Warwickshire Shadow Health and Wellbeing Board

Agenda

20 March 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 **Stoneleigh Room, Wedgnock House, Wedgnock Lane, Warwick** on **TUESDAY 20TH MARCH 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 of the Board 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 19TH January 2012 and Matters Arising

Draft minutes are attached for approval.

2. (12.25 – 12.55) Fair Share Budgets in Warwickshire (Report Attached)

Introduced by Glen Charman (Chief Operating Officer - North Warwickshire Consortium)

3. (12.55 – 13.15) The Emerging Health and Wellbeing Board Strategy (Draft to Follow)

Introduced by Wendy Fabbro (WCC Strategic Director – People Group)

4. (13.15 – 13.40) Arden Cluster Systems Plan

Introduced by Stephen Jones (Chief Executive – Arden Cluster)

5. (13.40 – 13.50) Performance Reporting to the Board

Introduced by Bryan Stoten (Chair)

6. (13.50 – 14.00) Section 256 Funding

Introduced by Wendy Fabbro (WCC Strategic Director – People Group)

7. (14.00 – 14.10) Plans for Primary Care Development in Warwickshire – Topic Introduction

Introduced by Dr Francis Campbell (Medical Director, Primary Care – Arden Cluster)

8. Any other Business (considered urgent by the Chair)

9. Closing Comments by Chair

Bryan Stoten
Chair

March 2012

Future meetings – Please note Changes in September and November and venues

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

Bryan Stoten – Chair

Warwickshire County Councillors: Councillor Heather Timms; 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 Officer: Wendy Fabbro Strategic Director for People

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

Warwickshire LINKS: Councillor Jerry Roodhouse

Borough/District Councillors: Councillor Bill Sheppard, Councillor Claire Watson, Councillor Michael Coker

General Enquiries: Please contact Paul Williams on 01926 418196
E-mail: paulwilliamscl@warwickshire.gov.uk

Minutes of the Meeting of the Shadow Warwickshire Health and Wellbeing Board held on 19th January 2012

Present:-

Chair

Bryan Stoten

Warwickshire County Councillors

Councillor Alan Farnell
Councillor Bob Stevens
Councillor Heather Timms

GP Consortia

Dr Charlotte Gath – Rugby CCG
Dr Kiran Singh – North Warwickshire CCG
Dr Heather Gorringe - North Warwickshire CCG
Dr David Spraggett – South 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
Gill Entwistle – Arden Cluster
Kevin McGee – Chief Executive, George Eliot Hospital NHS Trust
Gareth Owens, Executive Director - Nuneaton and Bedworth Borough Council
Monica Fogarty, Strategic Director – Communities Group
Paul Williams – Democratic Services Team Leader – WCC

1. General

(1) Apologies for absence

Councillor Izzi Seccombe
Dr Paul Batra
Dr Richard Lambert
Sue Roberts

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

None

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

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

2. Update on the Transformation Programme from the Perspective of the Arden Cluster

Stephen Jones commenced by offering Sue Roberts', the Transformation Programme Director's, apologies. The meeting was informed of several major challenges facing the health economy in the sub-region, namely,

- Health inequalities
- The sustainability of services and
- Limited resources. (The cluster is seeking to work with practitioners to identify efficiency savings)

Within the above, two key priorities have been identified. The first is the care of the frail and the elderly and the second is the need to develop sustainable specialities. With regards to the latter, Stephen Jones pointed out that the region had pioneered hyper acute stroke services and developed new approaches to major trauma work. He added that one key to success is having a strong workforce in the right place. In order to achieve this, however, it is necessary to have good communication with clinicians and the public. The cluster will consult on its transformation plans in May 2012. However, whilst it will welcome people's views the cluster recognises that it will be very difficult to achieve consensus.

A greater role is seen for community services and improvements in the quality of provision of primary care will be sought.

The relationship between the timetable for the development of the Transformation Agenda and the Health and Wellbeing Board Strategy was

discussed. The Chair informed the meeting that the Board Strategy was developing well and that a “concrete” draft was expected in the next four to six weeks. It was acknowledged that the general aims of the Transformation Programme and Board Strategy are in accord partly as they have used the same material. The Chair requested that Sue Roberts and Mike Caley liaise on their respective pieces of work.

Councillor Stevens felt that the timetable for the agenda is ambitious whilst Councillor Jerry Roodhouse suggested that its ambitious nature could lead to a mismatch between needs and service provision. In response, Stephen Jones stated that the rapidly changing health landscape and the escalating needs of the population serve to make the task of transformation very challenging.

John Linnane pointed out to the Board that there are other health transformation projects underway eg public health.

3 (i) George Eliot Hospital NHS Trust – Securing a Sustainable Future

The Chair welcomed Kevin McGee, the Chief Executive of the George Eliot Hospital NHS Trust to the meeting. In his presentation Kevin McGee made the following points,

- The governance structure for the sustainable futures project at the George Eliot is considered very robust
- By 2014 all NHS trusts will need to have achieved foundation status. The George Eliot is aiming for April 2013
- The search is underway for an appropriate partner. It could be NHS-based or a commercial organisation
- There is a need give people a say on what services should look like
- At present there is no preferred option for a partner.
- By May 2012 the strategic outline case will need to have been completed. If one clear NHS partner emerges from the exercise then the George Eliot will merge with them. If any other partners emerge then a more traditional tendering process will have to be adopted.
- Even if the partner chosen is not NHS the work of the hospital will continue firmly under the NHS banner.
- The Trust aspires to deliver local services but at the same time needs to ensure they can be sustained.
- Expressions of interest have been sought from potential partners. The Trust hopes to make public in early February who these are. There is no requirement to consult on which partner to choose but the Trust will work to ensure as much buy-in to the eventual partnership as possible. The Stakeholder Board will be involved in consideration of the options.
- In terms of the relationship between the plans of the George Eliot Hospital and the wider health transformation agenda, it will be necessary to take account of health inequalities and the delivery of community services. All partners will need to debate how services will

be delivered across the Arden Cluster. The George Eliot will be party to those discussions.

Kevin McGee stated that since coming to Warwickshire he had been shocked by the extent of health inequalities and stated that he would endeavour to work to see these reduced by supporting services in North Warwickshire.

Councillor Roodhouse expressed some concern at the way in which service reviews such as that of maternity and paediatric kept faltering. He stated that it would be important for the hospital to engage with partners and stakeholders and called for a sub-region wide debate on the future of the health economy.

In addition, Councillor Roodhouse expressed his concern that although University Hospital Coventry and Warwickshire is only a few miles away the George Eliot may choose to enter into a partnership with a trust much further away.

Councillor Timms requested that the Trust engage with the community forums. This suggestion was supported by the Board.

The Chair stressed that as well as considering hospital care the Trust should be very mindful of its interaction with social care. A partnership with a distant hospital such as Heartlands in Birmingham would make this difficult.

3 ii) Mortality Review

The Chair introduced this item questioning the statement in the Tripartite Formal Agreement (TFA) summary document (Page 8) that the HSMR has reduced from 143 to just over 100. In response, Kevin McGee stated that,

- The TFA is an older document and that mortality rates have increased again,
- Mortality rates are often used inappropriately,
- Doctor Foster showed a figure of 106 for October 2011, this improvement being as the result of actions taken by the George Eliot in September and October,
- Expected and observed mortality rates should be as close to each other as possible. The key is to see a positive trend emerging,
- The Trust has been very open about its performance. It has opened itself up to total scrutiny and will continue to do so in pursuit of patient safety.

An external review has taken place looking at,

i) Underlying clinical practices
ii) Coding
iii) The context in which the George Eliot works

i) For underlying clinical practices Kevin McGee informed the meeting that the HMSR figures only provide a partial picture. They don't make clear whether an organisation is safe or unsafe. Other indicators help to clarify the situation. For example the Care Quality Commission has stated that the hospital is "good". There is a need to look at clinical flows and there is now a drive to move the hospital onto a seven day footing (moving away form the approach when little happened at weekends and key staff were absent). In addition to looking at clinical practices there is a move to look at patient flows through the organisation. Overall the culture of the hospital is focused on a traditional clinical model.

ii) To date, coding of patients has been poor. All new patients are well recorded but older records have skewed the picture.

iii) The George Eliot receives a disproportionate number of patients from nursing homes. This is partly because of the way nursing homes are run in the area and partly due to the absence of hospice beds. In addition the patient cohort allied to the health inequalities that prevail mean that the hospital sees a large number of poorly patients. Kevin McGee added that a final contributing factor is that young patients (ie the ones likely to recover) are often sent to UHCW.

Stephen Jones, drawing on the paper from Martin Lee circulated at the meeting highlighted mortality rates at both the George Eliot and in South Warwickshire. He considered that the only way to get an accurate picture of mortality rates is through trend data. He welcomed the openness shown by the trust adding that each trust has a monthly mortality meeting and it would be important for the Health and Wellbeing Board to revisit the figures.

Councillor Farnell sought clarification regarding when a deceased patient becomes the responsibility of the hospital. He was informed that if a person dies at the hospital then they feature in its mortality figures. In addition, if a person dies at home but has been an in-patient at the hospital within the previous 30 days, they too feature in the SHMI mortality figures. A person regarded as deceased at home but certified as such at the hospital will not feature in the hospital's mortality figures.

Dr Heather Gorringe echoed Stephen Jones in welcoming the openness of the George Eliot and expressed the view that services delivered should meet the needs of the population. She stated that she hoped that greater clinician to clinician dialogue will help bring about the cultural change that is required.

Councillor Roodhouse observed that in the opinion of the Warwickshire LINk, palliative care at the George Eliot is not good. He added that nursing homes are too quick to get dying residents into hospital rather than giving them a comfortable and dignified death at their place of residence.

Dr Kiran Singh observed that a lack of inpatient hospice beds is a problem. Non-cancer palliative care patients require more support.

Stephen Jones stated the poor health of a population does not excuse high mortality and poor performance.

The Chair thanked Kevin McGee for his open and frank contribution adding that the desire of the Board is not to criticise the hospital but to seek ways in which to improve performance. He added that there are concerns, hence the visits from the Care Quality Commission, and closed by expressing the hope that further improvements in performance will be seen over the coming months.

4. Proposal to Revise the Membership of the Warwickshire Shadow Health and Wellbeing Board

Monica Fogarty introduced this item explaining that over the last four months the make-up of the Board had been questioned. Monica added that it is important top keep the Board a manageable size whilst at the same time ensuring the people that constitute it are the correct ones. The ensuing discussion focused largely on the representation from the district and borough councils. It was acknowledged that three of the five (matching the CCG boundaries) was acceptable but the Chair expressed the hope that the three representatives would together cover functions such as housing, leisure and environment.

Gareth Owens advised the Board that there remained a question over the constitutional position of officers on the Board. He felt that with County Council officers on the Board there may be a time when district and borough officers would be required to ensure parity. The point was taken but the hope was expressed that the Board will not to have vote on any of its decisions.

The Chair noted that a number of organisations were seeking to join the Board. This was welcomed but it was agreed that for the time being they should be invited to meetings on an occasional basis.

It was agreed that the Board should meet in public.

5. Fair Share Budgets in Warwickshire

Heather Gorringe introduced this item, asking the Board to support the North Warwickshire CCG in trying to redress the balance of funding in Warwickshire and to look at current Public Health spending patterns to ensure that currently, and in future, the resource from Public Health is directed to the areas with greatest health needs.

Gill Entwistle used a powerpoint presentation (that it was agreed should be circulated) to explain how the Arden Cluster manages budgets.

Dr Gorringe commented that the 2011/12 budget had been set on the basis of historical data that did not reflect the situation accurately.

It was acknowledged that the money follows the patient and given that there are fewer health services in the north of the county it was inevitable that some money would migrate to other parts of the county.

One challenge for the Cluster and its predecessor has been how to manage a major deficit that was inherited from Rugby. The imperative to remove this deficit allied to overall reductions in funding means that there is no spare money to direct to parts of the county where there may be a shortfall. Discussions are being held with CCGs to see if ways can be found to move money around. This will be something for the Federation to discuss.

It was agreed that the next meeting of the Board should be given an indication of spending on public health across the County.

The discussion on Fair Shares was curtailed owing to time constraints. To do the subject Justice the Chair proposed that it be brought back to a future meeting.

6. JSNA Update

John Linnane gave a brief update on progress with the JSNA explaining that it wil be launched on 7th March.

7. Any Other Business

The Chair expressed the view that in order to manage its business, the Board may need to meet more frequently, possibly every month. Concern was expressed that such frequency would place too great a burden on people's time. It was agreed that for the immediate future the current schedule of meetings every two months should remain

The Board was informed of a lunchtime meeting between the County Council Cabinet and Professor Steve Field to be held on 24th February and of a special Board meeting scheduled for 16th March to which Chris Ham, the Chief Executive of the King's Fund has been invited.

The meeting rose at 14.40.

Dates of future Meetings

16th March 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.

……..Chair

Agenda Item No 2

Warwickshire Shadow Health and Wellbeing Board

20 March 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. The matter was considered at the January 2012 meeting of the Shadow Health and Wellbeing Board but time constraints limited the opportunity for debate. For this reason the topic has been rescheduled for the 20th March. Again, 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
Chairman
North Warwickshire CCC
Red Roofs Surgery
31 Coton Road
Nuneaton
CV11 5TW

NHS Coventry
Christchurch House
Greyfriars Lane
Coventry
CV1 2GQ

Tel: (024) 7655 3344
Fax: (024) 7622 6280
contactus@coventrypct.nhs.uk
www.coventrypct.nhs.uk

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