

NHS COMMISSIONING BOARD

Minutes of the Board meeting held in private on 14 December 2012

Present

Professor Malcolm Grant (chair)
 Sir David Nicholson – Chief Executive
 Lord Victor Adebawale – Non-Executive Director
 Ms Margaret Casely-Hayford – Non-Executive Director
 Mr Ciaran Devane – Non-Executive Director
 Dame Moira Gibb – Non-Executive Director
 Mr Naguib Kheraj – Non-Executive Director
 Mr Ed Smith – Non-Executive Director
 Mr Paul Baumann – Chief Financial Officer
 Ms Jane Cummings – Chief Nursing Officer
 Sir Bruce Keogh – National Medical Director
 Mr Ian Dalton – Chief Operating Officer/Deputy Chief Executive
 Dame Barbara Hakin – National Director: Commissioning Development
 Mr Tim Kelsey – National Director for Patients and Information
 Mr Bill McCarthy – National Director: Policy
 Ms Jo-Anne Wass – National Director: HR

In attendance Mr Jon Schick – Board Secretary

Item	
1	<p>Minutes and actions arising from the last meeting</p> <p>The minutes of the previous meeting held on 8th November 2012 were accepted as an accurate record.</p>
2	<p>CSF Assurance/ State of readiness review</p> <p>Bill McCarthy introduced this stock take against the 13 Critical Success Factors, which would also form the first instalment of evidence to DH for their state of readiness review. He described significant progress overall but also drew attention to four key areas identified for specific focus, these being:</p> <ul style="list-style-type: none"> • Staffing – impressive progress had been made on recruitment (as part of a larger programme of workforce related activity). Contingency arrangements were in place to ensure that a shared HR service would be available to the NHS CB, Health Education England and NHS Trust Development Authority. The transition process from issuing offer letters to successful payroll entry was now the most significant risk; • Estates and corporate IT – final decisions on estate in some areas needed to wait until recruitment was closer to conclusion. This had consequences for ordering and the installation of IT, which was also likely to be impacted by DH rollout of the next version of their system with ATOS – with risks this may not be ready on time for April 2013. Therefore, the NHS CB was already actively planning implementation of contingency IT arrangements should they be required; • Finance infrastructure and capacity – with a separate report from

	<p>Deloitte's and recommended contingency arrangements having recently been discussed at the Audit Committee;</p> <ul style="list-style-type: none"> Information flows and handover – with significant risk of important information being lost during times of major restructure, even more so when there is less clarity about natural repositories in obvious successor bodies. <p>Given the major programme still underway, it was important to understand that when the NHS CB took on its full responsibilities in April 2013, it would still be embedding its new ways of working.</p> <p>Bill concluded by outlining next steps for the state of readiness review, which included:</p> <ul style="list-style-type: none"> Plans to make arrangements for further discussion with members of the Audit Committee over the next month; The provision of assurance on state of readiness to the Board Development Session in January 2013. This would feed in to DH. <p>In follow-up discussion:</p> <ul style="list-style-type: none"> There was further feedback from the Audit Committee Chair, who agreed the need to get in additional finance resource following discussion in private at the Committee – with a view that pushing harder on contingency plans now was a lesser risk than not doing enough in a high risk situation; It was agreed that the document should in future be expanded to include more detailed consideration of direct commissioning, CCGs and the CSUs; The Chief Executive made the point that in the current year funding is available and should be used to mitigate risk. <p>The Board noted the progress that had been made and approved the paper to be passed to DH as part of the NHS CB's initial self-assessment.</p>
Action	BM/BH/ID to include consideration of direct commissioning, CCGs and the CSUs.
3	<p>Remuneration and terms of service committee</p> <p>Jo-Anne Wass informed the Board of key items discussed at the meeting of the RTSC on 8th November and drew attention to three key issues:</p> <ul style="list-style-type: none"> The RTSC had approved policies on business travel and expenses and on relocation expenses. The former applied both to officers and NEDs; MiP had raised issues related to the VSM contract and the RTSC had agreed some minor amendments following legal advice; The Chair and Chief Executive would meet their counterparts from the BSA to thank them for their support and discuss their role in providing HR support going forward.

4	<p>CCG Authorisation update</p> <p>This item had been discussed during the Board meeting in public.</p>
5	<p>CCG Allocations</p> <p>Paul Baumann introduced this item and drew attention to the need to agree distribution of NHS CB resources generally, as well as decide the allocations to CCGs. He explained the analysis of the mandate distribution for 2013/14, which meant total core funding would be £91,936m (a 2.6% increase) and proposed this should be shared consistently across the local and national commissioning portfolios, with 2.3% growth for CCGs, providing headroom that should enable them to make a good start under the new arrangements and a 38% increase in NHS funding for local authorities, giving an overall increase of 2.6% for local commissioning. 2.6% was also proposed for direct (national) commissioning, including costs related to specialised services convergence towards the national criteria agreed by the Clinical Reference Groups.</p> <p>Ian Dalton provided further information to support the funding for nationally commissioned services, noting in particular the drivers in specialised services (new technologies and drugs, services not funded via PbR, costs of convergence). He considered there was a risk the Board needed to be aware of in that, with the current proposed 3.0% uplift in this area, it may not be possible to contain costs within the sums proposed; but he also acknowledged that provision of any additional funds for specialised services commissioning would cause significant challenges elsewhere. The Board noted that the significant reduction in NHS CB running costs meant that the overall direct funding to NHS CB increased by 2.6%, in line with funding for local decisions.</p> <p>Paul Baumann moved on to focus on the sums to be allocated to CCGs – with fundamental questions about how this should be distributed. He drew attention to the (ACRA) allocation formula, noting it had been extensively and successfully “stress tested”. It was able to deal with unusual circumstances and, being based on a rich data source at individual practice level, was a good predictor of likely spend. ACRA had drawn attention to the lack of evidence as to whether the failure to meet the need according to ideal pathways increased or decreased the cost incurred. External assurance on the formula spreadsheet calculations in the model had been undertaken by Grant Thornton, who would be providing a full report. This was not yet available but Paul Baumann noted they had found no problems with the model, and his judgement was that there was sufficient assurance the model was robust enough to be used.</p> <p>He moved on to the issue of redistribution, with a proposal that the two options to be considered were either flat growth of 2.3% for all CCGs, or a distribution based upon 1% minimum growth and maximum growth of 5% for those CCGs furthest below target. With regard to the latter:</p> <ul style="list-style-type: none"> • Financial resilience would potentially be improved, with the model generally providing more growth to those areas currently showing signs of significant financial risk; • Two-thirds of current financial resilience “red-rated” CCGs would receive higher levels of growth and a similar proportion of “green-

	<p>rated” CCGs would receive the lowest level of growth proposed;</p> <ul style="list-style-type: none"> • 120 out of 211 CCGs would receive the base 1% level of growth, less than real terms growth of 2% but sufficient to cover the 0.7% that it is estimated would be required to meet cost pressures on their budgets. <p>Following this introduction, the Board had detailed discussion in particular covering:</p> <ul style="list-style-type: none"> • Concerns the model did not address unmet need and, given its focus on current service utilisation, could reinforce the “inverse care law”; • Questions about whether the impact on health outcomes and deprivation was clearly understood, with concerns that increased allocations could go to those areas with the highest health outcomes, and lower increases to those areas with worse health outcomes; • Concerns about considering the allocation model for CCGs in isolation from other health expenditure, in particular that related to public health – with a need to consider whether areas of greatest deprivation needed to have additional public health and primary health care investment in order to address unmet need; <p>In further debate, the need to be able to support whichever methodology was chosen with very clear reasoning and messaging was agreed. On the one hand, the ACRA model used a formula that had been carefully tested, would support redistribution and improve financial resilience. On the other, it was unclear whether it would have the most beneficial impact on health outcomes and addressing health inequalities. In that context, it was noted that the NHS CB was independent within a highly volatile political environment in which there was commitment to invest in the NHS in real terms - but a significant proportion of CCGs could potentially receive less than this if the ACRA redistribution model was followed.</p> <p>At the end of a lengthy discussion, it was considered that the proposed redistribution might be in conflict with our objective of reducing health inequalities. Therefore the Board concluded by:</p> <ul style="list-style-type: none"> • Approving a uniform uplift of 2.3% for CCGs; • Recommending there needed to be an urgent review of the system wide allocation approach involving partners; • Confirming the need for a clear communication plan and messages – including for those CCGs who believed they were going to receive more.
	<p>NHS Planning guidance</p> <p>Ian Dalton introduced this item, explaining that in setting out a new planning system for new NHS, the guidance aimed to balance the need for stability with setting out the high ambition of the Board. It also sought to balance the national ask with scope for the new emerging organisations to focus on local priorities. “Everyone Counts” had been informed by previous Board discussions (November 2012) with much work since, including input from a Board Task and Finish Group. He considered the result was a radical, ambitious, forward looking document.</p>

	<p>Ian circulated an amendment relating to QIPP. This version incorporated a set of statements to make even clearer the whole system expectations that cost must never be systemically traded for quality in the NHS. The National Directors then summarised the five offers provided by the NHS CB to NHS commissioners, to assist them improving health outcomes:</p> <ul style="list-style-type: none"> • Sir Bruce Keogh drew attention to the beneficial impact on outcomes that could arise from moves towards seven day services and also described planned work on publication of results by summer 2013. Although the latter could be contentious, it could lead to greater focus on individual outcomes as well as upon design of service configurations to result in an optimal balance of outcome and volume; • Jane Cummings described work to support higher standards and safer care, with specific recommendations related to the national response to Winterbourne View supported by a Concordat signed with key stakeholders. The upcoming Francis Report was also expected to make a significant number of recommendations including on clinical and nursing care. The final wording of this offer would draw attention to Compassion in practice and the six Cs – which were applicable to all staff in all settings; not just nursing. The guidance drew attention to medical revalidation, and to work with the Leadership Academy – enabling those in management roles to support high quality care; • Tim Kelsey described the importance of listening to patients and increasing their participation. Measures to improve real time feedback would include the Friends and Family test and build so patients could leave feedback on any service in real time by 2015. In addition, there would be consultation during 2013 on the vision for how people will access their records across the whole health and social care system, patients being guaranteed access to their primary healthcare record by 2015. He also described the role to be played by high quality relevant data as a key commissioning tool, with enablers including an expectation that all GPs would provide a standardised clinical dataset to support analysis of outcomes across pathways of care and a requirement for universal adoption of the NHS number as the primary patient identifier. <p>Bill McCarthy also drew attention to the comprehensive data and outcomes benchmarking pack to be published and made available to local Health and Social Care communities. Along with the tools described in the offers within the document, this would help focus commissioners on tackling inequalities in outcomes and support bottom up ideas generation at local level.</p> <p>In follow-up discussion, the issue of whether and when the point would be reached when further financial efficiencies could impact upon quality was raised. A recently-published NAO report was a helpful contribution explaining good progress to-date and there was acknowledgement that if all areas of the service adopted best practice, then required financial efficiencies could be achieved without compromising quality. However, this would clearly remain an area for continued very close focus over future years.</p> <p>In summary, the Board considered the latest version of the document was impressive, and clearly signalled how the Board intended to operate. They</p>
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	<p>were keen to ensure the launch was used positively and beyond a traditional NHS audience. To that end, they were updated on the communications plans in place, including significant media relations work, opinion editorial pieces, press releases, a website, and launches across the country by LATs. The guidance would be used as a manifesto going forwards and could form a core script over the course of the next several months.</p> <p>The Board agreed to the publication of the planning guidance for 2013/14.</p>
	<p>NHS Planning 2013/14 – incentives and levers</p> <p>Dame Barbara Hakin introduced this item and drew attention to four aspects from the planning guidance where Board approval was required:</p> <ul style="list-style-type: none"> • Standard contract – the responsibility for which passes to NHS CB from the DH. Work had been ongoing over several months and improvements made as detailed in paragraph 14 of the report. <p>The Board agreed to the goals set for the contract as described in the report, and agreed to delegate the final sign-off of the contract to Dame Barbara Hakin and Ian Dalton.</p> <ul style="list-style-type: none"> • CQUIN – work to define CQUINs for 2013/14 had been undertaken with cross-directorate involvement. It was proposed that funding for CQUINs should remain at 2½% and, as with previous years, ½% would be covered by national initiatives, the remainder being local. Further information on the proposed programme and areas to be covered was included in paragraphs 21 and 22 of the report. <p>The Board agreed the CQUIN scheme for 2013/14.</p> <ul style="list-style-type: none"> • CCG Outcomes Indicator Set – it had been agreed there should be a commissioning outcomes framework. It was proposed there should be a name-change to “CCG Outcome Indicator Set” (CCG OIS), with arrangements being described in paragraphs 24-34 of the report. An outcomes indicator on cardiac rehabilitation would also be incorporated. <p>The Board approved the publication of the renamed indicator set and delegated authority to finalise the detail to Dame Barbara Hakin, Jane Cummings, Tim Kelsey, and Sir Bruce Keogh.</p> <ul style="list-style-type: none"> • The NHS CB was required, on the basis of CCG OIS, to identify a quality premium for CCGs. The first payment would be in 2014 to reflect 2013/14 performance. Although early indications had suggested this reward would be up to £5 per head (i.e. a maximum level had been set) the final figure was still subject to HMT agreement. In addition, the final details, including how the money could be used were subject to regulations expected to be laid in January. <p>The Board agreed that CCGs should automatically be debarred from receiving a quality premium payment if there was a significant quality failure in-year or if they overspent the approved resource limit and that failure to</p>

	<p>deliver certain patients' rights in the NHS constitution should also affect the reward. The Board would also have the right to withhold payment if there were issues in financial control.</p> <p>The Board approved the method for rewarding CCGs through the Quality Premium as outlined in paragraphs 40 and 41 of the report.</p>
	<p>Choice and competition framework update</p> <p>Bill McCarthy provided an update, explaining that joint work on rules and competition with Monitor would be subject to delay until March 2013, related to current internal debate within Monitor as they took on the extended responsibilities including the Cooperation and Competition Panel.</p> <p>The NHS CB was very clear that to back up its values and purpose, choice of provider and competition should be used as a means to an end for delivering improved health outcomes. This meant it would be important to identify the services and circumstances where choice of provider and competition would improve outcomes and, where that would not be productive, identify alternative approaches to be considered.</p> <p>The Board noted this update.</p>
Action	BM to keep the Board informed of progress
6	<p>Any other business</p> <p>The dates of the next meetings were noted:</p> <ul style="list-style-type: none"> • Board development session – 25th January 2013, London • Date of next Board meeting – 28th February 2013, Manchester

Signed as an accurate record _____

Date _____