NHS England

Minutes of the Board meeting held in public on 17 December 2013

Present

- Professor Sir Malcolm Grant (chair)
- Sir David Nicholson – Chief Executive
- Ms Margaret Casely-Hayford – Non-Executive Director
- Mr Ciaran Devane – Non-Executive Director
- Dame Moira Gibb – 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
- Dame Barbara Hakin – Interim Chief Operating Officer/Deputy Chief Executive
- Mr Tim Kelsey – National Director: Patients and Information
- Mr Bill McCarthy – National Director: Policy
- Ms Rosamund Roughton – Interim National Director: Commissioning Development
- Ms Jo-Anne Wass – National Director: HR and Organisational Development

Apologies

- Lord Victor Adebowale – Non-Executive Director

In attendance

- Mr Jon Schick – Head of Governance and Board Secretary

The Chair welcomed everyone, especially members of the public, to this significant meeting covering a number of substantial items of central importance to the future work of NHS England and its partners. He began the formal business by reporting that Naguib Kheraj had resigned from the Board following his successful appointment as non-executive director to the board of Standard Chartered Bank. He acknowledged the demands made on all of the non-executive directors and expressed his thanks both to Naguib and the non-executives for their contributions. He concluded his introduction by congratulating Mr Kelsey and his team for winning a computer industry award for innovation with big data.

Item	
1	**Declarations of interest in matters on the agenda**
	No member declared an interest in the items to be discussed.
2	**Minutes of the previous meeting**
	The minutes of the meeting held on 17 November 2013 were accepted as an accurate record. There were no matters arising from the minutes. The Chair confirmed that Board members received an action list detailing the status of actions arising from previous meetings.

3	**Chief Executive report**
	Sir David Nicholson echoed the Chair's comments, acknowledging this was a landmark meeting presenting a culmination of work relating to strategy, planning, tackling inequalities and seven day services. He presented his report highlighting significant events, which had taken, place since the last Board meeting. In particular he drew the Board's attention to the following: NHS England Mandate refresh The Board noted that the government had now published its mandate for NHS England for 2014/15. The refreshed mandate set out the Government's strategic objectives for the NHS. Its consistency of purpose and retention of a focus on outcomes were welcomed. Pharmaceutical pricing Regulation Scheme (PPRS) It was noted that the new scheme had been agreed and would start on 1 January 2014. This would provide stability and predictability to both government and industry to enable certainty of planning. Sir David confirmed that any rebate payments would be used to improve services to patients. Review of urgent and emergency care Sir David drew attention to this report which had been objective and clinically-driven, focused on issues of central importance. The Board noted the report proposed a fundamental shift in the provision of urgent care, making recommendations in five key areas. Children's takeover day The Board were updated on the Children's takeover day in November 2013, which had provided children and young people with an opportunity and voice to set out their agenda for improving services. **The Board received and thanked the Chief Executive for his report.**
	Patient insight
4	**Patient and Public Voice** Tim Kelsey presented the update to the Board drawing attention to the following areas: Information standard for accessible information A programme of work to develop and implement an information standard for accessible information had commenced. The Board were updated on engagement activity underway to inform the development of this standard. Commitment to transparency It was noted that new General Practice level data had been published via NHS Choices, enabling the public to participate more fully and equally in

	their health and care services. The Board were advised that NHS Choices was now already receiving over 30 million visits per month. Friends and family Test (FFT) update Six months' data had been published in October 2013 and more than a million patients had provided feedback through the FFT. The Board acknowledged the commitment of Trusts to involve patients and to act on the feedback, illustrated by an example in the report. In addition, Mr Kelsey: • Reported that the Treasury had given approval for funds to be used to support the digital revolution; the first tranche had supported programmes for digital services in 100 trusts; • Demonstrated the Patient Insight Dashboard, a live tool available to all and providing real-time information from a number of sources including social media, to provide a sense of the level of satisfaction amongst patients. The Board noted that no other public service was collating user feedback in this way and members were encouraged to review the website. Mr Kelsey confirmed that trends would be reported in future Board papers; • Demonstrated an app enabling the dissection of information , which could assist in the planning of services. In response to questions from members, Mr Kelsey confirmed: • Work was underway with patient experience colleagues based in regions to disseminate the examples of learning and best practice; • A report on health literacy would be brought to the next Board; • Fifty thousand people had signed up to the programme to show them how to use on-line tools as a mechanism for commenting on health services. In addition a mobile phone app was in development; and • Acting on patient experience was integral to the planning guidance. **The Board received and noted the update.**
Actions	**Tim Kelsey to provide information regarding the Health Literacy Programme to the January 2014 Board meeting.**
	Clinical quality
5	**Compassion in practice – one year on** Jane Cummings presented an update on progress in delivering 'Compassion in Practice'. The Board's attention was drawn to the following areas: Publication of staffing guidance Ms Cummings reported that guidance published on 19 November 2013 had set out 10 expectations to assist providers and commissioners to ensure they have the right staff, environment and culture to deliver compassionate care. The Board noted providers would be required to submit monthly workforce data, to be published from July 2014. Providers would be required to review evidence-based staffing levels at least once every six months.

	Launch of programme in North of England The Board were advised that a programme to publish detailed information had been launched in the North of England. This would include information about Never Events and serious incidents, linked to staffing levels. It was noted that 20 trusts had published information in the previous month. The programme would be rolled out with the Care Quality Commission. The Board also noted that detailed Never Event data would be published by NHS England on a quarterly basis. Chief Nursing Officer conference This conference had been attended by over 450 of England's most senior nurses and midwives from provider and commissioning organisations. The Board noted the impressive range of speakers who had supported the conference, including staff who had raised concerns on issues at Mid Staffordshire. Social media had been used in support; during the conference there had been 10,200 tweets with 25 million impressions. In addition the plenary sessions had been live-streamed. Priorities for 2014/15 Ms Cummings took the Board through the 2014/15 priorities for delivery of Compassion in Practice. The Board supported the intention to embed the 6C's across all staff in health and social care, not just nursing and midwifery, and recognised the significant cultural shift this represented. Ms Cummings described work underway to provide quantitative data to support the significant amount of qualitative data already available. This would include introducing a staff Friends and Family Test. Sir David Nicholson noted the historical data also available through staff surveys to show whether staff felt able to raise issues and whether they believed action would be taken in response to those concerns. Ms Cummings introduced a video of staff talking about their experiences of working with patients. Members acknowledged the powerful evidence this provided of staff feeling empowered within their profession. **The Board noted the progress made with Compassion in Practice and agreed the priorities for 2014/15**
	Planning and Strategy
6	**Draft Planning Guidance** Sir David Nicholson introduced the draft guidance, drawing the Board's attention to a diagram which encapsulated its aims. The Board recognised that the proposals represented a significant change in how the NHS will develop and interact with citizens; taken together with the allocations paper this set the direction for the NHS for the next five years. Members noted the guidance set out ambitions for delivering improved outcomes, underpinned by aspirations to improve health, reduce inequalities and deliver parity of esteem in mental and physical health services. Sir David reported that engagement work around the strategy, Call to Action,

showed there was wide spread-support for the stated outcomes from the community, patients and staff working in the NHS. This guidance now set out service models more likely to deliver these outcomes for patients, with detailed plans required in response both from CCGs and from NHS England itself, given its direct commissioning responsibilities.

Sir David outlined the model for integrating care around the patient so they are truly at the heart of what we do. Critically, primary care would need to be more widely available, and at scale with individual practices working together, to manage patients in the community and avoid unnecessary hospital admissions.

The Board noted plans to implement the Better Care Fund in 2015/16 through Health and Well Being Boards. This would make monies available for out of hospital care, including the introduction of the accountable doctor and urgent and emergency care work. Sir David outlined proposals for step changes in productivity in elective care and specialised services.

The Board noted the report also outlined how NHS England would help the NHS deal with the challenge outlined in the guidance. Organisations would be asked to think about what service would look like five years out, and a support package for CCGs would be available.

In response to comments from the Chair, it was explained that the planning guidance had been developed over a period of time, and its ambitions had been supported by the Commissioning Assembly. Business plans would be developed through an iterative process, initial plans being available for review in February 2014.

In discussion, Members:

- Supported the content of the guidance;
- Recognised that the support package to CCGs would be critical to meet the challenges of the planning process;
- Received assurance that the guidance had been developed in collaboration with the Local Government Association, where there had been some excellent joint work since the publication of the *Call to Action*, and with provider representatives (through the NHS Trust Development Authority and Monitor) in order to ensure a more integrated approach;
- Noted that work on delivery would need to happen at many levels, including Health and Well Being Boards for the Better Care Fund but larger geographical footprints for other issues such as urgent and emergency care proposals;
- Noted that a key part of the support package would be workshops planned to get “units of planning”, which were key, up and running effectively from the outset. Alongside that was the need to follow the change model setting out ways of working, which was embedded in the guidance;
- Received assurance that the guidance properly addressed the needs of children and the support they – and especially those with longer term conditions - should be given to be active citizens;
- Received assurance that the six transformational models outlined in the guidance did not require a trade-off between quality and cost.

	They had been developed from international best practice identifying the big strategic changes which would both satisfy the determination to improve outcomes and could realistically be achieved within financial constraints. These strategic changes would allow improvements in quality and service change whilst giving headroom and context for supporting cultural changes also required. The Chair reinforced the importance of providing CCGs with headroom which, alongside aligning resources and clinical leadership, would be critical to the success of the planning round. He drew the Board's attention to the detailed planning and support arrangements described in part two of the document and sought assurance that these, aligned with clinical leadership and clinical judgement, would deliver the ambitions set out in part one. Mr Baumann confirmed that the document set out the structure of the processes required whilst giving freedom on how these would be delivered as appropriate for each CCG. Critical to this would be NHS England's role in taking the content of part one and providing thought-leadership through transcribing this into a set of the key questions to be addressed. Mr McCarthy acknowledged that there would almost certainly be further iterations of the support package, particularly around financing and incentives, to help get to the five year vision. The Board reflected upon the role to be played by the Better Care Fund, which would need to be used to support the transfer of significant amounts of activity from the acute sector. Actions to enable this would need to begin in 2014/2015 in order to provide a credible platform for robust delivery from 2015 onwards. NHS England would need to keep closely informed of progress during 2014/2015, and plan a stocktake part way through the year in order to give an up-to-date judgement about deliverability. In conclusion, the Chair noted that the Board all shared an enthusiasm for the radical nature of the proposals contained within the planning guidance. The programme would be challenging and the Board would require regular updates to track progress over the course of the year, ensuring that required outcomes were being delivered during a time of financial constraint. **The Board approved the planning guidance**
Action	**Regular updates to track progress over the coming year to be reported to the Board.**
7	**Allocations** The Chair introduced the discussion by underlying the scale and importance of the decisions to be made; the allocation of £200bn of taxpayers' money over two years would require consideration in great detail. The plan to allocate funds over a two-year period would bring stability to the system and foreseeability for investment decisions. Building upon much engagement by the Board, including earlier discussions on the first draft of the proposals, held in a development session in November, this was the first time that such decisions had been made in public in the history of the NHS, underpinning the organisation's commitment to transparency and openness.

	Board members were reminded of the importance of making fair and evidence-based decisions, and of the parameters on allocations set by law. The Chair drew attention to the requirements of the Health and Social Care Act 2012 regarding health inequalities both in terms of access and outcomes. In addition, the NHS Mandate prescribed the outcomes sought in relation to investment on behalf of the Government and the responsibility for distributing the NHS commissioning budget. There had been a degree of speculation regarding the decisions to be taken by the Board. The Board had received a petition from citizens in Enfield, which had been drawn to the attention of Board members. Secondly, the Chair reported that he had received a letter from Andy Burnham MP, Shadow Health Secretary. The letter had been tabled for members in recognition of the question that it raised, rather than as a political standpoint. Paul Baumann explained that the final version of the report had been issued very shortly before the meeting as a result of the GDP deflator being published in the previous week; this had resulted in a need to thoroughly review the figures throughout the paper. The proposals marked the culmination of a year's work and extensive engagement, and had been informed by a wide spectrum of opinion and evidence. It was noted that decisions made today would inform the planning work discussed earlier in the meeting, by providing clarity about the future direction for allocations which would form a backdrop to CCG (and direct commissioning) activities. Mr Baumann outlined the three separate decisions to be made by the Board: • How funds should be divided between the different types of commissioning organisations; • What approach should be used for target allocations within each commissioning stream; and • What should be the pace of change from current to target allocations? <u>How funds should be divided between the different commissioning organisations</u> Mr Baumann drew the Board's attention to tables 1 and 2 in the paper which set out the finances coming into the commissioning system with particular attention to the percentage growth; 5.4% growth would be allocated to the system over the next two years which would be significantly in excess of real terms growth denoted by the GDP deflator. This equated to approximately £1.6bn to be invested in achieving the objectives set out in the Mandate and other challenges, including creation of the Better Care Fund in 2015/16. Table 2 set out broad proposals for how this money should be spread across the system. Mr Baumann drew the Boards attention to the key points in the table: <u>CCG programme costs</u> – money spent on patient care, this represented the largest allocation at £62.75bn; the Board noted proposals for 2.5% growth in 2014/15, and 2.1% growth in 2015/16. It was noted that the efficiency requirements would be greater in 2015/16, underlining the importance of making rapid progress with plans for the Better Care Fund and reduction of acute activity, as discussed earlier in the meeting. Over the two year period

	there would be a requirement to generate 9.2% efficiency in order to create the headroom to implement the strategy. The other additional resource available to CCGs was the Quality Premium which rewards successful CCGs in both 2014/15 and 2015/16 enabling further investment in local key priorities. Specialised Commissioning – the rate of growth of cost in specialised commissioning was significantly faster than in routine commissioning; the Board noted that this had been underestimated in 2013/14 resulting in an overspend. The teams would be required to control activity within budget in 2014/15 and to address the underlying deficit. This equated to a 6.2% efficiency to deliver in 2014/15, and 9.3% over the two-year period – similar to the level of efficiency required from CCGs. The Board recognised the pressure on specialised commissioning in 2014/15 and on CCGs in 2015/16; Mr Baumann reported that in mitigation the draw down on brought forward resources would be prioritised on specialised commissioning in 2014/15 and anticipated that CCGs with substantial surpluses coming forward would want to deploy these behind the Better Care initiatives. Primary Care – an increase of 2.1% in 2014/15 and 1.7% in 2015/16 was proposed. It was noted that these figures reflected the GDP deflator and represented a reasonable level of efficiency that could be delivered. Mr Baumann highlighted that as more was invested in primary and community care, the funding would need to come from integrated work between CCGs and primary care. Mr Baumann drew the Board's attention to the significant efficiency requirements for NHS England central programme costs, and the general requirement to reduce running costs. It was noted that there would need to be further discussion to agree a safe way to make these reductions whilst still delivering the legal duties and the ambitious agenda of the five year strategy. Mr Baumann took the Board through the proposals for reduction in administrative resources over the two-year period. It was noted that for CCGs, these resources for 2014/15 would be unchanged with a 10% reduction assumed in 2015/16. The Board would need to decide whether they agreed a move to absolute budgets for each CCG (promoting some stability) rather than the current methodology of resource per head (more clearly enabling money to follow the patient). What approach/formula should be used for target allocations within each commissioning stream The Board noted that in deciding how resources should be allocated, consideration needed to be given to how to discharge its responsibilities regarding inequalities. Mr Baumann reminded the Board that in the current baseline formula there was already a thorough differentiation related to deprivation and wide range of allocations per head as a result. There remained, however, an issue about unmet need, including in deprived communities, an area where evidence from research was ambiguous. The recommendations to the Board, nevertheless, included a proposed adjustment in relation to unmet need, as that was so fundamental to the

	organisation's purpose. The proposal was for an adjustment to redistribute 10% of CCG funding on the basis of relative deprivation, but with a stronger - 15% - adjustment in relation to primary care, in recognition of its central importance in driving changes to address unmet need. Following much work with the Advisory Council of Resource Allocation (ACRA), it was proposed that unmet need would best be reflected by using Standardised Mortality Rates (SMR) for under 75s as the underlying metric to inform the adjustment, this marking an improvement on the way that unmet need had been addressed under the old allocation system. Mr Baumann drew the Board's attention to tables 3 and 4 in the paper setting out the resulting redistribution of resource as a result of these proposals and described how deprivation had been properly accounted for alongside other issues such as population and needs of an elderly population in a multi factorial allocation. Mr Baumann took the Board through proposals for target allocations. With regard to primary care it was noted that, in general, Midlands and the East were underfunded, London was systematically over target and that there was a variable position in both North and South with some areas being under target and others being over target. The variances between current and proposed target allocations were, however, not significant. It was noted that target allocations for CCGs were mapped to IMD deciles as the best marker for deprivation. The Board's attention was drawn to table 6 in the paper which set out the impact of implementing this new formula. <u>Pace of change</u> The Board acknowledged that there was a need to strike a balance between redressing areas of underfunding whilst retaining a level of stability in the system. Mr Baumann took the Board through seven options that had been developed by the review team in relation to pace of change, highlighting the tables within the report which set out the impact of the options. Mr Baumann noted that the review team commended options three and four both of which had an element of population and pace of change built into them but also an element of protection to enable all CCGs to receive real terms growth. Of the two options, the preference recommended to the Board was option four. The Chair thanked Mr Baumann for his presentation of an immensely complex process. The Board needed to satisfy itself that for each step of the process there is evidence on which the proposals have been based and appropriate actions were being taken to overcome the problems of misallocation in the present formula. In follow up discussion: • Mr Baumann confirmed that money would be redistributed, rather than uplifted, in favour of deprived areas; • Dame Barbara Hakin described two drivers to address unmet need; firstly through the Better Care Fund moving money into primary and community care services, and; secondly in the planning guidance, the requirement that in 2014/15 CCGs must identify c£5 per head of

	population for practices through their accountable GPs to use to bolster either primary or community care; • Dame Barbara drew the Board's attention to the intention for Area Teams to publish primary care locality budgets and to account to local stakeholders for how patterns of deprivation reflected in their allocation have been reflected in their investment choices. **The Board noted the report and:** • **In relation to overall allocation, agreed the proposed allocation of funds between commissioning areas of spend.** • **In relation to handling inequalities and unmet need:** ○ **Agreed that NHS England should make a further adjustment for inequalities/unmet need when considering how to allocate funds;** ○ **Agreed that this adjustment should be applied to the primary care and CCG formulae;** ○ **Agreed that the quantum of the adjustment should be 15% for primary care and 10% for CCGs;** ○ **Agreed that the metric used to make the adjustment should be SMR<75, weighted in a similar way to the local authority public health grant formula.** • **In relation to allocations to CCGs and Area Teams:** ○ **Agreed that NHS England should introduce the proposed funding formula for primary care;** ○ **Agreed that NHS England should introduce the proposed funding formula for CCGs.** • **In relation to pace of change:** ○ **Following a lengthy debate related to the need to balance the requirement to correct previous misallocations versus the maintenance of some stability in the system, the Board agreed that option four should be adopted as the preferred pace of change option for CCGs, in particular given the significant challenges that would be asked of them over the coming planning period;** ○ **Agreed the recommendations regarding pace of change for primary care;** ○ **The Chair asked that further work be undertaken to look beyond the next two years to support a new NHS system working in a very different way.** • **Agreed that running costs would be allocated to CCGs per capita, but with an important requirement also to ensure that this would not over time have the consequence of resulting in the demise of smaller CCGs; and** • **Agreed that the resulting allocations to CCGs and Area Teams for 2014/15 and 2015/16 should be published, together with the related target allocations.**

	Board Committee feedback
8	**Audit Committee** Ed Smith presented the report drawing attention to the following key areas: <u>Legacy balances</u> The Board noted issues regarding completion of year-end balances. <u>Annual governance statement</u> Preparation of this statement had begun; the Board acknowledged that in the first full year of operation some systems were not yet fully matured. <u>NHS Protect</u> It had been agreed that the scale of the issues related to fraud merited reprioritisation of investment to reduce the main areas of exposure. <u>HSCIC</u> As previously reported, the Audit Committee would return to governance issues around the service over the next few weeks. **Efficiency Controls Committee report** The Board received and noted the report of the six meetings of the Efficiency Controls Committee held in this period. **Finance and Investment Committee** Dame Moira Gibb presented the update on committee activities for the period 2 October 2013 to 2 November 2013. The Board noted that the National Tariff for 2014/15 would be published later in the day. **Commissioning Support Committee** Ms Margaret Casely-Hayford updated the Board on Committee activities. It was noted that a report regarding proposals for CSU autonomy would be brought to the Board meeting in January 2014. **Directly Commissioned Services Committee** The Chair presented the report, noting continued challenges particularly in specialised commissioning, where attention was being focused on mitigating risk, particularly of overspends. The meeting had considered the variables leading to an increase in expenditure, with a view to identifying those which could more easily be controlled. The issue would be brought back to a future meeting of the Board for more substantive discussion, but in discussion the importance was also noted of the ability NHS England now had to push for consistent and high quality services across the country – an area where significant progress had already been made.
Actions	**CSU autonomy report to be brought to the January meeting.** **Specialised commissioning to be brought back for more substantive discussion at a future Board meeting.**

	Performance and assurance
9	**Performance report** Bill McCarthy introduced the comprehensive performance report updating the Board on delivery against the 11-point scorecard. The overall position was positive with improvements shown in 22 of 34 indicators, and actions being taken to address identified areas of concern. Paul Baumann asked the Board to note the updated financial position which built on the detailed report made to the previous meeting. In particular, there had been a small improvement (£25m) in the underlying financial performance of specialised services commissioning. Mr Baumann confirmed that the £150m winter monies had been taken into account in the risk assessed numbers in the report. This left the organisation slightly below target performance; Mr Baumann reminded members that this would be underwritten by the Department of Health if needed. Jo-Anne Wass highlighted the workforce measures in the report, describing plans to further develop these and introduce a single dashboard in future. The Board noted the staff turnover analysis, recognising this was higher amongst primary care support staff than in other areas. Ms Wass also drew the Board's attention to the absence reporting analysis, where the numbers were low but work was underway to ensure reporting was complete. The Board were pleased to be advised that there had been a 13% increase in staff responding to the staff barometer in October 2013, although as this represented around half of all staff it was acknowledged that further progress was required. A further barometer survey would be undertaken in March 2014. The Board noted that overall, 63% of responses were positive, whilst 16% were negative and 21% neither agreed nor disagreed. Members noted the themes arising from the barometer in relation to organisational "hygiene" factors and to introduction of new starters; Ms Wass confirmed these issues would be picked up in the Excellent Organisation programme, in particular its work streams related to agile working and barriers to doing a good job. Mr McCarthy noted that the IT open service was continuing to be rolled out; this would enable, in combination with adequate desk space, agile working to become real. Margaret Casely-Hayford drew attention to the question of whether staff would recommend NHS England as a place to work and reflected on the role of the line manager, proposing that it would be worth considering metrics about the relationship with line managers and how well-equipped they felt to communicate key messages to their staff. Dame Barbara Hakin drew the Board's attention to national performance against standards and performance drivers. It was noted that as we moved into winter, it would become more difficult to maintain the very high quality standards we have set. Dame Barbara highlighted that there had been ½m people attending A&E over the previous week with the highest numbers of emergency admissions in England since figures had been collected. In the context of the previous discussion on allocations, it was noted that a number

	of those areas currently struggling to meet performance targets were in the Midlands and the East – where the allocations formula suggested they were currently under-target so this may have been a contributory factor where the Board's decision on future funding could have a direct beneficial impact. The priority was to ensure that high quality, timely and safe services were provided over winter. It was noted that an additional £400m had been put into the system to support services over winter; specific allocations had been made to CCGs who commission high dependency beds and to those who lead on ambulance commissioning. An additional £15m had been provided for NHS 111 services, where there had been a smooth transition of services to new providers. However, in recognition that the service was anticipated to face particular pressures through the bank holiday and new year period, contingency plans had been established to bring on additional contingency if required for January and February 2014. Dame Barbara confirmed a winter health check was published every Friday. It was noted that the Urgent Care Working Groups' implementation plans for winter were being closely monitored and assessed to ensure delivery remained on track, and that NHS England was working closely with the NHS Trust Development Authority, Monitor and Local Government Authority. Members acknowledged the hard work of frontline staff to ensure that patients continued to receive a great service during the winter period, not just for urgent care but also in the elective service which was being maintained over this busy period. In follow up discussion, it was agreed that in future years, consideration would be given to long term planning and providing winter funding upfront rather than part way through each year. The importance of the Urgent Care Working Groups was also acknowledged, linking to the agenda set out in Sir Bruce Keogh's Urgent and Emergency Care Review and the requirement to work holistically to provide as much care for patients as close to home as possible. Communications with patients and the public was paramount and in response to questions from Members, Sir Bruce Keogh and Dame Barbara outlined the national activities and campaign to disseminate positive clinical advice and support patients to access appropriate care in the right place during winter. **The Board concluded by thanking the National Directors for producing this report in a much-improved and more helpful format. They received and noted the report.**
10	**Board assurance framework** Bill McCarthy presented the Board Assurance Framework which set out the strategic risks to the organisation's objectives, together with details of mitigating actions and internal and external assurances. The Board noted that the framework was reviewed by National Directors on a monthly basis through the Executive Risk Management Group. Mr McCarthy confirmed that work was on-going to simplify the document to give it greater impact, ensuring focus on the key risks to delivering better outcomes; these were areas requiring close management and upon which

	the Board would require robust assurance. The Board's attention was drawn to two areas where the level of risk had been increased, these being subject to close management focus: • Direct Commissioning, particularly around specialised commissioning – reflecting the issues highlighted in today's earlier discussions reported from the Directly Commissioned Services Committee; • Commissioning support services, with potential risks posed by the level of future commitment from CCGs to continue using CSU services, especially in the context of uncertainty about future running costs. **The Board were content with the management actions described and noted the report.**
11	**Equality, inequalities, diversity and inclusion** Bill McCarthy outlined the report setting out the obligations and approach to promoting equality and tackling health inequalities together with the NHS England Equality, Diversity and Inclusion Strategy. He drew the Board's attention both to the scale of the challenge and to three particular ways in which NHS England had the capacity to promote equality and tackling health inequalities: <u>As a system leader</u> in collaboration with other parts of the health and care system ensuring there was the appropriate degree of focus to enable change; <u>Through effective discharge of our commissioning functions</u> including the way we directly commission services and through support and assurance of CCG commissioning; and <u>As an employer</u> with the aim to be an exemplar. Mr McCarthy described the proposed approach to use evidence to prioritise actions in each area together with a significant effort to engage and involve members of the public and patients to describe what would make a difference to them. Mr McCarthy took Members through the nine resulting priorities described in the report that had emerged from this work and commended them, alongside the equality objectives identified in the Annex, to the Board for their agreement. Jo-Anne Wass took members through the Equality, Diversity and Inclusion in the Workforce Strategy. The Board agreed the principles described were fundamental to the organisation's vision. Ms Wass reconfirmed the high levels of ambition for the organisation to make step changes in this area, and the passion with which the Strategy would be pursued. The Board were advised of the intention to do things differently in order to avoid the danger of making only small and incremental changes, and to undertake root cause analysis to understand which actions would be likely to deliver more radical change. The organisation would be

	pushed, and set stretching strategic targets. Members were also advised of work underway to ensure that improved quality data was available to provide the best information about our workforce. An inclusive approach would be taken, with work supported by NHS Improving Quality to value the contribution and uniqueness of every individual we employ, in order to encourage creativity and innovation across the organisation. The proposed work encompassed some more traditional planning approaches alongside more radical streams to change mind-sets and establish social movements. The commitment was long term, with an important leadership role including for the Board itself. **The Board received the report and agreed the proposed equality objectives for NHS England. It wished to monitor progress very closely.** **The Board approved the priority deliverables for advancing equality and tackling health inequalities included in the Equality, Diversity and Inclusion in the Workforce Strategy.**
12	**Update on winter 2013/14** This item had been covered in the earlier discussion regarding the performance report (item 9 above).
	Strategy
13	**Seven day services** Sir Bruce Keogh presented the report setting out the findings of the first stage of the Seven Days a Week Forum. It was noted that the forum had been established to consider how NHS services could be improved to provide a more responsive and patient centred service across the seven day week. The Board noted the review provided an opportunity to show national leadership in providing seven day services, delivering safe, effective care and as positive a patient experience as possible. The focus of this first stage would be on urgent and emergency care services and their supporting diagnostic services. Sir Bruce acknowledged that, although many buildings and much equipment was under-utilised outside normal working hours, the intention was not for every service to function over seven days. Sir Bruce outlined the evidence of the review which pointed to significant variations in outcomes for patients admitted to hospitals at the weekend across the NHS in England. It was noted that this variation was seen in mortality rates, patient experience, length of stay and re-admission rates. The pattern mirrored that seen in other parts of the world, and the NHS was better equipped than any other to address this problem. The Boards attention was drawn to ten clinical standards proposed by the Forum, together with proposals for incentives, rewards and sanctions. The Board were updated on linked discussions related to the consultant contract, and to the supporting role to be played by NHS Improving Quality (NHS IQ).

	Members noted that a number of early adopter Trusts were at different stages of implementation; the HFMA had reviewed cost implications in eight of these organisations and reported that at best there had been some cost savings achieved, and at worst it appeared to be cost neutral. Information from those early adopter sites would inform more detailed analysis. Learning from experience in London, a next phase would consider in more detail the future role to be played by seven day services in primary care. Sir Bruce proposed that the best way to proceed was to use data gleaned from the first year of the contract, where organisations were developing action plans for implementation, alongside NHS IQ information from early adopter sites, to inform a more detailed analysis over coming months. He commended the forum's recommendations to the Board and sought their agreement to further work on how to roll the approach out more broadly, and into primary care services. The Board thanked Sir Bruce for the presentation and the compelling evidence to support implementation, with an exciting role for the NHS to be a global leader in this area. In discussion they agreed there was a professional and moral imperative to progress this agenda, and to disseminate the experiences from organisations that had managed to make steps in a way that had been cost-neutral. Members noted an imperative for strong links to community based services to ensure support was available to receive patients seven days a week, and agreed the need to reassure members of the public that services outside hospital were similarly just as safe outside normal working hours. There were strong connections also to the need to improve services for patients with longer term conditions. **The Board were grateful for the extent of support from the clinical community and media with the agenda, supported the proposals set out in the report, and:** • **Agreed that the Forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends.** • **Supported the commitment to driving full implementation of the clinical standards within the next 3 years using the range of commissioning tools and levers at its disposal.** • **Agreed recommendations for incentives, rewards and sanctions and, where appropriate, reflect them in the 2014/15 NHS planning guidance.** • **Noted recommendations for incentives, rewards and sanctions in relation to other organisations.** • **Agreed that the remit of the Forum should now be broadened and that it should be asked to report again in Autumn 2014 setting out proposals for the creation of a fully integrated service delivering high quality treatment and care seven days a week.**
Actions	**Sir Bruce Keogh to bring a report back to a future Board meeting in Autumn 2014 setting out proposals for the creation of a fully integrated service delivering high quality treatment and care seven days a week**

	For information
14	**Quarter two complaints report** Bill McCarthy presented the update on performance with complaints and customer contacts received by NHS England during quarter two. He described the significant improvements in response times and increasing levels of customer satisfaction that had been achieved, whilst recognising there was still room for further improvement. The Board reflected on recent impressive visits individual members had made to an area team and to the customer contact centre, recognising the complexity of cases being dealt with and the professionalism of all staff involved. They noted the encouraging picture especially as legacy/backlog issues had now been tackled, and also commended the work of the Area Teams and Regional colleagues in supporting this work, noting the additional pressure that this had caused. **The Board noted the report**
15	**NHS Improving Quality consultation** Sir Bruce Keogh presented the report seeking the Board's permission to launch a formal consultation with staff employed by NHS IQ. Sir Bruce outlined the background to the establishment of NHS IQ and the development towards its final form. **The Board noted the report and approved the commencement of the formal consultation process on 19 December 2014.**
16	**Any other business** No additional items of business were raised.
Date of next meeting	24 January 2014 – NHS Southside, 105 Victoria Street, London, SW1E 6QT