Warwickshire Shadow Health and Wellbeing Board

Agenda

19 January 2012

Please note that a buffet lunch will be available from 12 noon.

A meeting of the Warwickshire Shadow Health and Wellbeing Board will take place at the **Conference Room, Northgate House, Warwick** on **THURSDAY 19TH JANUARY 2012 at 12.15 pm.**

The agenda will be:-

1. (12.15 – 12.25) General

(1) Apologies for Absence

(2) Members' Declarations of Personal and Prejudicial Interests

Members are reminded that they should declare the existence and nature of their personal interests at the commencement of the item (or as soon as the interest becomes apparent). If that interest is a prejudicial interest the Member must withdraw from the room unless one of the exceptions applies.

Membership of a district or borough council is classed as a personal interest under the Code of Conduct. A Member does not need to declare this interest unless the Member chooses to speak on a matter relating to their membership. If the Member does not wish to speak on the matter, the Member may still vote on the matter without making a declaration.

(3) Minutes of the Meeting on 10TH November 2011 and Matters Arising

Draft minutes are attached for approval.

2. (12.25 – 12.55) Update on the Transformation Programme from the Perspective of the Arden Cluster

Presented by Stephen Jones (Chief Executive) and Sue Roberts (Transformation Programme Director)

3. (12.55 – 13.35) George Eliot Hospital NHS Trust –

i) Securing a Sustainable Future
ii) Mortality Review

Introduced by Kevin McGee (Chief Executive)

4. (13.35 – 13.45) Proposal to Revise the Membership of the Warwickshire Health and Wellbeing Board

Introduced by Monica Fogarty

5. (13.45 – 14.05) Fair Share Budgets in Warwickshire

Introduced by Heather Gorringe and Gill Entwistle (Arden Cluster Director of Finance)

6. JSNA update

John Linnane – Director of Public Health

7. Any other Business (considered to be urgent by the Chair)

8. Closing Comments by Chair

Bryan Stoten
Chair of NHS Warwickshire

Future meetings – Please note Changes in September and November

20th March 2012	12:15pm-2:15pm	Stoneleigh Room, Wedgnock House
22nd May 2012	12:15pm-2:15pm	Stoneleigh Room, Wedgnock House
17th July 2012	12:15pm-2:15pm	Stoneleigh Room, Wedgnock House
12th September 2012	12:15pm-2:15pm	Stoneleigh Room, Wedgnock House
13th November 2012	12:15pm-2:15pm	Conference Room, Northgate House

Shadow Health and Wellbeing Board Membership

Warwickshire County Councillors: Councillor Alan Farnell; Councillor Isobel Seccombe; Councillor Bob Stevens

GP Consortia: Dr Inayat Ullah/Dr Ram Paul Batra-Nuneaton and Bedworth; Dr Charlotte Gath-Rugby; Dr Kiran Singh/Dr Heather Gorringe-North Warwickshire; Dr David Spraggett -South Warwickshire

Warwickshire County Council Officers: Wendy Fabbro Strategic Director for People

Warwickshire NHS: Bryan Stoten-Chair; John Linnane-Director of Public Health; Stephen Jones - Chief Executive (Arden Cluster)

Warwickshire LINKS: Councillor Jerry Roodhouse

Borough/District Councillors: Councillor Bill Sheppard

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Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 10th November 2011

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Bob Stevens
Councillor Izzi Seccombe
Councillor Heather Timms

GP Consortia

Dr Charlotte Gath – Rugby CCG
Dr Kiran Singh – North Warwickshire CCG

Warwickshire County Council Officers

Wendy Fabbro – Strategic Director – People Group, WCC

NHS

John Linnane - Director of Public Health (WCC/NHS Warwickshire)
Stephen Jones – Chief Executive Arden Cluster

Borough/District Councillors

Councillor Bill Sheppard – Nuneaton and Bedworth Borough Council

Warwickshire LINk

Councillor Jerry Roodhouse

Others Present

Dr Mike Caley – NHS Warwickshire
Gareth Owens, Executive Director - Nuneaton and Bedworth Borough Council
Monica Fogarty, Strategic Director – Communities Group
Paul Williams – Democratic Services Team Leader – WCC
Claire Saul – Head of Strategic Commissioning – WCC
Anna Burns – Chief Operating Officer, South Warwickshire CCG
Richard Hancox – Chief Operating Officer, Nuneaton and Bedworth CCG
Elizabeth Featherstone – Head of Early Intervention Service - WCC

1. General

(1) Apologies for absence

Dr David Spraggett -South Warwickshire
Lorna Shaw – Local Government Improvement and Development Agency
Liam Hughes - Local Government Improvement and Development Agency

(2) Member's Declarations of Personal and Prejudicial Interest

None

(3) Minutes of the Meeting on 28th September 2011 and Matters Arising

The minutes were agreed by the board and signed by the Chair. There were no matters arising.

2. Presentation on Clinical Commissioning Groups and Social Care

Using Powerpoint, Claire Saul gave a presentation to the meeting. This focused on the work of the County Council's People Group and explained the commissioning cycle as well as setting out which services are subject to commissioning and what will change in the future.

It was explained that the presentation did not cover the interdependencies that exist between the People Group and other agencies. The role of telecare as a means of assisting independent living at home was acknowledged. Members of the board were advised by Wendy Fabbro to visit the enabling centre in Leamington.

The interrelationship between health, lifestyle and social care was acknowledged and the need to engage with schools (recognising the value of early intervention) was discussed.

Richard Hancox made a presentation on the commissioning intentions for the George Eliot Hospital. It was stressed that the general principles of the presentation apply across the entire county. There followed some discussion around low value activities, these being procedures that continue to be undertaken even though their value is questioned.

Mortality rates were explored with the discussion moving from GP practices to the current performance of the George Eliot Hospital. The Chair questioned what the CCGs would do in cases where deaths were higher than anticipated.

The meeting was informed that the key is to understand why performance may be lower than expected. This may be down to methods of coding or recording or it may be attributable to instances where ambulances are called to homes to convey people who are clearly dying to hospital.

QIPPs (Quality, Innovation, Productivity and Prevention) were discussed. These were listed in the presentation and Anna Burns explained how CCGs were working together to address them. Stephen Jones observed that the number of QIPPS make the whole concept seem fragmented. He suggested that there are two areas that should be the focus of work namely i) services for frail older people and ii) service change in hospitals.

Chairman cautioned that there might be a danger in CCGs dividing up whole County responsibilities between them then losing the core principle of "Liberating the NHS", namely local clinical knowledge would lead to different commissioning practices for different localities.

Councillor Roodhouse called on the CCGs to develop engagement strategies and Anna Burns confirmed that this would be done. It was also acknowledged that the relationship between CCGs and the local authority should be robust.

3. Joint Strategic Needs Assessment

John Linnane gave a powerpoint presentation on progress with the Joint Strategic Needs Assessment. He agreed to send out one page summaries of the key elements of the JSNA. It was suggested that particularly in the case of rare medical conditions support groups can provide valuable information that should be used in the document.

There followed some discussion about the health and life chances of looked after children and the difference in life span between the north and the south of the county.

Long-term conditions were defined as ailments such as diabetes and cancer where the patient is often expected to manage the symptoms. The Chair reminded the meeting that as people are working and living longer so the chances of developing these conditions and having to manage them whilst employed will increase.

4. The Relationship between the Children's Trusts and the SHWB

Wendy Fabbro circulated a paper that was then discussed. This illustrated the relationship between the trusts, the Board and the safeguarding agenda.

It was agreed that it would be necessary to look at the emerging legislation and the role of the LINk and Healthwatch in terms of children's NHS services.

5. The SHWB and the Local Enterprise Partnership

The Chair welcomed Louise Wall to the meeting. Louise briefed the Board on the background to the Local Enterprise Partnership (LEP). The LEP is led by the private sector and is a partnership with a focus is on economic growth. It has recognised that planning and a lack of financial support is stifling growth in the region and has developed a five year strategy with a view to creating an environment that will make it easy to do business.

Although resources to support the running of the LEP have not been forthcoming two funds (the LEP Capacity Fund and Start Up Fund) have now been established.

Health and wellbeing has not specifically featured on the LEP's agenda. Stephen Jones, on hearing this, suggested that the LEP would be fully occupied supporting business growth. The role of the Health and Wellbeing Board should be to support the LEP as and when required.

6. Any Other Business

Wendy Fabbro informed the Board that on Monday 14th November a serious case review report would be made public.

The Chair informed the meeting of a request from a student at Manchester University for assistance with their PhD. It was agreed that support should be given.

Nick Bosanquet from Imperial College will be present at the next meeting of the Board.

The Board of the George Eliot Hospital has accepted that it will not attain foundation status. It is now looking for potential partners to assist it.

Dates of future Meetings

19th January 2012
20th March 2012
22nd May 2012
17th July 2012
20th September 2012
22nd November 2012

All meetings 12.15 to 14.15. Venue to be arranged.

The meeting rose at 2.12pm

……..Chair

Agenda Item No 3(i)

Warwickshire Shadow Health and Wellbeing Board

19 January 2012

George Eliot Hospital NHS Trust – Securing a Sustainable Future

1.0 Executive Summary

1.1 George Eliot Hospital NHS Trust has concluded that it is not able to take forward an application to the Department of Health (DH) to become a stand-alone foundation trust. Consequently, it has entered into a Tri-partite Formal Agreement with the DH and the Strategic Health Authority (SHA), supported by the Arden Cluster (covering Warwickshire and Coventry PCTs) to identify a strategic partner that would enable it to become part of a foundation trust or to create some other organisational model.

1.2 A project has been established – Securing a Sustainable Future – to achieve this aim. The trust is leading this project which puts the retention of local services for local people, within an organisational model that is clinically and financially sustainable, at the forefront of its objectives. The Health & Wellbeing Board can be assured that this project will be conducted in an open and transparent way, subject to the restrictions of commercial confidentiality, and that the trust intends to engage local stakeholders and staff in the process.

1.3 At the present time, the project is running to its planned timetable. The Strategic Outline Case has been agreed by the trust board. The trust has communicated its plans throughout the NHS and to potential non-NHS partners. It has received expressions of interest from both NHS and non-NHS organisations. A plan is in place for producing the Outline Business Case involving dialogue with potential partners.

2.0 Contents of the Report

1. Summary of the Tri-partite Formal Agreement (full document at Appendix 1)
2. Summary of the Strategic Outline Case (full document at Appendix 2)
3. Developing the Outline Business Case

3.0 Summary of the Tri-partite Formal Agreement

3.1 All NHS trusts are required to achieve foundation trust status. All non-NHS trusts were required to agree a Tri-partite Formal Agreement (TFA) with the Department of Health by the end of September. This TFA confirms the commitments being made by the NHS Trust, its Strategic Health Authority and the Department of Health that will enable achievement of NHS Foundation Trust status before April 2014.

3.2 The trust relies on partnerships to provide high quality local care and this would be an essential component for future health service provision. The recent SHA-led review concluded that it was highly unlikely from a clinical sustainability, patient, quality and financial sustainability perspective that the trust could exist as a standalone foundation trust in its present form. This position was supported by the board.

3.3 However, the SHA also concluded that the future form and the shape of clinical services should be measured against the needs of patients and a programme to clearly set out a clinical strategy is being led by the Arden Cluster. The strategy will cover the whole of Coventry and Warwickshire clinical services. The Trust recognises that in conjunction with all providers it will need to consider proposals for future clinical model changes that will be developed in a framework where access, quality, safety and sustainability will take precedence over organisational considerations, which may have a substantial impact on the configuration of services across the cluster and on the range of services commissioned from all individual providers in the cluster.

3.4 In parallel with the work on the clinical strategy, the George Eliot board will lead a process to establish its future organisational form. The trust Chief Executive will be the Senior Responsible Officer and will lead the Project Board. The project will follow a process based on the Treasury 5 Case Model to establish a clear strategy and full business case for the preferred option. The business case will take account of the outcome of the Arden Cluster clinical strategy. This may lead on to a competitive procurement process being undertaken if there is no clear option based on partnership with an NHS organisation.

3.5 This project, while led by the GEH board, will operate within an overarching governance framework involving the SHA and the Arden Cluster. These three organisations will form a Project Assurance Board responsible for overseeing the project strategy and major milestones. Collectively, the Project Assurance Board is expected to agree any recommendations of the Project Board prior to proceeding to the next stage. The George Eliot board will remain responsible for leading each stage of the project unless following decision at the Project Assurance Board there has been agreement that subsequent stages will be led by the SHA.

3.6 In addition to the Project Board, there will be a Quality Assurance Group to ensure that key stakeholders including patients and staff can assure

themselves that proposals made as project outcomes will ensure that service quality and safety are maintained.

3.7 The key milestones agreed in the TFA are:

Date	Milestone
Nov 11	Complete Strategic Outline Case
May 12	Complete Outline Business Case
June 12/Nov 12	Procurement/negotiation
Nov 12	Complete Full Business Case
Dec 12	Complete approvals
Jan 13/ March 13	Mobilisation/implementation
Apr 13	Project completion

3.8 The TFA is accessible on the trust's website at: http://www.geh.nhs.uk/about-us/key-publications/tripartite-formal-agreement/

4.0 Summary of the Strategic Outline Case

4.1 The purpose of the Strategic Outline Case (SOC) is to set out the case for change and outline why GEH is undertaking this project. The reason for undertaking the project is the need to source a strategic partner to enable it to achieve foundation trust status by March 2014 in accordance with its Tri-partite Formal Agreement. Various options for a strategic partnership are considered within the SOC, and it also provides an introduction to the emerging themes falling out of early work undertaken to assess these options. The SOC reflects the HM Treasury 5-Case Model for business cases.

4.2 The strategic case demonstrates that GEH is unlikely to reach foundation trust (FT) status as a stand-alone entity and must find a strategic partner. A long list of possible options has been considered: Do nothing, merger with an equal-sized (NHS) organisation, merger with a specialist NHS organisation, merger with an larger NHS organisation, vertical integration, creation of an NHS super chain, chambers, breaking up and selling off parts of the organisation, a management contract, an NHS/Independent sector partnership, a social enterprise, an educational alliance or a GP clinical commissioning joint venture.

4.3 The economic case appraises the relative value of the long list of options that has been considered and describes the approach and methodology that the project has taken to arrive at the short list of options that will require further consideration at the OBC stage. The short list of options is:

- Equal merger
- Merger unequal
- Merger – specialist hospital

- Vertical integration
- Super chain
- NHS / Independent sector partnership

4.4 There is an additional option of 'do nothing'- whilst not feasible, this is included as part of the process to provide a public sector comparator and demonstrate value for money of the final preferred option.

4.5 The Independent sector option has been carried through because it was recognised that an independent sector merger would add value by virtue of the vast range of commercial options that could be proposed. However, at this stage this is an unknown entity and will not come to light until a dialogue commences with potential bidders.

4.6 At this stage it is apparent that a number of potential options could meet the objectives and needs of the Trust. Further work is required to refine the suitability of these options. This will be completed as part of the Outline Business Case, scheduled for completion in May 2012. An independent Gateway Review will take place in early January to ensure readiness for this stage of the project. During this stage there will be engagement with potential partners.

4.7 The SOC is published on the trust's website at: http://www.geh.nhs.uk/files/media/SOC%20GEH%20v1%201a-clean-25-11-11x.pdf

5.0 Developing the Outline Business Case

5.1 The Outline Business Case (OBC) will take forward the evaluation of the short-listed options from the SOC in order to determine the preferred option. It is not expected to determine the preferred partner.

5.2 This stage of the project will involve market engagement and dialogue with potential partners. Information from this work will be used to evaluate the options. The potential partners will also feedback on the economic and commercial viability of the options under consideration. There will be engagement with both patient/user representatives and staff as part of this process.

5.3 At the present time, a number of potential partners have expressed interest in the project. These include both NHS and non-NHS organisations. Introductory meetings have taken place, but formal dialogue has not yet commenced. The formal dialogue will take place following publication of a Memorandum of Information. This will ensure that potential partners have the necessary information about the trust to ensure successful dialogue and subsequent option evaluation.

5.4 The OBC stage of the project is scheduled to be completed by the end of May 2012. The course of events from that point will depend on the preferred option and the level of competition from potential partners in respect of that option.

5.5 Communication will be a key part of the project and there will be regular updates to staff and other stakeholders. The trust board will receive a monthly progress report on the project in its public meeting and that would also inform the Health & Wellbeing Board of progress.

5.6 We would be pleased to present the outcome of the Outline Business Case to the Health & Wellbeing Board in due course.

Agenda Item No 3(ii)

Warwickshire Shadow Health and Wellbeing Board

19 January 2012

Mortality Review – George Eliot Hospital

1.0 Context:

1.1 The George Eliot Hospital has been repeatedly identified as an 'outlier' against mortality ratings over the years, with a higher than expected HSMR. We have more recently been identified as having a higher than expected SHMI, which is the highest in England.

1.2 Over the past twelve months there have been significant leadership changes within the Executive Team at the George Eliot Hospital, specifically with the appointment of a new Medical Director in relation to this issue. The Medical Director is leading a review to fully understand what is causing the George Eliot to record consistently high rates of mortality to provide a reliable conclusion and the implementation of an action plan to ensure robust systems and processes are embedded within the organisation.

1.3 Also in train is the implementation of a revised organisational structure and governance review to increase accountability both managerially and clinically organisation- wide.

2.0 Actions:

2.1 As a direct and immediate response to the increase in HSMR in September and prior to the October SHMI being released, the Trust put an action plan in place to undertake a wholesale review of systems and processes in place, which included;

- Consultants requested by Medical Director to review significant outliers and feedback within four weeks.

- The Royal College and the Association of Surgeons of Great Britain and Ireland have been contacted and have agreed to undertake a service review of colorectal services at the George Eliot Hospital, dates confirmed as February 2012.

- A peer evaluation process will be undertaken between GEH and both a local and national outlier Trust.

- Internal processes for mortality review have been examined and redefined. All deaths are reviewed by a consultant within two days. An initial screening of potential preventable mortality is then undertaken utilising a trigger tool, and reported to the Medical Director and Associate Medical Director within two weeks of death. Any deaths which require further investigation undergo a full screening and in depth review and appropriate follow up with the consultant by the Medical Director. Consultants have been reminded of the importance and timeliness of this work.

- A weekly review of all deaths is undertaken by the Medical Director, Associate Medical Director and Senior Coding Manager to ensure process and systems put in place are followed and maintained.

- An external review is underway by Mott MacDonald of the following potential contributors to mortality statistics;

    1. The quality of medical care and delivery of care at GEH
    2. Coding
    3. The contribution of external factors such as the provision of palliative care in our area and the quality of primary care

    This review commenced in October 2011 and is due for completion at the end of this month. Initial findings include areas for improvement in IT systems and coding, continuity of patient care and the impact of external factors as outlined above.

- Action and implementation plans will be drawn up in response to findings from the above and amalgamated with other actions underway.

- The Trust Board has been provided with detailed information regarding HSMR and SHMI and they have been fully appraised of the actions and progress on a regular basis. A Board to Board meeting with the Cluster is to be arranged.

- We have discussed our actions with Executive Directors from the West Midlands and East SHA and have liaised with the Arden Cluster to keep all our partners appraised of progress.

2.2 The George Eliot Hospital is clear that any remedial action it needs to take to improve quality of care and reduce its mortality figures is being dealt with. But it also needs to be recognised that the GEH mortality figures are a systems problem and the GEH needs support from other agencies. The health statistics for North Warwickshire are significantly worse than surrounding areas, whilst a significant funding gap exists between the North and South of the County.

2.3 With the development of GP Commissioning and the strong supportive but challenging relationships that now exist between the GEH and the emerging Clinical Commercial Groups, we are confident that the overall health of our population can improve.

Kevin McGee
Chief Executive
George Eliot Hospital

Agenda Item No 4

Warwickshire Shadow Health and Wellbeing Board

19 January 2012

Proposal to Revise the Membership of the Warwickshire Health and Wellbeing Board

1. 0 Key Issues

1.1 The initial terms of reference of the shadow HWBB were agreed in May 2011 and set the current membership of the Board. The current membership comprises:

- Independent Chairman
- Warwickshire County Council Leader of the Council,
- Warwickshire County Council Portfolio Holder for Adult Social Care
- GP Clinical Commissioning Group Leads
- Warwickshire Joint Director of Public Health
- Warwickshire County Council, Strategic Director for Children Young People and Families
- Warwickshire County Council, Strategic Director for Adults and Social Care
- NHS Commissioning Board - representative of national board (when established)
- Local HealthWatch Chair (LINKs Chair in interim)
- Borough/District Council representative

1.2 Over the past ten months or so the Board has developed, and in addition there have been organisational changes within both the local government and health communities. There are a number of key issues:

a) Whether a single representative for five district/borough councils is sufficient to represent the public health contribution of these organisations
b) How best to engage with the main NHS provider organisations as key players in the local NHS.
c) Recognition that there has been some “creep” in the range and number of people attending Board meetings

2.0 Options

2.1 To address these issues it is proposed that:

I. Representation for district/borough councils be expanded to three seats on the shadow HWBB. It is proposed that representatives are coterminous with the three Warwickshire CCGs i.e. one representative for North Warwickshire and Nuneaton and Bedworth, one representative for Rugby, one representative for South Warwickshire – covering Warwick and Stratford on Avon. .

II. The Board decide how best to engage the following key partners in the business of the Board:

- Arden cluster/future National Commissioning Board
- George Eliot Hospital
- South Warwickshire Foundation Trust
- Coventry and Warwickshire Partnership Trust

III. That distinction is made at meetings between Board Members and non-Board Members

2.2 The revised membership of the health and wellbeing board is therefore proposed as follows:

Representing	No. of Seats
Chairman	1
Warwickshire County Council Portfolio holder(s) for • Health • Adult Social Care • Children Young People & Families	 1 1 1
Clinical Commissioning Group Lead/Chair	3
Warwickshire Joint Director of Public Health	1
Warwickshire County Council, Strategic Director for People	1
Local HealthWatch Chair (Chair,LINKs in interim)	1
Borough/District Council Portfolio Holders for Health	3
Arden Cluster	1
National Commissioning Board	1
TOTAL	**15**

2.3 It is proposed that this membership be reviewed in Autumn 2012/13 prior to the Board assuming full statutory operation in April 2013.

	Name	**Contact Information**
Report Author	Monica Fogarty	monicafogarty@warwickshire.gov.uk

Agenda Item No 5

Warwickshire Shadow Health and Wellbeing Board

19 January 2012

Fair Share Budgets in Warwickshire

1. In November 2011 it was agreed that the Shadow Health and Wellbeing Board would consider the allocation of health funding across Warwickshire. The matter has been a particular concern of the Chair of the North Warwickshire (emerging) Clinical Commissioning Group (NWCCG), Dr Heather Gorringe who on 23rd December 2011 sent the email attached at Appendix A to the Chair of the Board.

2. On the basis of this evidence and the discussion to be facilitated at the meeting by Gill Entwistle (Arden Cluster, Director of Finance) and Heather Gorringe the board is requested to express its views for further consideration by the Arden Cluster.

	Name	**Contact Information**
Report Author	Paul Williams	paulwilliamscl@warwickshire.gov.uk

Appendix A

Bryan Stoten
Chair, Shadow Warwickshire H&WB
By e-mail

23 December 2011

Dear Bryan

Fair Share Budgets in Warwickshire

Thank you for the e-mail of 20 December, I am delighted that the Health & Wellbeing Board are taking an interest in this issue which we believe is central to ensuring that the population of Northern Warwickshire receive appropriate health care provision.

From the beginning of my period as Chair of the North Warwickshire (emerging) Clinical Commissioning Group (NWCCG), in February 2011, I have been concerned that the resource allocation within NHS Warwickshire does not adequately support the provision of appropriate care for this deprived population.

Population Profile

Table 1 shows the clear differential in healthy life expectancy between different parts of the County; the residents of Warwick can expect almost 4.5 years longer of healthy life than those of Nuneaton & Bedworth and can expect to live two years longer.

Table 1	All Cause Death per 100 000	Life Expectancy Years	Healthy Life Expectancy
Nuneaton and Bedworth	724.6	76.2	67.7
North Warwickshire	639.6	77.7	69.2
Warwick	517.8	78.2	72.1
Rugby	579.2	77.4	71.3

Table 1 - PH Data from West Midlands Health Observatory England (DH)

Table 2 (below) compares the same populations using some key lifestyle indicators and shows that Northern Warwickshire residents consistently exhibit poorer results than those of Warwick and Rugby.

The poorer health outcomes for the residents of Northern Warwickshire are widely recognised, for example, the current Joint Strategic Needs Assessment (April 2009) recognises that life expectancy for men and women in Nuneaton & Bedworth is in the bottom quartile and yet the mortality rate amenable to healthcare is in the top quartile (p. 29). This suggests that the provision of additional, targeted resources within the Northern Warwickshire population could have a realistic chance of extending lives.

Table 2	Deprivation Index[1]	Adults Overweight	Alcohol Deaths Per 100 000
Nuneaton and Bedworth	117	29%	30.3
North Warwickshire	177	27.3	24.7
Warwick	264	21.9	14.3
Rugby		24.9	

Table 2 - PH Data from Health Profiles Information (DH)

Fair Share position

At the end of March 2011 NHS Warwickshire (NHSW) produced a paper (Appendix 1) which showed the respective positions of each of the CCGs within the County and the impact of changes to the Fair Share formula between 2010-11 and 2011-12. The paper showed that 2010-11 expenditure across Northern Warwickshire[2] was £21.9m[3] less than the 2011-12 Fair Shares (FS) toolkit (when applied to the 2010-11 allocation received by NHSW) indicated as appropriate (Table 3).

Whilst the NHSW paper focuses on the reduction in the gap (which arises solely from the technical changes to the FS toolkit between 2010-11 and 2011-12) of £5.3m[4] the revised position still represents a substantial deficit of funding to the local population – amounting to 10.5% of 2010/11 Forecast expenditure.

	Resource allocated using 2011/12 fair shares toolkit				
	North	N&B	Rugby	South	Total
	£000's	£000's	£000's	£000's	£000's
Forecast expenditure	160,313	48,566	115,604	309,708	634,192
Resource	179,230	51,517	112,259	291,185	634,192
Surplus / (Deficit)	18,917	2,951	(3,345)	(18,523)	0

Table 3 From NHSW paper '2011-12 Fair Share toolkit impact assessment, March 2011

[1] The deprivation Index is based on seven distinct parameters based on: Income deprivation, Employment deprivation, Health Deprivation, and Disability, Education Skills and Training Deprivation, Barriers to Housing and Services, Living Environment Deprivation, and Crime. The lower the ranking number, the greater the global index of deprivation.

[2] Representing the combined populations of North Warwick and Nuneaton & Bedworth CCGs.

[3] £18,917k + £2,951k = £21, 868k

[4] From £27.2m

It is important that we acknowledge that the 'Forecast expenditure' figures are not precise but also represent estimates, made by NHSW, of the NHS resources consumed within each of the CCG populations. For example, the Community and Mental Health provider 'block budgets' have been apportioned using assumptions which reflected the 'best estimates' at the time.

In September 2011, in response to a DH request (Gateway Reference: 16440), the chairs of the Warwickshire CCGs met together with NHSW Finance to discuss and agree the appropriate allocation method for NHSW to report 2010-11 expenditure by each practice to the DH, for the purpose of enabling an assessment of shadow indicative CCG allocations to be made. This meeting agreed that Mental Health expenditure should be reported based on the Mental Health element of the FS toolkit and that 'Community Health Services' and 'Other Contractual' expenditure would be based on the acute element of the FS toolkit.

I understand that the result of this change to the method of apportioning expenditure has resulted in a reduction of the gap to around £16m – although it should be recognised that no actual transfer of resource has occurred, this is purely a change of accounting. The original NHSW paper was based on the 'best estimate' of resource consumption and so the £21.9m gap remains the current best estimate of the shortfall in resources provided to our local population.

As far as I am aware there has been no attempt to repeat the analysis undertaken in March based on the forecast 2011-12 expenditure. It is the view of the NWCCG board that the planned expenditure across Northern Warwickshire for 2011-12 is likely to have led to an increase in the gap, compared with the 2011-12 FS toolkit. We anticipate this result as NHSW chose to use historic expenditure as the basis for planning CCG expenditure for this year.

My understanding is that in 2006 the DH first introduced the concept of a move to a fair share budget and that it has been the responsibility of PCTs to manage towards this outcome in each subsequent year. I am not aware of any plan, or movement, having been put in place by NHSW which has resulted in the position described above. I should also mention that, up until 2006, my understanding is that North Warwickshire PCT had been in a position of achieving recurrent balance – although the allocation remained below that of other parts of Warwickshire.

I recognise that to address the shortfall in funding for the population of Northern Warwickshire will probably require the decommissioning of certain services elsewhere in the County. Table 3 indicates that the majority (£18.5m) of the 'excess' resources are consumed within the area of South Warwickshire – with a smaller amount (£3.3m) associated with Rugby. I recognise that the development and implementation of appropriate plans to redistribute these levels of resource will not be achieved immediately; whilst it is very disappointing that more effort has not been made over recent years to address this gap, I believe that we now need to focus on delivering a solution during the next two – three years.

Discussions with Arden Cluster

I have corresponded and met with Stephen Jones, CEO Arden Cluster, and Gill Entwistle, Director of Finance & Deputy CEO, numerous times since April with the intention of agreeing how we can start to shift the balance of NHSW resources more towards the population of Northern Warwickshire in line with the demonstrated need. I would be happy to share copies of the letters which I have sent if this would be of interest or value to you.

I have received only one formal letter from the Cluster in response to this issue (Appendix 2, August 2011). In this letter Stephen states that he is *"committed to addressing the fair shares imbalance"* and suggests four specific proposals regarding how this can be achieved.

(1) A shift of community service resources, within the existing contract, to increase the level of community provision available to Northern Warwickshire patients. Additional investment of additional community service resources to, for example, expand our Community Emergency Response Teams, provide extended 24/7 response and increase the availability of 'night sitter' services would all help to avoid emergency admissions, reducing the adverse impact on our local acute provider and helping to deliver patient care closer to home.

    This is a welcome proposal which I have subsequently discussed further with both Stephen and Gill (for example, on the 10th and 17th November respectively). During these meetings I was advised that the Cluster, as the statutory organisation, would lead discussions with the local CCG chairs to develop a clear implementation proposal – and that this would be tabled for a meeting scheduled for the 6 December. Unfortunately no such discussion has occurred and I have recently e-mailed Stephen and Gill to ask that it is now tabled for our next meeting on the 3 January.

(2) In 2010, North Warwickshire CCG agreed to support NHSW with the closure of the local Bramcote Community Hospital, provided that all the resources freed as a result would be re-invested for the benefit of the local population, which was agreed.

    At present, although the contract negotiations with each of the providers is in progress, the CCGs have no agreed basis for the development of CCG or practice level plans. This means that currently we have no transparent way to ensure that the c. £2m of recurrent revenue expenditure associated with the closure is fully re-invested to benefit our local population.

(3) Whilst Stephen provides the Cluster's commitment to apply any *"growth gain above average to the NHSW allocation for 2012-13"* towards the Northern Warwickshire population, he also makes it clear that any such growth is likely to be very limited.

    It is perhaps worth observing that whilst the gap to target allocation for NHSW is 1.5% (£12m) the gap for Northern Warwickshire is almost twice this value (10.5% of 2010/11 expenditure). Our conclusion is that our local population shoulders the entire deficit for the County whilst simultaneously 'subsidising' more affluent & healthy populations by an additional c. £10m.

(4) The letter references the opportunity to prioritise funds for investment in Northern Warwickshire and references a *"process to set the financial envelopes for 2012-13 and agree shifts in resources with the other [CCGs]"*. Although financial envelopes have been established at provider level I am not aware of any specific funding or process which has been established to achieve the proposed shift in resources which will address the anticipated shortfall against the Fair Share toolkit levels of funding.

In addition, as part of the current review of maternity and paediatric services in Northern Warwickshire, the Arden cluster has agreed in principle that additional resources may need to be found to support the continued provision of a safe, quality service and that this would contribute towards closing the FS gap.

Summary

As mentioned, I welcome the interest that the Warwickshire H&WB, and also the local LMC, are now taking in this issue. I hope that you will be able to support the population of Northern Warwickshire to receive the appropriate levels of funding and resource to meet their health needs. It is clear to me that this is a fundamental requirement if we, as the North Warwickshire CCG, are to make a success of the commissioning reforms and to appropriately care for the health needs of our population.

If you require any further information at this stage please contact me and I will be delighted to help.

Best wishes

Yours sincerely,

Dr Heather Gorringe
Chair, North Warwickshire Clinical Commissioning Group

cc: CCG Chairs: Dr Adrian Canale-Parola, Dr Dave Spraggett, Dr Inayat Ullah
Arden Cluster: Stephen Jones & Gill Entwhistle

Appendices

Appendix 1 – NHS Warwickshire assessment of Fair Shares position, March 2011
Appendix 2 - Letter from Arden Cluster, August 2011

Appendix 1 – NHS Warwickshire assessment of Fair Shares position, March 2011

Predicted financial impact of the 2011/12 fair shares toolkit on consortia budgets

1. Purpose

To inform the emerging Warwickshire GP consortia of the impact on fair-shares funding allocations arising from the implementation of the 2011/12 toolkit as compared to that derived using the 2010/11 version.

2. The 2011/12 Toolkit – Changes from last year

The 2011/12 fair-shares toolkit was circulated to Primary Care Trusts in March. Changes from the 2010/11 version are :

- Practice populations updated to April 2010 attribution data set.
- Updated acute formula
- Mental health and prescribing methodology replaced with version that mirrors PCT allocation method.
- The facility to 'turn off' national prescribing formula has been removed from the model. Prescribing allocations for both 2010/11 and 20-11/12 are therefore presented using the toolkit , as opposed to local methodology.

3. Comparison of toolkit allocations

The 2010/11 forecast out-turn expenditure for the consortia's commissioning portfolio is £634,192K (See Appendix A). For illustrative purposes, this value has been apportioned to consortia using the current and previous version of the fair shares toolkits.

Table 1

	Increase / (Decrease) between 10/11 & 11/12 toolkit				
	North	N&B	Rugby	South	Total
	£000's	£000's	£000's	£000's	£000's
2010/11 toolkit	183,156	52,873	108,434	289,729	**634,192**
2011/12 toolkit	179,230	51,517	112,259	291,185	**634,192**
Gain / (loss)	(3,926)	(1,356)	3,825	1,456	**0**

Table 1 shows whether more funding , a positive number, or less funding (a negative number) is apportioned to Consortia by the 2011/12 toolkit compared to the 2010/11 version.

For example the Rugby Consortia receives £3.8m more funding with the 2011/12 toolkit, though Table 4 illustrates that in absolute terms, Rugby still has a £3.3m shortfall against historical expenditure .

4. Analysis of changes associated with specific formula components

This table shows how individual components of the fair shares formula have been affected by the formula changes.

Table 2

	Increase / (Decrease) between 10/11 & 11/12 toolkit				
	North	N&B	Rugby	South	Total
	£000's	£000's	£000's	£000's	£000's
Acute	4,465	1,142	6,694	12,112	**24,413**
Maternity	1,703	484	1,222	2,961	**6,370**
Mental Health	(353)	(125)	423	229	**174**
Prescribing	(1,649)	(503)	(244)	(1,695)	**(4,091)**
Inequalities	(8,092)	(2,354)	(4,270)	(12,151)	**(26,867)**
Totals	**(3,926)**	**(1,356)**	**3,825**	**1,456**	**0**

There are two significant changes. A reduction in inequalities weighting and an increase in acute funding. The Toolkit guidance outlines the changes in methodology associated with each change.

5. What would 2010/11 out-turn look like under fair shares?

The following tables compare 2010/11 forecast out-turn expenditure against 'fair shares' funding allocations, firstly utilising the 2010/11 toolkit and secondly using the 2011/12 toolkit. Consortia forecast expenditure is based on work undertaken earlier this year to obtain 'snap shot' view of likely position.

Table 3

	Resource allocated using 2010/11 fair shares toolkit				
	North	N&B	Rugby	South	Total
	£000's	£000's	£000's	£000's	£000's
Forecast expenditure	160,313	48,566	115,604	309,708	634,192
Resource	183,156	52,873	108,434	289,729	634,192
Surplus / (Deficit)	**22,843**	**4,307**	**(7,170)**	**(19,979)**	**0**

	Resource allocated using 2011/12 fair shares toolkit				
	North	N&B	Rugby	South	Total
	£000's	£000's	£000's	£000's	£000's
Forecast expenditure	160,313	48,566	115,604	309,708	634,192
Resource	179,230	51,517	112,259	291,185	634,192

Surplus / (Deficit)	**18,917**	**2,951**	**(3,345)**	**(18,523)**	**0**
Change	**(3,926)**	**(1,356)**	**3,825**	**1,456**	**0**

This table shows the revised gain / loss for each consortia, for example The North Consortia gains £18.6m with the 2011/12 toolkit compared to a gain of £22.8m from the 2001/11 version.

6. Summary

Fair shares formula changes have reduced the funding gain in the North of the County by £4m, Rugby are the main beneficiary of the changes but are still left with a £3.3m shortfall against forecast expenditure.

7. Next Steps

To agree develop consortia based [historical] budgets for each service line and to establish mechanisms to report actual expenditure against these on a periodic basis during 2011/12.

To consider the question of pace of change (which guidance indicates remains to be locally determined) by which any agreed move from historical to fair shares budgets would be based upon.

Toolkit & Associated Guidance
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125562

APPENDIX 1A

NHS Warwickshire
GPCC Fairshares Calculation
Illustration of budget being Allocated

From the Month 10 Board Report

		£'000	£'000
Acute Budget			408,860
LESS	Specialised services	57,458	
			(57,458)
Acute			351,402
Non Acute			199,887
Primary Care per Board report			195,824
Less	Pharmacy	17,274	
	nGMS	35,769	
	LES/DES	36,647	
	Dental	23,787	
	Ophthalmology	4,320	
			(117,797)
Add	Out of Hours	4,876	
			4,876
			82,903
Total Budget to be allocated to GPCC's			634,192

Appendix 2 – Letter from Arden Cluster, August 2011

22 August 2011

Heather Gorringe
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Dear Heather

North Warwickshire CCC

Thank you for your email of 18th August following our meeting on the 15th. I would like to re-iterate that I am committed to addressing the fair shares imbalance. We have discussed at our recent meeting how this might be achieved in the context of a number of other factors, a key one being that of managing the Arden system as a whole. I am also committed to supporting the consortium authorisation by working together to deliver the evidence necessary to secure that authorisation.

At our meeting I suggested a number of deliverable ways forward in progressing the shift of resources to the north, which will also avoid destablisation of the local economy;

(1) NW CCC agreeing with the other Warwickshire CCCs a quantifiable/evidenced shift in resource focus of the community contract, thereby maintaining income and stability for the local provider and securing additional resources for the north.

(2) Clearly identifying the Bramcote savings within the financial envelope process as north resources to offset the north QIPP target.

(3) Applying the growth gain above average to the NHSW allocation for 2012-13 (received as the national pace of change policy impact) as additional north resources for investment in north priorities, such as the top 5 JSNA priorities as you put forward at the meeting, to supplement the current focus of public health spend in the north. However, you should be aware that despite NHSW being 1.5% (£12m) below target, the pace of change policy has not always moved NHSW towards it's target and in 2011-12 in fact it moved further away, by 0.1%.

(4) Supporting work for local service development priorities, which you identified as the diabetes pathway, the COPD pathway and heart failure nurse resources. Resources for this have not been specifically identified and this would form a further element of the process to set the financial envelopes for 2012-13 and agree shifts in resources with the other CCCs.

With regard to your earlier letter and your assertions around historical PCT positions, it is not correct to assume that the overspend in the county at the time of PCT merger was related to South Warwickshire, in fact the overspend was entirely in Rugby at that time. Many parts of the system from a financial perspective have shifted over the intervening 5+ years and the picture is complex.

I am interested in what the tools we have available to us currently are telling us about the fairness of the expenditure picture, how that might change over the next 2 years as part of the Department of Health's new allocations formula and most importantly the new pace of change policy. Since we last met we have learned that the DH will be sharing its intentions in this regard, towards the end of the year.

In the meantime we will continue to work with you to ensure we make movements towards improving the fair shares position for the north and in maintaining a stable local health economy.

Yours sincerely

Stephen Jones
Chief Executive
Arden PCT Cluster