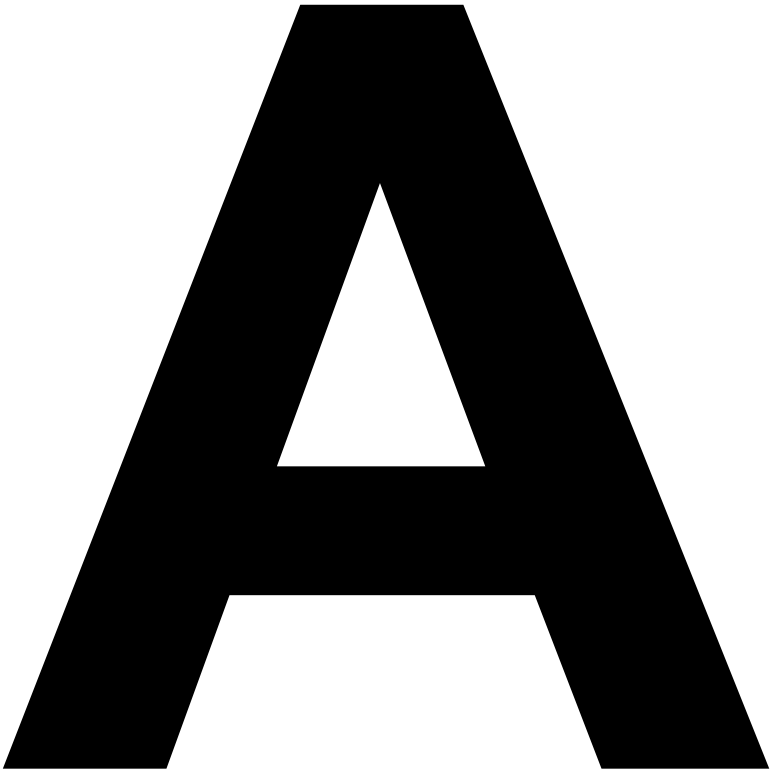
East Leicestershire and Rutland Clinical Commissioning Group

Meeting Title	East Leicestershire and Rutland Clinical Commissioning Group – Governing Body	Date	Tuesday 14 May 2013
Meeting no.	2	Time	10.45am – 1.00pm
Chair	Mr Graham Martin	Venue / Location	Pera Innovation Park, Nottingham Road, Melton Mowbray, Leicestershire, LE13 0PB

	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
B/13/18	Welcome and Introductions		Graham Martin		10.45am
B/13/19	To receive questions from the Public in relation to items on the agenda	To receive			
B/13/20	Apologies for Absences:	To receive	Graham Martin		
B/13/21	Declarations of Interest on Agenda Topics	To receive	All		
B/13/22	Minutes of the meeting held on Tuesday 9 April 2013	To approve	Graham Martin	**A**	10.50am
B13/23	Matters Arising: Update on actions from the meeting held on Tuesday 9 April 2013	To receive	Graham Martin	**B**	10.55am
B/13/24	Notification of Any Other Business	To receive	Graham Martin	**verbal**	
REPORTS					
B/13/25	Chair's Report	To receive	Graham Martin	**C**	11.00am
B/13/26	Accountable Officer's Corporate Report	To receive	Dr Dave Briggs	**D**	11.10am
PATIENT SAFETY AND EXPERIENCE					
B/13/27	Quality and Clinical Governance summary report	To receive	Warwick Kendrick	**E**	11.20am
B/13/28	Proposals for Improving Patient Experience	To approve	Carmel O'Brien	**F**	11.30am
GOVERNANCE AND ASSURANCE					

East Leicestershire and Rutland Clinical Commissioning Group

B/13/29	Terms of Reference • Remuneration Committee • Quality & Clinical Governance	To approve	Paul Sherriff	**G**	11.45am
B/13/30	Updated East Leicestershire and Rutland CCG Constitution	To agree	Paul Sherriff	**H**	11.55am
STRATEGY AND COMMISSIONING					
B/13/31	Locality Chairs' Report	To receive	Locality Chairs	**verbal**	12.10pm
FINANCE AND PERFORMANCE					
B/13/32	Budget 2013/14	To approve	Karen English	**I**	12.20pm
B/13/33	Finance Report: Month 12	To receive	Karen English	**J**	12.35pm
B/13/34	Performance Assurance Report	To receive	Jane Chapman	**K**	12.45pm
DATE OF NEXT MEETING					
B/13/35	The next meeting of the East Leicestershire and Rutland CCG Board will take place on Tuesday 11 June 2013, Voluntary Action Rutland, Lands' End Way, Oakham, Rutland, LE15 6RB.				11.00am



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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

Minutes of the Governing Body Meeting held on Tuesday 9 April 2013 at 10.45am in the Club Suite, Leicester Racecourse, Oadby, Leicester, LE2 4AL

Present:

Mr Graham Martin	Independent Lay Chair
Dr Dave Briggs	Managing Director
Dr Simon Wooding	GP, MRH Locality Lead
Dr Graham Johnson	GP, Blaby and Lutterworth Locality Lead
Dr Andy Ker	GP, MRH Locality Lead
Dr Nick Glover	GP, Blaby and Lutterworth Locality Lead
Dr Richard Palin	GP, Oadby and Wigston Locality Lead
Dr Tim Daniel	Consultant in Public Health
Mr Alan Smith	Independent Lay Member
Mr Warwick Kendrick	Independent Lay Member
Mrs Karen English	Chief Finance Officer
Mrs Carmel O'Brien	Chief Nurse and Quality Officer
Mrs Jane Chapman	Chief Strategy and Planning Officer
Mr Paul Sherriff	Chief Corporate Affairs Officer

In Attendance:

Mrs Kathy Reynolds	Rutland Transition Healthwatch Group
Mrs Daljit Kaur Bains	Head of Corporate Governance
Ms Emma Rogers	Head of Communications
Mr Eric Charlesworth	Leicestershire Transition Healthwatch Group
Mrs Claudia Thompson	Board Support Officer

There were three members of the public present.

ITEM	DISCUSSION	LEAD RESPONSIBLE
B/13/01	**Welcome and Introductions** Mr Graham Martin, Independent Lay Chair welcomed members of the public to the first meeting of the statutory body of East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG).	
B/13/02	**To Receive Questions from the Public in relation to items on the agenda** There were no questions received in relation to items on the agenda.	
B/13/03	**Apologies for Absences** Apologies were received from Mr Tim Sacks, Chief Operating Officer, Dr Hamant Mistry, Clinical Vice Chair and Dr Tabitha Randell, Consultant Paediatrician.	

B/13/04	**Declarations of Interest** All GPs presented declared an interest in any item relating to primary care.	
B/13/05	**Constitutional and Statutory Requirements** Mr Paul Sherriff, Chief Corporate Affairs Officer introduced the summary report detailing the key elements and progress made since authorisation on 5 December 2012, the removal of conditions and summarised the key issues around the management of policies and adoption and development of key Terms of Reference (Paper A). He drew members' attention to the Constitution which required further work to reflect statutory status and outlined the process to update the document. Mr Martin queried whether there was enough time to undertake the work on the Constitution. Mr Sherriff confirmed that work was already underway to ensure it was reviewed and comments had been received from practices regarding its comprehensiveness. The final document would include a scheme of Reservation and Delegation, the removal of the detailed Terms of Reference. It was RESOLVED - To receive and note confirmation from the NHS Commissioning Board that the authorisation conditions imposed on the CCG in December 2012 have been lifted and that the CCG is fully authorised to discharge its full statutory duties as from 1 April 2013; - To approve the composition of the CCG Board appointed or elected to their roles in line with national guidance and note that Dr Dave Briggs is the Accountable Officer; - To approve the Constitution as agreed by the CCG and the change to section 1.3.1 as advised by the NHS Commissioning Board; - To receive and note the terms of reference as previously presented to the Board for approval, any further updates will be presented to the Board in May 2013; - To receive and note the policies that form part of the Constitution and note work in progress to review the policies and requirement for any additional policies; - To note that a common seal will be obtained and adopt its use as outlined within the ELR CCG Constitution.	
B/13/06	**Minutes of the Meeting held on Tuesday 12 March 2013** The minutes of the meeting held on Tuesday 12 March 2013 (Paper A) were agreed as an accurate record.	
B/13/07	**Matters Arising: Update on Actions from the Meeting held on**	

	Tuesday 12 March 2013 The action log was reviewed (Paper B) and the following updates provided: **ELR/13/29 Chairs Report** Mr Martin confirmed that the response to the questions raised by the Campaign Group 38 Degrees had now been sent and he thanked Board members for their contributions. A copy of the letter would be made available to all members and would be included on the website. **ELR/13/32 Pressure Ulcer Ambition Progress Report** A paper had been produced by the Head of the CHC Team which would be considered at the next CHC Board and a recommendation would be made following that meeting in the next six weeks. **ELR/13/37 Committee Terms of Reference: Audit Committee and Remuneration Committee** These terms of reference were ready to come back to the meeting in May 2013. Action complete. **ELR/13/42 Performance Assurance Report** Mr Sherriff had been in dialogue with the Area Team since December 2012 about the future arrangements but the format was as yet unknown.	
B/13/08	**Chair's Report** Mr Graham Martin, Independent Lay Chair presented an overview of some of the key meetings and activities (Paper D) since the last meeting. He highlighted: • The removal of the conditions relating to the authorisation of the CCG and recognised the hard work and commitment of the staff and formally recorded his thanks from the Board's perspective for their contribution; • Members of the Board and Corporate Management Team • had attended seven local community discussion groups and he found it interesting to hear the range of questions and level of interest in the CCGs development of plans for services; • Appendix 1, detailing the dates and venues of the ELR CCG Board meetings for the rest of the year were highlighted. Mr Charlesworth queried how the CCG would ensure information was made available to members of the public as he felt this was a key cornerstone of transparency. Dr Briggs explained that normally the minutes of both the Emergency Care Network and	

	Better Care Together Board were received here for information. However currently a review and evaluation of their work was being undertaken and the outcome would come back to this Board including the new reporting mechanisms. It was RESOLVED - To receive the report.	
B/13/09	**Accountable Officer's Corporate Report** Dr Dave Briggs, Managing Director introduced the report detailing some of the key activities of the Corporate Management Team (CMT) since March 2013 (Paper E) and highlighted: • The review being undertaken to consider the UHL Summary Hospital-level Mortality Indicator because, although within acceptable statistical limits, the Board wanted to identify opportunities for learning and therefore a review had been agreed and was being led by the Leicester Medical School with involvement from local clinicians and lay members; • The CCG had noted the government response to the Francis Inquiry and were supportive of implementing the actions outlined. The CCG were currently considering a response and the impact on our patients and carers; • UHL and LPT did not meet the pressure ulcer ambition set out the by Department of Health. It was noted that the targets set were challenging and the CCG would be working with providers to set more achievable levels and hold delivery to account; • The Board were asked to note the update regarding the Freedom of Information Act requests and note the CCG had adopted the model publication scheme produced by the Information Commissioner's Office regarding the Freedom of Information Act 2000; • The Mental Health Awareness week between 13 to 19 May 2013. Mr Sherriff drew members' attention to paragraph 20 relating the transfer schemes with associated assets and liabilities and the transition to new NHS commissioning structures. He explained that the delegated group were unable to approve the Assets and Liabilities Transfer scheme as these were still awaited from NHS England. The transfer of clinical equipment had continued to be progressed and Mr Sherriff reported that he felt the CCG were in a much stronger position and it was noted that the implications would come back to this Board. It was RESOLVED - To receive the report.	
B/13/10	**Local Responsibilities for Transforming Care: A National**	

	Response to Winterbourne View Hospital (DH, Dec 2012) Mrs Carmel O'Brien, Chief Nurse and Quality Officer provided a briefing on the key issues for CCGs following the government's review of Winterbourne Hospital (Paper F) and a summary of the work undertaken across Leicester, Leicestershire and Rutland. Mr Martin queried whether the commission of an audit of current services for people with challenging behaviour had started (paragraph 22) and **Mrs O'Brien agreed to check**. Mr Kendrick queried whether the resources were available within our strategic plan to carry out this work by 1 June 2014. Dr Briggs confirmed that there were a number of issues. Firstly, it was necessary to ensure that patients received a high quality level of care in a safe environment. In terms of whether the CHC team was at the right capacity to discharge its responsibilities, plans would be received back here in the next few weeks. A second piece of work was also required to ensure that Local Authority partners had a complete understanding of the care of those placements in order to ensure the highest standards. Dr Ker asked whether out of county placements would be visited by our own CHC team and this was confirmed. Mr Martin queried when it would be sensible to bring back the plans and consider whether actions were having the desired impact. **Mrs O'Brien suggested that the action plans needed to be embedded and a gap analysis undertaken at three months with an interim report to the Quality and Clinical Governance Group and a report to the Board at six months**. It was RESOLVED - To note the findings of the Winterbourne review; - To review and approve the action areas.	C O'Brien C O'Brien
B/13/11	**University Hospitals of Leicester (UHL) Quality and Safety Review** Mrs Carmel O'Brien, Chief Nurse and Quality Officer presented a report about the concerns identified in quality and safety of services at UHL (Paper G) and the actions taken, outcomes to date and next steps. Dr Palin outlined the additional action following the visits which was the issue of a contract query relating to thrombolysis for stroke patients. He would be able to report back the UHL response following the next visit. Dr Ker queried the communications to be made available to practices. **Mrs O'Brien suggested circulating a short summary of this paper to locality meetings**.	C O'Brien

	Dr Glover asked when the impact of the Right Place Consulting review of the emergency pathways was expected (section 2, bullet point 3). Dr Briggs confirmed there were two elements, firstly ensuring the right patients were admitted from the acute care setting and received timely investigations and secondly that patients received timely discharge. Dr Briggs had queried the lack of impact and feedback had been received that there had been more structure within the department and when under significant pressure it had not felt as chaotic. The subsequent analysis of the right place review suggested that increased focus should have taken place on the discharge processes to address the bottlenecks in the system. Mrs Chapman explained that in terms of the current recovery trajectory the new processes would be embedded by the end of Quarter 1. At the present time the reduction in performance was due to delayed transfers of care. Mr Martin noted the clear commitment to tackle quality issues within UHL. It was RESOLVED - To note the position in UHL and; - Agree actions as set out in section 6 of the report.	
B/13/12	**Locality Chair's Report** • **Oadby and Wigston Locality** Dr Richard Palin, GP, Oadby and Wigston Locality provided an update on items discussed at their locality meeting which took place on the same day as the Practice Managers Forum and therefore resulted in a far more clinically focussed discussion. It was suggested that a clinician-only meeting be held on a monthly basis. Members discussed the protected learning time work which was well received and the opportunity to have joint locality meetings across the CCG was discussed and this would be taken forward with other GP locality leads. The funding of primary care to enhance services and GP Support Framework resources were discussed. The work on the pre-diabetes care pilot was being rolled out across the locality in May 2013 and this was well received and a positive movement for patients with pre-diabetes. Mr Martin asked whether the other localities had considered holding clinician only meetings. Dr Glover emphasised the need to discuss this further with Locality Managers because of the importance of timing in relation to quality and QOF framework indicators however he felt there would be items that practices would want managerial input. Dr Ker felt there was a different perspective provided from having clinician only representation and he felt the primary care team would need to help with the	

	scheduling of that type of discussion. • **Blaby and Lutterworth Locality** Dr Glover, GP, Blaby and Lutterworth Locality Lead reported that Dr Dave Briggs had been welcomed to the meeting. The main item of discussion was around the GP Support Framework which was well received. Dr Johnson presented an update on provider quality as there was interest from the GPs to be assured about the CCG monitoring arrangements. There were a number of standing items on the performance reports with information received about GP initiated activity and a prescribing update which this month helped practices understand the supply issues for widely prescribed medications. There was a specific request from practices for Dr Briggs to present the final outcome of discussions on UHL performance and financial balance and the role of the CCG and SHA to ensure stability of the health economy. This received an expected level of challenge but also recognition of the huge progress over the last three years to ensure that in exchange for support in achieving financial balance UHL were required to deliver on performance and quality issues. • **Melton, Rutland and Harborough (MRH) Locality** Dr Andy Ker, GP, MRH Locality Lead reported that the locality met on the 27 March 2013 at Billesdon and discussed standing items including prescribing, performance review and a board update. The two other items discussed included a presentation by the Neurological Task Group attached to LINk about the provision of a Community Parkinson's nurse and was a lot of interest in the use of their resources within the Protected Learning Time. A discussion was undertaken about the use of sub-locality meetings within MRH. The GPs within that locality felt they were well worth it particularly in respect of peer review and appreciated the additional work from the primary care team. However they did agreed to reduce to nine full and three sub-locality meetings. Dr Glover drew members' attention to the new Quality Outcomes Framework QP guidance which put the responsibility for agreeing the format with the Local Area Team and a meeting was taking place with Locality Managers to resolve the issue. This would be discussed further outside of the meeting.	
B/13/13	**Finance and Performance Summary Report** Mrs Karen English, Chief Finance Officer provided an overview of the main issues discussed at the Finance and Performance Committee on Tuesday 2 April 2013 which included: • The concentrated efforts focussed on year-end close down; • The Month 11 finance report showed a favourable position of £2m underspend at end of February 2013; • The principle reason for the underspend was the release of	

	flexibilities and contingencies held within CCG and Cluster resources from transformation funding; • The inherent pressures around the acute contracts had seen a reduction in the forecast around elective activity at UHL which had a favourable impact although it was noted that this was not the case from a performance and quality aspect; • Confirmation from the lead commissioners on the out of area activity was still awaited although over-performance was expected; • As a consequence of the practical and profiled management intervention led by Dr Briggs and the facilitated lead manager for Continuing Healthcare improvements in the value for money aspects of the contracts were being taken through and some of the procedures and processes were more streamlined leading to a much more effective service and led to a positive financial impact for the CCG; • The release of a contingency to fund pharmacist contracts had impacted on the primary care prescribing budget; • The final version of the Annual Plan would be submitted on 17 April 2013. A robust and sensible agreement had been reached with UHL which would move away from fluctuations previously seen towards year-end; • A year-end position and report would be taken to the Finance and Performance Committee including a proposed budget based on the final plan; • The new financial ledger system was in place within an integrated single financial environment. Mr Kendrick queried what would happen to the non-recurrent reserves if a £2m underspend was recorded at year-end. Mrs English confirmed that some of the reserves had already been protected and carried forward for next year as the CCG needed to protect as much as possible for the Continuing Healthcare commitments. It was RESOLVED - To receive the update.	
B/13/14	**Finance Report: Month 11** The Month 11 financial reporting update on the resources delegated to East Leicestershire and Rutland CCG (Paper H) was incorporated into the discussion under item B/13/13, Finance and Performance Summary Report. It was RESOLVED - To note the contents of the report.	

B/13/15	**Performance Assurance Report** Mrs Jane Chapman, Chief Strategy and Planning Officer presented the overview of performance for Leicester, Leicestershire and Rutland for the period January to February 2013 (Paper I). The key areas of risk were outlined in detail including: • A&E four hour wait; • Two week and 62 day cancer waits; • Referral to Treatment and diagnostics; • Delayed transfers of care; • NHS Health Checks; • IAPT; • Benchmarked report. Dr Briggs suggested incorporating the monthly run rate for UHL and non UHL contracts to ensure the necessary focus. Mrs Chapman explained that from her perspective it was essential provide information at Board level to ensure statutory responsibilities had been discharged. Dr Glover was keen include the monthly figures for A&E as reported by the NHS statistics website in order to compare local providers performance with similar benchmarked performance of providers across the country. Mr Charlesworth suggested that the corporate objectives box relating to engagement with patients, carers and their communities should be ticked because it showed that the CCG were willing to share information. Dr Ker asked whether it would be possible to include the out of county arrangements alongside the UHL data in order to provide comparisons. Mr Martin suggested that this information be presented to the Finance and Performance committee and any issues be escalated to the Board. **Mrs Chapman confirmed that the data was readily available and could be incorporated into the Finance and Performance narrative to the Board including the trends and themes considered at the subgroup and the escalation of any issues and concerns to the Board**. Dr Johnson felt that statistics were often difficult to interpret and he suggested comparing similar services in detail at the subgroup**. It was agreed that a topic would be chosen on a quarterly basis and the detail provided for discussion at the subgroup.** Members felt that receiving CCG specific figures for EMAS was fundamental because if the target was for overall performance they could achieve response rates for city but not county and could create a perverse incentive. Mrs Chapman outlined the	J Chapman J Chapman

	contracting arrangements which would ensure more robust contract management and integrity. Dr Ker queried the progress following the EMAS presentation about how to improve performance. Dr Briggs reported that EMAS had been subject to an independent review on investment from commissioners and their ability to deliver a service for patients. The review suggested that they were one of the lower funded services and EMAS were therefore looking for opportunities over the next three years to change infrastructure and improve performance. A lot of resource was being spent on buildings rather than the service so the EMAS Trust Board were asked to consider how to realign the resource to ensure that more money was spent on ambulances and staff. He felt there was a lot of sense with the new arrangements and noted the importance of having CCG targets as he would not like to see substations any further away from patients than currently. Mrs Chapman confirmed that this was a condition within the contract for 2013/14 and going forward. It was RESOLVED - To note the contents of the report; - To approve the documents attached.	
B/13/16	**Minutes of the Finance and Performance Group held on 5 February 2013** The minutes of the Finance and Performance Group (Paper J) were received for information.	
B/13/17	**Date of Next Meeting** The next meeting of East Leicestershire and Rutland CCG Board will take place on Tuesday 14 May 2013 at Pera Innovation Park, Melton Mowbray, Leics, LE13 0PB.	

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EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP

ACTION NOTES

Key

Completed	On-Track	No progress

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at May 2013	Status
ELR/13/32	March 2013	Pressure Ulcer Ambition Progress Report	D Briggs	• To bring back a fully articulated outcome in respect of the review and remodelling of the CHC team including linking in with the Local Authority in relation to the reporting mechanism;	August 2013	The action around pressure ulcers was picked up at the CHC meeting and agreement reached to look at a joint social care and health approach. This would be taken forward by Caroline Trevithick in the care home subgroup. There will be a more formal update at August Board. **ACTION COMPLETE**	**GREEN**
ELR/13/37	March 2013	Committee Terms of Reference: Audit Committee & Remuneration Committee	P Sherriff	• To bring back the revised terms of reference in relation to the Remuneration Committee for approval.	May 2013	Terms of reference on track for the May 2013 Board meeting. **ACTION COMPLETE**	**GREEN**

ELR/13/42	March 2013	Performance Assurance Report	P Sherriff	• To clarify the date of the next Area Team/CCG Performance Review.	April 2013	David Sharpe's office (Local Area Team Director) have arranged to see the three LLR CCG Managing Director's to discuss the CCG Assurance Framework. **ACTION COMPLETE**	**GREEN**
B/13/10	April 2013	Local Responsibilities for Transforming Care: A National Response to Winterbourne View Hospital	C O'Brien	• To check when the national Department of Health audit of services for people with challenging behaviour started (para 22); • Produce an interim report for discussion in three months at the Quality and Clinical Governance Group and a report to the Board in six months.	May 2013 October 2013	This had been checked and an update was awaited. This item had been added to the Board and Quality & Clinical Governance tracker. **ACTION COMPLETE**	**AMBER** **GREEN**
B/13/11	April 2013	UHL Quality and Safety Review	C O'Brien	• Produce a summary paper for circulation to the locality meetings.	April 2013	**ACTION COMPLETE**	**GREEN**
B/13/15	April 2013	Performance Assurance Report	J Chapman	• Incorporate data on OOC arrangements alongside UHL data into the F&P narrative to the Board including the trends and themes	May 2013	A discussion had taken place at the Finance & Performance subgroup meeting.	**GREEN**

				considered at the subgroup and the escalation of any issues and concerns to the Board; • To choose a topic to debate in detail on a quarterly basis at the F&P subgroup.		This had been incorporated into the Finance and Performance Subgroup work programme. **ACTION COMPLETE**	

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING 14 MAY 2013

Chairman's Report

Introduction

1. I would like to welcome members to the second meeting of the Governing Body of East Leicestershire and Rutland Clinical Commissioning Group.

2. The purpose of this report is to provide an overview of some of the key meetings and activities which I have been involved in since the last meeting of the Governing Body; and to provide an update on constitutional changes that affect the Governing Body.

Involving and informing update

3. Our CCG is committed to ensuring our patients, partners and stakeholders, staff and clinicians are truly involved and informed when it comes to local healthcare.

4. Over the last 18 months while operating in shadow form, ELR CCG has conducted our communications and engagement activity in line with our Involving and Informing Strategy 2012-13 and has developed strong links with many of our stakeholders as a result. We have started meaningful, ongoing conversations about our commissioning priorities and benefited from patient insight in the development of a number of our projects and work streams.

5. Now the CCG is fully authorised, we are taking the opportunity to refresh the Involving and Informing Strategy to build on the work we've undertaken to date and to further improve the way in which we involve patients, member practices and partners in our work. This work is being led by Emma Rogers, our CCG Head of Engagement and Communications.

6. The refreshed strategy, which is currently under development, will outline proposals for the formation of a patient advisory group whose outputs will inform and feed into all aspects of the CCG's work via the Corporate Management Team, project groups and Boards. There will also be renewed focus on GP engagement and the integration of patient experience plans with our wider work in involve and inform. Discussions with key stakeholders will be taking place in the coming weeks to aid in the development of the strategy which will then be brought to the CCG Governing Body for consideration and approval in June.

Meetings attended

7. On 17 April 2013 I attended a Patient Revolution Workshop designed to improve understanding of patient experience and how NHS organisations can work more effectively to listen to and act upon patient feedback and experiences of care.

8. I was invited to join University Hospitals of Leicester on 22 April 2013 to meet candidates and support the selection process for the recruitment to the post of Chief Operating Officer.

Recommendations

The East Leicestershire and Rutland CCG Governing Body is requested to:

RECEIVE the contents of the report.

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING 14 MAY 2013

Accountable Officer's Corporate Report

Introduction

1. This report sets out to the Governing Body some of the key activities the Corporate Management Team (CMT) and I have been involved in since the last Board meeting in April 2013.

ACCOUNTABLE OFFICER

Planned Care

2. From April 2013 the Right Care Board, which has been established since 2011 under the predecessor organisations, has transformed into the Planned Care Steering Group. The Group will include representatives from East Leicestershire and Rutland CCG, West Leicestershire CCG, Leicester City CCG, providers, public health representatives, contracting representatives and lay members.

3. The work stream will consist of
   a) Progressing with British Association of Day Case Surgery (BADS), thresholds and outpatient and follow up redesign.
   b) The Better Care Together planned care work stream will be taken through, or supported by, the Planned Care Steering Group
   c) The work programme will be discussed with clinicians and relevant staff and developed over the next few months.

CORPORATE AFFAIRS

NHS Litigation Authority (NHSLA)

4. Membership of the NHSLA has been confirmed. ELR CCG has joined the following schemes to begin on 1 April 2013 for three years:
   - The Clinical Negligence Scheme for Trusts (CNST)
   - The Liabilities to Third Parties Scheme (LTPS: covers non-clinical liabilities, typically employers' and public liability, together with non-clinical professional indemnity and the personal liabilities).
   - The Property Expenses Scheme (PES): covers first-party buildings and contents damage.

Staff Opinion Survey (SOS)

5. The 2012 national NHS SOS data collection took place from September to December 2012. PCTs were able to opt out of this year's survey which was the option chosen by the LLR PCT Cluster.

6. However, ELR CCG utilised the national survey processes to conduct the staff survey and the data collection ran from 28th November 2012 to 18th January 2013. It was accepted at the time that the results would need to be considered in light of the following:
    - national benchmarking data is a significantly smaller sample from previous years;
    - the size and scale of the organisation from the previous to the current year;
    - the results reflect a snapshot of the organisation during December 2012 – January 2013.

7. The response rate was 78%, 42 out of 54 staff completed the survey. This was better than the best PCT score nationally which was 73%. The key findings from the 28 national benchmarking and statistical analysis show:
    - 17 matched or were better than the best PCT score
    - 2 were better than the average PCT score
    - 5 were average
    - 6 matched or were worse that the worst PCT score

8. In comparing the 28 key findings against the previous year the initial results show:
    - 12 improved
    - 3 remained the same
    - 11 deteriorated

9. The results and an initial action plan are being considered by the corporate management team on the 20 May 2013. The Governing Body will receive an update at the June meeting, which will include a wider reflection on the delivery of our organisational development strategy.

QUALITY AND NURSING

10. New guidance was published in March and came into force on 15th April 2013 "*Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2013)".* This new safeguarding guidance replaces Working Together to Safeguard Children (2010); Framework for the Assessment of Children in Need and their Families (2000); and statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (2007).

11. The guidance seeks to emphasise that effective safeguarding systems are those where:

    - the **child's needs are paramount**, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates;
    - **all professionals who come into contact with children and families** are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;

- **all professionals share appropriate information in a timely way** and can discuss any concerns about an individual child with colleagues and local authority children's social care;
- **high quality professionals are able to use their expert judgment** to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;
- **all professionals contribute to whatever actions are needed** to safeguard and promote a child's welfare and **take part in regularly reviewing the outcomes** for the child against specific plans and outcomes;
- **local areas innovate** and changes are informed by evidence and examination of the data.

12. Effective safeguarding arrangements in every local area should be underpinned by two key principles:

    - safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and

    - a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

13. In addition NHS England published "*Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework"* at the end March 2013. The guidance sets out the distinction between responsibilities of NHS England (local office) CCGs and Public Health.

14. Both the CCG and NHS England (Area Team for Leicestershire and Lincolnshire) are statutory members of Local Safeguarding Children Board:
    - The NHS England (local office) will have oversight of the health wide system and monitor effectiveness
    - CCGs will be responsible for designated professionals for Safeguarding, as well as LAC and Child Death consultant
    - GP practice will be required to have a safeguarding lead and deputy to work closely with Named GPs.

15. A full summary of the guidance will be taken through the Quality and Clinical Governance Committee in May 2013.

STRATEGY AND PLANNING

Annual Plan

16. Further to the March 2013 meeting of the ELR CCG Governing Body the draft of our Annual Plan was circulated to Board Members for review and final comments and amendments. A delegated group of the Governing Body then reviewed and approved the final draft for submission to the NHS England Area Team (Leicestershire and Lincolnshire) as required within 'Everyone Counts', the NHS

England Planning Guidance for 2013/14. Progress against the commitments within the plan will be monitored at the Strategy and Delivery Sub-group. To aid patient and public understanding of our work, we are publishing a patient version of our 'Plan on a Page' and a prospectus detailing key information about our CCG.

OPERATIONS

17. The CCG arranged a meeting for 8th March 2013 with the health leads from Harborough District Council, Melton Borough Council, Oadby and Wigston Borough Council and Blaby District Council to determine how we can work together to improve the links between health and district councils for the benefit of local people. This meeting, chaired by Sandra Whiles (lead for health across the seven district councils in Leicestershire, member of the Leicestershire Health and Wellbeing Board and Chief Executive of Blaby District Council) agreed key principles on how best to improve communication, share ideas and work together.

18. As a result of the meeting and subsequent discussions with the Chief Executives of Harborough District Council, Melton Borough Council and Oadby and Wigston Borough Council, a number of actions have been agreed. These include the establishment of formal links between each district council health lead and CCG locality lead to share ideas and signpost health related council services to our member practices; regular CCG representation and updates at district council health forums; networking opportunities for councillors and GPs before CCG locality and sub locality meetings held at district council offices; and the development of a presentation to be delivered at council health meetings to detail how collaborative working between health and councils can benefit local people. It is anticipated that these positive steps in strengthening relationships will benefit patients, the CCG and councils, through a more cohesive and holistic approach to public and health services.

PUBLICATIONS AND UPDATES FOR INFORMATION

19. The following publications and updates have been published by the NHS England via its fortnightly newsletter *Bulletin for CCGs*. The Corporate Management Team review and consider implications and actions for the CCG.

20. **Revised Serious Incident Framework**

Making sure the NHS responds effectively and compassionately to serious incidents that occur during health care is vital, both to protect patients from further harm and to ensure patients' families and carers, and NHS staff, are fully supported to deal with the aftermath of a serious incident.

NHS England has developed and published a revised framework for serious incident management in the NHS. This revised framework explains CCGs', providers' and other organisations' responsibilities when managing serious incidents and also provides links to, and further information about, the tools available to help the new commissioning system from April 2013. It does not fundamentally alter the principles set out in the National Patient Safety Agency's

2010 *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation* and elsewhere, but does update them to reflect the new commissioning arrangements.

CCGs play a key role in holding their provider organisations to account for management of and responses to serious incidents.

21. **Winterbourne View Improvement Programme: Framework for individual care reviews**
    NHS England and the Local Government Association (LGA) have established a joint improvement programme following the abuse at the Winterbourne View hospital. CCGs will have a vital role in ensuring that services meet the needs of local people and in working with local partners to ensure a fundamental shift in care. The current focus of the programme is to review the implementation of the short term commitments made in the national programme of action and to design a programme of support for local commissioners.

    As part of this, a report has been developed that sets out the principles that should inform reviews of care plans, one of the key commitments for local partners. It is not intended as a definitive guide but intended for everyone who is involved in the current reviews and those who will develop future service plans across health and social care.

Recommendation

The East Leicestershire and Rutland CCG Governing Body is requested to:

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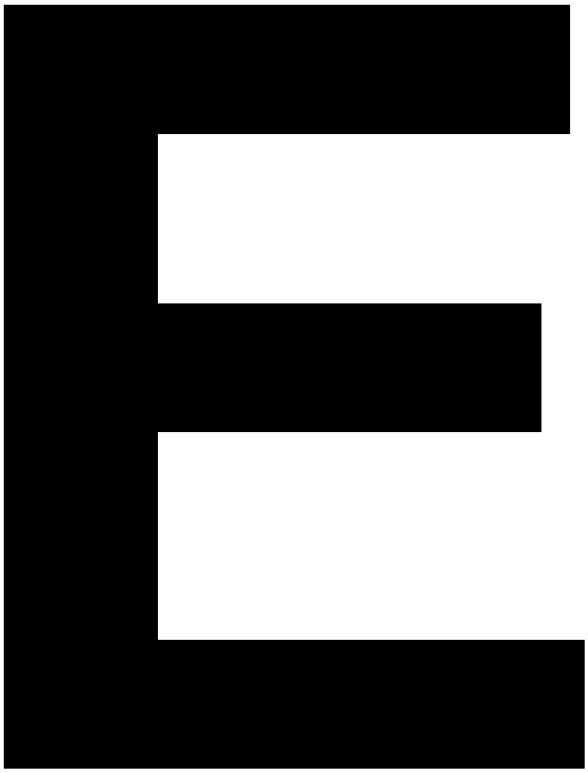

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Quality and Governance Subgroup summary**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Fiona Fretter, Quality Lead**
SPONSORED BY:	**Carmel O'Brien Chief Nurse & Quality Officer**
PRESENTER:	**Graham Martin, Independent Lay Member**

PURPOSE OF THE REPORT:
The report sets out the outcomes from the Quality & Clinical Governance Group held on Tuesday 23 April 2013.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Governing Body is requested to: **RECEIVE** the report for information.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	✓	Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS
Equality Analysis has not been completed as part of subgroup summary report.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:
Links to Board Assurance Framework Reference: 3.1 and 6.4

EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING 14 MAY 2013

Summary Report Quality and Governance Subgroup

INTRODUCTION

1. The following provides a summary of the items discussed at the Quality and Governance Subgroup of ELR CCG Board meeting held on 23 April 2013.

SUMMARY

2. The amended Terms of Reference for the Quality and Governance Subgroup were reviewed, noting that some changes had been made to core membership; however the objectives of the committee remained unaltered. Discussion took place regarding the length of the agenda. It was agreed to undertake a review of papers scheduled for future meetings to allow for more ELRCCG relevant papers to be included. This will take place following receipt of Quarter 3 and 4 papers. The Terms of Reference will also be amended to allow for delegated authority from the Board. The revised Terms of Reference will be presented to Board in May 2013 for final sign off.

3. The monthly pressure ulcer ambition progress report was discussed in detail and the increase in the number of new pressure ulcers reported by UHL in March 2013 according to the Safety Thermometer data was noted. Although when considering actual numbers reported by UHL, rather than prevalence, there had been a decrease in the number reported during March 2013. For LPT, the number of Grade 2 pressure ulcers remained static, and a substantial decrease in the number of Grade 3 and 4 pressure ulcers reported in March 2013.

4. Members expressed concern and disappointment at the rate of improvement being made in reducing pressure ulcers over the past eighteen months. It was agreed to seek data from local provider Trusts to give a comparison with LPT and UHL. Furthermore, it was agreed that the Quality and Governance subgroup would continue to receive a separate Pressure Ulcer report in future meetings.

5. Dr Richard Palin presented a report following a multi-agency audit review of readmissions into UHL. The report demonstrated that 21% of readmissions in 2011/12 were seen as avoidable. Members requested clarification of the actions being taken by UHL following the audit. Dr Palin confirmed that the number of regular consultant ward rounds had increased, as well as each UHL site having a dedicated Discharge Co-ordinator.

6. Mrs Tracy Yole presented a report detailing the proposals for improving patient experience for ELRCCG patients. A patient experience plan will be developed to detail how to collate, share and act on the patient experience data available to the CCG. It was suggested that a forum be convened, in order to bring together the voices of patients and patient groups. It was also proposed that patient

stories are included as standard agenda items on the ELR CCG Board. Members also agreed that the Patient Experience proposals would be presented to the May 2013 ELR CCG Board.

7. Ms Elaine Yates presented the new style Quarter 3 Safeguarding Team report. The report included an update of safeguarding work, developments and issues identified or progressed during Quarter 3 2013. In particular discussion took place over the review of the Multi Agency Risk Assessment Conference (MARAC) process. It was noted that input into the process would be sought from GP colleagues and it was agreed that an Executive Summary paper would be presented to the May 2013 GP locality meeting. This would include details of the MARAC process review and PREVENT agenda including signposting to GPs regarding training.

8. The Quarter 3 Incident and Serious Incident Report was presented, noting that the number of Sis reported by UHL during Quarter 3 have increased and SIs report by LPT have fallen. Members expressed concern at the levels of serious incidents in both providers. It was suggested that going forward further analysis of the root cause analysis would take place to ensure the causes of SIs can be learnt from.

9. It was agreed that the 2013 practice visits would include an agenda item on GP concerns being forwarded to the patient safety team as incidents. The data received would then be compared across LLR to share learning and best practice.

10. Mr Jeffery Meredith presented the NICE compliance update report. Discussion took place of the CCG's role in supporting practices in ensuring practice pathways and standards included integration of NICE compliance and guidance. It was agreed that this issue would be taken to the Primary Care Development Group to ensure practitioners have robust systems in place to demonstrate adherence to NICE standards.

11. Ms Louise Currie, Right Care Planning and Delivery Manager, presented a paper outlining an alternative treatment pathway to surgery for the management of Dupuytren's Contracture, seeking approval to support a contract change in the UHL management of Dupuytren's treatment, from a Day Case surgical procedure to an injection carried out in a treatment/clean room. Members felt that the paper was unclear as to the evidence of patient outcomes, furthermore NICE approval was awaited. It was agreed that a decision would be deferred until more information could be presented.

12. The Medicines Optimisation and Prescribing Strategy was presented for approval following updates made based on comments made at the December 2012 Committee. Members agreed that the Primary Care Team would oversee the action plan to ensure the CCG achieves the 5 competencies identified in the Organisational Competency Framework. It was also noted that the Head of Communications and Engagement should confirm that sufficient Patient

Engagement had taken place when developing the strategy before the Committee could approve the strategy.

13. The Continuing Healthcare Internal Audit Action Plan was presented following a review of LLR Cluster management of CHC services. The audit highlighted a number of areas where additional assurance was sought and the related actions. Going forward Dr Dave Briggs will Chair the CHC Oversight Board to monitor implementation of actions. It was agreed that an exception report will be presented to a future Committee.

RECOMMENDATIONS

The East Leicestershire and Rutland Clinical Commissioning Group Governing Body are requested to:

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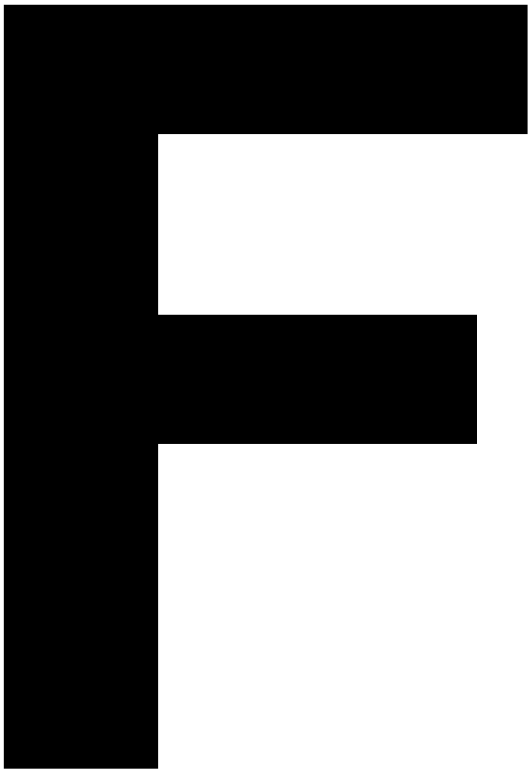

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Proposals for Improving Patient Experience**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Tracy Yole, Head of Quality and Clinical Governance** **Emma Rogers, Head of Communications and Engagement**
SPONSORED BY:	**Carmel O'Brien, Chief Nurse Quality Officer**
PRESENTER:	**Carmel O'Brien, Chief Nurse Quality Officer**

PURPOSE OF THE REPORT:

East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) is committed to improving the quality of health services and our patients' experience of the healthcare we commission on their behalf.
In March 2013 an initial assessment of available local patient experience data was completed by the Quality Team. The assessment revealed several useful sources of patient experience data as well as several gaps which the CCG will need to address.

In order to better understand patient experience and to make effective use of this knowledge to inform our commissioning plans, this paper outlines a number of proposed actions based on national research and guidance.

This plan is one programme of work which is contained within the overarching Involving and Informing Strategy and highlighted as an aim within our CCG Strategic Vision, it should not been taken in isolation. It is anticipated that following the refresh of the Involving and Informing Strategy, it will be necessary to consider how outputs from this branch of work will inform and be integrated into service developments.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Governing Body is requested to:

NOTE the findings of the initial patient experience assessment;

APPROVE the proposals for plans to improve ELR CCG's understanding of our patients' experience and the quality of services we commission.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	✓	Listening to our patients and public – acting on what patients and the public tell us.	✓
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate. However "Due Regard" requirements will be embedded within the patient experience programme of work.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

Board Assurance Framework risk 5.2: Failure to Comply with Duty to Involve and Consult with patients, public and stakeholders as within Section 11 of the Health and Social Care Act 2001.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING
14 MAY 2013

Proposals for Improving Patient Experience

Introduction

1. East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) is committed to improving the quality of health services and our patients' experience of the healthcare we commission on their behalf. This is evident in both our organisational vision, our strategic aims and in our commitment to effective public and patient involvement.

2. To aid shared understanding, we define patient experience as feedback from patients/relatives/carers/family on 'what happened' in the course of receiving (or having contact with) care or treatment, including objective facts and their subjective views of it. The factual element is useful in comparing what people say they experienced against what an agreed care pathway or quality standard says about their experience and helps to corroborate (or otherwise) other quality measures.

3. Our aim is to commission services for our patients that are of a quality that we would want for ourselves and our families. This is backed up by national research carried out by organisations such as the NHS National Quality Board (2011), the Kings Fund (2010), Kings College London (2012) and the NHS Institute of Innovation and Improvement (2011), that tells us that patients care about their experience of care as much as clinical effectiveness and safety. They want to feel informed, supported and listened to so that they can make meaningful decisions and choices about their care. They want to be treated as a person not a number and they value efficient processes. ELR CCG also has identified one of our strategic aims *as "Listening to our patients and public and acting on what they tell us'.*

4. The Government has made it clear that patient experience is a crucial part of quality healthcare provision and the NHS Constitution (2013), the NHS Outcomes Framework 2011/12 and the NICE Quality Standards for Experience and Mental Health Experience (2011) all reinforce the need for patient centred care.

5. The Francis Inquiry Report (2013) highlighted the need to understand and consider patient experience as a vital part of commissioning and quality monitoring work – "Section 1.167 Commissioners need to recognise their accountability to the public they serve by measures designed to involve the public in commissioning and enable their views to be taken into account."

'Recommendation 111: Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.' and' Recommendation 255: Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.'

6. By asking, monitoring, and acting upon patient experience, ELR CCG as commissioners will be better placed to work with providers to make improvements in the areas that patients say matter most to them. Having a clear plan on patient experience will be vital for achieving ELR CCG's vision: '*To improve health by meeting ours patients' needs with high quality and efficient services, led by clinicians and delivered close to home*' as well as fulfilling requirements under Domain 4 of the NHS Outcomes Framework – "Ensuring that people have a positive patient experience of care".

7. To support the formation of ELR CCG as an organisation, we developed our "*Informing and Involving Strategy – our approach to communications and engagement 2011-2013*". This strategy sets out our involvement model demonstrating where patient feedback and experience would influence and shape our decision making. This strategy is currently being reviewed and it should be noted that patient experience is a strand of this overarching strategy.

8. It is also important to note that the patient experience work programme will form a substantial part of our response to the Francis Inquiry (2013) and as such, the outputs should feature strongly and inform not only our approach to quality contracting, but also our decision making for commissioning priorities and plans.

9. The purpose of this report is to outline the results of an initial assessment of available patient experience data completed for ELR CCG by the Quality Team in March 2013 and initial proposals for a patient experience plan.

10. It should be noted that proposals for improving patient experience are distinct from other forms of public and patient involvement but the mechanisms used for both need to be complementary, and data from all sources used in an effective way to give a complete picture of the care our patients are receiving.

11. The NHS National Commissioning Board (2012) made explicit the requirement for CCGs to recruit a lay member with a lead role in championing patient and public involvement. A key a part of their role is to ensure that the CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public. This links well with our plans to better understand

patient experience and we anticipate formalising this role to ensure one of our lay members has oversight of both patient experience and involvement in line with the refresh of the ELRCCG Informing and Involvement Strategy.

Understanding our patients' experiences

12. An initial assessment of patient experience was undertaken by the Quality Team in March 2013. This assessment focused on identifying and reviewing patient experience data available to ELR CCG through quality monitoring, contractual monitoring processes and through information in the public domain including websites such as NHS Choices and Patient Voices.

13. The initial assessment highlighted that there is good available data for Acute Care providers (including out of county providers) and for Primary Care (General Practices).

14. For Acute Trusts sources of this data include the 'Friends and Family' test. The Friends and Family Test is a national, comparable test which, when combined with follow-up questions, provides a mechanism to identify both good and bad performance and aims to encourage staff within the organisation to make improvements where services do not live up to expectations.

15. For General Practice the yearly Quality Outcomes Framework (QOF) patient experience survey is a rich source of data. Some Practices produce a report about how they have or are improving patient experience as a result of their patient survey. The initial review of the QOF Primary Care patient survey identified that there were some practices that were high achievers with patient experience and somewhere improvement is needed in key areas.

16. Additionally in Primary Care, most GP Practices now have Patient Participation Groups or Patient Reference Groups (PPGs and PRGs) which provide patient experience information direct to practices. At present this information is recorded and analysed by individual practices.

17. There is also good availability of information about the number of incidents and complaints in all the Acute Trusts, for the Ambulance Service and for the Patient Transport Service (PTS). The initial review of Acute Trust patient experience information confirmed information already known about these Trusts.

18. While the sources of patient experience data identified above are very useful, the initial assessment also identified a number of gaps in the available patient experience data and in the way ELR CCG currently collates, analyses and acts on what our patients are telling us.

19. We know, for example that GPs pick up comments and views from their patients, when they see them in surgery regarding their care experience and that this data is not currently formally recorded, yet this is highlighted as a recommendation from the Francis Inquiry

20. Similarly, we know there is a wealth of information about patients' experiences of local healthcare available in the public domain through social media (eg. Facebook and Twitter); information via sites such as NHS Choices and Patient Voices and through more traditional media such as stories in newspapers and on radio and TV.

21. ELR CCG has also taken part in the pathfinder project with CCGs and providers across NHS Midlands and East. This has involved completing a suite of models focussed on understanding different aspects of patient experience and engagement. Members of ELR CCG staff and our Independent Lay Members took part in the modules; outcomes included a shared understanding of how to work strategically with provider organisations to improve patient experience locally and sharing of best practice examples.

Proposed next steps

Patient Experience Plan

22. The first step in acting on the findings of the initial assessment is the development of a plan for collating, sharing and acting on patient experience to enable ELR CCG to understand the things that are affecting our patients' experience of care and by extension to work with our providers to improve those services identified by our patients as offering anything less than positive care.

23. The aim of the plan would be to:

- Improve the quality of care for patients and their experience of that care;
- Combine commissioning and provider data with patient safety data and patient and carer feedback, including complaints, patient participation/reference groups and engagement events, to identify areas requiring improvement and attention and to ensure on-going improvement;
- Build effective governance processes to ensure patient feedback and experience data is used to inform the decision making of the Board, Sub-Committees, staff, members and partners;
- Ensure ELR CCG is making effective use of the NHS National Quality Board's Patient Experience Framework (2011) and other relevant national research;
- Ensure provider contract negotiations and contract performance and quality monitoring are informed by relevant patient experience data;
- Ensure our commissioning intentions and priorities continue to be informed by what matters most to our patients.

24. The Quality Team, supported by the Communications and Engagement team and Primary Care Lead for patient experience will lead this work programme, in line with the refresh of the Involving and Informing Strategy; it is also recommended that the plan is co-designed with the support of patients and patient groups. We anticipate that the Quality and Clinical Governance Committee will have oversight of progress against this plan.

Patient Experience Dashboard

25. To provide the framework for collating, sharing and acting on patient experience the Quality Team, working in conjunction with the Contracting Team and Communications and Engagement team, are developing a dashboard of patient experience data for all CCG contracts that can be used as an early warning system of problems with patient experience. The dashboard will include:
    - Summary Hospital Mortality Indicator (SHMI) data
    - Incidents
    - Complaints
    - Net Promoter scores
    - Patient Experience Composite Score
    - Real time patient experience (where available)
    - Contract information – themes and trends

26. The Quality and Clinical Governance Committee will oversee the development of this dashboard.

27. ELR CCG's Head of Communications and Engagement is conducting a review of sources of social media/media reports of patient experience to include in the dashboard and will work with the newly formed local Healthwatch organisations to understand how the information they receive about patient experience can be shared effectively and included in the dashboard.

28. It is proposed that the patient experience dashboard is used as a mechanism to highlight areas of positive patient experience within a provider or General Practice or where there may be a requirement to focus further scrutiny. This could be used to inform the basis of unannounced quality visit(s) to provider trusts

Patient stories at the Board

29. In order to demonstrate and fulfil our commitment to putting our patients at the heart of our work, it is also proposed that we bring patient experience to the regular attention of the Board by having patient stories as a standard agenda item on the ELR CCG Board agenda each month. We propose that patients (or carers/family members) with either positive or poor experiences come to the Board to share details. Research shows that patient stories bring experiences to life and encourage the NHS to focus on the patient as a person rather than a condition or an outcome. We believe inviting patients to speak to our Board in this way will be invaluable in helping ELR CCG to understand how the services we commission are impacting on our patients and what we can do to ensure

improvements are made. However we recognise that this needs to be carefully managed and handled sensitively.

Conclusion

30. ELR CCG has the opportunity to make a real difference to the way in which our patients experience healthcare in our area and to improve the quality of services our patients receive.

31. An initial assessment has highlighted gaps in available data which need to be addressed to ensure ELR CCG has a full and meaningful picture of patient experience in East Leicestershire and Rutland

32. To take this work forward, ELR CCG needs to develop, preferably through co design with patients, an effective plan to fully understand and act on patient experience and to improve quality of health services.

33. To raise awareness of patient experience and to fulfil ELR CCG's commitment to acting on what our patients tell us, it is proposed that real patient stories are shared at Board meeting by patients or their representatives and that the learning is also shared with ELR CCG staff.

34. This plan is one programme of work which is contained within the overarching Involving and Informing Strategy and highlighted as an aim within our CCG Strategic Vision, it should not been taken in isolation. It is anticipated that following the refresh of the Involving and Informing Strategy, it will be necessary to consider how outputs from this branch of work will inform and be integrated into service developments.

Recommendations

The East Leicestershire and Rutland CCG Governing Body is asked to:

NOTE the findings of the initial patient experience assessment;

APPROVE the proposals for plans to improve ELR CCG's understanding of our patients' experience and the quality of services we commission.

References

1. Department of Health (2011) *Maintaining and Improving Quality during the Transition: safety, effectiveness, experience*, Available at: https://www.gov.uk/government/publications/maintaining-and-improving-quality-during-the-transition-safety-effectiveness-experience

2. What Matters To Patients? Developing the Evidence Base for Measuring and Improving Patient Experience. (2010) / 'Time to think differently' (November 2012), Kings Fund, Kings College London

3. 'Helping Patients Improve their Experience', (October 2011), Transforming Patient Experience (2013), NHS Institute.

4. Department of Health (2013), *The NHS Constitution*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

5. Department of Health (2011) *NHS Outcomes Framework 2012/13.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/134662/dh_131723.pdf.pdf

6. National Institute for Health and Care Excellence (2011) *Quality Standards for Servicer User Experience in Adult Mental Health QS14.* Available at: http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14

7. Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationary Office

8. East Leicestershire and Rutland CCG (2012) *Involving and Informing Strategy 2012-13.* Available at: http://www.eastleicestershireandrutlandccg.nhs.uk/our-strategies-and-plans

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Committee terms of reference: Remuneration and Nominations Committee; and the Quality and Clinical Governance Committee**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Daljit K. Bains, Head of Corporate Governance**
SPONSORED BY:	**Paul Sherriff, Chief Corporate Affairs Officer**
PRESENTER:	**Paul Sherriff, Chief Corporate Affairs Officer**

PURPOSE OF THE REPORT:

1. The purpose of this report is to request the Governing Body to approve the revised terms of reference for the Remuneration and Nominations Committee and the Quality and Clinical Governance Committee.

2. The terms of reference for the Remuneration and Nominations Committee, as one of the statutory committees, has been reviewed and updated by Committee members in line with the guidance provided by the NHS England. The main changes to the terms of reference include the membership and remit of the Committee to include the role of a nominations committee. The revised terms of reference are as at Appendix 1.

3. The Governing Body is requested to approve the revised terms of reference for the Quality and Clinical Governance Committee. The purpose of the Quality and Clinical Governance Committee is to seek assurance and have oversight of quality and clinical governance mechanisms, ensuring quality and patient safety is integral to commissioning processes and to the monitoring arrangements for all commissioned services. The terms of reference have been amended by the Committee to reflect the following:
    - Public health representative as a co-opted member of the Committee;
    - Quoracy has been reviewed and clarified;
    - Remit now includes receiving prescribing and medicines management reports; and
    - Remit now includes approving clinical policies on behalf of the Governing Body.

4. The revised terms of reference for the Quality and Clinical Governance Committee is as at Appendix 2.

5. The terms of reference of the statutory committees of the Governing Body along with other committees within the structure will be reviewed regularly to ensure these committees remain fit for purpose and continue to operate within the Constitution of the CCG.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Governing Body is requested to: **APPROVE** the revised terms of reference for the Remuneration and Nominations Committee (as at Appendix 1). **APPROVE** the revised terms of reference for the Quality and Clinical Governance Committee (as at Appendix 2).

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the review of the terms of reference as the principles and duties outlined within the Act are covered within the CCG's Constitution. The Committees of the Governing Body are required to adhere to the requirements as set out within the Constitution and Standing Orders in the running of the Committee.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:
This report aligns to a number of strategic risks captured within the Board Assurance Framework including risk relating to ability to meet statutory duties.

APPENDIX 1

EAST LEICESTERSHIRE AND RUTLAND CCG

REMUNERATION AND NOMINATIONS COMMITTEE

DRAFT - Terms of Reference (v1, draft 2 – 15th March 2013)

1. Introduction

The Remuneration Committee (the committee) is established in accordance with East Leicestershire and Rutland Clinical Commissioning Group's (ELR CCG) constitution, standing orders and scheme of delegation. These terms of reference, which recognise within them the key principles as outlined within the UK Corporate Governance Code, shall have effect as if incorporated into the ELR CCG Constitution.

2. Responsibilities in relation to remuneration

a) The Committee will consider remuneration policies appropriate to the ELR CCG and in accordance with national guidance. These policies will be kept under review and the Committee will make recommendations to the Governing Body for approval. The objective of such policies will be to attract, retain and motivate individuals required by ELR CCG to discharge its functions efficiently and effectively.

b) The Committee shall at all times be mindful of the national guidance in relation to pay including the "Very Senior Managers Pay Framework" and seeking HM Treasury approval as appropriate in accordance with the guidance "Managing Public Money" and any additional guidance published by the National Commissioning Board (e.g. *"Remuneration guidance for Chief Officers (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers"*).

c) The Committee is responsible for determining the remuneration of each member of the Governing Body including the Chair of ELR CCG but excluding the independent lay members. Remuneration for this purpose includes salary, bonuses, performance relate pay, pension arrangements and any benefits in kind.

d) The Committee is responsible for determining, where appropriate, the form and content of contracts of employment.

e) If the Governing Body agrees to the principle of performance related pay, the Committee shall determine the targets against which performance is to be judged, consider the actual performance during the year and determine the payments, if any, to each individual at year end.

f) The Committee will determine the financial arrangements for termination of employment (excluding ill health and normal retirement) including the terms of

any compensation package, the proper calculation and scrutiny of termination payments taking account of such national guidance and any other contractual terms.

g) The Committee will ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

3. Responsibilities in relation to nominations

a) The Committee will review the structure, size, and composition of the Governing Body (including its skills, knowledge and experience) and make recommendations thereon to the Governing Body before any Chief Officer or other senior member of staff is appointed or replaced.

b) The Committee will identify and nominate, for the approval of the Governing Body, candidates to fill the Accountable Officer vacancies as and when they arise.

c) The Committee shall review succession plans produced by the Accountable Officer for his Chief Officers and other senior executives reporting to the Accountable Officer.

d) The Committee shall identify members of the Governing Body qualified to sit its Committees and recommend the appointment of members to the respective Committees.

4. Procedures

a) Meetings will be held as required but at least twice a year.

b) The Committee will apply best practice in its decision making processes including compliance with current disclosure requirements and ensuring that decisions are based on clear and transparent criteria in line with national codes of conduct and good governance practice.

c) The Committee will have the authority to seek external advice and commission any reports or surveys it deems necessary to fulfil its terms of reference

d) The Committee may speak to individuals (or their representative) when considering their remuneration but no one shall attend that part of the Committee's meeting when their remuneration is determined.

e) The Accountable Officer will normally attend meetings of the Committee and the Chief Corporate Affairs Officer will be in attendance to support the Committee in its work. The Accountable Officer may seek guidance from the Committee on any remuneration matter.

f) The meeting will be quorate when two members are present.

g) A decision put to a vote at a meeting shall be determined by a majority of the votes of members present with the Chair of the Committee having the casting vote in the event of an equal vote.

h) The Chief Corporate Affairs Officer will be responsible for and coordinate secretarial support for the Committee.

5. Membership

The membership of the Remuneration and Nomination Committee shall be:

- Independent Lay Member – Chair of the Committee
- Independent Lay Member – vice-chair of the Committee
- Chair, ELR CCG Governing Body

In attendance:

- Chief Corporate Affairs Officer – will be in attendance to act as support to the Committee in its work.
- Accountable Officer – will attend as and when invited to attend by the members.

6. Quorum

The meeting will be quorate when two members are present, with the Chair or deputy chair present.

A decision put to a vote at a meeting shall be determined by a majority of the votes of members present.

7. Administration

The Chief Corporate Affairs Officer will be responsible for and coordinate secretarial support for the Committee.

8. Frequency of meetings

Meetings will be held as required but at least twice a year as appropriate.

9. Reporting

The Committee chair shall report formally to the Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the confidential meeting of the Governing Body. The Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

Minutes / reports of meetings will be confidential and only one master copy of the report shall be produced and held in a private Minute Book by the Corporate Affairs Office. Extracts from Minutes will be made public as appropriate.

10. Review

The Committee will review its own performance, membership and terms of reference on an annual basis or sooner if required and recommendations made to the Governing Body for approval.

Date of approval:	
Review Date:	

APPENDIX 2

EAST LEICESTERSHIRE AND RUTLAND CCG

QUALITY AND CLINICAL GOVERNANCE COMMITTEE

DRAFT TERMS OF REFERENCE
(v2, draft 1, 1st May 2013)

1. Introduction

The Quality and Clinical Governance Committee (the Committee) is established in accordance with the East Leicestershire and Rutland Clinical Commissioning Group's Constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall effect as if incorporated into the Constitution.

2. Purpose

The Quality and Clinical Governance Committee is a committee of the East Leicestershire and Rutland CCG Governing Body. Its purpose is to seek assurance and have oversight of quality and clinical governance mechanisms, ensuring quality and patient safety is integral to commissioning processes and to the monitoring arrangements for all commissioned services.

3. Membership

The membership of the Committee will consist of:

- Independent Lay Member – chair of the committee
- 3 GP board members – one of the GP Board Members will act as the deputy chair
- Chief Nurse and Quality Officer
- Chief Operating Officer
- Secondary Care Consultant Board Member

Should Members not be able to attend, nominated deputies may take their place.

A decision put to a vote at a meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

Co-opted member:

The Consultant in Public Health Medicine (Leicestershire County Council) will attend the Committee meetings as a co-opted member and shall be considered as a full member of the Committee where voting may be required and in order for the Committee to meet its quoracy requirements.

4. Attendance:

The Chief Strategy and Planning Officer or deputy; Head of Medicines Management; and Head of Quality and Clinical Governance will be in attendance as required.

5. Quorum

The quorum for the Committee will be the following:

- Chair of the Committee or Deputy Chair
- 2 GP Board Members; or 1 GP Board Member and Chief Nurse and Quality Officer
- Chief Operating Officer
- Secondary Care Consultant Board Member; or Consultant in Public Health Medicine

6. Administration

The administration and minute taking for the Quality and Clinical Governance Committee is the responsibility of the Chief Nurse and Quality Officer.

7. Frequency of meetings

The Committee will meet on a monthly basis and conduct its meeting in line with the Constitution.

8. Duties

The Quality and Clinical Governance Committee will:

(a) Ensure that quality and patient safety is integral to commissioning functions by identifying themes and trends which influence commissioning decisions.

(b) Review the outcomes of General Practice quality visits advising on areas for further scrutiny and monitoring.

(c) Have oversight of the outcomes of the QOF review process and the QOF dispute resolution process.

(d) Consider and advise on the quality and clinical aspects of the ELR General Practice Performance Support Framework.

(e) Have oversight of and advise on the clinical and quality aspects of performance targets to ensure appropriate monitoring of and identification of risks.

(f) Advise on the quality and clinical aspects regarding the development of Local Enhanced Service Specifications including implementation plans.

(g) Receive, review and advise on actions in respect of quarterly reports which impact on quality and patient safety such as complaints, serious incidents, Health Care Associated Infections (HCAIs),safeguarding and prescribing and medicines management reports.

(h) Lead the development of and monitor patient and public engagement plans and activities.

(i) Review the clinical risks as within the Board Assurance Framework ensuring appropriate action is taken and reported.

(j) Advise and make recommendations to the Governing Body (in confidential meetings) of referrals to the Medical Director (NHS England's Leicestershire and Lincolnshire Area Office) in respect of General Practitioners whose performance may give case for concern.

(k) Approve clinical policies on behalf of the Governing Body.

9. Reporting responsibilities

The Quality and Clinical Governance Committee will provide a written summary report of the outcomes of the meeting, actions taken and risks to be escalated to the Governing Body following its meeting. The Committee will also provide a confidential report to the confidential meeting of the Governing Body where appropriate.

10. Review of Terms of Reference

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Governing Body for approval.

Date of approval:	
Review Date:	

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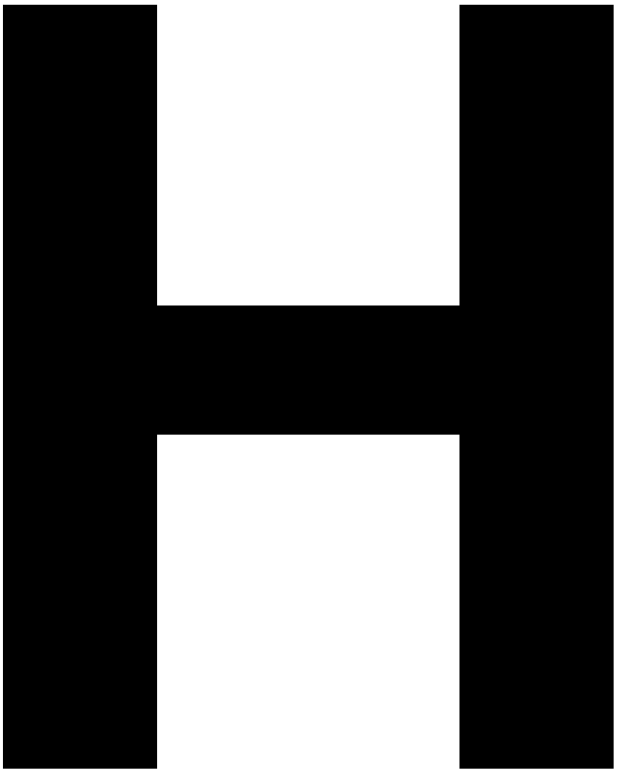

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Review of the Constitution**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Daljit K. Bains, Head of Corporate Governance** **Paul Sherriff, Chief Corporate Affairs Officer**
SPONSORED BY:	**Paul Sherriff, Chief Corporate Affairs Officer**
PRESENTER:	**Paul Sherriff, Chief Corporate Affairs Officer** **Daljit K. Bains, Head of Corporate Governance**

PURPOSE OF THE REPORT:
The purpose of the report is to provide the Governing Body with an overview of the proposed amendments to the CCG's Constitution and seek approval of the process for agreeing the content for onward submission to the Area Team for approval.

RECOMMENDATIONS:
APPROVE the approach outlined under next steps **ENDORSE** the approach for approval of the changes to the Constitution to be submitted to the Leicestershire and Lincolnshire Area Team following review of the Prime Financial Policies and the Detailed Financial Policies by the Audit Committee at its meeting in May 2013. **DELEGATE** authority to the Managing Director and the Chief Finance Officer to approve the draft Constitution for submission to the Area Team once the legal advice has been reviewed and comments from the Audit Committee incorporated into the Constitution.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has been undertaken in the development of strategies, policies and procedures that have been developed to support the statutory documents and requirements. The equality analysis can be found within each document, for example, within the policy documents referred to the Constitution.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:
This report aligns to a number of strategic risks captured within the Board Assurance Framework including risk relating to successful authorisation and ability to meet statutory duties.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING
14 MAY 2013

Review of the Constitution

Introduction

1. East Leicestershire and Rutland CCG (ELR CCG) is a clinically led membership organisation made up of general practices. The members of the CCG have agreed the governing arrangements for the organisation as set out in the ELR CCG Constitution.

2. The Constitution can only be varied in two circumstances:

   a) where the CCG applies to NHS England (via the Leicestershire and Lincolnshire Area Team) and that application is granted;

   b) where in the circumstances set out in legislation the NHS England varies the CCG's constitution other than on application by the group.

3. Members of the Governing Body will recall that work was underway to review the Constitution ensuring it reflected current arrangements following the disestablishment of the PCT. The process carried out and a summary of the amendments made are outlined below. In addition, the report provides an overview of the next steps to ensure that the updated Constitution can be submitted to the NHS England's Leicestershire and Lincolnshire Local Office for approval by 1st June 2013.

Process undertaken for updating the Constitution

4. The review of the Constitution involved seeking comments and feedback from various sources including:

   a. Member practices who were asked during January – March 2013 to confirm that they have read and understood the content of the existing Constitution. Member Practices were also asked to submit comments and suggestion for consideration in the review of the Constitution.

   b. The Governing Body and Corporate Management Team.

   c. Comments had previously been received from the BMA Law via the Leicestershire Local Medical Committee (LMC).

5. All member practices signed the relevant form confirming they have read and understood the content of the existing Constitution. A couple of comments were received for consideration in the review of the Constitution

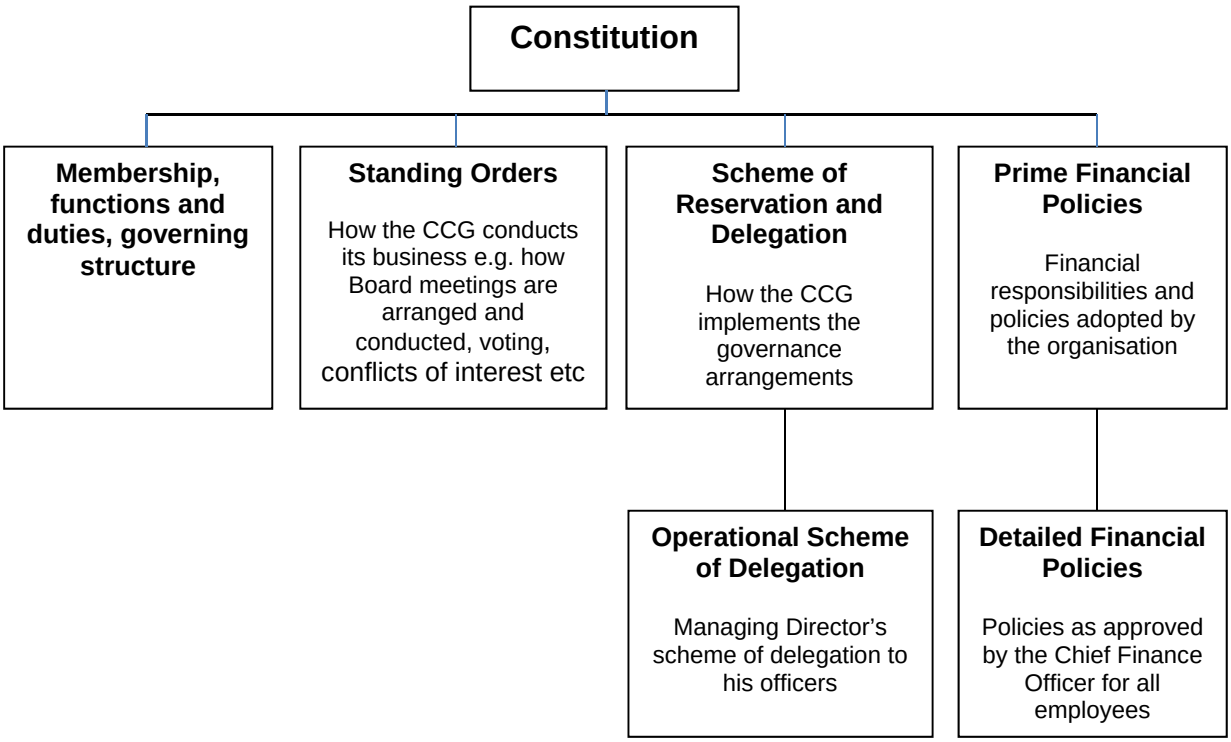
which related to ensuring the document enhanced the section on equalities clearly demonstrating the CCG's commitment to the Equalities Act.

6. The feedback from the Governing Body members and the Corporate Management Team in the main focused on ensuring that the references to the PCT Cluster be removed, Governing Body voting rights to be clarified, duplication in the document to be removed, and that a scheme of reservation and delegation is to be developed further supported by a detailed operational scheme of delegation.

7. Legal advice has also been sought in respect of delegated authority in relation to collaborative commissioning arrangements which will be included within the Constitution before submission.

Structure of the Constitution

8. The diagram below illustrates the four main sections that form the Constitution:
    a. the membership, functions, duties and governing structure;
    b. the Standing Orders;
    c. Scheme of Reservation and Delegation; and
    d. Prime Financial Policies.



Summary of amendments

9. The Governing Body is asked to note that the membership and governing structure section and the Standing Orders have no material changes other than the change to the voting arrangements of the Governing Body members as reflected in Appendix 1.

10. The amendments to the Constitution in the main have been made to include a Scheme of Reservation and Delegation underpinned by an operational scheme of delegation. In addition detailed financial policies have been compiled to support the Prime Financial Policies.

11. A summary of the amendments proposed are detailed within Appendix 1 with the proposed Scheme of Reservation and Delegation as at Appendix 2.

12. A copy of the proposed amended Constitution will be made available to the Governing Body members.

Next steps

13. The Governing Body is asked to approve the inclusion of the Scheme of Reservation and Delegation into the Constitution which will be supported by the Managing Director's operational scheme of delegation. Governing Body members are asked to note that legal advice has been sought in relation to the amendments proposed and the advice is awaited.

14. It is proposed that the Prime Financial Policies and the Detailed Financial Policies be reviewed by the Audit Committee in May 2013 prior to submitting the Constitution to the Leicestershire and Lincolnshire Area Team.

15. The Constitution in full will then need to be forwarded to the Leicestershire and Lincolnshire Area Team by end of May 2013.

16. It is proposed that the Constitution be reviewed on an annual basis to reflect any governance and organisational changes in conjunction with member practices.

17. The Corporate Affairs Team will progress activities required in order to ensure the CCG operates in line with the Constitution. Particular reference to be given to committee effectiveness, the development of the Collaborative Memorandum of Agreement, implementation of the scheme of reservation and delegation and the management of conflicts of interest with the CCG member practices.

RECOMMENDATIONS

The East Leicestershire and Rutland CCG Governing Body is requested to:

APPROVE the approach outlined under next steps

ENDORSE the approach for approval of the changes to the Constitution to be submitted to the Leicestershire and Lincolnshire Area Team following review of the Prime Financial Policies and the Detailed Financial Policies by the Audit Committee at its meeting in May 2013.

DELEGATE authority to the Managing Director and the Chief Finance Officer to approve the draft Constitution for submission to the Area Team once the legal advice has been reviewed and comments from the Audit Committee incorporated into the Constitution.

APPENDIX 1

Summary of proposed amendments to the Constitution

Section	Changes proposed	Rationale
All sections	• Formatting and main content aligned to the NHS England's model Constitution document as published in December 2013. • Typos and grammatical errors revised. • Reference to PCT Cluster and / NHS Leicestershire County and Rutland removed; this includes terms of reference appended to the Constitution relating to the PCT Cluster committees and contact details. • Reference to LLR CCGs removed as this alluded to arrangements under the PCT Cluster. This to be replaced with the Collaborative Commissioning arrangements. • All references to authorisation process removed. • Duplication of information removed and the information detailed within the appropriate section.	• The Constitution needs to reflect the format and main content as provided by the model document as the CCG has chosen to adopt the model document. Furthermore should the model document be updated in the future the references will match the CCG's Constitution making it easier to incorporate amendments required. • CCG is now authorised. • This avoids confusion and potentially avoid contradiction of information.
Section 1.4: Amendment and Variation of this Constitution	• Include summary in relation to the process for the consideration of the review of the Constitution.	• Interim process as provided by the Leicestershire and Lincolnshire Area Team

5.1.2 In discharging its functions the group will *meet the public sector equality duty*.	• section to include publication of sufficient information to demonstrate compliance with this general duty across all functions at least annually.	• Included as requested following feedback from a couple of member practices.
6.6 Composition of the Governing Body	It is proposed that the composition of the Governing Body remains the same however voting rights to be amended to reflect the following: Voting members: a) The Chair b) Managing Director (Accountable Officer) c) Six elected GP locality representatives of member practices: • 3 GP Locality Leads of MRH locality • 2 GP Locality Leads of Blaby and Lutterworth locality • 1 GP Locality Lead of Oadby and Wigston locality d) Chief Nurse and Quality Officer (Board Nurse) e) Chief Finance Officer f) Secondary Care Clinician g) 2 Independent lay members Other individuals none of whom carry voting rights: • Chief Strategy and Planning Officer • Chief Operating Officer In attendance (none of whom carry voting rights) shall be: h) A representative of public health	• With the increase of one lay member it is proposed that the CCG reduce the officer voting position to maintain clinical majority on the Governing Body.

	i) Head of Corporate Governance j) A communications and engagement lead	
Quoracy of the Governing Body	• To include situations where all GP Board members are conflicted.	• To ensure clarity is provided in respect of conflicts of interest.
Committees of the Governing Body	• Section to remove detailed information relating to the terms of reference and to provide an overview of committees of the Governing Body only i.e. Audit Committee, Remuneration and Nominations Committee, Quality and Clinical Governance, and Finance and Performance Committee. The Constitution to signpost readers to the full terms of reference which will be held by the Corporate Affairs Team. • To remove all reference to PCT Cluster committees.	• Terms of reference may need to be reviewed in-year and therefore the detail within the Constitution may be outdated. • Scheme of reservation and delegation details the delegations to the Governing Body Committees.
Section 8 – Conflicts of Interest	• Section to be updated to reflect the guidance published by NHS England in March 2013.	• Compliance with national guidance.
Appendix C – Standing Orders	• In the main the Standing Orders remain the same, all references to the PCT Cluster to be removed.	•
Appendix D – Scheme of Reservation and Delegation	• To include a detailed scheme of reservation and delegation as at Appendix 2 of this report. • To be underpinned by a detailed operational scheme of delegation.	• To provide clarity in relation to governance arrangements and responsibilities.
Appendix E – Prime Financial Policies	• In the main remain the same, reference to PCT Cluster removed. • To be underpinned by detailed financial policies.	• Development of detailed finance policies to enable good governance.
Appendix H – terms of reference	• To be removed	• See above
Appendix J – Committee reporting structure	• To be removed	• Out of date

APPENDIX 2

Matters Reserved to the Membership and Decisions Delegated to the Governing Body, Accountable Officer and Officers.

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
REGULATION AND CONTROL	Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.	✓									
REGULATION AND CONTROL	Consideration and approval of applications to the NHS England on any matter concerning changes to the group's constitution, including terms of reference for the group's governing body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.	✓									
REGULATION AND CONTROL	Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by			✓							

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	the group, delegated to the governing body or other committee or sub-committee or [specified] member or employee										
	Prepare the group's overarching scheme of reservation and delegation, which sets out those decisions of the group reserved to the membership and those delegated to the • group's governing body • committees and sub-committees of the group, or • its members or employees and sets out those decisions of the governing body reserved to the governing body and those delegated to the • governing body's committees and sub-committees, o members of the governing body,										**Head of Corporate Governance**

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	o an individual who is member of the group but not the governing body or a specified person for inclusion in the group's constitution.										
	Approval of the group's overarching scheme of reservation and delegation.		✓								
	Prepare the group's operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the clinical commissioning group, not for inclusion in the group's constitution.										**Chief Corporate Affairs Officer / Head of Corporate Governance**
	Approval of the group's operational scheme of delegation that underpins the group's 'overarching scheme of reservation and delegation' as set out in its constitution.							✓			

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	Prepare detailed financial policies that underpin the clinical commissioning group's prime financial policies.										**Head of Finance**
	Approve detailed financial policies.								✓		
	Approve arrangements for managing exceptional funding requests within delegated limits.							✓	✓		
	Set out who can execute a document by signature / use of the seal		✓								
PRACTICE MEMBER REPRESENTATIVES AND MEMBERS OF THE GOVERNING BODY	Approve the arrangements for o identifying practice members to represent practices in matters concerning the work of the group; and o appointing clinical leaders to represent the group's membership on the group's governing body, for example	✓									

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	through election (if desired).										
	Approve the appointment of governing body members, the process for recruiting and removing non-elected members to the governing body (subject to any regulatory requirements) and succession planning.		✓								
	Approve arrangements for identifying the group's proposed accountable officer.				✓						
STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the group.	✓									
	Approval of the group's operating structure.		✓								
	Approval of the group's commissioning plan.		✓								
	Approval of the group's corporate budgets that meet the financial duties as set out in section 5.3 of		✓								

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	the main body of the constitution.										
	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group's ability to achieve its agreed strategic aims.		✓								
ANNUAL REPORTS AND ACCOUNTS	Make recommendations to the Governing Body on the Group's Annual Report and approve the Annual Accounts.			✓							
	Approval of the group's annual report.		✓								
	Approval of the arrangements for discharging the group's statutory financial duties.		✓								
HUMAN RESOURCES	Approve the terms and conditions, remuneration and travelling or other allowances for governing body members, including pensions and gratuities.				✓						

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.							✓			
	Approve any other terms and conditions of services for the group's employees.							✓			
	Determine the terms and conditions of employment for all employees of the group.							✓			
	Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.		✓								
	Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.				✓						

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.		✓								
	Review disciplinary arrangements where the accountable officer is an employee or member of another clinical commissioning group .		✓								
	Approval of the arrangements for discharging the group's statutory duties as an employer.		✓								
	Approve human resources policies for employees and for other persons working on behalf of the group.							✓			
QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.					✓					

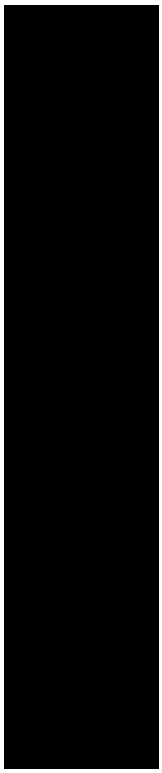
Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services.									✓	**Chief Operating Officer**
OPERATIONAL AND RISK MANAGEMENT	**Prepare** and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group.										**Head of Corporate Governance**
	Approve the group's counter fraud and security management arrangements.			✓							
	Approval of the group's risk management arrangements.		✓								
	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of		✓								

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	the NHS Act 2006).										
	Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the group.		✓								
	Approve proposals for action on litigation against or on behalf of the clinical commissioning group.							✓			**Supported by Head of Corporate Governance**
	Approve the group's arrangements for business continuity and emergency planning.		✓								
INFORMATION GOVERNANCE	Approve the group's arrangements for handling complaints.							✓			
	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of							✓			**Head of Corporate Governance**

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	information and data.										
TENDERING AND CONTRACTING	Approval of the group's contracts for any commissioning support above delegated limits.		✓								
	Approval of the group's contracts for corporate support (for example finance provision).							✓			
PARTNERSHIP WORKING	Approve decisions that individual members or employees of the group participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.		✓								
	Approve decisions delegated to joint committees established under section 75 of the 2006 Act.		✓								
	Approval of collaborative commissioning arrangements on behalf of the CCG within delegated limits.							✓	✓		**Chief Strategy and Planning Officer**

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
	Approval for making decisions within delegated limits pertaining to coordinating commissioner arrangements on behalf of the CCG in respect of Continuing Healthcare.							✓	✓		**Chief Strategy and Planning Officer**
COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the group's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.		✓								
	Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate		✓								

Policy Area	Decision	Reserved to the Membership	Reserved or delegated to Governing Body	Delegated to:							
				Audit Committee	Remuneration Committee	Quality and Clinical Governance Committee	Finance and Performance Committee	Accountable Officer	Chief Finance Officer	Chief Nurse and Quality Officer	Other
COMMUNICATIONS	Approving arrangements for handling Freedom of Information requests.							✓			**Head of Corporate Governance**
	Determining arrangements for handling Freedom of Information requests.							✓			**Head of Corporate Governance**
	Approvals for research projects within financial delegated limits.									✓	



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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Budget 2013/14**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Karen English, Chief Finance Officer**
SPONSORED BY:	**Karen English, Chief Finance Officer**
PRESENTER:	**Karen English, Chief Finance Officer**

PURPOSE OF THE REPORT:

The purpose of this paper is to describe the process for developing and agreeing the ELR CCG Financial Plan for 2013/14 and to detail the summary budget. The CCG Board are requested to note the process and associated documents included in the Appendix to ensure appropriate financial management in 2013/14.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Governing Body is requested to:

APPROVE the CCG financial plan for 2013/14;
NOTE that the financial plan delivers the financial requirements as set out in planning guidance;
ACKNOWLEDGE the risks associated with the financial plan and note the mitigating strategies;
ACKNOWLEDGE the specific risk arising from specialised commissioning allocations and how resolution will lie beyond the CCG's control;
AUTHORISE that NHS contracts will be entered into in line with financial planning assumptions and allowing for the management of the risk associated with specialised commissioning allocations.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:

Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING
14 MAY 2013

Budget 2013/14

Purpose

1. The purpose of this paper is to provide assurance that financial resource support the Strategic Plan of the CCG. Additionally, there are specific requirements and priorities that may arise from national guidance or local priorities. This report highlights the main issues, current thinking and approach, informing the Governing Board and supporting discussions to enable comprehensive understanding of the financial plans for 2013/14.

Background – Baseline Exercise

2. The former commissioning responsibilities of PCTs have been divided between the new commissioning organisations; namely, CCGs, National Commissioning Board (NHS CB), Local Authorities and Public Health England.

3. **CCGs** are responsible for the commissioning of the majority of secondary and community care services. In addition, they take responsibility for local enhanced services and the out of hour's service. Other responsibilities include the provision of healthcare for unregistered populations and charge exempt overseas visitors.

4. **The NHS England Area Team** takes responsibility for the commissioning of specialised services, the majority of primary care services and the provision of healthcare for armed forces. Other responsibilities include services for prisoners. The NHS CB is responsible for some public health services mainly concerned with screening and vaccinations and immunisations.

5. **The Local Authority** assumes the responsibility for a range of public health services including prevention services, sexual health and substance misuse.

6. A national exercise was undertaken in July and September 2012 to align PCT baseline allocations to the various receiving organisations. As such, Leicester, Leicestershire and Rutland (LLR) PCT's baseline was analysed by service and commissioning area and allocated to the new commissioning responsibilities of CCG, NHS England Area Team, Local Authority and Public Health England. The table below summarises the baseline values identified in the exercise for LLR PCT.

LLR Resources	£m
East CCG	313
West CCG	362
NHS England Area Team	252
Public Health LA	18
Public Health England	2
Total Baseline- LLR PCT	**947**

Allocation

7. As identified above, the CCG baseline identified in the Baseline Exercise was £313m. Following the national submission a number of adjustments were applied to the initial baseline:
   - **Running Costs** (all costs that are not purchase of healthcare), were deducted from the total to reflect commissioning budgets only.
   - A **Specialised Services Adjustment** was applied to account for the additional migration of services to and from secondary care budgets.
   - A **Redistribution of Headroom** to allocate all receiving organisations a share of the PCT's headroom surplus. This resulted in a reduction to the CCG allocation to transfer some funding to the other successor bodies.
   - An adjustment to reflect **actual Public Health 2010/11 expenditure** as reported in the Public Health Baseline return.
   - A **Public Health Prescribing** adjustment to reflect the cost of prescribing for services commissioned by Public Health.

8. The impact for ELR CCG is quantified in the table below:

Baseline	£m
Baseline	313
Running Costs	(7)
Specialised Services	(10)
Redistribution of Headroom	(2)
Public Health 2010/11	0
Public Health Prescribing	(1)
2012/13 Adjusted Baseline	**293**

9. This revised baseline of £293m forms the basis of the 2013/14 allocation. A national growth uplift of 2.3% has been applied to provide a Commissioning Budget Allocation of £300m for ELR CCG. The Running Cost Allowance has been updated to reflect revised population figures and added to the Commissioning Allocation to provide a total 2013/14 Allocation of £307m.

10. The overall summary of both recurrent and non recurrent allocations currently included within the 13/14 Financial Plan is shown in the table below:

Allocations Summary	Recurrent £m	Non Recurrent £m	Total £m
2012/13 Adjusted Baseline	293		293
Growth Uplift (2.3%)	7		7
Return of 12/13 PCT surplus		4	4
Overseas visitors		2	2
Dental Adjustment	(1)		(1)
Running Costs	8		8
2012/13 Adjusted Baseline	**307**	**6**	**313**

Expenditure Summary

11. The CCG's financial plan is effectively a second year of transition and the first year of a new outcome focussed organisation. This financial plan delivers the requirements as set out in “Everyone Counts” whilst continuing to support local providers, innovation, redesign and general efficiencies.

12. The financial plan has been built by using the month 8 forecast outturn projections for 2012/13 as a starting point. Adjustments have been made to reflect known changes and developments. The impact of specialised commissioning migrations has yet to be determined and as such is dealt with in their totality rather than on an individual contract basis. This process presents a significant risk to the CCG.

13. The CCG's QIPP plan estimates the achievement of QIPP savings of £5.8m. The CCG has achieved significant savings in Prescribing and is reporting £1.5m savings as a result of 2012/13 initiatives. Trust efficiency savings via contract deductions account for £4m. The progress against the achievement of the QIPP targets will be reported to the Governing Body via the Finance and Performance Committee. The external monitoring requirements have not been identified but the internal processes that have been established will facilitate these requirements.

2013/14 Budget

14. The annual budget can be classified into a number of broad headings. The table below summarises the 2013/14 budget.

Annual Budget	£m
Acute, Community & Mental Health	218
Continuing Health Care	22
Primary Care (including Prescribing)	53
Running Costs	8
2% Non-Recurrent Topslice	6
Contingencies & Reserves	3
Surplus	3
Total Annual Budget	**313**

15. Further details of the budgets identified are detailed in the following sections.

NHS Contracts

NHS Provider Trust	2013/14 Contract Values £m
Acute:	
University Hospitals Of Leicester NHS Trust	116
Kettering General Hospital NHS Foundation Trust	7
East Midlands Ambulance Service NHS Trust	7
Peterborough & Stamford Hospitals NHS Foundation Trust	6
Nottingham University Hospitals NHS Trust	3
University Hospitals Coventry And Warwickshire NHS Trust	3
United Lincolnshire Hospitals NHS Trust	1
Northampton General Hospital NHS Trust	1
George Elliot NHS Trust	1
Other SLAs (De-Minimus SLAs <£250k)	0
Non Acute:	
Leicestershire Partnership NHS Trust	48
Derbyshire Community Health Services NHS Trust	7
Other SLAs (De-Minimus SLAs <£250k)	0
Total NHS Contracts	**200**

16. The total budget for services commissioned through contracts with NHS organisations equates to £200m for 2013/14.

17. The contract offers have been made within the quantum of funding identified of £200m and have been based on recurrent 2012/13 forecast outturn reduced by net 1.1% deflator (2.9% inflation less 4% efficiency) with adjustments applied for service migrations, known developments and commissioning intentions.

Prescribing

18. ELR PCT Prescribing expenditure has reduced significantly over the past year. In 2012/13 there was a QIPP prescribing target of £1m which was achieved. The budget for 2012/13 was £43.1m. The final outturn was £41m. The budget for 2013/14 will also have a QIPP target applied to it.

19. The budget for 2013/14 has been based on forecast outturn for 2012/13. An inflationary uplift of 2.7% has been applied as well as demographic growth of 1.6%. A challenging QIPP target equating to a budget reduction of 3.1% has been allocated to the prescribing budget for 2013/14. The total annual budget has been set at £46m.

Continuing Healthcare

20. The 2013/14 budget for Continuing Health Care equates to £22m. This category of budget includes the commissioning of services for both children and adults and includes joint commissioning and complex patients. Adult services include the cost of care home and domiciliary care for patients and services commissioned jointly with the local authority under a Section 75 agreement. Joint funded services account for £1.4m in 2013/14.

Running Costs

21. The CCG must provide appropriate levels of running cost support within an allocated target budget. This budget equates to £25 per head of population (as per ONS figures). This budget is used to provide the support functions including contract management, programme support, finance, procurement, communications and governance. The total Running Cost Allowance (RCA) for ELR CCG for 2013/14 is £7.7m.

22. The areas to be funded from within the RCA include the statutory Board, clinical engagement from member practices, overheads and a range of back office functions, both in house and bought in.

23. The remainder of the services required are provided in house by directly employed staff with some specialist services commissioned from subject experts, for example health & safety training, internal and external audit. The total of the in house provision accounts for approx. 68% of the RCA budget. The breakdown of the running costs is shown in the table below.

Category of Spend	£m
Pay	4.19
GEM SLA	2.59
Other Non Pay	0.99
Total	7.77

Use of 2% Non-Recurrent Funding

24. There is a requirement for the CCG to demonstrate a 2% recurrent surplus within its financial plan. This equates to £6.2m for ELR CCG. The CCG can commit this funding non recurrently within 2013/14. As such, details of the planned use of the return of the 2% funding are required.

25. The CCG has outlined schemes accounting for the available funding as detailed in the table. These schemes will require approval by the Governing Body and will form part of the investment prioritisation process. It is proposed that 0.75% (£2.25m) of the overall CCG resource be available for reinvestment in schemes and programmes that have been supported by the Commissioning Collaborative and is shown across the individual headings in the table below.

2% Headroom	£m
Acute Service Redesign	0.9
Community Health Services/Intermediate Care	0.7
Continuing Care	0.6
NHS 111	0.6
Primary Care	0.4
Contingency	3.0
Total	6.2

QIPP

26. The CCG's QIPP plan estimates the achievement of QIPP savings of £5.8m. The table below outlines the schemes identified as part of the 13/14 financial plan.

QIPP Schemes	£'000
Continuing Healthcare	1,200
BADS	467
Outpatient Follow Ups	507
Surgical Thresholds	13
Referral Thresholds	157
Prescribing	1,500
GP initiated activity – clinical variation & admission avoidance	286
EMAS conveyance scheme	160
Single Front Door scheme	116
Frequent Flyers/Choose Better Programme	100
Notts ISTC	173
Diabetes (UHL)	90
Integrated Care	400
Care Home Scheme	270
Intermediate Care/Geriatric Assessment	100
Right Place Project	200
COPD	100
Total	5,839

Risk

27. A number of key financial risks have been identified and detailed below:

• Specialised Commissioning Migration
The final calculations relating to the specialised services reduction have yet to be agreed.

• PCT Legacy Issues
The legacy impact of LCR PCT and LLR Cluster decisions may present a financial risk to the CCG for example Continuing Health Care.

• Local Authority Budget Reductions
The planned budget reductions affecting social care may impact on demand for health services. This has not been quantified.

• Financial Challenge to Providers
The ability of Providers to continue to make year on year cost reductions becomes increasingly challenging.

Risk Mitigation

28. Following the identification of potential risk areas it is imperative that a risk management strategy is formulated. The key strategies are identified below:
    - The development of close working relationships with other successor bodies, for example; Leicestershire and Lincolnshire Area Team, Specialised Commissioning Team and Leicestershire County Council.
    - The exploration of the potential of formal risk share arrangements with other CCGs.
    - The adoption of a joint commissioning approach to the 2013/14 contract round.
    - The development of the investment prioritisation process to facilitate the appropriate utilisation of the 2% non-recurrent resource.
    - On-going review of budget levels and quantification of potential cost pressures to determine the appropriate level of contingency.
    - Effective monitoring of spend plans including a comprehensive training and support package to empower responsible budget holders.
    - Timely monitoring of new developments to facilitate early identification of cost and performance variances and the implementation of alternative or exit strategies.
    - Sound governance arrangements for the monitoring of QIPP delivery
    - Formal Risk Assessment to the Audit Committee

Summary

29. The Financial Plan has been set to ensure that the CCG meets its statutory requirements and delivers a balanced financial position.

30. The plan complies with the requirements set by the NHS CB to provide a 2% recurrent surplus, 1% in year surplus, to plan for the use of 2% non-recurrent funding and provides a 0.5% contingency budget.

31. A number of risks have been identified including the impact of the specialised commissioning migration, impact of social care changes, transition and legacy issues and the ability of the CCG to operationalise plans and use the non-recurrent funding.

32. The risks can be mitigated via a range of actions most notably the availability of reserves and contingencies and the joint commissioning proposal for specialised services.

33. The key to success is the delivery of investment plans and to ensure the resources are used in line with the investment priorities.

Recommendation

The East Leicestershire and Rutland CCG Governing Body is requested to:

APPROVE the CCG financial plan for 2013/14;

NOTE that the financial plan delivers the financial requirements as set out in planning guidance;

ACKNOWLEDGE the risks associated with the financial plan and note the mitigating strategies;

ACKNOWLEDGE the specific risk arising from specialised commissioning allocations and how resolution will lie beyond the CCG's control;

AUTHORISE that NHS contracts will be entered into in line with financial planning assumptions and allowing for the management of the risk associated with specialised commissioning allocations.

Karen English
Chief Finance Officer

Appendix 1

ELR CCG - Build Up of 2013/14 Budgets						
Recurrent Budgets:	**Infrastructure £**	**Acute £**	**Non Acute £**	**Primary Care £**	**Reserves £**	**Total £**
Month 8 Recurrent Budget	**5,388,375**	**145,329,822**	**93,899,900**	**49,273,903**	**358,996**	**294,250,996**
Cost pressures @ M8	-97,974	6,477,871	-509,827	0	-358,996	5,511,074
FOT at Month 8	**5,290,401**	**151,807,693**	**93,390,073**	**49,273,903**	**0**	**299,762,070**
Movement on FOT			-519,438			-519,438
Remove CQUIN		-3,419,232	-1,301,303			-4,720,535
FYE	2,342,982			2,679,592		5,022,574
13/14 Opening Recurrent Baseline	**7,633,383**	**148,388,461**	**91,569,332**	**51,953,495**	**0**	**299,544,671**
Inflation	132,768	4,006,488	2,472,372	1,238,503	0	7,850,131
Provider Efficiency		-5,935,538	-3,662,773			-9,598,312
Demographic Growth		3,205,191	1,901,198	788,382		5,894,771
Non Demographic Growth			2,177,020			2,177,020
QIPP		-3,139,000	-1,200,000	-1,500,000		-5,839,000
Investments		619,000	577,000			1,196,000
Cost Pressures		3,567,000	685,000			4,252,000
CQUIN		3,519,720	1,597,454			5,117,174
Revisions to envelopes following contract negotiations - impact of SS on contracts		-2,420,498	-2,466,813	34,871	310,000	-4,542,440
13/14 Final Recurrent Budget	**7,766,151**	**151,810,823**	**93,649,790**	**52,515,251**	**310,000**	**306,052,015**
Non Recurrent Budgets:						
Month 8 Recurrent Budget		1,512,640	3,332,703		3,109,865	7,955,209
Cost pressures @ M8			-3,298,112		-3,109,865	-6,407,977
FOT at M8	**0**	**1,512,640**	**34,591**	**0**	**0**	**1,547,232**
13/14 Opening Recurrent Baseline	0	1,512,640	34,591	0	0	1,547,232
Inflation		40,841	934			41,775
Provider Efficiency		-60,506	-1,384			-61,889
Demographic Growth		32,673	514			33,187
Investments					8,932,939	8,932,939
13/14 Final Recurrent Budget	**0**	**1,525,649**	**34,655**	**0**	**8,932,939**	**10,493,243**
Total CCG Budget	**7,766,151**	**153,336,472**	**93,684,445**	**52,515,251**	**9,242,939**	**316,545,258**

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EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Finance Report: Month 12**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Sarah Ferrin, Head of Finance**
SPONSORED BY:	**Karen English, Chief Finance Officer**
PRESENTER:	**Karen English, Chief Finance Officer**

PURPOSE OF THE REPORT:

The Finance and Performance Group took place on Tuesday 7 May 2013 where detailed scrutiny of the following took place:

- The Month 12 financial reporting update on the resources delegated to East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG), together with a year-end financial reporting update for 2012/13.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Governing Body is requested to:

NOTE the contents of the report.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that the financial reporting underpins the commissioning strategy and priorities of the CCG. The commissioning strategy and priorities have and continue to be equality impact assessed as the strategy is reviewed and refreshed and

this includes the financial plans.

This completes the due regard required.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

This report aligns to “Risk 6.1 The CCG fails to ensure financial management to achieve economy, effectiveness, efficiency, probity and accountability in the use of resources” as within the Board Assurance Framework (August 2012) and highlights main areas of financial risk under the “key issues” section.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING
14 MAY 2013

Finance Report: Month 12

Introduction

1. This report provides details of resources delegated to East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) together with a year-end financial reporting update for 2012/13.

Budget

2. There were no budget changes during the month.

Financial Performance

3. **Appendix A** – the budget statement details performance against budgets as at 31st March 2013, year end.

4. Actual expenditure against the overall budget has resulted in a year end under spend of £2,958k. This reflects a £963k improvement from the forecast out-turn position reported at month 11 for the following reasons:

Table 1: Summary of Key Movements in Financial Position from Month 11 FOT to Year End Actual Position.

Area	M11 FOT VAR (£'000)	M12 ACTUAL VAR (£'000)	MOVEMENT (£'000)
Total CCG Financial Position	**(1,995)**	**(2,958)**	**(963)**
Due to:			
Out of County Contracts	2,627	2,260	(367)
Continuing Health Care	(2,614)	(3,145)	(531)
Other Movements	(2,008)	(2,073)	(65)
Total	**(1,995)**	**(2,958)**	**(963)**

Secondary Care Services

University Hospitals of Leicester

5. The final year end position for UHL is an over spend of £3,032k, with only a minor favourable movement from the month 11 forecast out-turn. Actual spend has been based on monitoring data for month 11.

6. The areas of over spend to date are detailed in Table 2 below:

Table 2: UHL over spends

Activity	Over spend at Year End (£'000)	Reasons/Actions
Emergency	1,907 (net of MRET)	• Main specialities include Geriatric Medicine, Diabetology, Thoracic Medicine, Cardiology and General Surgery.
Non Elective	1,257	• Within the main contract (£893k) and Oversees Visitors (£364k). Majority is Obstetrics/Midwife Episode activity (£728k).
Out Patients	673	• OPP (£379k plus £105k OSV) • Admission Unit Attendances (£149k)
Day Case	(521)	• Main specialities include Breast Care, ENT, Neurology, Orthopaedic Surgery, Paediatric medicine.
Inpatient	(816)	• Main specialities include Breast Care, Orthopaedic Surgery, Plastic Surgery and Vascular Surgery.
A&E	146	
Direct Access	190	• DA Diagnostics (£161k)
	196	• Various minor over-spends
Total	**3,032**	

Out of County Contracts (OOC)

7. The year end variance for Out of County contracts is an over spend of £2,260k, reflecting a £367k favourable movement to the month 11 forecast out-turn. Actual spend has been based on monitoring data for month 11.

8. The areas of over spend to date are detailed in Table 3 below:

Table 3: Out of County contract over spends

Provider	Over spend at Year End (£'000)
Peterborough	1,008
University Hospitals of Coventry & Warwickshire	395
Nottingham University Hospitals	659
Kettering General Hospital	187
Other OOCs	11
Total	**2,260**

9. A majority of the favourable movement from the month 11 FOT is due to Peterborough where a significantly larger MRET adjustment was required than anticipated (£321k).

Independent Sector

10. The Independent Sector financial position has improved by £102k from the month 11 FOT, reporting a final year end over spend of £1,593k.

11. The areas of over spend to date are detailed in Table 4 below:

Table 4: Independent Sector over spends

Provider	Over spend at Year End (£'000)
Spire	901
Nuffield	521
Ramsay Woodlands	225
Other IS	(54)
Total	**1,593**

12. **The overall year end position for Acute Commissioning is an over spend of £6,989k. This has moved favourably by £343k to the month 11 FOT, mostly due to the Out of County Contracts, (Peterborough).**

Non Acute Commissioning

13. The final year end position for non-acute commissioning is an under spend of £3,589k. The actual position has improved by £582k during the month due to an improvement in Continuing Healthcare.

14. The main areas contributing to the Non Acute financial position are detailed in Table 5 below:

Table 5: Non Acute financial position

Provider	(Under)/over spend at Year End (£'000)
Leicestershire Partnership NHS Trust	(934)
East Midlands Ambulance Service	169
ECRs/CHC	(3,140)
Voluntary Sector	(148)
Non Acute Reserves	461
Other Non-Acute	3
Total	**(3,589)**

15. The final figure calculated for the ELR CCG element of the retrospective CHC claims is £4,038k. This additional cost has been fully funded via slippage on Transformation Funding for 2012/13. This provision will be carried forward into the ELR CCG Balance Sheet for 2013/14 to fund any successful claims in the future.

Primary Care Commissioning

16. The final year end position for Primary Care Commissioning is an under-spend of £2,499k, reflecting a £129k deterioration from those figures forecast at month 11, due to GP prescribing. There have been no other material movements in forecast figures during the month.

17. The Primary Care Commissioning financial position is detailed in Table 6 below:

Table 6: Primary Care Commissioning financial position

Provider	(Under)/over spend at Year End (£'000)
Clinical Engagement	(261)
CCG Prescribing	(124)
Practice Prescribing	(2,049)
Local Enhanced Services/Directly Enhanced Services	(72)
Minor Injury Units	7
Total	**(2,499)**

Infrastructure Budgets

18. The new structure for ELR CCG falls within the running cost 'allocation' of £25 per head of population.

19. The adverse movement of £127k from those figures forecast at month 11 is due to additional costs being incurred in relation to additional support required within the strategy and development/contracting team plus advertising costs for senior roles within the organisation.

Reserves

Transformation

20. The final slippage against these budgets is £7.3m which has been fully assigned to fund CHC retrospective claims.

CCG Reserves

21. The reserves budget of £3,993k includes a recurrent development budget of £759k which was created to fund specific CCG developments during the year, plus an additional £209k transferred from the LPT contract during month 11.

22. The remaining £3,110k is non recurrent funding in relation to the 1% Commissioning Reserve as outlined in the financial plan.

Table 7: Analysis of Reserves

Scheme	Funding (£'000)	FOT (£'000)	Forecast Variance (£'000)
Recurrent:			
Acute Contingency - specific	296	16	(280)
Integrated Care Model	315	200	(115)
Unallocated	63	0	(63)
Addition transferred from LPT	209	0	(209)
Recurrent Total	**883**	**215**	**(667)**
Non Recurrent:			
1% Commissioning Reserve	**3,110**	**0**	**(3,110)**
Total Development Funding	**3,993**	**216**	**(3,777)**

23. At the year end, the CCG is reporting an under spend of £3,777k against budget. There has been a favourable movement of £294k from month 11 forecasts due to spend on the Integrated Care Model being lower than anticipated.

Better Payment Practice Code (BPPC)

24. All NHS organisations have a statutory duty to pay invoices within 30 days of receipt. The BPPC performance for the CCG at the Year End is shown in **Appendix A**.

25. The CCG has achieved all 4 BPPC targets for the financial year.

QIPP (Quality, Innovation, Prevention & Productivity)

26. The CCG has a QIPP performance target of £5.769m to deliver during 2012/13. **Appendix A** shows that the CCG has achieved this, although a large proportion of this (36%) has been delivered non recurrently.

Summary

27. A the end of the financial year 2013/14, the CCG is reporting an under spend of £2,958k which has contributed to the overall achievement of the County PCT to hit its required financial target.

Recommendation

The East Leicestershire and Rutland Clinical Commissioning Group Governing Body is asked to:

NOTE the contents of the report.

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Month 12 Finance Dashboard (March 2013)

ELR CCG Budget Statement

	Year End Position			Month 11	Movement from
	Budget (£)	Spend (£)	Variance (£)	FOT Variance (£)	M11 FOT (£)
Acute Commissioning					
UHL Contract	112,203,983	115,235,749	3,031,766	3,002,171	29,595
Out of County Contracts	21,331,486	23,591,576	2,260,091	2,626,908	(366,818)
Non Contracted Activity	1,249,261	1,352,644	103,382	7,749	95,634
Independent Sector	4,298,595	5,891,859	1,593,264	1,694,941	(101,677)
Total Acute	**139,083,325**	**146,071,829**	**6,988,504**	**7,331,769**	**(343,265)**
Total Non Acute	**103,918,563**	**100,329,964**	**(3,588,599)**	**(3,006,520)**	**(582,079)**
CCG Clinical Engagement	**1,953,329**	**1,692,724**	**(260,605)**	**(256,409)**	**(4,196)**
CCG Prescribing	**2,801,497**	**2,677,848**	**(123,649)**	**(134,928)**	**11,279**
GP Practice Prescribing	**43,068,981**	**41,019,327**	**(2,049,654)**	**(2,169,949)**	**120,295**
Enhanced Services	**2,048,527**	**1,976,465**	**(72,062)**	**(70,925)**	**(1,137)**
Minor Injury Units	**954,898**	**961,508**	**6,610**	**3,794**	**2,816**
Total Primary Care	**50,827,232**	**48,327,872**	**(2,499,360)**	**(2,628,417)**	**129,057**
Infrastructure	**4,904,304**	**4,822,986**	**(81,317)**	**(208,433)**	**127,115**
Reserves	**3,992,541**	**215,518**	**(3,777,023)**	**(3,483,423)**	**(293,600)**
Total Central Budgets	**8,896,845**	**5,038,504**	**(3,858,341)**	**(3,691,856)**	**(166,485)**
Grand Total	**302,725,965**	**299,768,169**	**(2,957,796)**	**(1,995,024)**	**(962,772)**

Better Payment Policy Code

	NHS Creditors		Non NHS Creditors	
	C	F	C	F
	% of Bills Paid Within Target %	% Value of Bills Paid Within Target %	% of Bills Paid Within Target %	% of Bills Paid Within Target %
Totals	**98.28**	**99.35**	**95.60**	**98.32**
Previous month Totals (reported to Board)	**98.16**	**99.30**	**96.45**	**98.20**

ELR CCG 2012/13 Savings Plans

	Scheme Total £	Activity £	Annual Plan £	Annual Saving £
Recurrent Identified QIPP Schemes:	**4,494,162**	**5,489**	**4,494,162**	**3,718,162**
Non Recurrent Identified QIPP Schemes:	**1,400,000**	**0**	**1,400,000**	**2,049,654**
Total Savings Identified	**5,894,162**	**5,489**	**5,894,162**	**5,767,816**
QIPP in v10 of plan	**5,769,158**			**5,769,158**
(Shortfall)/Overachievement in Identified Savings	**125,004**			**-1,342**

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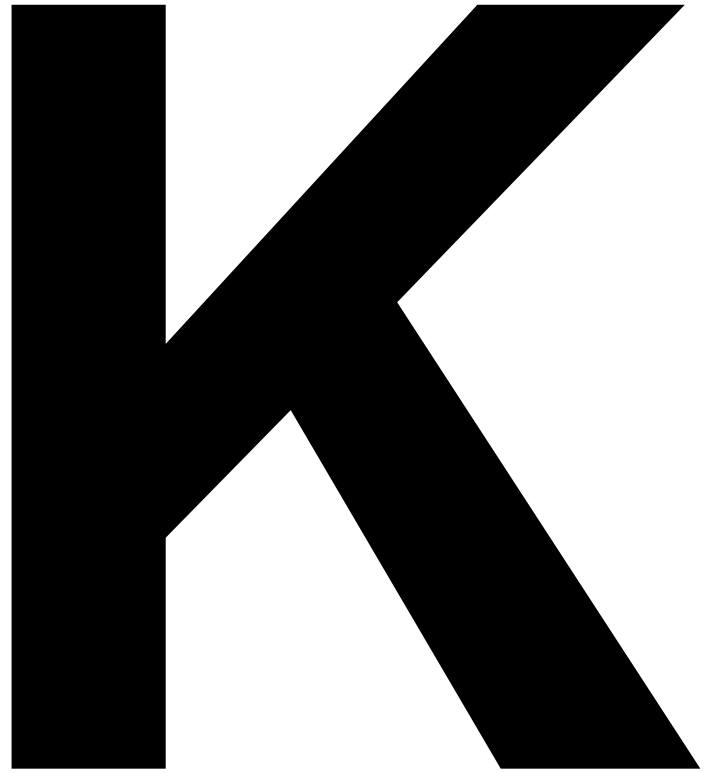

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Performance Assurance Report**
MEETING DATE:	**14 May 2013**
REPORT BY:	**Alison Buteux, Performance Manager, GEM Leicester & Lincoln**
SPONSORED BY:	**Karen English, Chief Finance Officer**
PRESENTER:	**Karen English, Chief Finance Officer**

PURPOSE OF THE REPORT:
This report provides an overview of performance for Leicester, Leicestershire & Rutland, and is for the reporting period of February 2013 & March 2013 where data is available.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Board is requested to: **NOTE** the contents of the report and **APPROVE** the documents attached.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2013 – 2014:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that the Performance Assurance reporting underpins the commissioning strategy and priorities of the CCG. This completes the due regard required.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:
This report aligns to “1.1 Failure to meet performance against targets due to limited capacity to deliver resulting in deteriorating position and inability to demonstrate good performance.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING 14 MAY 2013

Performance Assurance Report February/March 2013

INTRODUCTION

1. This report provides an overview of performance for EL&R CCG covers the following areas:

    - Appendix One: The Performance High Risk Summary Dashboard for 2013/14, which details the high risk performance indicators for 2012/13 Outturn within EL&R CCG.

HIGH RISK PERFORMANCE INDICATORS FOR 2012/13

2. The Performance High Risk Summary provides an overview, and presents by exception the performance status for ELR CCG. The dashboard highlights key risks for 2013/14 service standards and includes actions where performance is below the standard for the 2012/13 Outturn.

3. The areas RAG rated as "Red" at risk are as follows:

    - RTT 18 Weeks at specialty level

        - All overall admitted, non-admitted and incompletes are being achieved.
        - Actions to ensure achievement at specialty level include re-investment of contract penalties applied in 2012/13 to support UHL in improving operational management and eliminate the longest waits.
        - This indicator will contribute to the Quality Premium.

    - 52 Week Waiter

        - One 52 week waiter was reported in February 2013 for General Surgery was due to failure to follow the Trust policy on patient cancellations.
        - No recurrences are expected.
        - Zero tolerance is in place for 2013/14.

    - A&E 4 Hour Wait

        - At March 2013 year to date (YTD), 91.94% of patients were seen within 4 hours against a 95% standard.
        - Focus is on actions as a result of the continuation of schemes in 2013/14 that related to transformational and winter funds, includes right place, right time, single front door and review of intermediate care.
        - This indicator will contribute to the Quality Premium.

- Delayed Transfers of Care

  - A change in monitoring which now includes Ward 2 at UHL has seen a negative impact on performance in April 2013. Actions include increasing community rehabilitation services with LPT and working with care homes.

- Cancer 62 day waits

  - UHL under-performed against the cancer 62 day target for February 2013 (75.3%), taking the YTD 82.9% (YTD estimate pending final confirmation from national cancer database).
  - The backlog of patient's still awaiting treatment increased in the period November 2012 to January 2013, but has now returned to stable levels.
  - UHL have stated that recovery plans are being developed at tumour site level, however performance may not recover the 85% standard until July 2013.

- EMAS (Ambulance Response Times)

  - February, Cat A 73.78%, target of 75%.
  - February Cat B 93.63%, target of 95%.
  - Funding for 2013/14 has been finalised and agreed. A process evaluation outcomes analysis has been undertaken by EMAS which looked at the deployment points and estates strategy for this service. Plans will be developed however will not impact on the service immediately.

- Mixed Sex Accommodation

  - Outturn 2012/13 reported is 7 breaches, these occurred in April 2012.
  - There have been no further breaches during the year. Zero tolerance is in place for 2013/14.

PERFORMANCE INDICATORS IMPROVING FOR 2012/13

4. The areas RAG rated as "Green" are as follows:

- RTT – Incomplete non-emergency pathways

  - Performance for January 13 was 92.93% and improved to 93.03% Feb 13 YTD (UHL only), target of 92%.
  - Non-admitted median waits 6.69 weeks for January 13 reduced to 6.1 weeks for February (UHL only), target of 6.6 weeks.

- A&E waits

  - Time to treatment in A&E – median waits for January - 79 mins reduced to 60 mins in February, target of 60 minutes.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG Governing Body are requested to:

NOTE the contents of the report and;

APPROVE the documents attached.

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NHS
Greater East Midlands
Commissioning Support Unit

EAST LEICESTERSHIRE & RUTLAND CCG
PERFORMANCE HIGH RISK SUMMARY DASHBOARD FOR 2013/14

The summary of this report provides an overview, and by exception the performance status for East Leicestershire & Rutland CCG. The report highlights key risks of 2013/14 ambitions and includes actions for those areas where performance is below the ambition level.

NHS Outcomes Framework
19 indicator baselines are Green against a national baseline
2 indicators baselines are Blue as data is not yet available or are in development
1 indicator has not been RAG'd as there is no threshold to apply a rating

All indicator baselines are better than the national average as reported in the Outcomes Benchmarking Support Packs at CCG Level. They are RAG rated "green".

Baselines are not yet available or cannot be RAG rated for:
Domain 2 - Average health status score for individuals aged 18 and over reporting that they have a long term condition (indicator is in development) and Dementia diagnosis rate
Domain 4 - Patient experience of hospital care and friends & family test

NHS Constitution **17 indicators are Green** **6 indicators are Amber** **7 indicators are Red** **3 indicators are Blue**	**Improvement Status**	**2012/13 Outturn**	**2012/13 Outturn CCG**	**2013/14 Standard/ Ambition**	**2012/13 YTD Comparison**	**2013/14 YTD Comparison**	**13/14 3 month rolling average**	**13/14 Actual (Monthly/ Quarterly/ Annual)**	**Delivery Actions**
Referral to Treatment waiting time for non-urgent consultant-led treatment									
Admitted patients to start treatment within a maximum of 18 weeks from referral	⇩	92.7% Jan 13 (All providers) LCR	91.44% Feb 13 YTD (UHL Only)	90%					UHL achieved all targets for admitted and non-admitted clock stops in February 2013 at the aggregate provider level, and for all specialties with the exception of non-admitted Ophthalmology. UHL are achieving the standard of 92% of incomplete RTT waits within 18 weeks (at aggregate level for all specialties combined), nonetheless the number of long incomplete waits (>26 week RTT) has increased significantly since 1 April 2012. There are, however, two >26 week stage of treatment waits as at 7 April 2013, both of which have surgery dates. UHL have indicated that for March 2013 admitted ENT will under-perform, due to an increased backlog of long waits and lost capacity during prolonged non-elective bed pressures, but this will not compromise achievement of aggregate (bottom line) performance. However, commissioners have been informed of the likely failure of aggregate performance in April 2013 for admitted patient care, due to a combination of reduced capacity, non-elective bed pressures and planned backlog reduction. Commissioners have requested a formal submission quantifying the extent and phasing of the required backlog reduction by specialty, and the likely impact on performance. Commissioners have also reinvested 2012/13 RTT contract penalties with UHL, linked to a stretch target for 2013/14 which will support the Trust to improve operational management and eliminate the longest waits. This indicator is included within those NHS Constitution measures for 2013/14 which will contribute to the CCG Quality Premium in 2014/15.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	⇩	97.62% Jan 13 (All providers) LCR	96.9% Feb 13 YTD (UHL Only)	95%					
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	⇧	94.3% Jan 13 (All providers) LCR	93.03% Feb 13 YTD (UHL Only)	92%					
52 week waiters	⇔	1		Zero Tolerance					UHL had one >52 week non-admitted clock stop in February 2013 in General Surgery (the first such breach in 12 months). UHL's exception report indicated that this was due to failure to follow the Trust policy on patient cancellations, and no further recurrences are expected.
Diagnostic Waits									
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	⇩	98.8% Feb 13 (UHL LCR)	99.31% Jan 13 (UHL LCR)	99%					UHL have maintained the 6 week maximum wait diagnostic standard for each month since August 2012 following a failure to observe correct waiting time rules earlier in the year (April – July 2012). This indicator is included within those NHS Constitution measures for 2013/14 which will contribute to the CCG Quality Premium in 2014/15
A&E									
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	⇩	91.94% UHL (31/03/13)		95%					Negative impact on performance has been largely due to key winter funded schemes finishing on 1st April 2013. Key transformation or winter funded schemes where continuation has been possible have been agreed for April 2013 with full funding flow for 13/14 expected at April CCB. Key updates: 1. Right place, Right time workstreams Phase 1 is complete with phase 2 expected to complete in June 2013. 2. Single front door pilot due to go live on May 10th 2013 3. Intermediate care and outflow review: Review complete, plan being drafted with CCG's.
Delayed Transfers of Care (UHL) - No. of delays per 100,000 population.	⇧	6.4 (UHL) 6.0 (LCR) 28/03/13		2.3 (UHL) 1.5 (LCR)				5.1 (UHL) 3.5 (LCR) 04/04/2013	DTOC rate for April has increased significantly as ward 2 (UHL) patients are now included. Primary cause of delay is a lack if community rehabilitation services across city and county. Key actions: 1. Care home select pilot achieving its targets of reducing the time taken from referral to transfer 2. Additional care home assessment support has been funded by the CCG's to further reduce care home delays 3. LPT has restructured the ICS service to take patients from a wider geographical area. Conversations have begun with commissioners to widen the amount of services offered in the community at each CCG.

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EAST LEICESTERSHIRE & RUTLAND CCG
PERFORMANCE HIGH RISK SUMMARY DASHBOARD FOR 2013/14

NHS Constitution	Improvement Status	2012/13 Outturn	2012/13 Outturn CCG	2013/14 Standard/ Ambition	2012/13 YTD Comparison	2013/14 YTD Comparison	13/14 3 month rolling average	13/14 Actual (Monthly/ Quarterly/ Annual)	Delivery Actions
Cancer Wait - 62 days									
Maximum 62 day wait from urgent GP referral to first definitive treatment for all cancers	⇩	84.4% (LCR FOT Jan 13)		85%					The Open Exeter system has been temporarily closed down to allow data to be reported at CCG level. UHL further under-performed against the cancer 62 day target for February 2013 (75.3%), taking the year to date performance to 82.9% (YTD estimate pending final confirmation from national cancer database). The backlog of >62 day cancer patients still awaiting treatment increased in the period November 2012 to January 2013, but has now returned to stable levels. UHL have stated that recovery plans are being developed at tumour site level, and these include actions impacting on processes, pathways and leadership / governance arrangements. The Trust have indicated, however, that performance may not recover the 85% standard until July 2013. The Contract Performance Meeting on 26 March 2013 requested a revised recovery plan and trajectory against the original contract management process, and asked that CCG clinical input on the recovery plans be sought prior to formal submission. Drs Nick Pulman (WL CCG) and Richard Palin (ELR CCG) will review the plans with UHL clinicians to ensure they provide the best opportunity to secure the necessary performance improvement. Contract penalties associated with under-performance in 2012/13 have been reinvested with the Trust to support improvements. This indicator is included within those NHS Constitution measures for 2013/14 which will contribute to the CCG Quality Premium in 2014/15.
Cancelled Operations									
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	⇔	92.7% Feb 13 YTD (UHL)		100%					Performance has deteriorated during 2012/13 at UHL. This is due to non-elective bed pressures which are contributing to the issue. This will be monitored through the contract in 2013/14, alongside the new indicator and ED performance
Category A Ambulance Calls									
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1&2)	⇧	73.78% Feb 13 YTD (EMAS) 68.28% Feb 13 YTD (LCR)		75%					Further investment has been funded during 2013/14 to improve A8 & A19 performance; this includes increasing the number of head count ambulance staff, plans to create 9 hubs, 19 ambulance stations and 108 community ambulance stations. The additional hubs are part of a 5 year plan so changes will not be immanent.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	⇧	93.63% Feb 13 YTD (EMAS) 93.02% Feb 13 YTD (LCR)		95%					The EMAS change programme looks to deliver an overall 4.9% improvement in each of the performance targets. ED plans are also in place with will impact on EMAS response times, and will be closely monitored during 2013/14.
Mixed Sex Accommodation Breaches									
Minimise breaches	⇔	LCR 7 (FOT)		Zero Tolerance					The breaches reported occurred in April 2012. There have been no further breaches during the year. UHL have re-emphasised the reporting, escalation and processes internally. There is zero tolerance for 2013/14
Mental Health - IAPT									
The proportion of the people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies	⇔	11% (LCR FOT)		15%					Rethink achieved 11.8% against a target of 13%. It is important to note that the 13% target was set in April 2012 and in October guidance was issued, changing the methodology of counting for this target. This has adversely effected achievement of this target. Additionally the SHA requested training for all IAPT services for 5 days per staff member (14 staff total) some of this training impacted on March figures. The service has also been running below capacity since Q3, however there has been a continual recruitment process in place to address this issue. In conjunction with the above the extract for March data is carried out early and therefore validated figures will affect overall % reported

Key		
	Green	Achieved
	Amber	Underachieved
	Red	Failing Target
	Blue	Data Not Available

Produced by LLR Performance Team April 2013