable Officer/Director of Commissioning Implementation

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 12

Governing Body

25th July 2013

Gloucestershire NHS 111 Update

1 Introduction

1.1 This paper is intended to update the Governing Body on the current position with regard to the NHS 111 service in Gloucestershire and to seek agreement on next steps.

2 Overview of NHS 111 Service

2.1 The NHS 111 service model was developed nationally and is based upon national guidance. The core principles of provision of the service include:

- completion of a clinical assessment and information on the first call without the need for a call back;
- ability to refer callers to other providers without the caller being re-triaged;
- ability to transfer clinical assessment data to other providers and book appointments;
- ability to dispatch an ambulance without delay.

2.2 Figure 1: Schematic of principles of NHS 111 services

3 Current NHS 111 Service for Gloucestershire

3.1 From 19th February 2013, NHS 111 replaced the Out of Hours (OoH) call handling for Gloucestershire. This meant that the call handling previously provided by Great Western Ambulance Service (now South West Ambulance Service Trust) was transferred, as were the staff (under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) to the new service. The Out of Hours (OoH) services remained in place i.e. the GP telephone advice, face to face and home visiting services.

3.2 The 'soft launch' as this was termed was due to be followed by a 'hard launch' in which the service would take calls from 0845 NHS Direct and be available 24/7 to the public for non-emergency, urgent problems. However, due to initial under performance by the provider, Harmoni, working from the call centre in Bristol, Gloucestershire CCG (GCCG) has remained at 'soft launch' (complete OoH transfer) since 19th February 2013.

3.3 The service is effectively in a transition position, between soft launch and full service launch, with operating contingency capacity in place to support it, such as 0845-NHS Direct and other contingencies from Out of Hours providers.

3.4 Commissioners across the region have worked collaboratively with the Harmoni team to improve performance. A Rectification Plan was put in place on 24 April 2013 to cover a 9 week period, until 26 June 2013. This Rectification Plan set out additional recruitment of clerical call handlers and clinical advisor staff, and delivered a gradual improvement in performance, linked to total number of staff available and improvement in operational processes in the Bristol call centre.

3.5 In addition we have also put in place a range of contingency arrangements in collaboration with other healthcare providers. These include providing additional clinical advisors to manage calls going into the service and keeping in place the NHS Direct service as an alternative route for patients.

3.6 To provide additional assurance the GP clinical governance leads across the region have routinely sampled call quality. This feedback has helped inform training and coaching for call handlers.

3.7 All feedback on the NHS111 service received from healthcare

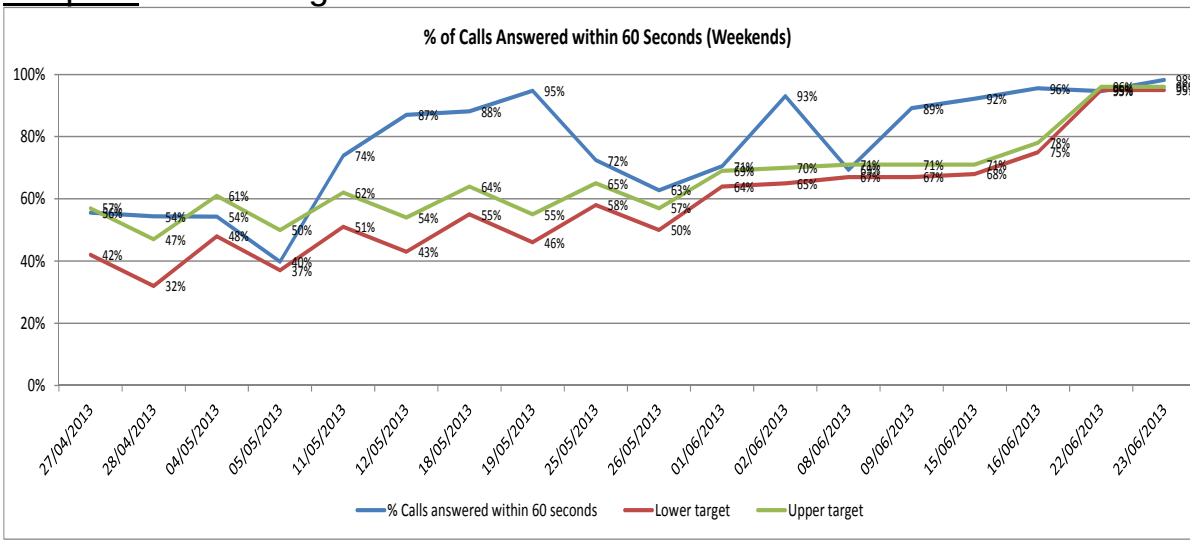
professionals and patients has been reviewed by the CCG clinical lead and appropriate action taken.

4 Performance at end of Rectification Plan (26/06/13)

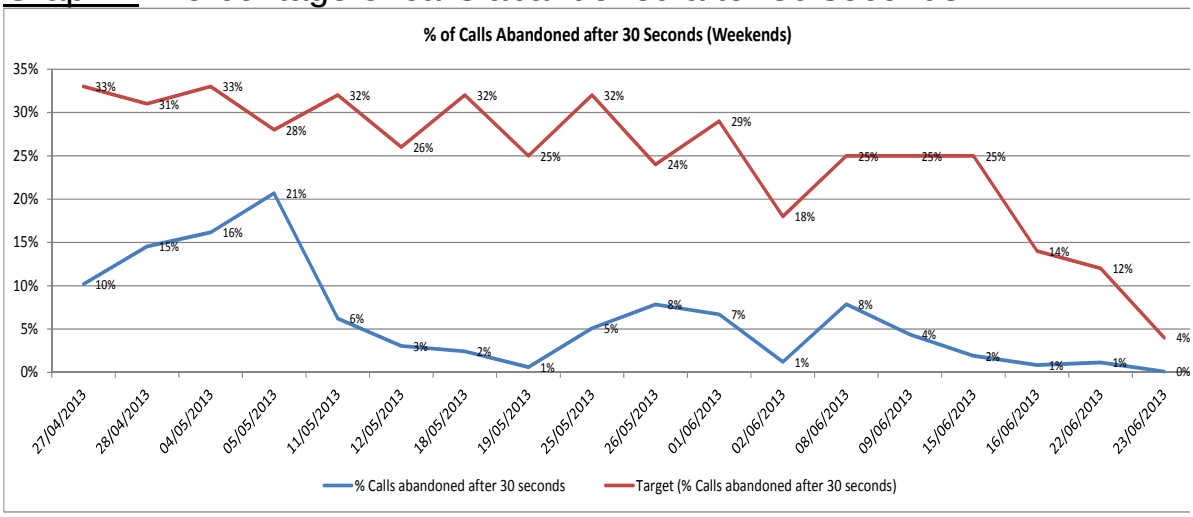
4.1 The Rectification Plan was supplemented by a weekly performance dashboard. The plan focused initially on the call answering key performance indicators (KPIs) whilst there were operational contingencies in place, as well as documenting the clerical and clinical recruitment and training that Harmoni were undertaking.

4.2 The KPIs focused on performance at weekends, as this was when there had been worst performance. Weekday performance was also monitored but showed consistent performance achievement. Weekend performance (at 24/06/13) against improvement trajectories are shown below:

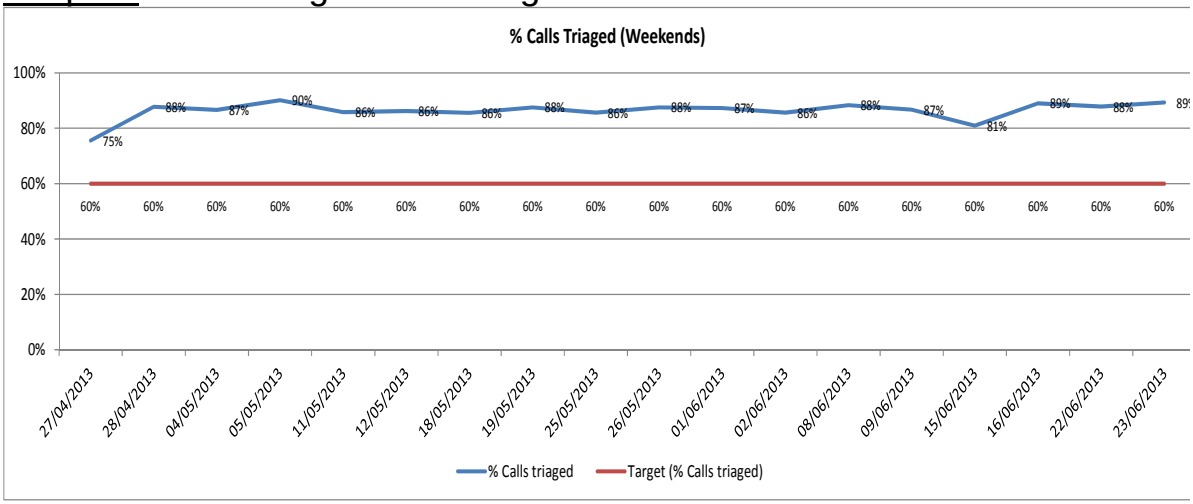
Graph 1: Percentage of calls answered within 60 seconds



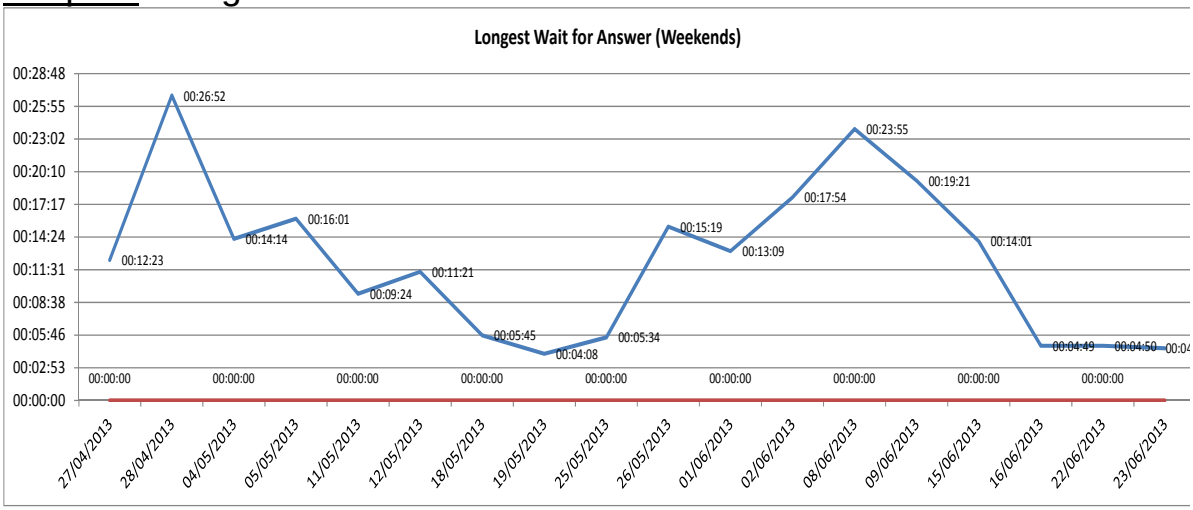
Graph 2: Percentage of calls abandoned after 30 seconds



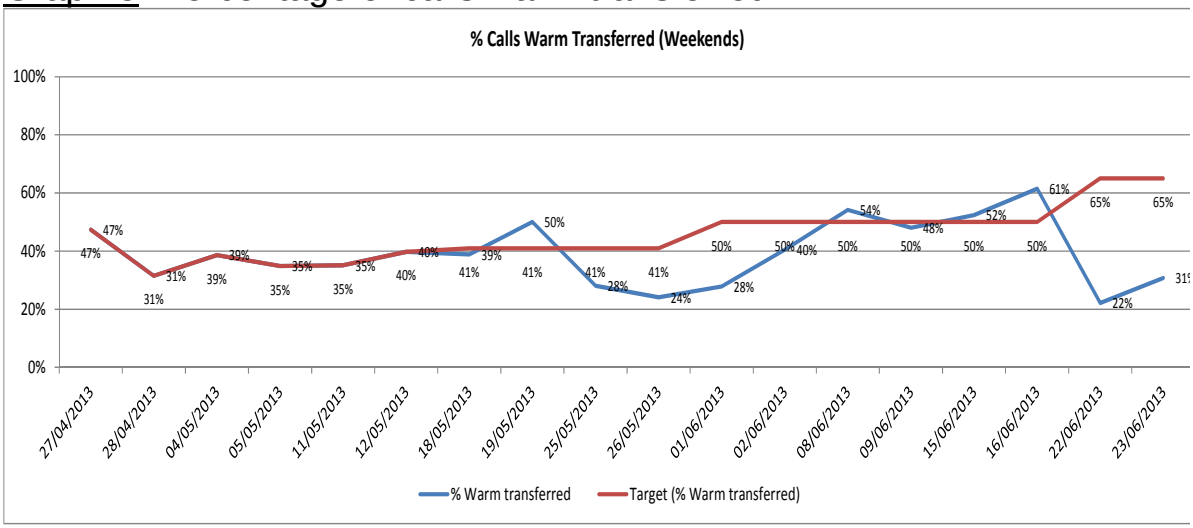
Graph 3: Percentage of call triaged



Graph 4: Longest wait for an answer



Graph 5: Percentage of calls warm transferred



4.3 At the end of the Rectification Plan achievement against KPIs was as follows;

- % calls answered within 60 seconds: Achieved
- % calls abandoned after 30 seconds: Achieved
- % calls triaged achieved: Achieved
- % calls warm transferred: Failed
- Call Handlers (clerical): 150 of 164 in post
- Clinical Advisors (clinical): 29 of 43 in post

5 Warm Transfer KPI

5.1 The warm transfer KPI (% of calls passed as a 'live transfer' to clinical advisor, not a call back) is used as a measure of clinical quality of the service and is nationally set target is 98% achievement. Harmoni have not achieved this target to date. This is due to the inability to recruit clinical advisor staff as quickly as they anticipated. A further process is underway to recruit additional clinical staff to ensure this KPI can be consistently met.

5.2 At all times during the Rectification Plan contingency capacity remained in place with clinical advisors being used at the front of call queues. It is acknowledged that this was important for the immediate quality and safety of the service, but that appropriate levels of clinical recruitment must also be achieved so that all KPIs can be met in a sustained way for the long-term.

5.3 Overall Harmoni have worked during Rectification Plan to demonstrate some improvements and appear to have significantly improved call handling performance. However the Rectification Taskforce have asked for specific assurance on when they expect the warm transfer KPI to be met.

5.4 Harmoni are currently working to establish when additional recruitment will have taken place and when the warm transfer KPI will be achieved. This modelling will also include the date from which all KPIs will be delivered and performance sustained over a minimum of a three week period.

5.5 Initial feedback from Harmoni suggests 98% warm transfer will be met for the first time from 31st July 2013, due to an additional 15 clinical staff completing training, and performance for all KPIs at required levels will be sustained thereafter. Commissioners and Harmoni are currently working through the supporting modelling and evidence for

this, to ensure this is a realistic and achievable expectation.

6 National sign off process for further roll out of the NHS 111 service

6.1 Since February 2013, NHS England has set out a national process with clear requirements for further roll out of NHS 111 services (see table below), and representatives from NHS England have been involved in the Rectification Plan process to date.

Checkpoint	Stage	Description
CP1	Soft launch	The 111 number is turned on in the NHS 111 area and a known volume of OOH calls are diverted into the NHS 111 service
CP2*	Increase OOH transfer	A further tranche of OOH calls are diverted into the NHS 111 service
CP3*	Increase OOH transfer	A further tranche of OOH calls are diverted into the NHS 111 service
CP4	Complete OOH transfer	All OOH calls are diverted into the NHS 111 service
CP5	0845 switch off	The 0845 4647 service is switched off in the NHS 111 area and calls diverted to 111. At this stage the service will also receive a % share of calls received nationally into 111 with an unknown location
CP6	Public launch	Local marketing and publicity commences in the NHS 111 area

6.2 All CCGs involved with the NHS 111 service operated from Harmoni's Bristol call centre have been consistent in their view that all Rectification Plan Targets must be achieved over a minimum of 3 weekends before any contingencies can be considered to be removed, as well as needing additional assurance about the level of clinical quality and safety.

6.3 In light of this, all CCGs had previously proposed to NHS England that there is some variation of the national checkpoint process for the NHS 111 service being provided by Harmoni from the Bristol call centre.

6.4 These variations were suggested in light of the experience to date and the anticipated outcome of the Rectification Plan, with the aim of proceeding to full public launch as quickly as possible, whilst maintaining clinical safety and confidence of the NHS 111 service.

6.5 The proposed sequencing of gateways is follows;

Step 1: Harmoni achieve all Rectification Plan Targets.

Step 2: Switch off NHS Direct 0845 (CP5).

Step 3: Include Swindon activity into Bristol call centre.

Step 4: Turn off all OoH operational contingencies, provided by Gloucestershire Care Service (GCS), Ambulance service (SWAST), and Wiltshire Medical Services (WMS).

Step 5: Public launch (CP6).

6.6 In putting this sequence together, Commissioners believe it would allow the service to be tested more rigorously and with greater call volumes, before any contingencies were removed. However this would only be done once Harmoni have achieved acceptable standards of delivery of the KPIs over a minimum 3 week period, and it is expected that there would be a minimum of 2 week period between each step, with performance continuing to be achieved during these periods.

6.7 This plan is also predicated on having a robust second phase Rectification Plan in place. Commissioners started discussing the need for this second Rectification Plan in June with Harmoni. Harmoni are preparing this document, with updated risk logs and dashboards, in order to demonstrate the following:

- Continued recruitment of agency and substantive staff.
- Clear demand modelling (including for winter period) linked to sustained performance achievement.
- Full achievement of the warm transfer KPI.
- Full performance achievement of all KPIs into August in order to demonstrate sustained delivery.

7 Next Steps

7.1 Until a full second Rectification Plan is delivered by Harmoni, it is proposed that Gloucestershire CCG does not proceed to recommend that the NHS Direct 0845 number or any other contingencies are removed, but will keep these in place until further assurance on service performance can be provided by Harmoni.

7.2 Gloucestershire CCG has a requirement to keep NHS England informed of expected timescales, and will continue to provide a weekly report in this regard.

7.3 Gloucestershire CCG will also continue to work collaboratively with Harmoni to ascertain when delivery of warm transfer will be achieved, and to set out revised timescales for removal of operating contingencies and full service launch. This work will include the following actions:

- To continue to meet Harmoni weekly as part of the Rectification Plan Taskforce.
- To prepare weekly briefing for the Area Team.
- To obtain a robust second phase Rectification Plan from Harmoni.
- Pending delivery and assurance provided in second Rectification Plan, to set timescales for the following:
  - Date to switch off NHS Direct 0845.
  - Date to work to remove further contingencies.
  - Date to aim for full public launch.
- Via contract process to explore Harmoni's ability to sub-contract elements of the service to other Providers.
- Via contract process to consider Quantum Meruit payment to Harmoni for elements of service delivered.

7.4 It is anticipated that Harmoni will provide their second Rectification Plan by the end of July.

8 Recommendation(s)

8.1 The Governing Body are asked to:

- Support the proposed next steps set out in section 7.

- To provide delegated authority to Mark Walkingshaw (Deputy Accountable Officer) and Dr Jeremy Welch (NHS 111 Clinical Lead) to agree and formally sign-off each step in the Gateway Process (in negotiation with Harmoni and NHS England).

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 13

Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	**Joint Case for Change and initial Provider response for the strengthening of adult health and social care Integrated Community Teams**
Executive Summary	The purpose of this paper is to set out a joint Case for Change and Provider response to strengthen the existing 20 health and social care integrated community teams (ICTs) managed by Gloucestershire Care Services NHS Trust (GCS). The Case for Change has been reviewed and agreed by an ICT Steering Group, prior to being presented to the Governing Body.
Key Issues	The ICT Programme is joint activity between commissioning and provider organisations due to there being a preferred option (see the economic case section) to strengthen existing health & social care ICTs. This means it is has been appropriate to develop, in the context of the programme, a joint Case for Change.
Risk Issues: Original Risk Residual Risk	A risk register is set out in the extended summary included with the report at Appendix 1
Financial Impact	The proposal sets total recurrent investment requirements of £3.9m and a gross return on investment of £6.7m.
Legal Issues (including NHS Constitution)	In respect of the proposal, all legal commitments contained within the NHS Constitution and other national guidance

	will be adhered. As this development concerns health and social care, proposal will also adhere to local authority legal requirements within this field. Specifically, in respect of procurement regulations a decision not to tender is attached at appendix 2.
Impact on Health Inequalities	The joint Case for Change and Provider response sets out key requirements to help address around the following: • implementation initially focussed on areas of greater need; • longer term, the service has an equitable allocation of resources and there are plans in place to address any current inequity; • the service ensures effective safeguarding of adults; • the service is integral to the wider community based assets that support people in their communities, connecting people with their community and co-producing solutions that help them live a good life.
Impact on Equality and Diversity	An equalities impact assessment will be carried out as part of implementation planning and any specific issues and actions will be reported to the Governing Body
Impact on Sustainable Development	A sustainable impact assessment will be carried out as part of implementation planning and any specific issues and actions will be reported to the Governing Body.
Patient and Public Involvement	Support for the development of Integrated Community Teams has been endorsed by accumulated engagement and consultation activities led by Gloucestershire's NHS commissioners over several years. Subject to this joint Case for Change achieving agreement, a stakeholder communications and

	engagement plan and supporting materials will be produced. These will be aligned with the agreed implementation timetable so that engagement is focussed at the local level.
Recommendation	Members of the Governing body and requested to consider the contents of the paper and are requested: • To approve the joint Case for Change to strengthen adult health & social care Integrated Community teams, which includes service, financial and implementation implications; • To formally agree the decision not to tender; • Agree how the Governing Body would like to kept up to date on progress.
Author	Andrew Hughes
Designation	Locality Implementation Manager
Sponsoring Director	Mary Hutton, Accountable Officer

Governing Body

Thursday 25th July 2013

An integrated Case for Change for the strengthening of adult health & social care integrated community teams

1 Summary

1.1 The purpose of this paper is to set out an Integrated Case for Change for a first phase strengthening of the existing 20 health and social care integrated community teams (ICTs) managed by Gloucestershire Care Services NHS Trust (GCS) with an additional £3.9m recurrent monies spread over the next two financial years

The investment will increase capacity, capability, availability and support the cultural changes required within current teams so that they are best placed to play a key part in the response to the demographic, financial and patient experience challenges facing Gloucestershire's health and social care commissioners over the next five years. Implementation will commence from October 2013 and the first phase will be fully effective by the end of December 2015.

The investment will increase capacity, capability, availability and support the cultural changes required within current teams so that they are best placed to play a key part in the response to the demographic, financial and patient experience challenges facing Gloucestershire's health and social care commissioners over the next five years.

The key aim is to improve outcomes for predominantly older people across health and social care through: -

- Better outcomes for people across health and social care including the prevention of some hospital and care home admissions, less time spent in hospital, increased identification of people who are at risk of requiring services in the future and increased provision of preventative services and services to extend the ability to live

independently;

- Greater clarity on who is involved in a person's care, what the expectations are for the person and more focus on the 'goals' and quality outcomes defined with the patient;

- Improved communication between professionals and organisations to ensure that services are better coordinated, service responses are timely and there is improved connection to wider community based assets so that people feel valued and supported to live in the community.

The Joint Case for Change sets out an anticipated gross annual return on investment of £6.7m by year 5, provides sensitivity analysis, describes a 'break even' position and signals further potential additional returns, requiring further testing and relating to the management of high risk patients identified through predictive modelling.

It follows a five case format and includes the following : -

- Strategic case - provides the context and rationale, overall vision and critical success factors;
- Economic case- sets out the options and a strategic option appraisal. Due to this being an Integrated Case for Change, it describes a response, ' an integrated health and social care service model' from GCS regarding the preferred option;
- Financial case – set outs the costs of the initial GCS response to confirm viability;
- Commercial case- Return of investment, contestability and contractual arrangements;
- Management case - engagement, consultation, programme approach, implementation timetable, risks and risk management.

In respect of governance arrangements, it is proposed that the ICT steering group report through to the Joint Commissioning Board. However, it is assumed that the Governing body will require regular updating on progress The Case for Change has been reviewed and agreed by the

ICT Steering Group prior to being presented to the Governing Body.

A full copy of the joint Case for Change is available on request and an extended summary is attached at appendix 1

1.2 Approach

At the request of the Multiagency ICT Steering group, this is a joint piece of work between colleagues in Gloucestershire County Council (GCC), Gloucestershire Care Services NHS Trust and Gloucestershire Clinical Commissioning Group (GCCG).

Normally, in respect of a commissioning led Case for Change, a separate formal provider response would follow. The ICT Programme is joint activity between commissioning and provider organisations. This means it has been appropriate to develop, in the context of the programme, a joint Case for Change.

As there is a clear case for not market testing (see commercial case section of the Case for Change), Gloucestershire Care Services NHS Trust has been requested to set out an 'integrated health and social care service model' for meeting health & social care commissioner requirements. It is recognised that commissioning governance arrangements still need to apply with service and funding requirements considered and agreed by the appropriate boards and bodies

1.3 Contestability & procurement

Whilst the value of the investment to strengthen Health & Social Care ICT is above European Union procurement thresholds, there are clear and legitimate reasons to refrain from procurement and it is not contractually permissible to undertake a competitive tender process for the entire community contract at this time. In view of this, GCCG seeks to amend its existing contract with Gloucestershire Care Services to significantly improve its current service provision. The amendments will ensure strengthened service integration and is in keeping with the Governments May 2013

commitment to seek fully joined up Health and Social Care provision in England by 2018. A completed decision not to tender assessment is attached at appendix 2

2 Recommendation(s)

2.1 Members of the Governing body and asked to consider and agree the following :

- To approve the Integrated Case for Change to strengthen adult health & social care integrated community teams, which includes service, financial and implementation implications;
- To formally agree the decision not to tender;
- Agree how it would like to kept up to date on progress.

3 Appendices

- Appendix 1 – Joint Case for Change and Provider response extended summary
- Appendix 2 – Decision not to tender assessment

Gloucestershire Care Services NHS Trust

Gloucestershire Clinical Commissioning Group

Gloucestershire COUNTY COUNCIL

A joint Case for Change and initial provider service model developed by Gloucestershire CCG, Gloucestershire County Council and Gloucestershire Care Services NHS Trust to strengthen adult health & social care Integrated Community Teams (ICTS) in Gloucestershire to deliver sustainable, person centred and coordinated care

Extended summary

Version 1.1

July 15th 2013

1. Introduction

The purpose of this document is to set out a Joint Case for Change and initial service model to strengthen the existing 20 adult health and social care integrated community teams (ICTs) managed by Gloucestershire Care Services NHS Trust (GCS) with an additional £3.9 recurrent monies spread over the next two financial years

The investment will increase capacity (additional staff and redesign of existing teams), capability (skills development), availability (extended opening) and support the cultural changes required within current teams so that they are best placed to play a key part in the response to the demographic, financial and patient experience challenges facing Gloucestershire's health and social care commissioners over the next five years, particularly able to manage more people with long term conditions and support frail elderly, closer to home. Implementation will commence from October 2013 and the changes will be fully effective by the end of December 2014.

The key aim is to improve outcomes for predominantly older people across health and social care through: -

- preventing specific medical hospital admissions;
- reducing requirements for some packages of social care, including placements in care homes;
- wherever possible, helping people to spend less time in hospital;
- Effective case management; and
- increasing managed care and preventative services to extend the ability of more people to live well and live independently.

The proposal sets out an anticipated gross annual return on investment of £6.7m (base case) by year 5, a description of the models of care provides sensitivity analysis, describes a 'break even' position and signals further potential additional returns, requiring further testing and relating to the management of high risk patients identified through predictive modelling. It should be noted that potential finance returns for social care will be modelled as part of the next phase of work.

Normally, in respect of a Commissioning led Case for Change, a separate formal provider response would follow the development of commissioning intentions. The ICT Programme is joint activity between commissioning and provider organisations due to there being a preferred option (see the economic case section) to strengthen existing health & social care ICTs. This means it is appropriate to develop, in the context of the programme, a joint Case for Change. Gloucestershire Care Services NHS Trust has been requested to set out an 'integrated health and social care service model' for meeting health & social care commissioning requirements. It should be noted that the 'service model' will be enhanced by detailed implementation plans and progress reporting. It is proposed this is managed through the ICT programme governance arrangements set out in the management case of this document.

2. Strategic case

Over the next five years health and social care commissioners must have responded to the challenges set out in this section to ensure that services remain 'fit for purpose' and that people can continue to access the right care when they need it . Commissioners need to have worked with local communities and individual patients and carers and agreed the different ways support and care for people will be provided. It is clear from demographic challenges set out above that attention will need to be increasingly focussed on those aged 65 years and over. Finally, changes needs to be affordable and sustainable and provide the best service and financial return on investment.

In essence, the joint Case for change is based on a requirement to commission a service model that improves the alignment of primary care, health and social care teams and a range of other stakeholders in the community with relevant acute teams. There needs to be an optimal blend of expertise to provide the right clinical risk assessment and management, particularly for older people who need to attend hospital and also to develop systems to reduce the need for people attending in the future.

Commissioning integrated health and social care systems that address care across the continuum will help deliver safe, efficient, effective and a high quality care and more likely to lead to better joined up care for the people of Gloucestershire with the following key aims: -

- Better outcomes for people across health and social care including the prevention of some hospital and care home admissions, less time spent in hospital, increased identification of people who are at risk of requiring services in the future and increased provision of preventative services and services to extend the ability to live independently;

- Greater clarity on who is involved in a person's care, what the expectations are for the person and more focus on the 'goals' and quality outcomes defined with the patient – named key workers;

- Improved communication between professionals and organisations to ensure that services are better coordinated, service responses are timely and there is improved connection to wider community based assets so that people feel valued and supported to live in the community.

3. Economic case

3.1 Commissioner preferred option

A strategic appraisal agreed by the ICT Steering Group confirmed a preferred option to respond to strategic challenges by building on the existing 800 multi professional health & social care registered, non-registered and administrative staff working across 20 integrated community teams as the springboard for further development. Health and social care commissioners seek a response to the following requirements: -

3.2 Commissioner requirements

Key commissioning requirements are set out below: -

- services to be available 24hrs, 7 day per week with appropriate availability matching need, which recognises that fewer staff out of hours;
- service for adults over 18years old and focussed on those aged 65 years and over;
- Staff will work in an integrated way to most effectively support the person to remain in the community;
- method for contacting service is simple and as soon as practicable, is through one telephone number and call handing service is available 24/7
- There is a case management function;
- there is a care coordinator function (also referred to as ward clerk type function);
- service is able to respond urgent care requirements within 1hr of request using agreed protocols based on best in class standards;
- staff have the required advanced skills to provide a safe and effective service;
- the user/ patient is at the centre of everything that is done and there are effective feedback mechanisms to monitor views;
- GPs are a key part of the ICT and teams remain aligned around each Practice and small groups of practices of around 30,000;
- ICTs are able to use risk predictive modelling systems available in general medical practices and their regular discussion of risk stratified patients to agree care plans to be developed with identified patients ;
- the service ensures effective safeguarding of adults;
- the service promotes independence, choice and control for the person;
- the service is able to support carers and families;
- services support more people with end of life care needs;
- Services support people to manage their longer-term health and/or social care needs and conditions;
- the service will regularly review patient types to maximise opportunities and it is expected this will include respiratory, heart failure, cellulitis, falls, COPD, urinary tract infections, dementia, end of life care and appropriate medical exacerbations caused by the interaction of various conditions;

- the service supports increasing independence and less dependency on health and social care solutions;
- the service reduces or eliminates hand-offs between professionals or organisations, offering a key worker or case manager/ coordinator that understands the person; can sign post or draw on resources as needed and communicate widely in order to ensure all care providers are fully briefed;
- information management and technology facilitates and supports better coordination and coordination;
- the service wraps rapid-access multi-disciplinary care around the person;
- there is more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time;
- the service has an equitable allocation of resources and there is a plan in place to address any current inequity;
- the service provider staff are clear as to which practice(s) they are attached, notwithstanding the need to support staff and patients in other practices when necessary;
- staff work flexibly to meet the needs of the county when required;
- there is sufficient community pharmacy input to support strengthened ICTs;
- the service is integral to the wider community based assets that support people in their communities, connecting people with their community and co-producing solutions that help them live a good life;
- the service reduces preventable admissions to hospital and/or enables speedier discharge from hospital through services that are able to support people in their own home with more intensive health & social care support, including the use of specific diagnostic and other equipment normally within 4 hours of request;
- the service has agreed protocols for the use of the community hospitals and or other methods for securing safe have/ step up inpatient bed provision;
- there is strong alignment and cohesiveness with relevant teams and services in acute hospitals, ambulance services, mental health teams and, voluntary organisations and the independent sector;
- the service will promote equality and diversity and will not discriminate will recognise protected characteristics
- the service adopts and works within agreed integrated care pathways; and
- the service demonstrates value for money and provides a return on investment.

Commissioners have indicated, potential investment, (some of which might be for pump priming changes and not be recurrent) in the following:-

- Urgent (also referred to as rapid) response and community based urgent care functionality;
- investment required for high intensity functionality from 5pm to 10pm Monday to Sundays and day hours, Saturdays, Sundays and bank holidays ;
- investment for training (large non recurrent and residual recurrent for staff turnover/ succession planning and updates) – advanced skills, prescribing and long term conditions management. It is assumed this will be a blend of in-house and external provision;
- Safe haven beds for Cheltenham and Gloucester due to these areas not having a community hospital;
- Night sitting services;

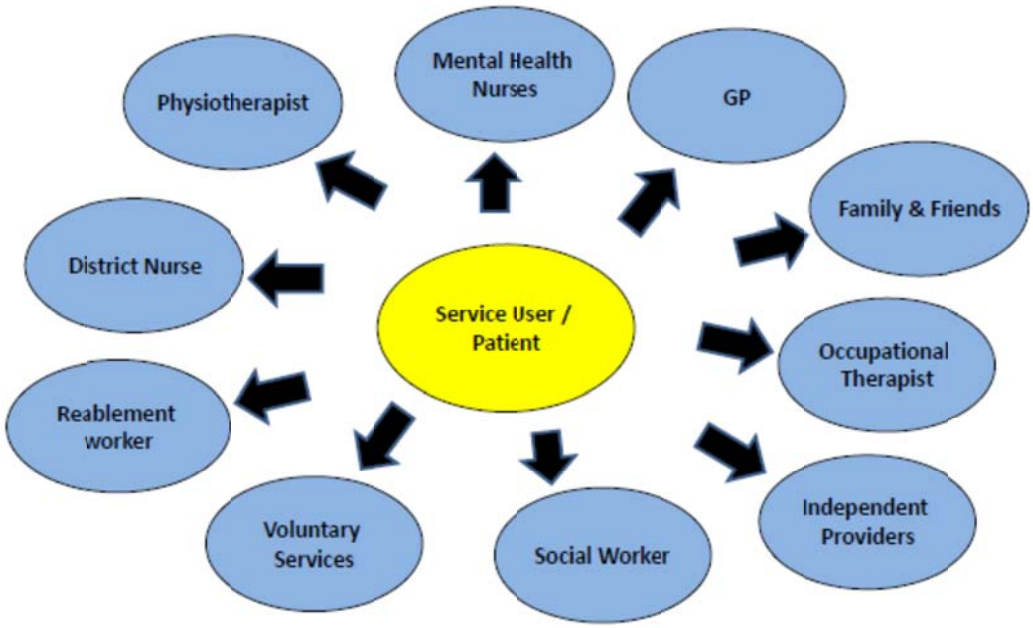
- Community pharmacy;
- Defined community based medical input
- Community equipment and diagnostics
- IT and mobile working equipment (recognising there is a specific plan in place already);
- The specific funding of the difference required to support skill mix changes to ensure around 30 case managers in place;
- non recurrent programme implementation costs.

For the avoidance of doubt, with the exception of specific funding to support skill mix changes to support case manager roles, no additional funding will be considered for high intensity and step up/ down functionality for Monday to Friday 8am to 5pm period. This needs to be created from improved team working, better systematic reviews of all caseloads, better skill mixing and use of roles and more efficient administrative processes to free up contact time. It should also be noted that commissioners expect the workforce to be used flexibly across the extended working day. Team development will also need to be covered by existing funding provided to GCS.

3.3 Preferred option – GCS response, the clinical and social care service model

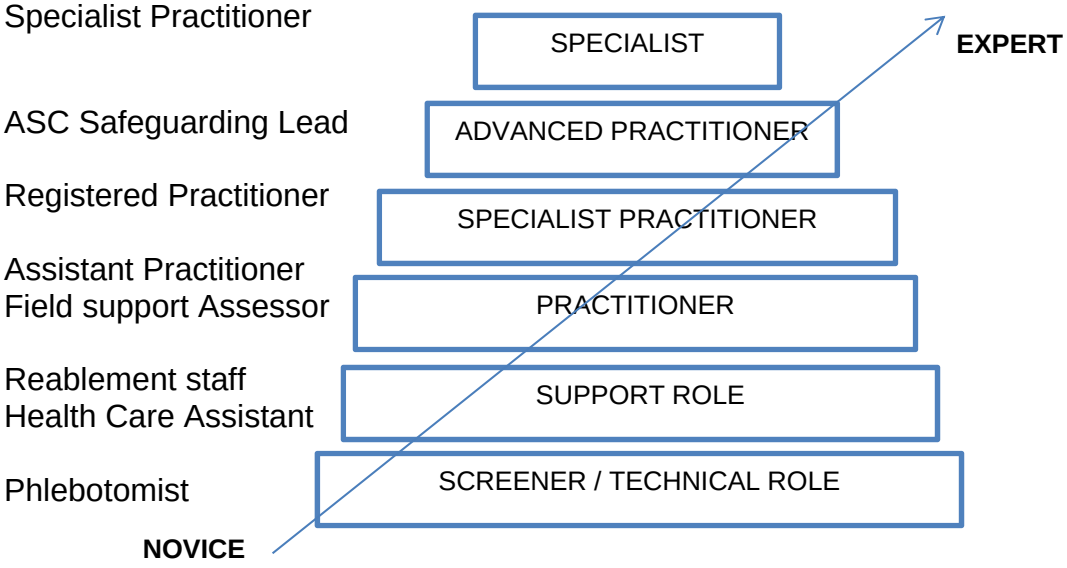
3.3.1 Overview

The core members of an ICT are represented in model 1 below. Currently not all the teams have a mental health practitioner allocated to work with them. GCS aspire for all the ICT's to have a mental health practitioner within the teams in the future and will work with commissioners to implement this.



Model 1. The Integrated Community Team

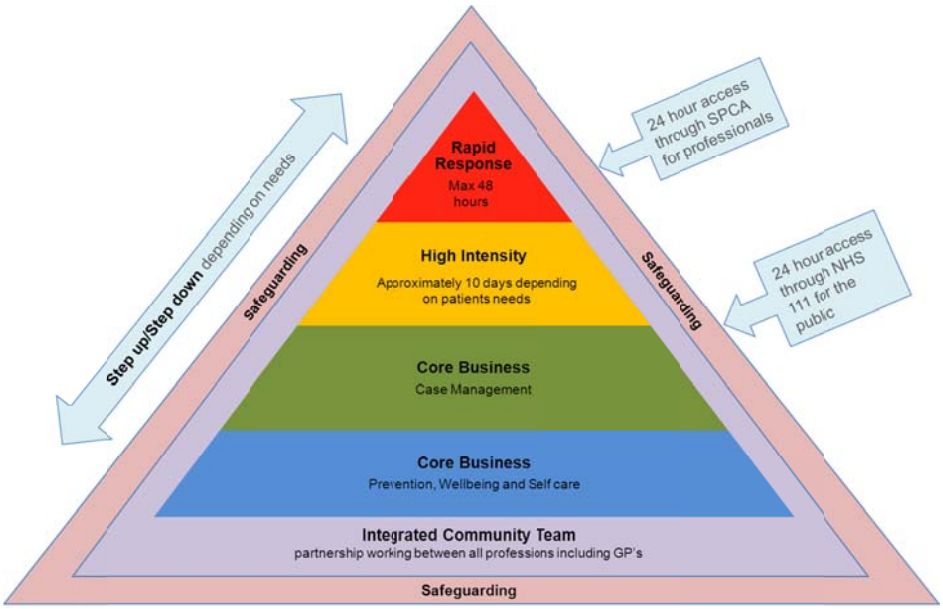
The roles that are incorporated within an Integrated Team are outlined in model 2 below, using generic terms that are relevant for health and social staff. The team structure is based on the principle that staff will be working from "novice to expert" developing skills and knowledge set out within a competency framework.



Model 2. The Integrated Community Team roles

3.3.2 The functioning ICT

The ICT will be 'one team' made up of three components; rapid response, high intensity and the core business. The ICT will provide different functions and inputs according to a person's health and social care needs, as shown in model 3. Each ICT will have competent and trained staff to provide a range of services that will respond to the levels of patient needs, which are identified in the model 3. GCS recognises that the core business and the high intensive components, 08.00-17.00, will use current staff and will continue to create productive working teams. This model describes functions of the ICT that will provide urgent and non-urgent care in order to meet commissioned requirements that will be delivered as an integrated model.



Model 3. The Integrated Community Team Components

The main functions of the ICT are described as follows:

3.3.2.1 Urgent care functions within the ICT with the objective to avoid unnecessary hospital admissions

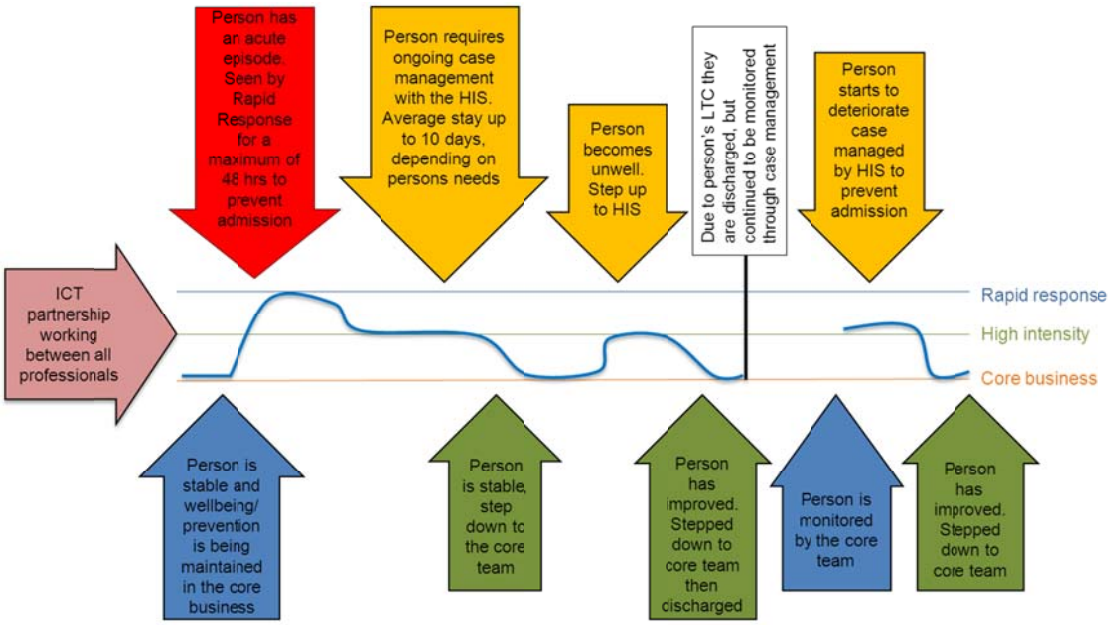
- **Rapid Response component** - the functions of the rapid response component will manage acutely ill and complex care for those people living in their own homes it is likely that the primary need will be health related and require immediate stabilisation but due to complexity social care needs will also need to be addressed. Staff will respond within **one hour**, assess, plan and actively deliver care for up to 48 hours. At the same time they will co-ordinate with other services as appropriate once acute needs have been addressed. This is a new service and has been signed off by commissioners in a separate business case. Work is underway in GCS to develop referral criteria for and clinical pathways.

- **High Intensity component** - The functions of the high intensity component of the ICT will be to provide a level of enhanced support for people who are stepping down from the rapid response component immediately after the urgent situation has been stabilised but where on-going needs require intensive health and social care interventions necessitating up to four visit over 24 hours. The service will also provide support for people who are on existing caseloads where there is a likely deterioration that requires additional support for a prolonged period of time in order to prevent acute hospital admission. This team will respond within **four hours** of referral. It is acknowledged that if the team works with a person for longer there can be significant benefits and can possibly prevent or reduce future needs. Due to this the team will work to provide care for approximately 10 days depending on the person's needs. It is anticipated that the cohort of patients that require this level of service are likely to have health and social care needs. The current ICTs are not commissioned to provide this service from 17.00 to 22.00.

3.3.2.2 Non-urgent care functions

- **Core Business** - the functions of the core ICTs are the management of long term conditions, prevention of health and social care crisis and promotion of wellbeing and self- care. The ICTs will provide planned and routine community care and access into this team will come from a variety of routes. This group of patients will make up the majority of the teams caseload at any time and therefore the majority share of the team capacity, for example;
  - Planned and routine reablement input
  - Planned and routine social care, nursing, physiotherapy and occupational therapy.
  - Early intervention through case management
  - Proactive prevention and wellbeing

Model 4 demonstrates how a person might step up and down through the ICT pathway.



Model 4. ICT step up and down through the pathway

The ICTs will have access to and be supported by a comprehensive network of additional GCS services such as the following;

1. Specialist Clinical Teams: Diabetes, Heart Failure, Respiratory, Tissue Viability, Neurological, IV Therapy, the Care Homes Support Team and MSKCAT;
2. Assistive technology to support care at home as needed: Telehealth and Telecare;
3. Social care support service: Carers emergency schemes, the Sensory team.
4. Self–management and self-care programs such as The Expert Patient and Self-Management Programme;
5. CTs will have access to other GCS provision such as bed based services, community assessment services ICATs, and community based clinics;
6. Village agents and other community networks that support communities.

3.3.3 Underpinning care principles

- Service specific pathways will be followed for Rapid Response and High intensity service and will describe access criteria, assessment and treatment and discharge processes and routes access to step up /down services provided by the ICTs;
- LTC pathway redesign will be followed, making sure that ICT's have a systematic approach to delivering best practice care and make sure that the right things are delivered at the right time. Additional training will be provided to staff to ensure they have the correct awareness of LTC enabling them to provide person-centred care;
- Each ICT will be staffed with existing resources and strengthened by the staff who have the enhanced skills, knowledge and provide the rapid response and the high intensity component. Staff skills will be developed to reflect the ever-changing needs and demands of the population;
- There will be 20 ICT across the county and each will have an identified clinical lead and team co-ordinator, an identified physiotherapist, nurse and OT, non-registered healthcare and social care support workers who will be supported by local administration staff to support the teams;
- The ICT will work closely with the mental health nurses for advice and on-going training;
- Self-management will remain paramount to the health prevention/promotion agenda. GCS will provide education sessions for patients, training for carers/relatives and other care professionals primarily in areas of basic care delivery.
- GCS will operate self-management programmes such as 'Expert Patient Programme' and 'Living Life to the Full';
- Learning from the Living Well methodology the ICT will increase patient involvement in their care, introduce a systematic feedback process for patients and service users and involving patients in service redesign;
- Patients with complex health needs will have a Case Manager (CM) allocated to them from their local ICT. The patient will know how to contact their CM or another member of the ICT directly, or out of hours will have a contact number. The allocation, monitoring and management of case managed cases will be through the team manager and multi-disciplinary meetings. Once the patient has been discharged from active case management, patients will be reviewed by the core team on a regular basis, either face to face or by phone, depending on the person's risk of deterioration and complexity of their care. Patient choice and consent will be embedded within all protocols and systems and will be integral to the assessment and care planning process;
- The Case Manager's skill set will depend on the patient's individual needs and existing relationships;
- The principles of a virtual ward is to case manage the patients who require a high intensity component and is described in more detail later. Virtual wards are a model for delivering multidisciplinary case management to people at high predicted risk of unplanned acute care hospitalisation. The virtual ward will be provided by the rapid response and the high intensity functionality. GCS model has two elements: -

- using a predictive model to identify those at high risk of future emergency hospitalisation, and
- offering these people intensive, multidisciplinary preventive care at home using a hospital ward's systems, staffing and daily routines. GCS virtual wards will vary in patient selection, ward configuration, staff composition, and ward processes. A specialist nurse with the ICTs will run the ward day-to-day, liaising closely with the patient's GP and with other care professionals to undertake full medical examinations and prescribe medicine and treatment. GCS will comprehensively assess those patients with complex needs to provide case management to those with LTCs. GCS will co-ordinate complex care packages in partnership with patients, carers, colleagues, members of the multi-disciplinary team within primary and secondary health and social care, allied health professionals and hospices. GCS is confident that it will discharge patients earlier from hospital and prevent them being in hospital longer than necessary.

3.3.4 Activity and profiling

The proposed number of patients anticipates to be seen in the rapid response and high intensity components from October 2013 to December 2014 is 4,015 of which 2920 is admission avoidance and 1,095 is and additional specific urgent response cohort where 'see, treat, close' is as shown in the table below.

Locality	Number of teams	Total Admissions	Admissions over 65s	% over 65s	Rapid Response / High Intensity proposed target	% of over 65s	% of Total admissions
Cheltenham	4	6,119	3,468	56.7%	787	22.7%	12.9%
Forest	3	2,230	1,361	61.0%	309	22.7%	13.9%
Gloucester City	4	6,672	3,322	49.8%	754	22.7%	11.3%
North Cotswold	1	986	624	63.3%	142	22.8%	14.4%
South Cotswold	2	1,809	1,139	63.0%	258	22.7%	14.3%
Stroud and Berkeley Vale	3	3,563	2,120	59.5%	481	22.7%	13.5%
Tewkesbury	3	1,433	833	58.1%	189	22.7%	13.2%
Grand Total	**20**	**22,812**	**12,867**	**56.4%**	**2,920**	**22.7%**	**12.8%**
Additional 1095					1095		
Locality	Number of teams				Rapid Response / High Intensity proposed target	% of over 65s	% of Total admissions
Cheltenham	4				295		
Forest	3				116		
Gloucester City	4				283		
North Cotswold	1				53		
South Cotswold	2				97		
Stroud and Berkeley Vale	3				180		
Tewkesbury	3				71		
Grand Total	**20**				**1,095**		
Locality	Number of teams				Rapid Response / High Intensity proposed target	% of over 65s	% of Total admissions
Cheltenham	4				1,082		
Forest	3				425		
Gloucester City	4				1,037		
North Cotswold	1				195		
South Cotswold	2				355		
Stroud and Berkeley Vale	3				661		
Tewkesbury	3				260		
Grand Total	**20**				**4,015**		

Table 1, The proposed target number of patients for Rapid Response and High Intensity

3.3.5 Development focus

GCS intends to strengthen ICT's in two ways;

1. Expanding Single Point of Clinical Access (SPCA) to offer a single contact number for professionals 24 hours a day;
2. Strengthening the existing ICT's.

3.3.5.1Single Point of Clinical Access (SPCA**)**

SPCA currently provides a service from 08.00-21.00 Monday to Friday and 08.00-17.00 on weekends and bank holidays. Outside of these hours, call handling is managed and routed to the South West Ambulance Service Clinical hub at Waterwells, Gloucester. This service level agreement has now expired.

GCS offer will be to increase this provision in a phased approach. Phase 1 to be completed by December 2014 will provide a health professional single point of access 24 hours per day, 365 days a year. Phase 2 to be completed by April 2015 and will establish a model for offering a single point of access for public calls as well, working closely with GCC and NHS 111. The SPCA will improve GCS ability to achieve the right response first time, with minimal transfers and care will be better coordinated, more consistent and more seamless for the patient and their carer/family because of:

- Referral of patients by phone, from all sources (including complex discharges from acute care) for all services via a single number;
- Operating 7 days/week, 24 hours per day, including bank holidays;
- Calls being answered within 60 seconds, with no answer machines used during core hours i.e. 08:00-22:00;
- Triaging referrals to the appropriate team and then coordinating to ensure an appropriate and timely response;
- Management of healthcare enquiries from health professionals in phase 1 and service users, carers, and other members of the public in phase 2;
- A comprehensive directory of services that will allow more effective signposting;
- A clinical co-ordinator to support clinical decision making and signposting;
- Knowledge of specialised equipment available;
- Better working knowledge of the services available and their operating times in the out of hours period;
- They will know the patients on the caseloads;
- SPCA will know the knowledge, skills and experience of the clinicians in each urgent care service so that each patient is despatched to the right clinician, in the right place at the right time;
- Improved geographical working that will reduce costs such as non-pay, i.e. petrol and staff time;
- Initially GCS will be using the existing IT system, Adastra. In the future the organisation will be moving to SystmOne (TPP). GCS recognise the need for a joint process to identify a holistic solution that meets the needs of the community service and GPs;
- In phase 2 an aspiration is that SPCA will be able to populate an electronic first contact assessment form for all calls/referrals that is part of the generic assessment documentation and becomes part of the care record;
- SPCA will have the ability to look up existing patients' records from health and social care records. Management of urgent and non-urgent calls will differ after completing the generic part of the pathway;
- SPCA will continue to develop working relationships with the Integrated Discharge Team based in the acute hospital in particular in the ED departments to support discharge within 4 hours.

3.3.5.2Strengthening the ICT

The ICTs will be strengthened to provide the High Intensity functionality, which will be available from 0800-2200. GCS anticipates that the current ICT resources will, through improved productivity as part of the GCS cost improvement programmes (CIPs), be able to provide the increased visiting requirement during the daytime hours 08:00-17:00. They will simultaneously utilise the advanced skills of the rapid response practitioners to support ICTs a higher level of clinical care when required. GCS are making the assumption that some end of life patients will be included in the high intensity component of the ICT, this will be based on needs and dependency. The current ICTs will need to be enhanced to provide this service from 17:00-22:00 7 days a week.

Routine/short term care/prevention and well-being services will be available 0800-1700, Monday to Friday, and response times will vary based on needs and the schedule of planned work. GCS anticipates that the current ICT resources will, through improved productively and efficiencies as part of the GCS cost improvement programmes (CIPs), be able to provide this service with no additional funding.

The business case identifies funding requirements for the following and should be read in conjunction with section 4 financial case:

- **High Intensity components** - Additional staff required to provide the High Intensity component 17:00-22:00, 7 days a week, including skill mix changes to ensure case management available at an appropriate level;

- **Overnight sitting service** this will be a contractual arrangement with an independent provider;

- **Safe haven beds** - Members of the Rapid Response and High Intensity components of the ICT will have direct admitting rights to these beds, which in the early stages of implementation the safe haven bed identified will be in a community hospital, this will be reviewed to agree medium to long term options;

- **Clinical and non -clinical equipment to support people at home** - This includes clinical equipment required by staff to support assessment and treatment;

- **Pharmacist and drug costs from prescriptions** - There will be three pharmacists, one per locality, see table 3. The pharmacist will undertake medication review in the community; this role will enhance and strengthen the ICT in supporting them to manage people with long term conditions;

- Currently the contract for Patient Transport Services (PTS) is under offer to a new provider, it is unclear at the moment whether part of the new contract will include transportation of people from the community to the safe haven beds and in the future travel that includes access to diagnostics. For this reason **patient transport** has been included in this business case;

- **Telehealth**- It is anticipated that as the numbers of patients accessing the high intensity components of the ICT there will be increased opportunities to integrate assistive technology as part of the care plan will also increase;

- **IM+T** for mobile working and connectivity GCS is committed to the use of technology such as laptops to assist teams to realise productivity and efficiency at the same time as reducing the need for referrals and hand offs. This will cost £9,613 per annum;

- **Education and training** -The strengthening of ICT's, the provision of rapid response and high intensity components of the ICT is underpinned by a substantial programme of education and training to up skill staff. This includes training in advanced assessment skills, clinical intervention skills and for all members of the ICT a programme of competency training.

3.3.6 IM&T

GCS has experience in delivering clinical systems to enable us to meet the national "digital by default" strategy. GCS will drive the strategic roadmap towards system rationalisation working towards system integration delivering clinical portals. As part of the Southern Programme for Community and Child Health Systems, GCS will be implementing the TPP SystemOne Community and Child Health system. This will support the ability to create an electronic clinical patient record which will capture clinical detail, support the clinical decision process and track clinical progress through the patient's care pathway in Gloucestershire.

There is also the development of integrated information systems that allow sharing of relevant information across the health and social care system. GCS are working with partners to ensure compatible IT systems and adopt and sustain information systems that support registration, recall and review for people with multiple conditions and enable effective data sharing across all relevant partners and care settings.

3.3.7 Estates and accessibility

Although, most of the Business Unit ICT's are co-located in one building, some of the community nurses remain based in GP practices. To support integrated working between the professionals the desire is to ensure that ICT staff have regular opportunities to work together, ideally co-located in one place, whilst simultaneously ensuring staff remain aligned with GP practices to ensure prime relationships are maintained. It is recognised that as the teams strengthen there might be a need for more capacity to be able to accommodate new staff. If this occurs GCS would appreciate the opportunity to work with the commissioners to consider different options going forward.

3.3.8 Workforce and Organisational Development

GCS is committed to developing a flexible and productive workforce through effective skills utilisation of the existing workforce to ensure strengthened ICTs deliver commissioner requirements. The strengthening of ICTs will be underpinned by the overall Workforce plan and includes the following:

- Further develop new roles at levels three to four of the NHS Career Framework;
- Expand apprenticeship schemes and work experience schemes;
- Introduce back to work schemes;
- Review succession planning/ career pathways;
- Develop the capacity and capability of the volunteer workforce;
- Develop management and leadership skills, competencies and behaviours;
- Further develop the roles of Integrated Support Workers (e.g. Generic Rehabilitation Assistant);
- Develop a more flexible and responsive contingent workforce;
- Develop a competency framework for ICTs;
- Complete a comprehensive training needs analysis;
- Develop a training and development programme by April 2014.

GCS has developed a competency framework, induction package and training program for staff that are recruited to the Rapid Response Team and this will be suitable for staff working at the higher end of support in the ICTs. GCS see the Rapid Response staff as pivotal in supporting the training of ICT staff working alongside teams, being accessible for advice and delivering bespoke training.

3.3.9 Workforce change & consultation

The newly commissioned services will require consultation with staff on changes to working patterns, in particular staff will have a 6 week period of consultation on extending their working times to provide core services from 08.00-22.00. This consultation will be with all members of the ICT including GCC staff. GCS will continue its organisational change programme and work with leaders, teams and staff groups to understand the implications of changing services.

4.Financial case (GCS service model)

The following funding requirements are subject to ongoing as consequence of evaluation and learning harnessed from initial implementation sites in Gloucester, Cheltenham and the Cotswold.

The additional services will cost around £3,900k per annum plus an initial setup of £203k. The cost by each element is shown below:

The additional costs of moving the single point of clinical access to 24 hours a day, 7 day a week cover is an additional £173k per annum plus an initial setup cost of £10k. It must be noted that this excludes any increase in call volume due as a result of schemes identified in the Urgent Care Recovery Plan

The high intensity functionality (with the exception of funding to support the skill mix changes to ensure more senior case management available, week day hours from existing resources) from 17.00-22.00pm each day) will cost an additional £1,861k per annum plus an initial setup cost of £193k. This includes a senior project manager dedicated to this programme to ensure that all setup of processes, recruitment, training and reporting are managed efficiently in order to get the service up and running smoothly as quickly as possible. Within the £1,816 is around £360k which will fund the delivery of an overnight sitting service.

The rapid response functionality will be an additional £1,802k, in addition to the already approved £310k which has been funded non-recurrently from the NHS Social Care project funding that is managed through the Joint Commissioning Board. Please note that for 2014/15 onwards, this £310k will need to be made recurrent.

At a high level, the additional capacity and training detailed above that is being added to the existing Integrated Community Teams should be sufficient to manage the case load and activity to ensure the avoidance of 4,015 (2,920 plus 1,095) ED admissions.

Detailed capacity modelling needs to take place to understand the element of the caseload that is to be managed by the HIS, and the proportion of that activity that will happen during the day. GCS has productivity targets for the various peripatetic teams that will need to be met to deliver the required Cost Improvement Programs that are required to achieve GCS' annual plan and so increases in activity above 2012/13 levels will need to have funding agreed with the CCG.

The same detailed modelling will need to ensure that recruitment is targeted at the teams where there is demand for the various services to ensure that the additional capacity is utilised most effectively.

5. Commercial case

5.1 Contestability and procurement

Whilst the value of the investment to strengthen Health & Social Care ICT is above European Union procurement thresholds, there are clear and legitimate reasons to refrain from procurement and it is not contractually permissible to undertake a competitive tender process for the entire community contract at this time. In view of this, GCCG seeks to amend its existing contract with Gloucestershire Care Services to significantly improve its current service provision.

5.2 Contractual & performance arrangements

The current Health based contract with Gloucestershire Care Services has in excess of 50 separate Service Specifications. The development of Strengthened ICTs is of such a transformational nature that it is expected that there will be major revisions to all current contracted services and their associated paperwork. The clear intention of commissioners across health and social care is to agree, wherever possible, a single suite of key performance indicators replacing the several hundred that currently exist.

5.3 GCCG Medium Term financial plan

GCCG's medium term financial plan assumes minimal real terms growth in funding for the next five years with the delivery of a 1% surplus each financial year. Within the financial plan the impact of the increase in the population, especially those over 65 years, and the associated increase in use of health care have been modelled along with increased drugs and technology costs and other investments required to improve the quality of services.

Investment is set out in the MTFP to fund the strengthening of ICTs including rapid response, high intensity and other essential additional functionality. Delivery of the benefits of these schemes has been factored in a phased manner within the plan with full delivery expected in 2015/16.

5.4 Return on investment

5.4.1 Introduction

The CCG medium term financial plan, described in the previous section, describes the challenges of over the next five years. Strengthened ICTs and the service model described in Section 3.4 will contribute to the planned reduction in costs through a reduction in emergency hospital admissions. A core assumption of this model is that new emerging growth is managed by the ICT service and that existing acute capacity continues to be required, as part of evaluation it will be necessary to assess what level of growth actually materializes and if there is a significant change to the casemix utilising acute bed capacity. The output of this element of evaluation would in-turn need to be made available for commissioners to utilise within annual contracting decisions around capacity and demand.'

In 2012/13 there were 38,300 adult emergency admissions to local and neighbouring acute hospitals, occupying 610 acute hospital beds at a total cost of £81.6m. Based on demographic projections for the next 5 years and current patterns of hospital use, the number of admissions is expected to rise to around 41,100 at a cost of around £88.5m. This represents an increase of 2,800 in emergency hospital admissions at an additional annual cost of £6.9m by 2017/18.

5.4.2 Modelling

For the purposes of QIPP emergency admissions have been categorised into two main groups:-

1. "Medical" admissions where the patient has no surgical or significant investigative intervention, where QIPP schemes are expected to have the most impact;
2. "Surgical/Diagnostic" admissions where the patient has either a surgical or significant investigative procedure, where QIPP schemes are expected to have minimal impact in the short to medium term.

The projected impact of demographic growth on the two groups of admissions is summarised in the table below: -

	2012/13	5 Yr Projected Increase
Medical Admissions	22,812	1,657
Surgical/Investigative Admissions	15,504	1,105
Total Admissions	**38,316**	**2,762**
Medical Admissions - Beddays	101,434	9,895
Surgical/Investigative Admissions - Beddays	121,256	11,001
Total Beddays	**222,690**	**20,896**
Medical Admissions - Beds	278	27
Surgical/Investigative Admissions - Beds	332	30
Total Beds	**610**	**57**
Medical Admissions - £000s	£36,379	£3,247
Surgical/Investigative Admissions - £000s	£45,190	£3,683
Total £000s	**£81,569**	**£6,930**

Table 1- Demographic growth and impact on admissions

In order to contain the cost of emergency admissions at current levels over the next five years the CCG needs to reduce the cost of admissions by £6.9m. Assuming that QIPP will have minimal impact on "surgical/investigative" admissions this equates to a £6.9m (19%-20%) reduction in the cost of treating the cohort of patients currently admitted as "medical" emergencies. The new operating model will provide an enhanced community service aimed at reducing emergency hospital admissions in four ways: -

1. Urgent response functionality for patients who require urgent short term intervention in the community to prevent hospital admission (Aimed at reducing short stay hospital admissions and facilitating transfer of patients to other community services where appropriate);

2. A 24/7 alternative to hospital service providing intensive multi -disciplinary support from teams with enhanced clinical skills for patients with an exacerbation of their condition who would otherwise be at immediate risk of hospital admission (Aimed at reducing "medical" hospital admissions, principally for patients aged over 65 who represent the majority of these patients);

3. Case management and care coordination supported by fully integrated health and social care teams for patients with complex health needs who would otherwise be at risk of hospital admission. (Aimed at reducing risk of future exacerbation and hospital admission)

4. Early intervention for patients predicted to be at future risk of hospital admission. (Aimed at reducing the overall number of admissions further downstream).

The potential impact on hospital admissions has been modelled on the basis of the additional community created by urgent response (1) and the 24/7 intensive support service(2). The impact of (3) and (4) are difficult to relate to specific capacity so that no impact on hospital admissions has been assumed for years 1 to 3. There is however an assumption that a combination of prevention and pre-pre-emptive intervention will make a substantial contribution to containing demographic growth in years 4 and 5. This will need to be reassessed in the light of evidence[1] and experience.

Assumptions relating to the community capacity created by the new operating model are summarised below:

1. Urgent response functionality is expected to have the capacity to see, treat and discharge an average of 3 patients each day who would otherwise have been admitted to hospital for less than 2 days. Patients are expected to stay on urgent response caseload for up to 2 days. This equates to an annual caseload of 1095 patients[2];

2. The 24/7 intensive support functionality is expected to have an average daily caseload of 100 patients, of whom around 80 would otherwise have been admitted to hospital for an average of 9-10 days and 20 have been discharged from hospital earlier than would otherwise have been possible. Patients are expected to stay on caseload for an average of 10 days.

[1] For example- Detailed Nuffield Report on the impact of the systematic use of predictive modelling on emergency admissions has been due since the spring of 2013.

[2] This is based on a cautious estimate of known numbers from other CCG areas and informed by data analysis from South West Ambulance NHS Trust.

The criteria for admission is still being finalised and the expectation is that most patients, if not all, will be age 65 and over with one or more health condition with key conditions. This equates to an annual caseload of 2920 patients who would otherwise have been admitted to hospital and 730 early discharges from hospital requiring on average 3-4 daily interventions;

3. Integrated teams are expected to hold an average daily caseload of 500-600 patients with complex needs, requiring enhanced case management. Assuming and average stay of 28 days on caseload this equates to an annual caseload of around 6500- 7800 patients requiring on average one intervention per week;

4. The CCG is currently in the process of implementing a predictive modelling tool across Practices. Expectations around early intervention based on case finding have yet to be specified and as such additional impact will be modelled.

5.4.3 Sensitivity analysis

There is a risk that community capacity intended to provide services to a new and more complex client group, who would otherwise be admitted to hospital, in reality provides an enhanced service to existing users with little impact on hospital admissions, although potentially reducing pressure on core services.
The impact on hospital admissions will depend on how well this risk is managed. Scenarios have been used to model the potential impact on hospital admissions to reflect more, or less, effective use of the new capacity: -

1. Scenario 1: The base case assumes that the newly created capacity in the community (urgent response and the 24/7 high intensity functionality) is 75% utilised by patients who would otherwise have been admitted to hospital, and that prevention and pre-emptive community intervention will contain 75% of demographic growth in years 4 and 5;

2. Scenario 2: The downside case assumes that only 50% of the newly created capacity (urgent response and the24/7 high intensity functionality) is utilised by patients, who would otherwise have been admitted to hospital, and that prevention and pre-emptive community intervention will contain 50% of demographic growth in years 4 and 5;

3. Scenario 3: The upside case assumes that 100% of newly created capacity (urgent response and the 24/7 high intensity functionality) is utilised by patients who would otherwise have been admitted to hospital, and that prevention and pre-emptive community intervention will contain 100% of demographic growth in years 4 and 5.

The estimated QIPP savings and return on investment associated with each scenario are summarised in Table 2 below:

	Estimated 100% Community Intervention Capacity	Average Hospital Tariff 2012/13	Scenario 1: Base Case		Scenario 2 : Downside		Scenario 3: Upside	
			Assumption 1: 75% of capacity is used by patients who would otherwise have been admitted to hospital and pre-emptive intervention contains 75% of demographic growth in Yrs 4 and 5		**Assumption 1**: 50% of capacity is used by patients who would otherwise have been admitted to hospital and pre-emptive intervention contains 50% of demographic growth in Yrs 4 and 5		**Assumption 1**: 100% of capacity is used by patients who would otherwise have been admitted and pre-emptive intervention contains 100% of demographic growth in Yrs 4 and 5	: Prevention
			Avoided Admissions	**Estimated Saving/(Cost)**	**Avoided Admissions**	**Estimated Saving/(Cost)**	**Avoided Admissions**	**Estimated Saving/(Cost)**
Rapid Response	1095	£680	821	£0.6	548	£0.4	1095	£0.7
24/7 Intense support service	2920	£2,000	2190	£4.4	1460	£2.9	2920	£5.8
Prevention/Pre-emptive intervention	1100	£1,600	825	£1.3	550	£0.9	1100	£1.8
Total Hospital Cost Saving (Years 1-5)			3836	£6.3	2558	£4.2	5115	£8.3
Total Investment				(£3.9)		(£3.9)		(£3.9)
Net saving/Return on investment				£2.4		£0.3		£4.4
% Return on investment				62%		8%		112%

In addition there is a potential avoided A&E attendance associated with each avoided hospital admission at an estimated average cost of £110 per attendance. If A&E attendances are included the net return on investment is: -

- Base case: £2.8m (72%)
- Best case: £5.0m (128%)
- Worst case: £0.6m (15%)

5.4.4 Phased geographical & functional Implementation impact on QIPP contribution in years 1 and 2

Evidence[3] recognises that planning and implementing large scale service change takes time, needs to implemented well and interim markers of success are required. A recent report from the Nuffield Trust suggests that two years of initial development followed by a minimum one year 'live working, and almost certainly longer, is required to show initial effects of major changes to service organisation and provisions, particularly in financial savings.

Simultaneously, there is a recognition that as service change occurs there will be impact and this will increase over time. In the absence of a specific tool, the programme team is developing a 'reasonable assumption' approach to finalise a timetable to full functionality by January 2015 taking into account initial geographical, operational and referrer constraints increasing.

[3] Evaluating integrated and community based care: How do we know what works; Nuffield trust, June 2013

5.4.5 Contribution to Acute Hospital Bed Reduction

As described in 5.4.2 the integrated teams will also have the capacity to manage an average daily caseload of 20 early discharge patients from acute hospitals reducing demand on hospital beds. Whilst no saving accrues directly to the CCG it does contribute to the overall objective of reducing hospital length of stay and the overall efficiency of the local health system.

5.4.6 Return on investment conclusions

In summary the estimated return on an investment of £3.6m is as follows:

- is around 75% assuming 75% of the new capacity is accessed by patients at risk of hospital admission;
- falls to 16% if only 50% of the new capacity is accessed by patients at risk of hospital admission;
- exceeds 100% if the new capacity is only accessed by patients at risk of hospital admission;
- falls to zero only if less than 43% of capacity is accessed by patients at risk of hospital admission.

The estimated reduction in hospital activity equates to between 11% and 22% on 2012/13 medical emergency admissions and between 7% and 13% of all emergency admissions.

The gross contribution to the QIPP target reduction of £6.9m is between £8.9m (best case), £6.7m (base case) and £4.5m (worst case) which after costs equates to a net contribution of between £5.0m (best case), £2.8m (base case) and £0.6m (worst case). Although service changes commence from October 2013, full service functionality will be from January 2015 onwards so full benefit effective from this date.

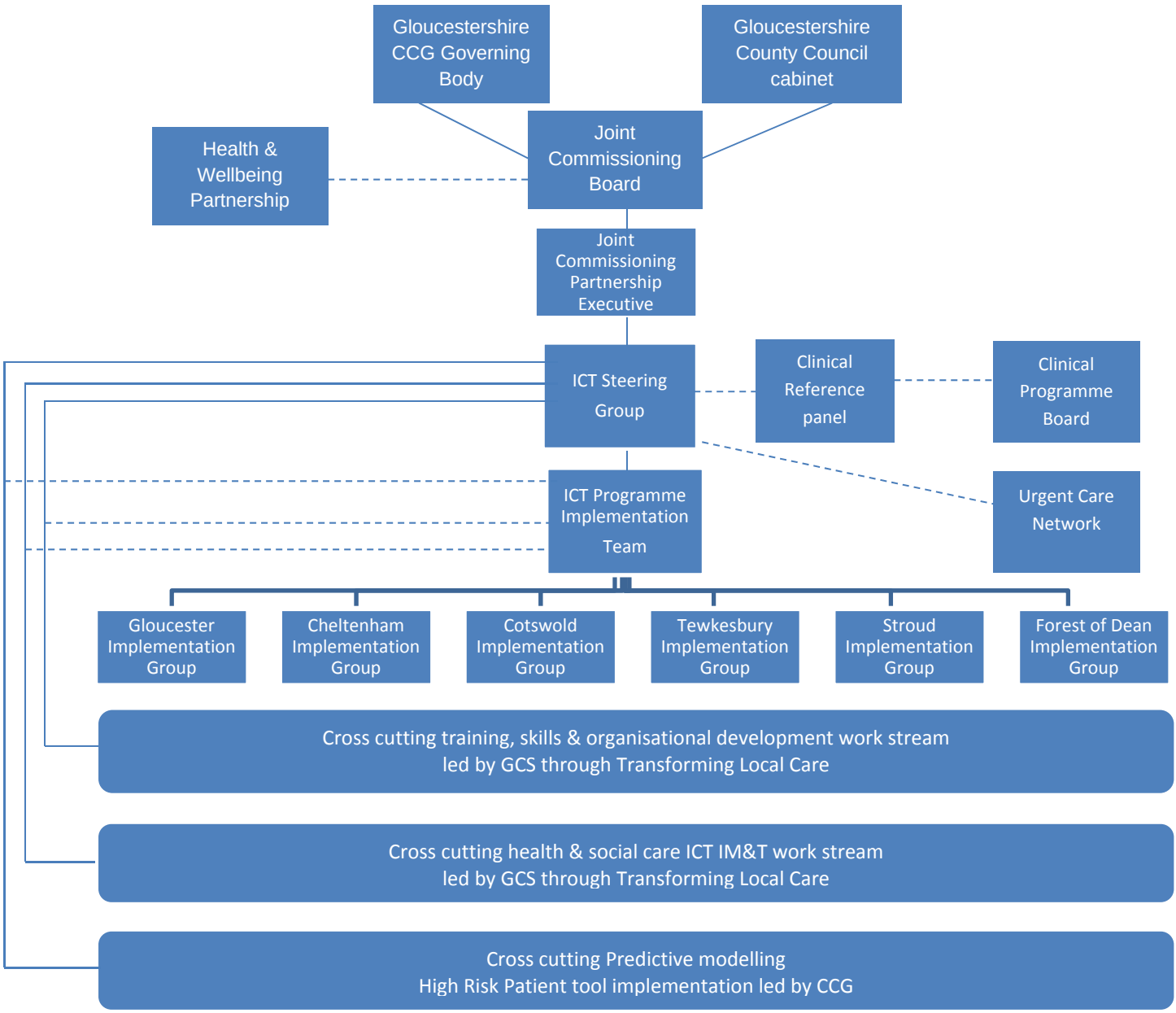
6 Management case

6.1 Public and stakeholder engagement

It is recognised that more substantial engagement will be required to scrutinise the emerging model and evaluate the impact of the strengthened service in the test areas before progressing to full roll-out countywide. This activity will be a blend of information giving as well as opportunities for shaping more detailed elements of service provision. Subject to this joint Case for Change and Provider service model achieving agreement, a stakeholder communications and engagement plan and supporting materials will be produced.

6.2 Strategic programme management & governance

The overarching joint programme governance arrangements are set out in the diagram below



- **Reporting line**
- **Relationship line**

6. Programme milestones

Item	Key deliverable(s)	Planned date	Status
Programme initiated	Steering group established, programme team in place, key programme plan and core aim and objectives	April 2013	Completed
commissioning model	High level health & social care commissioners requirements	May 2013	Completed
Case for Change	Joint Case for change & Provider service model completed and approved by ICT Steering Group	July 16th 2013	On track
Case for Change approval	Review and agreement of Joint Case for Change and Provider service model by CCG Governing Body	July 25th 2013	On track
Staff consultation	GCS formal staff consultation undertaken on key proposals, finding collated, considered and agreed changes made	July to August 2013	On track
Stakeholder and public engagement	Engagement plan, countywide and localised approaches, through implementation groups	From August 2013 onwards	On track
Service Delivery Plan	Detailed Operating model from GCS	End of September 2013	On track
Contractual requirements	Detailed service specification, contractual, financial and performance requirements	End of September 2013	On track
Wave 1 service launch	Commencement of service changes covering Gloucester, Cheltenham and Cotswold	October to end of December 2013	On track
Wave 2 service launch	Commencement of service changes covering Tewkesbury, Stroud and Forest of Dean	February to April 2014	On track
Handover	Programme Implementation Teams handover phase 1 to business as usual and agreed programme reporting secured completed	December 2013 to May 2014	On track
Phase two planning	Review of next stage aims and objectives, likely to include mental health services, Living Well and Asset Based Community Development	October 2013 to March 2014	On track
Phase 2 starts	Review of phase 1 and ongoing reporting requirements agreed and incorporated into phase 2. Phase 2 programme plans in place, programme board and team membership reviewed and confirmed.	April to May 2014	On track
Phase 1 closed	Phase 1 completed	May 2014	On track

6.3 Key programme risks & risk management

Key risks associated with the ICT programme are set out in the table below. These risks will be managed through the ICT steering group and individual organisations will also ensure that appropriate risks are reported and managed where responsibility rests with that specific organisation.

Risk	Probability	Impact	Initial risk	Controls & assurance	Revised risk score
There is insufficient clarity on the aims and objectives of the programme, which means the benefits are not achieved , only partially achieved, delayed and/ or there is disagreement on proposed outputs and outcomes	3	5	15 high risk	• Programme owner in place; • Identified programme team; • Programme plan; • Core fundamentals agreed; • Commissioner service requirements agreed; • Business case and service model sign off; • Programme governance arrangements	2x5=10 Medium risk
There is insufficient programme resource to deliver the requirements of the programme , which leads to delay in completing	3	4	12 Medium risk	• Programme team in place • Additional resource being recruited by commissioner • Provider programme resource set out in Case for Change financial section • Implementation in waves	2x3 =6 Low risk
There is a risk that that requirements are not mobilised timescales due supplier factors such as lack of staff, additional training requirements, redesigning of existing structures	3	5	15 High risk	• Identify staff with skills close to the specification of the roles that are needed • Enable secondment with backfill. • Use of agency staff • Review and agree revisions to functional capacity roll out	2x3 =6 Low risk
There is a risk that commissioning expectations around financial savings are too ambitious in terms of assumed value and when these begin to be realised, which leads to the programme being seen as failing	3	5	15 High risk	• Prudent return on investment assessment with base case, downside and break even position • Phased functional effectiveness to avoid optimism bias • Demographic response model	2x4 =8 Medium risk
There is a risk that the agreed service and operating model are not supported by local people, staff groups and key stakeholders, which hinders implementation	3	4	12 Medium risk	• Establish Implementation groups with key local involvement • Staff consultation • clear communication strategy • Enactment of engagement plan • Monitoring of patient satisfaction • Feedback mechanisms for key referrers to ICT	1x4 = 4 Low risk
There is a risk that a decision not to tender proposed additional service requirements receives a legal challenge, leading to implementation being stalled or a requirement to contest, which hinders implementation and requires a fundamental review of current contract arrangements.	2	5	10 Medium risk	• Specific procurement advice • Review requirements against procurement regulations • Decision not to tender assessment and agreement with health & social care commissioners	1x5= 5 Low risk
There is a risk that services are launched but there is low uptake by potential users, particularly GPs and wider health & social care colleagues due to lack of knowledge and/ or trust, and/ or confidence with delayed or partially realised benefits	3	3	9 Medium risk	• • communication strategy beyond launch date • Monitoring of patient satisfaction • Feedback mechanisms for key referrers to ICT	2x3= 6 Low risk

Risk	Probability	Impact	Initial risk	Controls & assurance	Revised risk score
There is a risk that the cost of proposals outweighs the financial savings accrued from optimisation of expenditure in other parts of the health & social care delivery system	2	5	15 High risk	• Financial model review • Prudent return on investment assessment with base case, downside and break even position • Contract and performance management	2x3 = 6 Low risk
Capacity is not correct and quickly the demand exceeds the services ability to cope leading to loss of confidence of referrers and potential loss in user satisfaction and services are stretched or less responsive	3	4	9 Medium risk	• Contract and performance management arrangements • Programme management implementation oversight and review for early detection • Potential for additional investment to expand capacity if clear return on investment	2x3 =6 Low risk
There is a risk that the agreed service model is insufficient to meet the acuity model and is beyond the competency of the service to manage people in the community and therefore results in admission to hospital and/ or care homes	2	5	10 Medium risk	• Competency frameworks • Training and development • Agreed care pathways • Contract and performance management	1x5=5 Low risk
There is a risk that the additional and type of work generated by strengthened ICT impacts on the other specialist teams activity, which increases beyond their capacity limits	2	4	8 Medium risk	• Contract and performance management arrangement • Regular review of data • Training and development of staff to widen competencies	2x3= 6 Low risk
There is a risk of staff culture potential for resistance in systematically adopting behaviours and mindsets to continually deliver requirements of new service model	2	5	10 Medium risk	• Regular communication • Regular checking staff feedback • Robust training and education • Strong leadership development • Team development	2x3 =6 Low risk

NHS Gloucestershire Clinical Commissioning Group
Procurement Service

Decision Not to Tender

Project Manager: *(Name)*	Andrew Hughes
Project Director: *(Name)*	Mary Hutton
Date:	12 July 2013
Reference:	002

Project Title and Background:
(Include summary of proposed service and cross reference to annual operating plan)

Title:

Joint Case for Change and Provider response for the strengthening of adult health & social care Integrated Community Team

Background:

To set out an integrated Case for Change to strengthen the existing 20 health and social care integrated community team (ICTs) managed by Gloucestershire Care Services NHS Trust (GCS) with recurrent and non-recurrent monies spread over the next two financial years.
The investment will increase the capacity, capability, availability and support the cultural changes required of these teams so that they are best placed to play a key part in the response to the demographic, financial and patient experience challenges facing Gloucestershire health and social care commissioners over the next five years.

The key aim is to improve outcomes for, predominantly for older people across health and social care; prevent specific medical hospital admissions; reduce requirements for some packages of social care; wherever possible, help people to spend less time in hospital; through the use of systematic risk profiling, to target case management on those with greater need; and to increase managed care and preventative services to extend the ability of more people to live well and live independently.

The case for change business sets out an anticipated gross annual return of investment of £6.7m by year 5, provides sensitivity analysis, describes a 'break even' position and signals further potential additional returns, requiring further testing and relating to the management of high risk patients identified through predictive modelling.

At the request of the Multiagency ICT Steering group, this is a joint piece of work between colleagues in Gloucestershire County Council (GCC), Gloucestershire Care Services NHS Trust and Gloucestershire Clinical Commissioning Group (GCCG). It follows a five case format and includes the following:-

- Strategic case - provides the context and rationale, overall vision and critical success factors;
- Economic case- Sets out the options and a strategic option appraisal. Due to this being an integrated Case for Change, it describes an initial response, ' a service offer' from GCS regarding the preferred option, which will be supported over the next few months by a more detailed Service Delivery Plan;
- Financial case – Set outs the costs of the initial GCS response to confirm viability;
- Commercial case- How the proposal supports QIPP requirements, contestability and contractual arrangements;
- Management case - engagement, consultation, programme approach, implementation timetable, risks and risk management.

Proposed Contract:

(Include proposed provider, contract duration and proposed commencement date)

The proposed provider is Gloucestershire Care Services NHS Trust, the additional functionality will form part of the existing contractual arrangements and implementation will be phased from w/c 30th September 2013 and full functionality in place by December 2014.

Market Assessment:

(Summary of outcome of market assessment supporting the proposal)

It is worthy of note that the services, currently under contract, are fully integrated across the Health and Social Care gamut of provision and as such significant elements of the service are provided under Social Care legislation and guidance. In addition to the above the integrated nature of the current provision delivers unique benefits such as additional productivity and a seamless service.

Financial Assessment:

(Anticipated total aggregated contract value)

The additional annual amount is £3.9m. The existing NHS contract with Gloucestershire Care Services NHS Trust is due to expire at the end of March 2016. Based on full service commencement from the 1st October 2013 total aggregated value is deemed to be £9.75m.

Reasons for Not Tendering::

(MUST ensure that reasons are permitted in accordance with the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013)

GCCG is responsible for the commissioning of high quality, value for money health care services to the patients of Gloucestershire. As a commissioner, GCCG seeks to use competition as a means of improving quality and securing value for money. Commissioners may procure health care services via a competitive tendering process to encourage providers to re-evaluate existing services, re-design pathways, consider whether to introduce new technologies and improve efficiency The GCCG has an up-to-date procurement strategy that sets out its approach to achieving its delivery objectives through the application of good procurement practice [1].

Whilst the value of the investment to strengthen Health & Social Care ICT is above European Union procurement thresholds, there are clear and legitimate reasons to refrain from procurement and it is not contractually permissible to undertake a competitive tender process for the entire community contract at this time. In view of this, GCCG seeks to amend its existing contract with Gloucestershire Care Services to significantly improve its current service provision. The amendments will ensure strengthened service integration and is in keeping with the Governments May 2013 commitment to seek fully joined up Health and Social Care provision in England by 2018.

Improvements to the existing integrated service solution will be achieved by:

- Additional investment to enhance existing service provision. GCCG is proposing to fund extending opening times of existing services (evenings and weekends);
- Improving functionality across existing services. A combination of training (existing staff and additional posts) to cover urgent response within one hour and the management of people with greater acuity;
- Investment will be used to fund skill mix changes and enhance the capability, through training of staff employed by both Health and Social Care (Gloucestershire County Council)

GCCG is acting in accordance with Regulation 2 of the National Health Service Procurement, Competition and Patient Choice (No.2) Regulations 2013, which clearly state that a health commissioning body must act with a view to:

(a) Securing the needs of the people who use the services;
(b) Improving the quality of the services; and
(c) Improving efficiency in the provision of the services

including through the service being proved in an integrated way (including with other health care services, health-related services, or social care services).

GCCG is also acting in accordance with Regulation 10 (anti-competitive behaviour). When commissioning health care services for the purposes of the NHS, a relevant body (in this instance, GCCG) must not engage in anti-competitive behaviour (a) unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include:

(a) By the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or
(b) By co-operation between the persons who provide the services in order to improve the quality of the services.

Risk Assessment:

(Identify risks to patients if proposal is rejected / Identify risks to GCCG if proposal is accepted)

The key risks of rejecting the proposal are as follows:

1) Significant delay in establishing new service models required by local population as time is spent reviewing existing contract structure with existing Provider to agree existing services that would need to form part of procurement, prior to any procurement taking place;
2) Procurement leads to increased fragmentation as different community providers providing different elements of the service;

The key risk of accepting the proposal are as follows:

3) There is a risk that a decision not to tender proposed additional service requirements receives a legal challenge, leading to implementation being stalled or a requirement to contest. Implementation is hindered and requires a fundamental review of current contract arrangements;
4) There is risk that he CCG foregoes the potential opportunity of a more innovative solution that delivers higher quality and a greater return on investment that proposed by the Gloucestershire Care Services NHS Trust.

Due Diligence:

(Basic financial and quality assurance checks must be undertaken in respect of proposed service provider. This will include: financial viability, economic standing, clinical capacity & capability, governance, affordability / value for money)

Requirements are set out in a Joint Case for Change and Provider response, which has been reviewed by an ICT Steering Group. Additional due diligence has been undertaken by internal CCG QIPP assurance group. Ongoing implementation assurance provided through joint programme arrangements

Stakeholder Engagement:

(Is the proposal acceptable to patients? Include findings of any patient engagement)

Support for the development of Integrated Community Teams has been endorsed by accumulated engagement and consultation activities led by Gloucestershire's NHS commissioners over several years.

Feedback from the public, key stakeholders and staff has consistently demonstrated support for the following principles, as set out most recently in two publications in 2012: *'Fit for the Future'*, the county's 20 year Health and Wellbeing Strategy and the county's five year Strategy for care: *'Your Health Your Care'*. These principles clearly underpin the ethos of Integrated Community Teams:

- supporting communities to take an active role in improving health;
- encouraging people to adopt healthy lifestyles to stop problems from developing;
- taking early action to tackle symptoms or risks;
- helping people to take more responsibility for their health;

- helping people to recover more quickly from illness and return home;
- Supporting individuals or communities where life expectancy is lower than average or where quality of life is poor.

Compliance with Principles and Rules for Cooperation and Competition: *(Indicate Yes, No or N/A)*	
Principle 1 - *Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.*	Y
Principle 2 - *Commissioning and procurement must be transparent and non-discriminatory.*	Y
Principle 3 - *Payment regimes and financial intervention in the system must be transparent and fair.*	N/A
Principle 4 - *Providers and commissioners must cooperate to improve services and deliver seamless and sustainable care to patients.*	Y
Principle 5 - *Commissioners and providers should promote patient choice, including, where appropriate, choice of Any Qualified Provider and ensure that patients have accurate, reliable and accessible information to exercise more choice and control over their health care.*	N/A
Principle 6 - *Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers interests.*	N/A
Principle 7 - *Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commission or patient choice against patients' and taxpayers interests.*	N/A
Principle 8 - *Commissioners and providers must not discriminate unduly between patients and must promote equality.*	N/A
Principle 9 - *Appropriate promotional activity is encouraged as long as it remains consistent with patient's best interests and the brand and reputation of the NHS*	N/A
Principle 10 - *Vertical integration is permissible where there remains sufficient choice and competition to ensure high quality standards of care and value for money.*	Y

Approved / Rejected by GCCG Governing Body: *(Signature)*	
Date:	
Comments: (including reasons for approval rejection where applicable):	

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 14

Governing Body

Meeting Date	**Thursday 25th July 2013**
Title	**Winchcombe Outpatient Physiotherapy Services and Development of Extended Scope Physiotherapy Services plus proposed accommodation solutions**
Executive Summary	This paper follows earlier papers in January and March of this year. It sets out a business case for the future of Outpatient services in Winchcombe. It proposes within Winchcombe town the development of community based clinics, with a focus on Physiotherapy and Extended Scope Physiotherapy to be accommodated within an extension to be built onto the GP Practice. It is recognised that this solution will take some time and an alternative short term solution is proposed.
Key Issues	• Service change • Activity • Financial commitment
Risk Issues: **Original Risk** **Residual Risk**	• The financial framework for the preferred estates solution cannot be agreed. Risk: 3L x 4C = 12 GCCG commit to ensuring a solution is reached, including the support to any required agreement between the relevant provider(s). • The local community does not support the new service model, resulting in inefficiency an under-utilisation. Risk: 1L x 4C = 4 The result of the consultation exercise shows local support to the preferred option identified.
Financial Impact	• Reduction in estate costs per annum • Longer term financial commitment
Legal Issues(including NHS Constitution)	Proposal to be considered in light of commitment to provide care closer to home.
Impact on Equality and Diversity	No impacts have been identified.
Impact on Health Inequalities	Consideration is given to the differential impact on people with reduced mobility.

Impact on Sustainable Development	This proposal will result in less travel for Outpatient Physio Services which is the outpatient service most frequently used by local residents.
Patient and Public Involvement	Activity undertaken is described in the paper.
Recommendation	To approve the business case for the identified community based clinics and the building extension to the GP Practice in which they will be accommodated.
Author	Fiona Hallaran
Designation	Interim Project Manager
Sponsoring Director (if not author)	Mary Hutton Accountable Officer

Agenda Item 14

Governing Body

25th July 2013

Winchcombe Physiotherapy and Extended Scope Physiotherapy Services

1	**Purpose**
	This paper follows earlier papers approved at the January and March 2013 meeting of the NHS Gloucestershire and Swindon Board. It sets out a proposal for the future of physiotherapy outpatient services in Winchcombe. It proposes (within Winchcombe town) the development of physiotherapy and Extended Scope Physiotherapy (ESP) service, delivered by Allied Health Professionals, to be accommodated within an extension to be built onto the GP Practice. This extension will be built to house the physiotherapy service and other community services and will be funded through SLA's with providers supported by the CCG.
2	**Background**
	The full background for this proposal is set out in the January 2013 board paper on this subject and concluded that the current out patient activity levels do not justify continuing to provide separate stand-alone accommodation for general out-patients in Winchcombe. Following the January 2013 board paper three key areas were developed: • engagement exercise with the Winchcombe local community, • the potential to commission outpatient services locally in relation to activity flows • an evaluation of the three main options in relation to the estate solution. The above was reported back to the Board in March where approval was given for the development of physiotherapy and extended scope physiotherapy services within the town, cessation of outpatient services within the town and endorsement to pursue accommodation options. The physiotherapy service in Winchcombe is almost exclusively used by Winchcombe Medical Centre patients. However the majority of physiotherapy provision for the Winchcombe Medical Practice is provided from other locations.

	In activity and clinical terms, physiotherapy services appear to be a viable and valued local service. There is sufficient demand for this service to be developed and increased, to overcome the current limitations of lone working and longer wait times, in order to provide a responsive and effective local service to the population of Winchcombe. The advantages of this are that when people are having physiotherapy for a spell they attend frequently. This proposal would favour those who have reduced ability to travel to locations outside of the town. This proposal is to develop physiotherapy services in the town. In addition there would be benefit in developing an Extended Scope Physiotherapy (ESP) service. It is anticipated that local referrals into physiotherapy services would be increased if the availability of days was greater and ESP was also available. Gloucestershire CCG aims to agree with GHNHSFT a plan for future outpatient provision however physiotherapy services are now delivered by Gloucestershire Care Services.
3	**Current position in Winchcombe**
	All outpatient services are delivered from a 'portacabin' which was intended as a temporary solution once the hospital closed and has now been in place for much longer than envisaged. The accommodation is leased and the planning consent was based on a temporary arrangement. Permission has been granted to extend the lease to October 2013 then on a month by month basis so a permanent solution is required urgently. The Physiotherapy service is provided by GCS and due to issues over lone working the physiotherapy service is provided by 2 physiotherapist's working one session per week concurrently usually on a Monday or a Friday. Local people (including the active and constructive Patient Participation Group (PPG) from Winchcombe Medical Centre) are pressing for GCCG to deliver the commitments they believe were given at the time of the Winchcombe hospital closure – i.e. to find a satisfactory permanent solution for outpatient provision in Winchcombe. The PPG also maintain that clinics are not scheduled to be held in Winchcombe as much as could be justified by the requirements of the local population, hence the utilisation of the temporary facility appears to be poor. In particular, the PPG want to see increased physiotherapy and orthopaedic clinic provision. The PPG meet regularly and have surveyed local people and those attending clinics in Winchcombe. The survey results show support for local provision particularly for physiotherapy and rehabilitation.

	The practice also wish to use more space within the current premises and so the extension would also house community services. This is the role of NHS England is not relevant to this business case
4	**Activity**
	The annual activity into Physiotherapy outpatient services for Winchcombe practice patients was 1163 attendances of which 30%, 354 attendances were delivered from the local portacabin. Although just 27% of the registered practice population are over 65 years old 63.5% of the local physiotherapy was delivered to this age group with 12.7% delivered to the 55 to 65 year age group. 52.9% of the physiotherapy provided at other sites was for people over 65 years old and 15% to people aged 55 – 65 years old. Please see appendix 1. A survey by the PPG in 2012 showed that many residents were not offered clinic appointments in Winchcombe though the service was available. It is feasible to believe that the number of people using this local service could easily be doubled and increased further if an ESP service is delivered from the same premises. If the services were provided from a shared premise then the clinics could be delivered on several days with just one physiotherapist present, as this would overcome the current lone working problem. If the current activity delivered within Winchcombe was doubled, this is quite feasible as the support for local services and registered population increases, then there would be a need for four clinics a week. This would not be an increase in overall physiotherapy provision across the county but a repatriation of services to a local setting for Winchcombe residents. <u>Developing Extended Scope Physiotherapy (ESP) Service</u> As part of the Clinical Programme Approach to develop musculoskeletal services in 2013/14 a focus is placed upon developing the interface services across the county. The development of interface services offers the opportunity for Winchcombe to commission local musculoskeletal services. It is proposed that an Extended Scope Physiotherapy service be delivered from Winchcombe. This is a physiotherapy specialist with an extended scope of practice who works beyond the recognised scope of physiotherapy practice, for example requesting investigations e.g. US scans/nerve conduction studies, using the results of investigations to assist clinical diagnosis and appropriate management of patients; listing for surgery and referring to other professionals. The ESP service will provide diagnostic triage which forms the basis for decisions about

	referral, investigations and further management. It is widely acknowledged that ESPs (physiotherapy and podiatry) in Primary Care have a low referral rate (circa 20%), of new patients, to an Orthopaedic Consultant opinion and of those conversion rates to surgery are high especially for hips and knees. This compares favourably to the general secondary care orthopaedic conversion rates of 50% (average across all conditions), indicating appropriate referral. ESP therefore assist in achieving the orthopaedic waiting times from referral to appointment. The Criteria for referral to musculoskeletal ESP Clinics; • Any adult with a musculoskeletal problem that would have normally been referred to secondary care services i.e. orthopaedics, rheumatology, pain • Patients with complex musculoskeletal conditions Patients previously unresponsive to outpatient physiotherapy/podiatry for the same condition. Patients who may benefit from ESP skills e.g.corticosteroid injection therapy for peripheral conditions, complex bracing or orthotics The ESP will assess the patient and decide upon their management: • Advice/Exercise/self management and discharge • Peripheral soft tissue or joint injection • Provision of specialist braces or othotics • Referral to physiotherapy/podiatry or other services • Referral to Ultrasound , x-ray, MRI • Referral to orthopaedic consultant • Referral to other consultants or clinics e.g. Rheumatology, neurology, oncology or Pain Clinic An average of 980 orthopaedic outpatient appointments were attended each year, over the past 3 years, by patients registered with the WInchcombe practice. Almost 200 of these relate to fracture clinics or specialist orthotic service but the remainder relate to planned OPD appointments. An ESP could review all referrals to orthopaedics apart from those which fit the exclusion criteria i.e. red flags, patients under 18 years, suspected oncology, patients who have had recent surgery and emergencies/trauma. A development of ESP will have a direct effect on the orthopaedic outpatient clinics. If initially just 50% of the remaining orthopaedic outpatient activity was provided locally within ESP, then local provision would need to be provided for circa 350 appointments. Based on an average of 10 patients per session there would need to be for 35 clinics per annum (3 per month).

The current cost of secondary care orthopaedic OPD appointments is £128 for a first appointment and £75 for follow up appointments. Approximately one third of appointments are first appointments so an estimated cost of 350 appointments would be £26,250.

ESP clinics are offered at a lower cost than outpatients. Based on the current demand for Musculoskeletal (MSK) services it could be viable to commission a clinic locally for ESP services. In 2013/14 there are planned changes to transition MSK services across Gloucestershire. It is expected that these changes will see more consistent interface services that provide general and specialist physiotherapy and podiatry services at a number of community locations.

<u>Other GCS services delivered from the GP practice</u>

The GP. need to be able to utilise all of the current accommodation for GP practice services and therefore will need to ask other providers to find alternative accommodation. The practice currently accommodates GCS and 2gether Trust delivered services;

- podiatry service 6 sessions per week
- district nursing – one office and 2 clinical sessions per week for leg ulcer clinics
- Midwifery – 1 session per week
- Community Learning Disability Team – 1 session per week
- Primary Mental Health Care Worker (Becca Forster) – one to two sessions per fortnight
- IAPT (Mike Gallant) – 1 session per week
- GHNHSFT – phlebotomy 2 sessions per week

- Turning Point (formerly independence trust) use adhoc sessions

The county wide development of Integrated Community Teams may result in a requirement for office/treatment space for other members of the team in addition to district nurses.
Total space required;

	Clinical sessions per week	**Office space per week**
Services currently in GP practice		
Podiatry	6	
District Nurses	2	Full time
Midwifery	1	
Community Learning Disability Team	1	
PHM	1	
IAPT	1	

	GHNHSFT phlebotomy	2	
	Turning Point	Adhoc sessions	
	Services to be accommodated		
	Physiotherapy	4	
	ESP clinic	1	
	Total	**19**	**10**

So of a total available 30 sessions;

- 24 would be recharged to GCS
- 4 would be recharged to 2gether Trust
- 2 would be recharged to GHNHSFT

If the total cost of this accommodation is £9000 then each session space would cost £300 per annum.

5 **Estate solutions**

The temporary building has a lease agreed until the end of September 2013 which can then be extended on a month by month basis. As described within the January 2013 Board paper the three main options with regards to the estate solution were:

- standalone re-provision of the service on land adjacent to the Winchcombe Medical Centre
- alternative sites within the town.
- extension of existing Winchcombe Medical Centre premises

Stand Alone re-provision of the service on land adjacent to the Practice.

To build a stand-alone building would be more costly than either of the other two options in capital outlay and economies of scale would not be realised with a separate site requiring reception, security system, car park, insurance and access road. Lone working could be an issue with no shared infrastructure in place and capital outlay would be required.

On the basis of the disadvantages outlined above, and the feedback from engagement not providing support to this option, this option is dis-counted from the options appraisal.

Alternative Site in Town

At present there is no available accommodation from which to provide healthcare services on a permanent basis, in particular to ensure DDA compliance. As there are very limited options for suitable facilities within the local area, in particular to ensure access to clinical I.T. systems and would raise the issue of lone working, it is highly unlikely that this option is viable. There is a privately owned clinic which has 2 rooms on the ground floor which could serve as a short term measure until a

	permanent premise is available. However these rooms are not currently clinically sound and would require some minor works e.g. installation of sinks etc to make them suitable as an interim measure. **Extend the Winchcombe Medical Centre premises** The existing facility already utilised for health purposes and addresses the issues with regards to lone working. No initial capital outlay is required as the current premises are under a leasehold arrangement. This solution would offer an integrated primary and community care health services for local patients of Winchcombe. This option is strongly supported by the GP practice, PPG members and local residents as shown from the recent engagement exercise. It also allows for the development of space which could be used differently in the future. However this would result in a longer term commitment as the landlord would be looking for a leasehold to be in place for a 20 year time frame (this means a new lease agreement and therefore an addition of 8 years over the current position). The lease exists between the practice and the landlord and clarity is now being sought on this proposal. Further plans would need to be drawn but it is estimated that the services as described require an area of around 50 sq. metres. This would be costed at the cost agreed by the District Valuer but would be in the order of £7,000 – £9,000 p.a. plus VAT. This is however significantly less then the current costs of the temporary accommodation which are £54,300 per annum.
6	**Stakeholder Engagement**
	NHS Gloucestershire's engagement team conducted an exercise in early 2013 to discuss the Development of Physiotherapy services in new accommodation in Winchcombe, and the cessation of other outpatient services in Winchcombe. The overarching themes were; • Experience in the last three years has been that booking appointments at the portacabin has not been easy for patients. • Of those who expressed a preference for one of the options, there was strong support for Option 2 (as presented to the January 2013 Board) for physiotherapy services, alongside expanded musculoskeletal services, to be provided locally. • The physiotherapy service should be provided as close as possible to the Winchcombe Medical Centre, integral to it in an extension if possible. • Poor public transport was identified as an issue for many. However, many respondents were unaware of current community

and voluntary transport options.

- Many suggested that an extended physiotherapy facility in the town should be designed to be flexible to allow other services to use the space e.g. health promotion, mental health consultations.

Recent discussions with the PPG chair and active members endorsed the proposal to accommodate extended physiotherapy services within an extension of the GP practice.

7 **Finance**

The table below sets out costs associated with premises changes;

	Current costs	**Proposed costs**
Temporary portacabin	£54,300	
Charges to GCS for physiotherapy use of premises		£1,500
GP premises charges for GCS	£2,843.05	£5,700
GP premises charges for 2gether Trust	0	£900
GP premises charges for GHNHSFT	0	£600
Unused session or adhoc use	0	£300

It is assumed that the activity provided in the premises will be a transfer of activity.

8 **Conclusions**

There is growing pressure to find alternative accommodation and continue to deliver and develop local physiotherapy services in Winchcombe. There is much local support for the commissioning of local physiotherapy outpatient services and the development of ESP and for these to be housed along with other GCS services within an extension of the GP practice.

8 **Recommendation**

The Board is asked to:

- Approve the proposal to commission physiotherapy services at Winchcombe Practice in an extension to the current premises which will also house the current community services.

- Agree to progress for a short term solution in alternative premises in Winchcombe as it will take some time to have proposals agreed and

	the extension actually in place.

Appendix 1

All physiotherapy attendances at Winchcombe Outpatients Centre (by year and practice)

	Winchcombe Medical Practice patients		**Other practice registered**		**Grand Total**
Year	First	Follow Up	First	Follow Up	
2009/10	148	88	4	0	240
2010/11	110	193	4	26	333
2011/12	145	122	9	6	282
2012/13	186	158	10	26	380

NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 15

Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	**Integrated Governance Committee (IGC) minutes.**
Executive Summary	The attached minutes provide a record of the IGC meeting held on the 9th May 2013.
Key Issues	The following issues were discussed: • Terms of Reference • Assurance Framework • Policies for approval • Information Governance
Risk Issues: **Original Risk** **Residual Risk**	Not applicable.
Financial Impact	Not applicable.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Julie Clatworthy IGC Chair and Registered Nurse

NHS GLOUCESTERSHIRE CCG

Integrated Governance Committee (IGC)

Minutes of the meeting held on Thursday 9th May 2013, Board Room, Sanger House

Present:		
Julie Clatworthy	JC	Chair
Dr Steve Allder	SA	Secondary Care Specialist
Andrew Beard	AB	Head of Financial Planning/Deputy Chief Finance Officer (Deputising for the Chief Finance Officer)
Caroline Bennett	CBe	GP – North Cotswolds Locality
Dr Charles Buckley	CBu	GP – Stroud Locality
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Colin Greaves	CG	Lay Member – Governance
Teresa Middleton	TM	Head of Medicines Management (deputising for the Director of Nursing & Quality)
Mary Hutton	MH	Accountable Officer
Mark Walkingshaw	MW	Deputy Accountable Officer
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Alan Potter	AP	Associate Director Corporate Governance
Geoff Sanders	GS	Information Governance/FOI Support Manager Central Southern Commissioning Support Unit (CSU)
Emma Simpson	ES	Board Administrator

1. Apologies for Absence

1.1 Dr Shona Arora, Marion Andrews-Evans, Dr Malcolm Gerald, Dr Martin Gibbs, Cath Leech, Dr Helen Miller.

2. Declarations of Interest

2.1 There were no declarations of interest received.

3. Review of Terms of Reference (TOR)

3.1 AP introduced the report that set out proposed changes to the TOR which were approved at the inaugural CCG Governing Body Meeting on 2nd April 2013.

3.2 The Committee noted the increased emphasis on patient safety following the publication of the Francis Report had driven the paper.

3.3 It was also noted that guidance from NHS England states that CCG's should have a separate Quality Committee rather than it being a subgroup.

3.4 The Committee acknowledged that any changes to the TOR would have to be approved by the Governing Body and will have an impact on policies.

3.5 Debate took place on fragmenting governance arrangements by forming a separate Quality Committee.
Areas of discussion included:

- Dangers of fragmented approach which include losing the whole picture. Governing Body having to scrutinise a greater level of information.
- Fragmenting v keeping the committee as a single entity.
- Quality elements going to programme groups.
- If the two areas are split, it is felt important that the appropriate individuals attend each section of the meeting.
- More checks and balances required if separation occurs. Logistics of how the new committee would look were discussed.
- Concern was raised regarding potential omissions.
- Concern was also raised regarding potential overlaps with the Audit Committee.
- Importance of defining quality and performance roles in order to be aware if another Mid Staffs is happening.

- Importance of meaningful data, looking at how data is collected and not looking at data in isolation.

3.6 The following proposals were put to the Committee:

1. Leave the IGC as it is currently with a separate Quality Committee.
2. Separate the IG Committee into two halves; governance and quality.

3.7 The Committee discussed the attached TOR in detail. Concerns were raised in relation to sections;

- 1.1.
- 1.3
- 6.1.1.
- Amendment to 2.1 membership job titles
- 4: Meetings bi-monthly
- 5: Add Research Governance; removing 5.1.7 out of line with Serious Incident Policy.

Further clarity required on how over arching Governance system works including between IGC and Audit Committee.

3.8 <u>RECOMMENDATION</u>

Option 1 received 1 vote and option 2 received 9 votes. The recommendation for Option 2 was carried that the IG Committee remains but is run in two halves to cover Corporate, Clinical, Quality, Research and Information Governance. The Audit Committee is responsible for Financial Governance.

3.9 It was agreed that TOR will be needed for both halves of the Committee, therefore the current TOR need to be enhanced with mapping attached. Once agreed at the next IGC in June they will go to the Governing Body for endorsement. AP

4. Assurance Framework

4.1 The report was presented by AP who outlined that the

attached Assurance Framework for 2013/14 provides details of the assurances that will be provided to the Governing Body regarding the achievement of the organisation's Annual Objectives.

4.2 The background to the report was outlined to the IGC. Members heard that the Annual Operating Plan was brought to the April Governing Body Meeting and comments were made about how key objectives were set out.

4.3 CG felt that an explanation of what the Assurance Framework is, which explains how it works as a tool or mechanism, should be included within the report.

4.4 Concerns were raised in relation to the report:

- Section 1.3 - it was felt that "encouragement" was the wrong word.
- It was felt that the Assurance Framework should also be used at meetings of the Governing Body not just the IGC so that it informed decision making.
- Feeling that it needs to be a live 'tool'.
- Committee members were keen to emphasise the importance of regular sightings of the Assurance Framework, not just once a year.

4.5 <u>RECOMMENDATION:</u>

The IGC approved the recommendation for the Assurance Framework to be taken to all Governing Body meetings, starting with the July meeting.

CBe left the meeting.

5. Policies for Approval

5.1 The IGC discussed 4 policies set out in the report in detail:

- Risk Management Policy
- Risk Management Procedure
- Serious Incident Policy

- Incident Policy
- Safeguarding Children Policy

5.2 Risk Management Policy - It was highlighted that directorate Risk Registers are being advocated and that there will be a risk champion within each directorate.

5.3 Key risks will be discussed at the CCG's Thursday Business meetings. The Risk Register's format will not be changed but consideration is being given to the use of the Datix Risk Register software.

5.4 A number of concerns were raised by the Committee:

- Need for clarity on frequency of when the Register will go to Board.
- Consultation on this policy is weak, future policies should include member practices and localities views in their development and be clear how risks are managed from Joint Commissioning.

5.5 **RECOMMENDATION:**

The Risk Management Policy and Procedure were approved subject to the addition of Clinical to categories of risk (Appendix A).

5.6 Serious Incident Policy – a brief discussion took place regarding Disaster Recovery. It was noted that there is an Emergency Planning lead within the CCG. There is also a team within Gloucestershire County Council and a Major Incident Plan. There is also an incident room within Sanger House. It was noted that the CCG is a Category 2 responder.

5.7 The Committee wanted to see wider consultation on this document in the future.

5.8 RECOMMENDATION:

The Serious Incident Policy was approved subject

to minor changes:-
1.2 learning should also be shared with social care where appropriate.
5.3: and reported to relevant Professional Body
10.1: Add Joint Commissioning arrangements
5.1: Grade 2 include Serious Case Reviews

5.9 Incident Policy – a brief discussion took place on the policy.

5.10 <u>RECOMMENDATION:</u>

The Incident Policy was approved.

5.11 Safeguarding Children Policy

5.12 A brief discussion took place on organisational responsibility. AE was particularly concerned that the policy should relate purely to the CCG.

5.13 Several issues were noted with the policy:

- P6 – Add 'or draw down on specialist advice'
- P7 – Named PH professional now LA responsibility not GCCG
- P8 – state who the NED lead for childrens issues is
- Contact details missing from P9.
- P10 – abbreviations need to be qualified.
- P11 – SCR's through SCOG and IGC, same for 5.8 Incident reporting
- P13: Consultation – helpful to include LA, Child Protection Lead and SCB in consultation.
- P14 – target audience – contractors to be added to this, and how often CP training is required

5.14 <u>RECOMMENDATION:</u>

It was agreed that the policy needs to be updated and brought back to the IGC.

6. Information Governance Update

6.1 GS introduced the paper which outlines the arrangements within the CCG for Information Governance and Freedom of Information.

6.2 Discussion points included:

- Relationship with CSU (particularly with regard to holding information).
- Training – employees carry out e-learning but face to face training can be delivered where necessary.
- On page 3 of the report, and thereafter, the Director of Nursing should be amended to read the Executive Nurse and Quality lead.

6.3 <u>RECOMMENDATION:</u>

The IGC noted the report.

7. Any other Business

7.1 CB asked about governance training and whether it would be delivered in order to ensure that everyone was working at the same pace.

8. Schedule of Future Meetings

8.1 The schedule was agreed.

9. Agenda Map

9.1 Brief discussion took place on the proposed Agenda Map and it was agreed that the standing item entitled Update on IG Toolkit should be amended to read IG Update. ES/AP

10. The meeting closed at 11.16am.

Date and time of next meeting: Thursday 20th June 2013 in the Board Room at 9am.

NHS
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Clinical Commissioning Group

Agenda Item 16

Governing Body

Governing Body Meeting Date	Thursday 25th July 2013
Title	**Audit Committee minutes**
Executive Summary	The attached minutes provide a record of the Audit Committee meeting held on the 2nd May 2013.
Key Issues	The following principal issues were discussed: • Internal Audit Plan • External Audit • QIPP Programme • Update on PCT accounts
Risk Issues: **Original Risk** **Residual Risk**	Not applicable.
Financial Impact	Not applicable.
Legal Issues (including NHS Constitution)	Not applicable.
Impact on Health Inequalities	None.
Impact on Equality and Diversity	None.
Impact on Sustainable Development	None.
Patient and Public Involvement	Not applicable.
Recommendation	The Governing Body is requested to note these minutes which are provided for information.
Author	Alan Potter
Designation	Associate Director Corporate Governance
Sponsoring Director (if not author)	Colin Greaves Audit Committee Chair and Lay Member

NHS GLOUCESTERSHIRE CCG
AUDIT COMMITTEE

Thursday 2nd May 2013, Biffen Room, Sanger House

Minutes

Present:		
Colin Greaves	CG	Chair
Alan Elkin	AE	Lay Member – Patient and Public Engagement
Dr Andy Seymour	AS	Deputy Clinical Chair
Valerie Webb	VW	Lay Member - Business

In Attendance:		
Sallie Cheung	SC	Counter Fraud Manager
Paul Dalton	PD	Price Waterhouse Cooper
Cath Leech	CL	Chief Finance Officer
Lynn Pamment	LP	Price Waterhouse Cooper
Peter Smith	PS	Grant Thornton
Dr Will Haynes	WH	GP Liaison Lead
Alan Potter	AP	Associate Director Corporate Governance
Emma Simpson	ES	Board Administrator
Fazila Tagari	FT	Board Administrator

1. Welcome

The Chair welcomed the Committee to the Inaugural Meeting of the Audit Committee.

2. Apologies

Dr Hein Le Roux, Liz Cave.

3. Declarations of Interest

There were no declarations of interest received.

4. Internal Audit Plan

4.1 PD presented the NHS Gloucestershire CCG Initial Internal Audit Plan and Timeline for 2013/14. It was noted that this is indicative and would be subject to continuous review during the first 6 months of the CCG. A formal plan will be presented to the next (July 4th) Audit Committee meeting. PD & LP

4.2 A question was raised in relation to reference point VP.8 Commissioning Support Unit (CSU) – Contract monitoring and performance. It was noted that the performance of the CSU as an organisation is not a concern of the CCG but that contract performance is. The Committee noted that performance is felt to be crucial due to the fact that it is one of the biggest areas of risk.

4.3 It was noted that Internal Audit plans should be based on the Assurance Framework.

4.4 <u>RECOMMENDATION:</u>

The Committee approved the draft Internal Audit plan. It was agreed a more detailed plan would be brought to the July meeting.

5. Introduction to External Audit

5.1 PS introduced the report and outlined a number of key points.

5.2 The Committee heard that external auditors have 2 main responsibilities:

1. To give an opinion on the financial statements.
2. To ascertain whether value for money (VFM) arrangements are adequate.

It was noted that the cycle of work is different to that of Internal Audit.

5.3 PS explained in greater detail the main headings of the report including:

- Programme of work
- Audit Fees
- The Audit Cycle
- Corporate Responsibility

5.4 It was noted that there will be a development session on July 25th following the Governing Body meeting which will cover Conflicts of Interest.

5.5 A question was raised as to whether the cycle of work will vary much from that of the PCT. It was noted that the first year of a new organisation is a learning curve and that Audit is based on risk and therefore it is necessary for Grant Thornton to re-asses what the risks are for the CCG. This process will be started at a meeting on May 8th with CL.

5.6 The Chair summed up that the CCG's objectives are the foundation of the Assurance Framework and Risk Register, which will then drive the Audit Plan.

5.7 <u>RECOMMENDATION:</u>

The draft External Audit Plan was approved.

6. Draft Counter Fraud Plan 2013/14

6.1 SC introduced the report which highlights that the CCG has a contract with Gloucestershire Hospitals Foundation Trust (GHFT) Counter Fraud Service to provide a counter fraud service for 2013/14 which provides continuity of service during the first year of operation.

6.2 Key points in the action plan which are aimed to achieve a green rating for the CCG were outlined to the Committee. It was noted that guidance is currently

only available for providers not commissioners. In the meantime the plan is based on the latest guidance issued to provider services and an assessment of key risks for the CCG.

6.3 The number of activity days scheduled as set out in the report was outlined to the Committee and also the areas of focus. Members heard that the Bribery Act and Conflicts of Interest have been identified as main areas of focus.

6.4 A question was raised by CG in relation to whether the number of days (115) is fixed. It was noted that this is not fixed and is based on the previous year's indications. This will be refined for future guidance.

6.5 AS asked what the relationship is with the CSU. The Committee heard that the CF service belongs to the CCG but that there is a mechanism for any issues to be flagged to SC and then to the CSU CF service (which is yet to be set up and is currently in the planning stages). It is aimed that both organisations will be able to investigate jointly. This service will come up for tender and has to go to full procurement.

6.6 <u>RECOMMENDATION</u>

The Audit Committee approved the draft counter fraud plan based on the limited amount of information and subject to further work with management.

7. QIPP Programme Update

7.1 CL introduced the report which gives an overview on the PCTs 2012/13 savings target delivery which impacts on the CCGs 2013/14 plans, outlines the planned 2013/14 QIPP programme for the CCG and outlines the governance arrangements for QIPP performance and reporting.

7.2 Key areas of under/over delivery were outlined to the Committee which included Continuing Healthcare

(CHC), prescribing, urgent care and planned care.

7.3 It was noted that further details on the 2013/14 QIPP programme will be brought to a Board Development Session on May 30th.

7.4 AE requested more information regarding GHNHSFT risk share. It was agreed that this would be brought to a future Audit Committee meeting. CL

7.5 CG also raised concerns regarding the presentation of the paper. It was agreed a connecting narrative is required and that the presentation will be reconsidered prior to the July meeting. CL

7.6 <u>RECOMMENDATION</u>

The Audit Committee agreed to:

- **Note the reported position of planned savings across the QIPP programme 2012/13,**
- **Note the 2013/14 outline QIPP programme,**
- **Note the programme governance arrangements moving into 2013/14.**

8. Summaries of Procurement Decisions

8.1 There were no summaries of procurement decisions to review.

8.2 It was noted that this issue needs to become a standing item on future Audit Committee agendas.

9. Losses and Special Payments Register

9.1 The Committee was advised that there have been no losses or special payments since 1st April 2013.

10. Register of Waiver of Standing Orders

10.1 The Committee was advised that there is no information to review but that the register is currently being revised.

11. Update on PCT Accounts

11.1 The Audit Committee noted that the PCT accounts were submitted to the Department of Health on April 22nd 2013 in line with the deadline and are currently being audited. As of 1st of May no issues of concern have been identified.

11.2 The timetable for the sign of of the final accounts was outlined to the Committee:

- The Audit Committee for the PCT will meet on May 22nd and 6th June with the final sign off for accounts on 10th June by NHS England and Area Team representatives.
- CG will attend these meetings as an observer.

12. Schedule of Future Meetings

12.1 It was agreed that the next Audit Committee meeting will take place on Thursday 4th July 2013 and thereafter as per the agreed schedule.

13. Agenda Map

13.1 Brief discussion took place on the proposed Agenda Map and it was agreed that the order of Internal Audit, External Audit and Counter Fraud should be adjusted.

13.2 It was also agreed that Review of Procurement Decision should become a standing item.

14. Any Other Business

14.1 A number of areas were outlined for analysis prior to the July meeting:

- Work on the Assurance Framework. It was noted that strategic objectives have been determined and that the draft Assurance Framework will be presented to the Integrated Governance Committee (IGC) on 9th May.
- The Performance Management Framework will

come to the Governing Body Meeting in May.

- A draft Risk Register has now been set up.
- Concern was raised in relation to areas of potential duplication/omission within the Terms of Reference for the Audit Committee and IGC. It was agreed a revised set of TOR for the Audit Committee will be brought to the next (July) Audit Committee Meeting.

14.2 It was noted that a list of Audit Committee members should be clarified and circulated to members. FT/ES

15. The meeting closed at 9.55am.

Date and time of next meeting:
Thursday July 4th 2013 in the Board Room at 9am.