NHS Commissioning Board

Minutes of the Board meeting held in public on 28 February 2013

Present

- Professor Malcolm Grant (chair)
- Sir David Nicholson – Chief Executive
- Lord Victor Adebowale – 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
- Mr Ian Dalton – Chief Operating Officer/Deputy Chief Executive
- Dama Barbara Hakin – National Director: Commissioning Development
- Mr Tim Kelsey – National Director: Patients and Information
- Mr Bill McCarthy – National Director: Policy

Apologies

- Ms Margaret Casely-Hayford – Non-Executive Director
- Mr Naguib Kheraj – Non-Executive Director
- Ms Jo-Anne Wass – National Director: HR

In attendance

- Mr Robert Francis QC
- Mr Jon Schick – Head of Governance and Board Secretary

The Chair welcomed everyone, especially members of the public. This would be the last meeting of the NHS Commissioning Board (NHS CB) before the organisation took on full powers from 1 April 2013. Lots of the business to-date had been about making sure that from April there would be a new organisation in place that works, with the Board providing focus on patients and maximising the value of investment in the NHS to patients. He underlined the organisation's commitment to openness and conducting as much of its business in public as it could.

Item	
1	**Declarations of interest in matters on the agenda**
	There were no declarations of interest in matters on the agenda.
2	**Report of the Mid Staffordshire NHS Foundation Trust public inquiry**
	The Chair was delighted to welcome Robert Francis QC who had joined the meeting to open up a discussion about the role of commissioning in the post-

	Francis Report world. He had shone a forensic spotlight on the darkest areas of the NHS. Many felt shock and dismay that such appalling treatment could occur, and this moment needed to be a catalyst for change in culture and approach, which this board must lead as it undertook its business over the coming years. Robert Francis welcomed the opportunity to talk to the Board of an organisation which would be crucial to the provision of safe and effective care to patients. He began by commenting that the experience of commissioning in Staffordshire had been that, while PCTs had a duty to ensure quality of services, in practice they had neither the tools, expertise nor inclination. They had been subjected to a relatively constant process of reorganisation with associated lack of corporate continuity and memory. Further, the targets which PCTs had focused upon did not touch many areas of quality or fundamental requirements of running safe patient services. PCTs had limited public profile and there had been a lack of engagement with patients or the public. This was reflected in the genuine horror of PCT officials when they did meet with a group of patients who shared their stories; stories and experiences add significantly to understanding of the service. Robert Francis felt the NHS CB had a real opportunity to make a fundamental difference to the service. His report had recommended the establishment of fundamental standards, but commissioners also needed to devise, implement and enforce a range of enhanced standards, focused on improvement. Arrangements in place with providers needed proper documented specification of standards, with rigorous monitoring to see if they were being met. Measurement attached to each standard needed to be understood and owned by clinicians and front line staff, and a system of sanctions was required if standards were not met; Services should not continue to be commissioned from providers who could not meet important standards. The NHS CB had a part to play in stopping services that could not comply with fundamental standards. Openness and honesty was required about an inability to provide proper services, and a proper partnership was needed with patients – to find out from them what they require and then make a judgement about what is possible within the available resources. Transparency and candour was required from commissioners just as much as providers. Complaints needed to be welcomed, with explanations about what was being done about them. Transparency about performance meant discussing difficulties and deficiencies as well as claiming credit for what was going right. The NHS CB would need to ensure providers were being similarly transparent and honest, including with commissioners. In conclusion, the NHS CB and commissioners needed to acknowledge their responsibilities for promoting overall culture change and associated individual and collective responsibility. Three key points should be borne in mind: • GPs did not emerge well from the enquiry. They had concerns but did not put them together to form a picture. GPs needed to be reminded about their continuing obligation towards their patients once they had been referred to another provider. They were our eyes and ears; • The NHS CB needed always to remember that individual patients

	receive the service it has paid for; where there are complaints of poor service, the NHS CB would need to ensure that a remedy is given and there is a form of redress so it obtains value for money; • Providers had been very strong, almost monopolistic. Commissioning needed to ensure there are choices and alternatives, with competition on quality issues but never on fundamental standards. In a lengthy follow up discussion, a wide range of issues were covered including: • Handover, with discontinuity in the care pathway often coming up as an issue. For example, lack of services in the community could lead to inappropriate care and associated problems; • The importance of relationships between clinicians and patients, where meaningful measures and consensus on what could be achieved needed to be agreed with patients, doctors and nurses; • The obligations of GPs, where the experience had been that they did not feel it was their responsibility to do anything systemic, but rather concentrated on individual patients without joining the dots. However, some encouragement could be taken from the establishment of patient forums by a number of practices, sometimes feeding into a larger geographical forum to link feedback from patients and their representatives into the system; • The importance of placing commissioning at the front line of discussions with the public about what they want. The conversation about commissioning needed to change if the NHS CB was going to succeed in addressing some of the fundamental problems that exist in health care, including the reluctance to close down or remove services that could be better provided somewhere else. An honest and open conversation needed to be held about what care can be afforded and where; • The role the NHS CB should play in being an activist for patients and giving citizens a voice. When asked about particular priorities around transparency, Robert Francis felt patients wished to know how good a particular hospital and particular doctor was, how safe, how effective, and how they compared. He felt the professions needed to be given responsibility for devising fair and effective measurements, but acknowledged that would have resource implications; • The complex relationship between clinical autonomy, professionalism, and the federalised NHS system – with resulting flaws in the isolation of professionals from the business of running the establishment and a reluctance of clinicians to engage in collective activity for the good of patients. It was important to ensure clinicians' voice was effectively felt in hospital management and professions needed to accept the importance of working in teams, standard procedures, etc in order to make sure care was safe and effective; • The importance of ensuring confidence in the service is not further

	eroded if the commitment to openness and transparency opens up many more problems. However, families are already experiencing the bad news where it occurs; by acknowledging that and taking it seriously, confidence should increase; • The need for effective partnerships and alliances to safeguard the interests of patients, including the most disadvantaged groups. This would require open and effective communication across the system with conversations about what would be helpful to each partner, rather than guesswork about what the other party may need. • The urgency of training for leaders, with a requirement for as diverse a pool of candidates as possible, with professional development to ensure they are ready. Leaders needed to be imbued with a common culture and evidence they demonstrated the right values – openness, transparency and candour. A physical staff college could play a central role; • The central role of the nursing profession, where recruitment for values and ability to maintain them was essential, and reassurance required for the public on the role of healthcare support workers. Thought needed to be given about whether they should be regulated or registered; • The importance of building a mature dialogue between finance and the front line, with a requirement for the finance function to understand the meaning of figures in terms of care for patients. Where it was important to make cuts, honest conversations were required about the effect. Where it is not possible to meet fundamental standards, then services should be stopped or money found from elsewhere. It was important not to pretend problems did not exist as that caused danger and risk to the patient; in Stafford, reductions were made without any impact assessment. The Chair thanked Robert Francis for this opportunity to engage on many questions that had been troubling the organisation, and for reinforcing the need to enable and facilitate, and above all listen to the patient voice and ensure it informs everything we do. David Nicholson similarly thanked Robert Francis and emphasised the importance of personally reflecting on what the outcome of his work means for each of us and the way we work. This would be very important in the way the NHS CB set itself up. He covered three themes: 1. The need to avoid complacency and a belief that somehow everything would be alright. At its worst, the traditional response has been the preparation of “lines to take” rather than absorbing criticism and doing something about it; 2. The issue of getting the right culture in an organisation was fundamental. For example, the development of the NHS Constitution had been an important stake in the ground but the difficulties in embedding it had been under-estimated; 3. His personal passion about improving services for patients and intolerance of poor performance. The NHS CB would need to be

	much more reflective about why people were doing what they do. He identified dangers for the NHS CB, if people chose a "pick and mix" response to the Francis Report, concentrating on the aspects they liked. The Government response would need to be comprehensive, but the NHS CB was also keen to take immediate action. To that end, he discussed the central role of standards, which patients needed to understand, engage with and monitor on our behalf. Patient safety needed to be at the heart of all we do, and international expert Don Berwick had therefore been commissioned to undertake work in this area on behalf of the whole system. There needed to be zero tolerance to failures of patient safety, and the NHS CB had to be engaged in this area. That engagement would include areas not traditionally considered to be within the realm of commissioners – for example staffing levels on wards – but there was a critical connection between having a trained and motivated workforce, and patient safety and satisfaction. For some of the most vulnerable patients, this would be supported by a national clinical director to focus on frail older people, about to be appointed. In conclusion, David Nicholson reflected on some of the key themes from the morning's discussions: • Incentives and sanctions - the NHS CB was committed to reviewing all those in the system, to ensure they were aligned with the desired service and direction, and used in a much more direct way; • Openness, transparency and candour – the NHS was starting its work with the implementation of the Friends and Family Test, and it would be important for the NHS to embrace this given the good evidence around its pilot implementation. In addition, the service needed to change its attitude to complaints, seeing them as a fragment of information that could help to improve the service – Jane Cummings was therefore working on a review of complaints handling. The proposed duty of candour was being considered by the Government but also included in the contract this year; this made an important statement and signal about future direction; • Care and compassion – Jane Cummings was leading the work nationally, with a major set of initiatives to be announced over the coming weeks. Leadership would play an absolutely critical role, with great leadership having enormous impact in an organisation. The NHS CB's business plan would set out the investment required in leadership for the whole system, including a physical presence. This would recognise that current predominant behaviours are around pace-setting but needed to move to a more facilitative and supportive style to deal with complex issues going forward; • Connections between providers – the NHS CB was sponsoring academic health science networks to think though how to improve services and spread good practice across the system; • Useful information – in some cases, quality accounts had been little more than marketing, but they needed to be provide a full reflection of

	performance, good and bad. The NHS CB had already provided a commitment that patients would be able to access their own records in primary care; getting more information to patients in a way that can help would be a beginning, supplemented by work led by Sir Bruce Keogh across ten surgical specialties. The Chair concluded this section of the meeting by giving a statement about the Chief Executive. He explained that we stand poised at the commencement of major change in the NHS – with change in culture coupled with extensive devolution. The power of commissioning would be unleashed perhaps for first time in history of the NHS – a hugely complex organisation treating around one million people each day. The wake-up call the Francis Report had provided had drawn attention to numerous failings in a system that had focused from time to time on the wrong things, with dire consequences. There has been a search for those suffering dismay and shock for accountability, in particular a focus on the work of David Nicholson, who was a senior executive in the SHA for much of this time. David's current formal position was that he was 50% employed by the NHS CB and 50% by the Department of Health. From 1 April he would be employed 100% by the NHS CB. The Chair had been deeply worried by media speculation about David's future. He had reflected with David over several weeks and discussed this with all directors of the Board including collectively with the NEDs. They had come to a clear view that they wished David Nicholson to continue to lead a strong exec team at the NHS CB; his commitment, passion, and leadership would be essential to the future of the Board.
3	**Minutes of the previous meeting**
	The minutes of the meeting held on 14 December 2012 were accepted as an accurate record. There were no matters arising.
4	**Prioritising patients in every decision we make**
	<u>Public and patient voice</u> Tim Kelsey introduced this item; it would be fundamental to the NHS CB that it had a real time understanding of what patients think of the services they are receiving, as well as feedback from the conversations taking place about health and care more generally. He drew attention to three dimensions of insight which will develop over time: (1) What people tell us about services – for example: online feedback, 111 (presented as a wordle in the accompanying illustrative slide); (2) Complaints – of which we need to make much more use, including a move from annual to monthly to daily analysis as fast as we can; (3) Friends and family test for patients and staff – which had been very well tested in many other industries. There was confidence it would work in the NHS context following pilot work in Midlands and the East. He concluded by noting these kind of activities would genuinely transform conversations the NHS CB and NHS more widely could have.

	In discussion: • The desirability of extending the proposal to cover care outside the NHS was agreed. Initially, work would focus on data obtainable within the NHS, but there were a range of developmental priorities to move towards a more seamless method of collecting insight from across the care environment; • The importance of listening to local communities and disadvantaged groups was emphasised, with the proposed approach to insight information being an enabler to make those conversations more real. Linked to this, the importance of <u>using</u> the insight information and demonstrating what we do with the data was underlined. For example, the NHS CB could use it in discussion with CCGs, specialised services and primary care, getting the whole system to think and talk about it. In addition, linking it to the work of the Patient Experience team would help in closing the loop to demonstrate improvement; • There was acknowledgement of the need to make information available through a variety of channels and formats (so it was accessible beyond the "iPad generation"); There was great enthusiasm for the proposed approach and the Board noted and commended the paper. <u>Building citizen and community engagement in the NHS CB</u> Tim Kelsey introduced this paper, explaining that it was about how the NHS CB reinvents the way in which patients and the public will be able to participate in key decisions. Although there were existing fantastic case studies of local partnership with patients and the public, there were also numerous examples of more tokenistic approaches. The Board was asked to authorise a design group for a civil society assembly – for anyone who wished to hold the NHS CB to account for what it was doing and to help the organisation learn new things about how it engages. The model was based on learning from the Open Government partnership and would be entirely separate from the NHS CB (although the NHS CB would fund the secretariat). Lord Victor Adebowale and Ciaran Devane had both agreed to be involved in leading the design. In response to follow-up questions, it was confirmed that Healthwatch had also been involved in the proposals, although this assembly would have no formal powers. In addition, the importance of attracting members from the most disadvantaged groups was underlined, alongside an associated need to be prepared for uncomfortable messages provided as a result. The Board agreed the assembly could be important in helping to define commissioning in the interests of patients and the consumer and agreed to set up the design group described, with launch at the March NHS Expo.
Actions	Tim Kelsey to establish design group for the civil society assembly.

5	**NHS Commissioning Board programme status**
	Bill McCarthy introduced the regular update on implementation of the establishment programme, which was fundamental to defining and embedding of the NHS CB's values and behaviours for the future. Paragraphs 30-37 of the report summarised key changes made to risk assessments since the last Board discussion. There were four positive changes (the December 2012 recruitment target had been met, CCG allocations complete, the establishment of the Operations directorate was progressing well and there was an improved assessment of risk around stakeholder involvement). Three areas of increased risk were also signalled: • dealing with parliamentary business and briefing (extra attention was being given to ensure Area Teams were connected to a strong central process, and good progress had been made since this report was prepared); • basic building blocks around estate and IT (much attention had been put into this and suitable arrangements were expected to be in place by the week ending 8 March to see the organisation into next year); • payroll issues, with concerns about accurate transfer in accordance with planned deadlines (although plans were in place to ensure that staff would be paid). Although the Board were reassured at the scale of the recent successful recruitment campaigns, they were keen to understand how the process had felt to the staff going through it; there was acknowledgement that, although the numbers were getting better, some of the people behind the numbers were feeling bruised from a drawn out process over the past several months. Joiners were coming on board to an organisation in its set up mode, were often still responsible for operational delivery over the remainder of 2012-13, and had not received as much support and help as the NHS CB would ideally want. There was much work to do from now on in order to ensure people had high morale and understood the values across the organisation. The Board received and noted the report, which provided reassurance about the work that continued to be undertaken, but also highlighted the scale of risks that continued to face the organisation.
6	**Safe transfer of Emergency Preparedness, Resilience and Response**
	Ian Dalton reminded the Board of how essential it was that the NHS was prepared for and could deal with threats to its operation. This report was about ensuring the right capacity was in place and the role of the NHS CB sufficiently established that it could take on this responsibility from 1 April 2013, working with 36 local resilience partnerships. Board discussions had been held in November 2012, and this update highlighted very significant progress over the intervening months. Key highlights included: (1) Building requirements for emergency preparedness into Everyone Counts, thus providing guidance to the whole NHS; (2) Launch of a comprehensive set of key documents developed with the

	NHS, so staff were aware of what they needed to do (eg for issues such as command and control, business continuity); (3) Undertaking a major exercise to recruit and equip the NHS CB's own staff to deal with EPRR at every level from local to national; (4) Extensive training of on call directors, strategic leadership in a crisis events, and rotas put into place across the country; (5) Excellent progress in each of the 36 multi-agency local resilience partnerships that would drive the resilience agenda going forward. Further assurance could be obtained from a series of command post exercises that had taken place and proved beneficial. Lessons had been learned from these, in particular related to communications. Assessments of readiness were being undertaken and declarations required from each of the four regions; this material would be required by 15 March 2013, and the NHS CB would be able to demonstrate readiness by the end of March. In summary, an immense work programme had been undertaken with very significant progress and Ian's judgement was that work was on track to go live 1 April 2013. In discussion, the Board were reassured by the progress over recent months and Ian Dalton was thanked for his leadership of this significant programme. He was also asked to work with Ed Smith in order to confirm formally the levels of assurance that had been obtained and would be available before the end of March 2013. The Board received the report and noted the progress that had been made.
Actions	Ian Dalton to liaise with Ed Smith on levels of assurance to be provided before the end of March 2013.
7	**NHS Commissioning Board governance review**
	Bill McCarthy updated the Board on work to refresh governance arrangements, aimed at making sure there was patient focus at the centre of how decisions were made, that there was transparency in decision making, and that the NHS CB could be properly held to account. The paper summarised work in the following areas: (1) Scheme of delegation – which had been developed with NED involvement from Ed Smith and Margaret Casely-Hayford. The principles incorporated were that the Board and its committees would establish frameworks and that delegation of decisions should be as close to the operational frontline as possible. The governance team were working with area directors to finalise the scheme, giving particular focus to ensuring arrangements were in place for decisions that could be required from day one. The Board were asked for delegated authority to sign off the finalised scheme of delegation, including any consequent amendments to ensure consistency with other components of the corporate governance framework; (2) A recommendation to set up a Quality and clinical risk committee. This was very important as it placed, in a transparent way, matters of clinical quality at the heart of board and made sure the right expertise and clinical advice would be available to the Board. This proposal had been discussed and strongly supported at the Audit Committee,

	and the Board were asked to agree to establish the proposed committee; (3) Progress to produce a refreshed suite of corporate policies, which the Board was asked to note; (4) Proposed delegated financial limits for the period up to 31 March 2013, which the Board was asked to agree. A specific related issue was that some of the earliest expenditure decisions for 2013-14 would be around specialised commissioning, and the Board were asked to agree these could be signed off by the Chair and Chief Executive before being discharged through the Operations directorate. In follow up discussion, Ed Smith strongly endorsed the need to establish a Quality and clinical risk committee and noted that work would then need to be undertaken to map the respective roles of that committee and the Audit Committee in providing assurance to the Board. Bruce Keogh also considered this was an absolutely appropriate thing to do, noting that patients understood there were risks associated with disease and treatment but that the way in which services are organised should not add to that risk in any way. The Committee therefore provided two opportunities: (1) to understand the powerful role the NHS CB can have to make sure the best quality care is commissioned and to understand emerging risks in the system; and (2) to bring in powerful external clinical advice from people who had perhaps previously found it difficult to be involved in roles other than as commentators. In concluding these discussions, the Chair asked for the structure of committees and delegation to be kept under review. His preference was for analytical work to be undertaken at committees which would then provide strong recommendations to the Board. The Board could then maintain focus on future strategy, clinical quality and patient voice. The Board noted the position and agreed the recommendations made above. <u>Pricing governance</u> Bill McCarthy outlined the NHS CB's joint responsibility with Monitor to set annual prices for hospital care via the national tariff. The proposals in this paper were that some of the joint work should be done through a joint pricing executive which could make a range of day to day decisions as defined in the paper. Both boards would retain responsibility for strategic decision making, especially on long term pricing strategy, the scope and structure of the tariff (matters closely related to the vision of the service the NHS CB would want to provide for patients), as well as on publishing the tariff each year. There was a good working relationship with Monitor with a shared desire to act as a joint team in the interests of patients and the service. The same paper and recommendations were also going to Monitor's Board. The Board agreed the recommended joint governance arrangements and the suggested delegation of authority to the new Joint Pricing Executive.

Actions	Bill McCarthy and Jon Schick to ensure the governance review was completed and arrangements in place to ensure its sign off before 1 April. Sir Bruce Keogh to lead the establishment of the Quality and clinical risk committee.
8	**Recruitment and OD Strategy update**
	<u>Recruitment Update</u> Bill McCarthy introduced this item by sharing the feedback from staff surveys within his directorate, which had consistently shown four themes: (1) Staff were bought into the mission of the NHS CB and enthused by the opportunity to do the right things for patients and concentrate on outcomes and patient voice; (2) Staff were bought into the values and behaviours of the organisation and workshops held with Tim Kelsey had helped to make these real; (3) People felt there was a massive workload – delivering current priorities as well as designing the new organisation. They felt very significant work pressures; (4) Recruitment had been tough and extensive but there remained anxieties about whether all the process would be successfully concluded – for example: timely offer letters and accurate payroll entry. The report overall was positive; good progress had been made with recruitment (now over 80% of posts had been successfully recruited to – higher in the operations directorate and area teams but lower in support centre directorates), but there was a backlog getting offer letters out (which was consistent across all players in the system); it was hoped this would be cleared by the end of next week. There had been a very good partnership with the BSA who had brought in additional capacity, and sampling of offer letters suggested they were, in the most part, accurate. The Board's attention was drawn to the pressures that would now be felt by the payroll provider, with a need to check the accuracy of the data once placed on the system. There was confidence that staff would be paid in April and contingency arrangements available in case of isolated problems. There was an improving position related to diversity both in the workforce overall and at VSM level – however, although the organisation now better represented the communities it served, the position was not uniform and there was need to maintain the existing working group to understand diversity of the workforce, ensure lessons were learned and help the organisation live up to its commitment for fairness and equality for the people it recruited. In follow up discussion, the Board reflected on the sheer complexity and human element of what it was doing and asked for further reassurances about workload issues. Although there was recognition this was a time of complex transition and that some of the workload pressures should therefore ease, the Board were also reminded that the NHS was attempting to reduce the administrative costs of the commissioning system by nearly 50%. The NHS CB was being as creative as it could in the way it worked (eg more streamlined process around financial spine) but workload challenges would

	need to be kept under review in coming months. The Board noted the report. <u>Organisational development strategy phase 2 (2013/14)</u> Bill McCarthy introduced this paper which recommended a next phase of the OD strategy as the organisation moved on into the next phase of its development post-April. He drew attention to three themes from paper: (1) The vision for how the NHS CB wants to be was set out in paragraphs 9-22; (2) Paragraph 40 summarised conclusions from engagement with teams on what was important for OD. As a result, a sixth principle had been added to the OD strategy - to build morale with staff through meaningful engagement and action to respond; (3) Appendix 3 explained how the impact of the OD strategy would be evaluated the Board were asked to endorse this framework. In follow up discussion, David Nicholson raised the importance of making connections between the NHS CB, as a national body, and patients, carers and people in local communities. For example he proposed the promotion of Dementia Friend training for staff in the NHS CB, as well as developing options for volunteering at local level. Including these kind of initiatives as part of continuous professional development would ensure that the OD strategy helped the NHS CB keep a connection with local people. The Board concluded its consideration of the OD strategy by referring back to the workload concerns raised earlier, and suggested these could be linked into the analysis proposed in Appendix 3 of the OD strategy. In addition, the Board could ask for examples of changes that had enabled the reduction in staff, with a focus on checking the organisation was working smarter rather than placing staff under too much pressure. It was agreed this could be linked to current pilot work being undertaken through the cultural barometer. The Board agreed to the proposals in the paper and asked for the ideas above to be taken forward.
Actions	Jo Anne Wass to include OD initiatives that would ensure a connection is made with local communities. Jo Anne Wass to reflect on the Board feedback about workload issues and how the measurement of impact of the OD strategy might address these.
9	**Operating plans**
	Ian Dalton explained that from 1 April 2013, the NHS CB would be the sole commissioner of specialised services for people across England. This paper provided an update on significant work being undertaken to bring about national consistency in relation to those services, with the aim of ensuring everyone across the country could access consistent services. Clinicians working in clinical reference groups had considered standards and eligibility criteria – the first time that such an exercise had been done nationally by the NHS. Service specifications and policies had been

	discussed with many local organisations and stakeholders, and the NHS CB wished to thank the over 3,500 organisations that had taken part in this. Work has now being undertaken to analyse their feedback and engage with them, which had consequences in terms of policies and specifications, and the Board was asked to support the use of more time to continue the process of engagement. Ian drew the Board's attention to the need for clinical access policies, which would describe the eligibility criteria. Around 30 such policies would need to be in place from 1 April, and it was proposed that a clinical priorities advisory group be established to work as part of the structures described within the governance review. The group would bring together clinicians and patient representatives to advise on clinical and cost effectiveness, appropriateness and relative priorities. This would result in a significant on-going work programme once the initial policies required for 1 April were signed off. In the light of the volume of comments that had been received, it was also suggested that more time was required to finalise service specification, which would be phased in once they had been properly considered and taken through advisory structures from 1 October 2013. In follow up discussion: • Sir Bruce Keogh noted the proposals had been prepared jointly with the medical directorate, and he was very supportive of them; • The importance of the interface between specialist services and mental health was raised - an area where significant improvements were required in order to get parity of esteem. It was noted that a strategy on mental health services would be coming soon to the Executive Team, so this issue could be considered initially at that point. In addition, it needed to link to wider conversations about the development of the commissioning system as a whole, ensuring that service provision from primary to specialised care was joined up; • It was proposed that the additional time requested could also be used to widen participation beyond the mostly clinical input to the process to-date. The arrangements proposed in the paper were agreed by the Board.
Actions	Ian Dalton to ensure that the comments from the discussion were addressed in the on-going work programme
10	**Feedback from Board sub-committees**
	<u>CCG authorisation sub-committee</u> Lord Victor Adebowale introduced this update and noted the upcoming meetings planned for March before the authorisation process was concluded. The Board agreed the process had been impressive, especially given the scale of the task that had been completed over a rapid timescale; much had been done with the time and resources available. There was one typographical error in the paper, with minutes of the meeting held on 18 January referring to joint work between Bromley, Harrow and Ealing CCGs; this work involved Brent rather than Bromley, and the corrected minutes had been placed on the website.

	In conclusion, the report was commended to the Board, who expressed their gratitude to Dame Barbara Hakin and the team for delivering this very significant work programme. <u>CSU sub-committee</u> The Board received a verbal update from Dame Moira Gibb, who summarised the highlights from two meetings held to provide assurance around the hosting process. A balanced scorecard had been agreed and development programme supported to assure the quality of CSU processes. The Board's approach to commissioning support had led to significant discussion at the second meeting, and it was agreed this should come back for a wider Board development session, with CSU involvement to enrich the discussion. Initial discussions on the future market strategy would also be further pursued at future meetings of the sub-committee. The Board also noted additional assurance related to CSUs that had come from an independent assessment by RSM Tenon, which had concluded the CSUs posed low risk in terms of their operational ability and handling of financial issues over the next 12 months. A key current priority was to confirm the plans for delegation to CSUs – an area requiring finalisation before 1 April, linked to the wider governance review discussed earlier on the agenda. <u>Audit Committee</u> Ed Smith described the recent work of the Committee, which had met to focus on readiness at this stage as well as consider governance and structures for 2013/14. He described an enormous amount of work that had been done related to the transition of the finance function, which had also been assessed twice by Deloitte. In summary: • The build-up of the finance function had been slower than hoped so additional resources had been brought in and good progress made. There remained risks around operation of the financial spine, which involved a new system with new accounts for new organisations, but without the ability to double-run. An assurance report had been commissioned from Ernst and Young; this would report at the end of February and would be reviewed by management with conclusions drawn to Audit committee members attention as soon as practicable; • There was a substantial training programme underway, with associated need for staff to be released to attend; • The Audit Committee would continue to closely monitor progress with the recruitment of staff and associated records and payroll issues; • Additional resource would be devoted to the design of the management reporting framework, ensuring this would provide the information required; • The Committee would be addressing issues including direct commissioning (ensuring clarity about how funds were being directed) and NHS Property Services (ensuring payment was only made for properties that are occupied and not for those surplus to requirements);

	• The Committee were keen to ensure as clean a balance sheet for the NHS CB as is possible for 1 April 2013. This was an area subject to much on-going work; risks associated with asset transfers required close negotiation and discussion with the DH, especially with respect to inherited liabilities. These issues would be raised with DH at the upcoming Board to Board; • Good progress was being made in relation to recruitment of internal audit and specification of the external audit; • The Audit Committee strongly endorsed the proposal for a Quality and clinical risk committee; • Work to identify risks beyond the transition and establishment programme was in progress. The Board welcomed this comprehensive update and noted their appreciation of the support provided by the Audit Committee.
Actions	Barbara Hakin and Jon Schick to agree arrangements for future Board development session on the Board's approach to commissioning support. Jon Schick, Paul Baumann and Bill McCarthy to ensure that delegation to CSUs was finalised as part of the recommendations from the on-going governance review.
11	**Any other business**
	There was no other business.
Date of next meeting	12 April 2013, Maple Street, London