NHS COMMISSIONING BOARD

Minutes of the Board meeting held in public on 8 November 2012

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

Apologies Mr Ciaran Devane–Non Executive Director

Item		Action
1	**Welcome and introduction** The Chair welcomed everyone to the meeting of the Board of the NHS Commissioning Board (NHS CB). There were no declarations of interest in matters on the agenda.	
2	**Minutes of previous meetings** The Board agreed the minutes of: • the final meeting of the Board of the NHS Commissioning Board Authority on 20 September; and, • the first meeting of the Board of the NHS CB on 1 October.	
3	**Chief Executive's report** Sir David Nicholson drew attention to the significant structural and cultural changes occurring across the system. The NHS CB had a central role in ensuring all parts of the system work together to benefit future outcomes for patients, which meant particular importance was attached to partnership work and the bilateral discussions taking place with a range of organisations including the Care Quality Commission and National Trust Development Authority.	

	The 1st April 2013, when the NHS CB would take on its full powers, was also fast approaching and the Mandate, which sets out the Government's ambition for the NHS, would be published shortly. The Mandate would be pivotal in enabling frontline clinicians and clinical commissioning groups (CCGs) to deliver improved outcomes for the populations they serve. The 211 CCGs had all entered the process of authorisation and members of the Board had visited CCGs, witnessing first-hand the potential of these organisations and level of responsiveness possible at local level. Sir David concluded by explaining how the next ten weeks would be crucial for the new system: • allocations would be made to CCGs to provide them with the resources to take forward their commissioning responsibilities; • expectations for the whole system would be set out through the planning arrangements; and, • the commissioning outcomes framework would be published, ensuring the levers are in place to support patient focus and commitment to outcomes.	
4	**NHS Commissioning Board – programme status** Bill McCarthy introduced his regular update on the status of the delivery of the NHS CB establishment programme, and the development of the new commissioning system that would provide maximum benefit to patients. Good and steady progress had been made, particularly in relation to recruitment, CCG authorisation and the development of the Commissioning Support Units. The agreement between the Local Government Association and the NHS CB was formally launched at a joint conference the previous month and the organisations had set out publicly their agreement to work together locally and nationally, particularly important in ensuring the needs of the more vulnerable members of society are met. In addition, two leadership forums had taken place at which directors from the NHS CB's National Support Centre, Regions and Local Area Teams (LATs) discussed how to work in collaboration to secure improved patient outcomes. The Board discussed the risks and challenges associated with the considerable task of developing and implementing the new commissioning structures – recruitment, premises, estates and the IT infrastructure that would enable the new system to work in a collaborative way. Bill McCarthy noted progress was accelerating in these areas, and was asked to bring further assurance on the delivery of these basic building blocks of the new system to the December Board. In addition, the State of	***BM to bring back detail on progress against key building blocks of the underpinning infrastructure required for the new organisation with an update to the Board members in December before a review of the state of readiness which will come to the Board in February***

	Readiness Review which would include an assessment against critical deliverables would be brought to the Board before being published in February 2013. The Board noted progress on the delivery of the programme and the strategic risks identified in the Board Assurance Framework.	
5	**Programme critical success factor 1 – safe transfer of functions** Jane Cummings introduced this paper, informing the Board of the Nursing, midwifery and care-givers vision and strategy. An engagement exercise had been undertaken with the nursing, midwifery and care-givers professions to develop the strategy, and a further engagement exercise was currently underway with the professions, people who are cared for by the professions, the public, the third sector, the independent sector and other NHS and social care organisations. The Board noted the significance of the strategy and the relevance of the six Cs (of care, compassion, competence, communication, courage and commitment) to other healthcare professionals. Consideration would be given to how these principles could be used more widely, for example embedding them into patient feedback, the appraisal process and 360 feedback, in addition to how these principles could be incorporated into professional education. The Board discussed how the organisation would support the success of the strategy, in particular the role employers play in creating a good working environment, through the work of the Leadership Academy in developing front line and top-level leadership, and the new Improvement Body. They agreed that an implementation plan should be produced at the conclusion of the consultation process. In that context, it was noted that the NHS CB is responsible for patient and staff surveys, and could seek to include a measure of the six Cs of care within these as part of wider work to measure the six Cs in a variety of contexts in order to reinforce their impact and make real their implementation. In that context, the Board also asked for consideration to be give to how the six Cs might influence the future curriculum for nurse training. The Board supported the launch of the strategy and the proposed launch on the 4 December 2012 at the Chief Nursing Officer's conference. They asked that the final document be made available in a very accessible form which can then be used to engage a wide audience including staff, patients and the public.	***JC to ensure actions to ensure that leadership and support to staff are included within an implementation plan to be produced at the conclusion of the current engagement process.*** ***JC to lead work to ensure the Six Cs are seen in different contexts to make real their impact.*** ***JC to consider how the Six Cs can be used to inform the curriculum for nurse training.*** ***JC/TK to ensure the final document is available in a very accessible form which can be used to engage a wide audience.***

6	**Programme critical success factor 2 – Safe transfer of emergency preparedness, resilience and response** Ian Dalton introduced this paper, informing the Board of progress towards implementation of the new emergency preparedness resilience and response (EPRR) model by 1 April 2013; the risks to delivery; and transitional assurance process. The Board noted the particular responsibility of the NHS CB in relation to EPRR and how risk is managed and mitigated through the transition. The NHS CB's role was to ensure the NHS is prepared to deal with potential disruptive threats and, if necessary, that there is the capacity to intervene and take command of the NHS in emergency situations, sharing resources to ensure patients' needs are met. The key risk to delivery was the timescale for implementation and the Board noted progress made to-date. The assurance process was also endorsed by the Board. The NHS CB would have a strong national and regional support role, and structures had been developed to ensure there is senior responsibility at a local level through CCGs. Partnership working was recognised as being fundamental to the process and the Board was assured that local engagement activity was already underway to ensure good working relationships before an incident occurs. Local health resilience partnerships (LHRPs) would be the key local strategic groups for health EPRR and would link with the existing 38 multi-agency Local Resilience Fora (LRFs). Membership would comprise all local health partners, co-chaired by the lead director locally for the NHS CB and a Director of Public Health (who would play a crucial role in local implementation). A broader transition assurance process was also being established to assure the Board the new arrangements could be implemented effectively across the country from 1 April 2013. This would include test processes across the Regions. In addition, a considerable piece of work was being undertaken to redefine standards and expectations and ensure best practice.	
7	**Programme critical success factor 3 – The NHS commissioning board is established** Sir Bruce Keogh presented this paper, setting out the role of the NHS CB in maintaining quality, updating Board members on the model for maintaining quality developed by the National Quality Board (NQB), and fulfilling an NQB commitment that each statutory organisation represented on the NQB would hold a Board-level discussion on their role in relation to quality. It was recognised that all parts of the system are responsible for quality, requiring collaboration to safeguard patients and drive continuous quality improvement. The Board noted the specific	

role of the NHS CB in maintaining quality and endorsed the actions that various directorates within the NHS CB are taking to ensure that the organisation fulfils its distinct role:

- working with the Care Quality Commission to continually raise the 'quality bar' through the commissioning processes;
- supporting and enabling CCGs to set quality requirements locally, through the provision of data and in supporting their capability to make the right choices for their populations through a range of commissioning resources;
- ensuring the NHS Standard Contract is best used to support improvement in quality.

Sir Bruce noted the shift in procedural and philosophical emphasis that accompanies the NQB's statement that commissioners are responsible for ensuring quality. Guidance, to be published before April 2013, was being developed jointly by the NHS CB and CCGs through the Quality Working Group of the Commissioning Assembly to communicate this shift. Commissioners and regulators would be required to work together through a network of Quality Surveillance Groups, to share information and intelligence on quality to identify the early signs of failure. It would be the role of the NHS CB to support and facilitate these across the country. Guidance would be issued to these groups by January.

The Board was informed that risk summits would continue and that the NHS CB, through its Regions and LATs, must be prepared to facilitate or Chair these summits. Guidance would also be issued to support this function. The Board acknowledged the NHS CB's role to drive continuous quality improvement. Safeguarding measures were discussed, in particular the revalidation of members of the medical profession which was considered to be a standardised approach to individuals that could be aggregated up to local teams, regional teams and the NHS CB. Data are required to measure individual performance against outcomes.

The Board was keen to establish a clear line of sight within the system - from local Medical Directors, through to responsible officers in the LATs, to regional medical directors, up to the National Medical Officer in the NHS CB. This would be an important lever.

BK/BM to ensure there are opportunities for the involvement of local authorities in the quality surveillance undertaken at regional level

The role of Local Government at a regional level was discussed and the Board was keen to ensure local authorities were involved in the quality surveillance undertaken at regional level as well as the local surveillance described within the document. In addition, the importance of patient and carer voice in relation to quality was emphasised, in particular in relation to the most vulnerable groups.

8	**Programme critical success factor 4 – The NHS Commissioning Board is adequately resourced** Jo-Anne Wass introduced this paper, providing an update on the implementation of the recruitment strategy and risks associated with delivery. She reported good progress on overall recruitment, and explained she was cautiously optimistic about the achievement of the December 2012 deadline to ensure all staff who are at risk, or affected by change in sender organisations, had clarity about their future employment. Action was being taken by the Human Resources directorate, in conjunction with the Operations directorate, to ensure action was taken to alleviate any blockages in the process as they occurred. VSM recruitment in particular was well underway. Jo-Anne expressed confidence in the NHS CB's ability to fill the majority of posts in the organisational structure by March 2013. Recruitment data would be provided to the Board and placed on the NHS CB website. The risks associated with the sender-led matching process were noted, which covered some 70% of jobs available, the process due to be completed by the end of November. Jo-Anne Wass expressed thanks to the SHAs and PCTs for the considerable work they had undertaken (covering 2,900 jobs) to ensure this process remained on track. Given the progress that had been made, the Board agreed to a proposal that the risk rating currently attached to the recruitment process should be reconsidered, including a separate consideration of the risks associated with the December 2012 and March 2013 targets. At the September Board meeting, it was agreed that the diversity profile would be analysed in more depth and recognised that diversity in recruitment was an on-going challenge. A number of immediate actions had been taken to focus the attention of senior management on this issue throughout the recruitment process. For example, recruiting managers had been asked to: • consider the diversity of recruitment panels; • ensure that at least one member of the panel had received diversity training in the last twelve months (with e-training made available); and, • pay attention to values and inequalities, giving this equal weight to experience and technical expertise. The Board gave its support for a task and finish group to develop a strategy on promoting diversity within the NHS CB.	***JW to place figures on the website which show the latest position on job matching*** ***JW and BM to discuss the risk rating currently attached to the recruitment process and consider whether this needs to be revised downwards, including separation of the targets for December and March*** ***JW to establish a task and finish group to develop the future strategy and work programme for equality and diversity, including external experts***
9	**Programme critical success factor 4 – The NHS commissioning board is accurately resourced** Jo-Anne Wass presented this paper on the transitional Partnership Forum set up to cover the transition period (up to the end of March 2013). The Forum comprised trade union	

	representation from sender organisations. A strong relationship had been developed based on engagement, involvement and a 'no surprises' approach. The forum would consider the policies, procedures and practices currently in development, and shared the NHS CBs aims and ambitions to be an exemplar employer. The Board approved the current terms of reference for the NHS CB Partnership Forum for the period to March 2013.	
10	**Programme critical success factor 9 – Agreed operating plans in place** Ian Dalton presented the paper, setting out the arrangements for specialised commissioning. The NHS CB would be responsible for commissioning these services nationally, and it was vital that specifications and commissioning policies were the same to ensure equitable access across the country. It was highlighted that the number of specialised services had increased following a review of specialised services undertaken by the Clinical Advisory Group and Department of Health. A clinically led process had been used to identify specialised services, based on the following criteria: • numbers of individuals that use the service; • number of teams that can provide the service/facility; • financial cost of providing the service/facility (high cost/low volume); and • financial implications for CCGs if they were to commission this service. The Board noted the immense importance of this work, and the considerable size of the commissioning budget (£11.8billion). Work was already underway to standardise specialised commissioning - a total of 132 service specifications and 51 commissioning policies had been developed, and been subject to review by a patient and public engagement assurance group, a finance assurance group and a clinical assurance group. The approach was endorsed by the Board, including the next steps which included public consultation. In so-doing, they agreed that the timescales for consultation should be considered following completion of work on clinical prioritisation and affordability, in order to ensure the maximum opportunity for feedback and engagement through the current involvement process already underway.	***ID to consider the timescales for final consultation***
11	**Programme critical success factor 12 – The NHS commissioning board can demonstrate that patients, the public and their representatives feel they have been engaged** Tim Kelsey provided a verbal update on progress with work on patient insight. Good progress had been made, and workshops	

	with the NHS Alliance and National Voices had gone a long way to establishing how the NHS CB can place patient voice at the heart of its work. However, there was still a long way to go to build patient voice. The Board supported a proposal to approve the formation of a Civil Society Network to allow the co-design of this work programme with the patient advocate community. Tim Kelsey explained the NHS CB has to be more than exemplary in building strategic engagement and public voice in to its work. Work was being undertaken with specialised and primary care commissioning to develop examples of engaged, participative healthcare. The fundamental vacuum of information and data on citizens and patients in relation to how they perceive outcomes was highlighted. Work would be required to generate this information and put it to use in clinical contexts to support outcomes. It was noted that the NHS CB would be responsible for the Friends and Family test from 1 April, and would publish data on A&E and overnight stays from this date. By October 2013, the test would be rolled out to all maternity services. Consideration was also being given to the use of other insight measures. In line with the transparency agenda, data were also to be published on clinical audit and primary care. The Board recognised the importance of creating a data rich environment, not only in driving clinical decisions but also in encouraging innovation and growth, enabling the NHS to interact with life sciences and research, adding value world-wide. The Board agreed that they should receive a regular paper with metrics to measure how patients feel and how they are engaged. The Board requested as part of this work, that consideration be given to how to develop insight into those patients at the sharp end of the inverse care law, and that the work had a patient and carer focus to capture the full breadth of responses.	***TK to develop a routine paper for future Board meetings including metrics for reporting back on the involvement and influence of patient and carers on the work of the NHS CB***
12	**NHS CB governance** The Board noted a finance update from Paul Baumann, who reported that it is anticipated that all funds would be used by year-end.	
13	**Feedback from Board sub-committees** There was no feedback from the Board sub-committees.	

14	**Any other business** The next meeting of the Board of the NHS CB would take place on 14 December (location to be determined).	

Signed as an accurate record _____

Date _____