Health and Social Care Board

MINUTES OF THE MEETING OF THE HEALTH AND SOCIAL CARE BOARD HELD ON THURSDAY 29 MARCH 2012 AT 10.00AM IN THE BOARDROOM, HSCB, SOUTHERN OFFICE, TOWERHILL, ARMAGH BT61 9DR

PRESENT: Dr Ian Clements, Chair
Mr John Compton, Chief Executive
Mr Paul Cummings, Director of Finance
Mrs Fionnuala McAndrew, Director of Social Care and Children's Services
Ms Louise McMahon, Director of Performance and Service Improvement
Mr Dean Sullivan, Director of Commissioning
Mr Robert Gilmore, Non Executive Director
Mrs Lily Kerr, Non Executive Director
Mr Stephen Leach, Non Executive Director
Dr Melissa McCullough, Non Executive Director (left the meeting at 1.00pm)
Mr Brendan McKeever, Non Executive Director
Mr John Mone, Non Executive Director
Dr Robert Thompson, Non Executive Director

IN ATTENDANCE: Dr Sloan Harper, Director of Integrated Care
Mr Michael Bloomfield, Head of Corporate Services
Dr Carolyn Harper, Director of Public Health/Medical Director, Public Health Agency
Mrs Mary Hinds, Director of Nursing and Allied Health Professionals, Public Health Agency
Mr Sheelin McKeagney, Chair, Southern Local Commissioning Group
Dr Brendan O'Hare, Chair, Western Local Commissioning Group
Dr George O'Neill, Chair, Belfast Local Commissioning Group
Dr Nigel Campbell, Chair, South Eastern Local Commissioning Group (left the meeting at 1.05pm)

Mrs Carol Mooney, Corporate Secretariat Manager, HSCB

APOLOGIES: Dr Brian Hunter, Chair, Northern Local Commissioning Group

41/12 CHAIR'S REMARKS

The Chair welcomed members to the March meeting and paid a particular welcome to representatives of Independent Health Care Providers (IHCP) who had requested speaking rights on agenda item 9 'Proposed Independent Sector Care Home Tariffs'. The Chair explained that he would invite Mr Hugh Mills, IHCP Chief Executive, to address the Board when the meeting came to that agenda item.

The Chair advised that, since the February Board meeting, he had attended a number of NICON events. He said that the NICON Conference, which the Chief Executive and he attended, was held on the afternoon of the February Board meeting and was a very successful event.

He reported that he had joined NICON representatives in a meeting with the Permanent Secretary on 26 March 2012. There was, he said, an interesting and helpful discussion over the challenges facing health and social care and he added that he looked forward to further exchanges.

At the additional Board meeting on 15 March 2012, the Board approved the business case to provide support to take forward the implementation of Transforming Your Care. The Chair indicated that the Chief Executive would provide an update on the current position in his report.

The Chair said that, at that meeting also, the Board was briefed on the arrangements to improve performance at a number of Emergency Departments. He said that there had been considerable media attention on this issue since that meeting and advised that the Board would receive a more detailed update today on the plan to tackle the long waiting times in A&E.

Concluding his remarks, the Chair said that members may have heard reference in the media in the last few days about a meeting the Minister had with the Chairs and Chief Executives of HSC organisations. He advised that he attended the meeting on Tuesday along with the Chief Executive, and had asked the Chief Executive to say more about the purpose of the meeting in his monthly report to the Board. The Chair clarified that this was one of a series of scheduled meetings between the Minister, Trust Chairs and Chief Executives.

42/12 PREVIOUS MINUTES

The minutes of the meeting held on 23 February 2012 were **APPROVED** by members.

43/12 MATTERS ARISING

It was noted that any Matters Arising would be dealt with on the main agenda.

44/12 CHIEF EXECUTIVE'S REPORT

The Chair invited the Chief Executive to provide his report to the Board.

The Chief Executive advised that the Board had now received preliminary financial information on the 2012/13 year and said that officers were examining this and detail would be brought back to the Board in due course.

The Chief Executive advised that the inaugural meeting of the Transforming Your Care Programme Board had been held on 27 March 2012. He advised that membership comprised Trust Chief Executives, LCG Chairs and the SMT of the HSCB. He said that the main focus of the meeting had been to confirm the Terms of Reference and governance for this Programme to ensure that the work could be progressed and delivered over the next number of months. In addition to the Programme Board, the Chief Executive said that a workshop to continue work on the Population Plans had also been held and added that it was hoped that the Populations Plans would come to the June Board meeting for consideration. He added that he had also recently met with the Assembly Health

Committee to keep them apprised on arrangements for implementing TYC. The Chief Executive said that it was expected that the Minister would issue a letter shortly setting out the arrangements and lead responsibility to progress each of the 99 recommendations contained within TYC.

The Chief Executive referred to recent media coverage which had reported on the Minister's meeting with Chairs and Chief Executives of all HSC organisations on Tuesday 27 March 2012. He said that, while the media had reported that the meeting was in relation to current concern about performance in a number of A&E departments, the meeting had centred on a number of issues, including the implementation of TYC, communications and performance against targets. The Chief Executive said that the Minister had stressed the importance he placed on improving A&E performance and said that this would be discussed in more detail later in today's' meeting.

In relation to the investigation into the possible theft of documents the Chief Executive advised that the Investigating Team was in the process of finalising its report and had undertaken the third strand of the work which involved reviewing the Board's information governance arrangements, and making recommendations about how these can be strengthened. He said that a final update, including any recommendations, would be brought to the April Board.

Referring to the implementation of TYC, Mrs Skelly highlighted the importance of a clear communication plan.

The Chair, agreeing with Mrs Skelly's comment, was of the view that a communication plan would be fundamental to the success of TYC and said that the need for a plan had also been referred to at a recent NICON event.

Brief discussion took place in relation to recent press coverage concerning efficiency savings to be achieved by HSC organisations. The Chief Executive said that this issue had been the subject of discussion throughout the organisations and stressed that the documentation considered by members at the time represented planning at that point in time. He indicated that more work was needed to reach a definitive position where plans could be agreed.

The Chair thanked the Chief Executive for his report and said that members would look forward to receiving regular updates on TYC implementation.

45/12 FINANCIAL REPORT – TRUST FINANCIAL POSITION AT MONTH 9/HSCB FINANCIAL POSITION AT MONTH 10

Mr Cummings reported that the overall financial position for Trusts for the nine months to the end of December 2011 continued to show an improving position with a cumulative surplus of £1.7 million recorded as compared to November's break-even position.

He said that all Trusts continued to show improvements in their year to date financial positions due to ongoing expenditure controls, realisation of savings plan and additional funding. He added that, in respect of the forecast year end out-turn, all Trusts were now projecting break-even or slight surplus positions.

Referring to the staffing level information, Mr Cummings reported that the 'Trust staff' element of Belfast HSC Trust's numbers now reflected 'staff in post' whereas previously reported figures had been derived by dividing the total payroll expenditure by an average payroll cost. He drew members' attention to the revised figures for April – December 2011 for the Trust.

Turning to the HSCB Financial Report for the period to the end of January 2012, Mr Cummings reported that the HSCB was now anticipating a small surplus at the year end. This, he said, was a significant achievement, given that approximately £40 million of a deficit had been predicted at the beginning of the financial year.

In relation to General Pharmaceutical Services, Mr Cummings reported that the £30 million of savings would be achieved. He explained that the movement in January was due to a revised assessment of the expenditure profile between now and the end of the financial year which required an adjustment and added that the budget was expected to break-even at the year end.

Turning to General Medical Services, Mr Cummings reported that this area was projected to have a small surplus at the year end while General Dental Services was projected to have a deficit of £6

million and General Ophthalmic Services a small deficit of £613k at the year end.

Mr Cummings said that, with regard to Extra Contractual Referrals, the total budget remaining in year was £2 million. He added that £6 million had been transferred to Belfast and South Eastern Trusts in November with a further £1 million being transferred to the Belfast Trust in January. This budget was showing a slight overspend but was forecast to breakeven at the year end.

Mr Cummings reminded members that a process was underway to standardise and amalgamate legacy contracts with voluntary organisations. He said that this budget was projected to breakeven at the year end.

Referring to HSCB Salaries and Wages, Mr Cummings reported that all Directorates were currently showing salaries budgets with surpluses for the year to date. The Goods and Services budget was also showing a surplus.

Mrs Kerr said that she had on a number of occasions expressed concern over the staffing figures provided in the financial report and said that there was a discrepancy between the figures in the HSCB report and those on the DHSSPS website. Mrs Kerr said that, mindful of the lengthy agenda for today's meeting, she would like to have further discussion on this at a future meeting.

Referring to the pharmaceutical services figures, Mr McKeagney asked if it would be possible to separate the goods and services financial information. Mr Cummings agreed that this was possible.

The Chief Executive referred to recent meetings at which the Minister has signalled that the DHSSPS would be returning £15 million to the Department of Finance and Personnel. He assured members that the health and social care system had fully utilised all resources allocated to it.

The Chair thanked Mr Cummings for his report, and congratulated him and his team for delivering a break-even year end position, given the significant challenge earlier in the year

46/12 PERFORMANCE REPORT (MONTH 11)

The Chair invited Ms McMahon to provide her performance report.

Ms McMahon said that, as previously reported, Trusts had continued to sustain the progress made in 2010/11 across a number of target areas.

With regard to elective access outpatients, Ms McMahon reported that there had been a further very substantial reduction in the numbers waiting longer than 9 and 21 weeks for a first outpatient appointment in February by 14,251 and 8,558 respectively. The action being taken to achieve this and to ensure progress was maintained was described to the meeting.

Ms McMahon also reported considerable progress in relation to the number of patients waiting longer than 13 weeks and 36 weeks for treatment at the end of February.

Ms McMahon described the position in relation to diagnostics which had reduced by 334 to 9,231 in February for those patients waiting longer than 9 weeks. McMahon noted that the regional position is strongly influenced by neurophysiology within the Belfast HSC Trust. Ms McMahon explained that the HSCB has commissioned an additional two consultants but the Trust has had difficulty recruiting to these posts and alternative arrangements are being explored. She added that the Trust had now submitted a business case to the Board reviewing how the service is delivered and indicated that the business case would now be considered within the discussions around the recurrent elective investment for 2012/13.

In relation to endoscopy, the meeting noted that, at the end of March 2011, 4,173 patients were waiting longer than 13 weeks for a scope. This had increased during the first four months of 2011/12 and, at the end of July, 5,629 patients were waiting longer than 13 weeks. However significant progress had since been made and at the end of February 2012, 1,391 patients were waiting longer than 13 weeks. No patients are expected to be waiting longer than 13 weeks at the end of March 2012.

Reporting on AHP figures, Ms McMahon indicated that there had been a significant reduction against the previous month in the

number of patients waiting longer than 9 weeks for AHP treatment in February. 1,427 patients were waiting longer than 9 weeks at 29 February, a reduction of 1,908 on the previous month.

Ms McMahon advised that, regionally in the year to end of January, 82% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days, with performance against the 62-day standard below the level required in all Trusts. The HSCB is now meeting with Trusts weekly to improve this position and a detailed programme of specific actions is agreed and being monitored with each Trust.

Ms McMahon reported that, in relation to mental health services, at the end of February, 303 patients were waiting longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues. Of these 303 patients, 145 were waiting for Child and Adolescent Mental Health Services (CAMHS) and 105 for dementia services. Ms McMahon explained the HSCB's escalated processes with Trusts to improve this position. Detailed action plans have been received from all Trusts.

Ms McMahon described the current position with regard to resettlement within learning disability and mental health, and progress against the targets. Whilst progress against the targets had been initially slower than required the inhibiting factors were now being worked through with Trusts and progress will now be more rapid over the next number of months.

Dr Thompson asked if it was expected that progress in relation to elective care would continue in the early part of 2012/13 and if the previous deterioration in the first part of the year could be avoided.

Mr Sullivan said that it had not been helpful to have 'peaks and troughs' of service delivery and expected that this would not be the case for 2012/13. He added that delivery plans had been agreed with Trusts and additional activity would continue from April onwards. Mr Sullivan said that there was now clarity in terms of the minimum volume of services to be delivered by Trusts going into the new financial year.

The Chief Executive said that there was a very clear commitment on the part of the providers to deliver the agreed volumes of service.

He said that the priority was to ensure services were delivered to the patient in a timely, high quality and safe manner, and acknowledged the very significant improvement in recent months as a result of the huge effort by the Board and Trusts.

Mr Mone commended the progress in the area of HCAI.
Dr C Harper thanked Mr Mone and also acknowledged the contribution made by Trusts and said that the Western and Southern HSC Trusts deserved particular recognition for their efforts in this area.

Mr Mone asked whether Mrs McAndrew was concerned about any aspects of children's services. Responding, Mrs McAndrew acknowledged the general improvement that had been made in relation to unallocated cases and said that the service remained on target. However she said that the family support pathway remained a challenge for staff to ensure it remained flexible to respond to those families who required a lower level of input. Mrs McAndrew said that progress in the area of CAMHS within the Northern HSC Trust had been slow and, as a result, the Trust had initiated a review of how it delivered these services. Mrs McAndrew said that the Trusts continued to work closely with Board officers and believed that this was to the benefit of all involved.

Brief discussion took place on the need to ensure sustained improvement in relation to performance against the cancer targets and the issues impacting on performance.

Dr O'Neill commented that TYC was premised upon moving services out of secondary care into primary care and said that it would be important to ensure sufficient capacity within the primary and community care sectors.

Dr Campbell commented that a significant number of elements identified within TYC were already being taken forward by Primary Care Partnerships; for example, work on reforming patient care pathways. He said that the South Eastern LCG had recently received a presentation from the Southern HSC Trust on how it managed delayed discharges and he suggested that the information provided by the SHSCT should be included in the next performance report.

Dr O'Hare referred to work which had been taken forward by the Western LCG to repatriate minor surgery work from hospitals to general practice. He said that, through this work, approximately 500 cases had been treated within a three month period.

The Chief Executive reminded the meeting that the implementation of TYC would take place over a 3-5 year timeframe. In response to a comment from Mrs Kerr, the Chief Executive agreed that there were elements of TYC which could be implemented in a short-term basis while others would require a longer timeframe.

The Chair thanked Ms McMahon for her report.

47/12 OVERVIEW OF ACTION PLAN TO IMPROVE PERFORMANCE IN EMERGENCY DEPARTMENTS IN NORTHERN IRELAND

The Chair invited Mrs Mary Hinds, Director of Nursing and AHPs, to take members through the overview of the Action Plan to improve performance in Emergency Departments in Northern Ireland.

Mrs Hinds advised the meeting that the excessive waiting times experienced by patients in a number of Emergency Departments in Northern Ireland were unacceptable. She said that the paper before the Board detailed the action plan to improve performance and had been developed by the HSCB, working with the PHA. Mrs Hinds advised that it would be a three-month programme with the objective of ensuring that 12-hour waits are eliminated from the system or occur only on a very exceptional basis and that performance against the 4-hour standard and other measures improve significantly.

Mrs Hinds emphasised that patient care should be at the centre of this work and referred to the 18 unscheduled care key actions to be taken forward. She indicated that the action plan had been shared with both the DHSSPS and Trust Chief Executives and was before members today for information.

The Chief Executive stressed that the responsibility for the operation and delivery of Emergency Departments remained with the respective Trusts. However the development of the Action Plan represented an escalation of performance management

arrangements by the Board. Referring to the 18 key actions to be implemented by Trusts, the Chief Executive said that these actions were very much evidence based to improve the patient journey.

Mrs Kerr said that, in many instances, improvements could be made to the systems in place at little or no cost.

The Chief Executive said that it would be important for the system to respond in a holistic way and added that the cultural change necessary within the system should not be underestimated.

In response to a comment from Dr McCullough on how the system would measure cultural change, the Chair agreed that it would be important to ensure that there were real measurable outcomes. Ms McMahon said that real improvement was possible and cited the example of the SHSCT where there had not been any breaches of the 12-hour standard. Ms McMahon said that the WHSCT had also improved its performance in this area.

Mrs Skelly said that the PCC welcomed the initiative and said that it would be important not to lose sight of other aspects of care that had caused concern to patients, for example access to GPs out-of-hours.

Dr S Harper pointed out that there were detailed service specifications, which included access standards, in place for each of the five GP out-of-hours services.

Members welcomed the action plan and emphasised the need for patients to remain at the centre of this work. Brief discussion took place on possible financial incentives to be introduced from 1 April 2012 as a commissioning lever to encourage an urgent improvement in performance against the 4- and 12-hour standards and other key quality measures.

Mr Sullivan advised that at this stage there were no plans to introduce financial penalties and added that the scheme would be revisited for the 2013/14 financial year.

Mrs Kerr said that she looked forward to receiving details on how the incentive scheme would work in practice.

Mrs Skelly referred to the PCC helpline which is in operation and indicated that, while there were a number of complaints/concerns received about the service, approximately 40% of calls had been to compliment the service, with 20% of calls from patients wishing to make suggestions as to how services might be improved.

Mr Leach welcomed the Chief Executive's assertion that responsibility for the operation and delivery of Emergency Departments remained with the respective Trusts. He questioned whether the Governance Committee should have a role in monitoring the risk to improving A&E performance.

The Chair, agreeing with Mr Leach's comment, said that it would be important to identify the risk to the HSCB as an organisation accountable for performance and describe the action being taken to improve on the current situation.

The Chair thanked Mrs Hinds for her significant contribution to this work and said that the Board looked forward to further updates.

48/12 PROPOSED INDEPENDENT SECTOR CARE HOME TARIFFS 2012/13

The Chair welcomed Mr Hugh Mills, Chief Executive of the Independent Health Care Providers (IHCP), and Mrs Janet Montgomery, Honorary Secretary, to the meeting.

The Chair advised members that he had granted a request received from IHCP for speaking rights at today's meeting and he invited Mr Mills to address the meeting.

A copy of Mr Mills' address to the meeting is appended to these minutes.

The Chair thanked Mr Mills for his address and asked Mr Cummings to take members through the detail.

Mr Cummings explained that the HSCB is required to set the Nursing and Residential Home tariff on an annual basis and added that this tariff is used as the base for calculating any top-up fee for homes charging above this rate. Mr Cummings explained that

homes are free to set their own price in line with normal commercial practice.

Mr Cummings advised that, in 2011/12, the Board agreed a freeze on both tariffs, keeping them at 2010/11 levels. He said that Board officers had consulted with a range of providers, IHCP and Trusts regarding the availability of rooms at tariff and current inflationary pressures. The views and information received suggested inflationary pressures ranged from 2.5% to 5%. Mr Cummings clarified that at 5%, this included a 3.5% uplift in pay costs. He pointed out that the Board's view is that pay inflation is on average 1%.

Mr Cummings indicated that Trusts have had the funds available to purchase nursing and residential care reduced by 2.6% - 2.8% in line with the DHSSPS' overall efficiency target of 4%. However, he said, IHCP has stated that its members are unable to make further efficiency savings in 2012/13.

Mr Cummings said that he was seeking the Board's approval to a 2.5% uplift in tariffs and that the 2.6% minimum efficiency targets was not passed on, thus providing an uplift equivalent to 5.1%.

Mrs Kerr expressed concern that the Board paper had not made reference to the recent Human Rights report on nursing home care. She also said that she did not feel the paper was clear on whether efficiency savings were also being applied to the independent sector as well as the statutory sector.

In response to a query from Dr McCullough, Mrs McAndrew explained that 'failure to comply' notices are issued by the Regulation and Quality Improvement Authority (RQIA) and relate to a service. She cited an example of 'failure to comply' notices on failure to maintain proper pharmaceutical records or failure to have care plans in place.

Mr Cummings reminded the meeting that a nursing or residential home was free to set its price. He explained that if a Trust was unable to secure a nursing/residential home place at tariff, then the Trust would be responsible for paying any price difference.

Responding to a question from Mrs Skelly, Mrs McAndrew advised that the Board was currently developing a procurement strategy for nursing and residential home care and said that this would be the subject of an officer workshop at the end of April. This, she said, would examine the actual prices being set for beds and added that the strategy would be brought to a future Board meeting.

The Chief Executive said that it would be important for members to be reassured that the recommendation before them was a fair, reasonable and proportionate tariff.

Mr Cummings pointed out that there are providers providing home places at tariff and indicated that, while IHCP represented a number of homes, the organisation did not represent all nursing/residential home owners. He said that the HSCB was not legally obliged to undertake consultation on setting the tariff but undertook to seek further legal advice in relation to this. Mr Cummings advised members that he had written to a number of major organisations and had contacted Health Authorities in England to ascertain the tariff. He stated that occupancy levels in nursing/residential homes were the most significant factor in the viability of any home, not the tariff.

Mr Leach said that he was of the view that the Board was required to set a tariff to enable the appropriate level of care to be provided and cautioned against the Board being in a position of supporting the care home infrastructure.

Members expressed a desire to have further discussion at Board level. Noting members' uncertainty, the Chair suggested that the Board hold further discussions with RQIA to seek their view on any link between tariff and quality. He suggested that either an invitation be extended to RQIA to attend a future Board meeting or a paper be developed following discussions with RQIA and brought to a future meeting.

The Chief Executive pointed out that, it was important in the meantime, to agree a tariff as the Board would be required to pay nursing/residential homes from 1 April 2012.

The Chair said that, in view of the discussion, he would seek Board approval, without prejudice, to the tariff as set out in the paper subject to further discussion with RQIA.

Members accepted this suggestion and **APPROVED** the tariff on this basis.

The Chair again thanked Mr Mills and Mrs Montgomery for attending and they withdrew from the meeting.

49/12 RQIA REVIEW OF PRIMARY CARE READINESS FOR MEDICAL REVALIDATION

Dr O'Neill declared an interest in this discussion.

The Chair invited Dr S Harper to take members through the detail of this agenda item.

Dr S Harper explained that, since November 2009, the General Medical Council (GMC) has required every practising doctor to have a licence and in future all doctors will be required to undergo a process of revalidation in order to retain that licence to practise. The revalidation of doctors will commence late in the 2012/13 year.

Dr S Harper advised that Dr Margaret O'Brien, Assistant Director of Integrated Care, Head of General Medical Services (GMS) is the designated HSCB Responsible Officer with responsibility for making revalidation recommendations for all GPs on the NI Primary Medical Performers List (NI PMPL).

Dr S Harper explained that, during May 2011, the Regulation and Quality Improvement Authority (RQIA) undertook a review of readiness for revalidation in primary care in Northern Ireland. He indicated that this review involved the provision of evidence by the HSCB in relation to the governance arrangements in general practice, the management of the Primary Medical Performers List, the management of performance concerns and the GP appraisal system.

Dr S Harper drew members' attention to the RQIA report which had been published in December 2011 and said that it had been very

positive in terms of the existing arrangements in place within the HSCB.

In response to a question from Mr McKeever, Dr S Harper explained that part of the revalidation process centred on 360^{o} feedback where the views of patients and GP colleagues of the GP being revalidated were sought.

Dr O'Neill explained that he had been involved in the appraisal of GPs for a number of years and assured members that the system in place was very robust.

Dr O'Neill said that it was unclear whether the DHSSPS or the HSCB was responsible for the management of the process and said that it would be important to ensure the implementation and operation of the revalidation process were appropriately resourced. Dr O'Neill suggested that it would be helpful to have a number of named officers as Responsible Officers and appropriate administrative support.

Dr S Harper drew members' attention to Appendix 2 where there was a summary of the recommendations relating specifically to the HSCB, and the current plan to meet them over the period up to 31 March 2012. However it was noted that the GMC's requirements for the revalidation of doctors were not yet finalised and plans would require to be adapted when formal GMC guidance was received.

He advised that the Chief Medical Officer had established a Responsible Officer Forum where ROs can share best practice across the sectors.

Dr S Harper clarified that the revalidation of General Medical Practitioners had been devolved to the Board by the DHSSPS and added that it was hoped that additional funding would accompany this devolved function. A bid has been submitted to DHSSPS.

Mr Leach suggested that the revalidation of doctors should be identified as a potential risk in the Corporate Risk Register.

Dr Thompson welcomed the RQIA report and believed it to be a strong endorsement of the process to date.

Dr S Harper agreed to keep members apprised of progress.

Members **NOTED** the RQIA Review of Primary Care Readiness for Medical Revalidation.

50/12 COMMISSIONING PLAN FOR 2012/13 – VERBAL UPDATE

Mr Sullivan advised that the Commissioning Direction had been received by the Board at the end of February and the allocation letter within the last week.

He said that officers were working towards bringing the draft Commissioning Plan 2012/13 to the April Board meeting for consideration. He added that a provisional date of 20 April 2012 had been identified for a joint workshop, involving PHA Board members. This date would be confirmed in the next few days.

Mr Sullivan explained that the Board hoped to be in a position to forward the Commissioning Plan to the DHSSPS by the end of April. He said that Trust Delivery Plans would then be received by the Board for examination prior to bringing them to the May Board meeting for consideration.

Mrs Kerr offered her apologies for the April workshop and Board meeting.

51/12 PATIENT CLIENT EXPERIENCE REPORT

The Chair advised members that the Patient and Client Experience Report had been considered in detail by the Governance Committee, and invited Mrs Hinds to highlight the key issues for Board members.

Mrs Hinds said that the Patient Client Experience Report was an important part of the reporting process on safety and quality issues to the Boards of the HSCB and the PHA. She stressed that the report was to be viewed as a starting point.

Brief discussion took place on the need to learn from the comments made by patients and to ensure that measures were put in place to ensure issues were resolved. Mrs Hinds pointed out that reports

would be presented to the Governance Committee in the first instance before coming to the Board for information.

In response to a question from Mr Gilmore, Mrs Hinds said that it was possible to identify the wards in which the patient had received care, in order to determine if an improvement had been made in the care offered to patients.

Mr Leach assured the Board that the Report had been discussed in detail at the Governance Committee meeting on 1 March 2012 and added that the Committee had felt that the Report was of such significance that it should be brought to the attention of the full Board.

The meeting **NOTED** the Patient Client Experience Report.

The Chair thanked Mrs Hinds and said that Board members looked forward to receiving further updates.

52/12 COMMUNITY DEVELOPMENT STRATEGY

The Chair welcomed Mr Martin O'Neill, Community Development Manager, HSCB, to the meeting.

By way of introduction, Mrs McAndrew reminded members that approval had been given for the Strategy to go out to consultation. This had now been completed. She advised that the Strategy had been developed jointly by the HSCB and the PHA and added that both organisations viewed community development as a key instrument to improve health and wellbeing, to address health inequalities and help to ensure the most effective use of the health and social care budget.

Mr O'Neill explained that, in developing the Strategy, the HSCB and PHA jointly held pre-consultation workshops during 2011 with all Trusts and had engaged widely with the community and voluntary sector. The Strategy, he said, set out the community development commissioning priorities for the HSCB and PHA in relation to Trusts in the first instance.

Mrs McAndrew advised that preliminary discussions had already been held with the PHA in relation to identifying key actions to be taken forward to ensure implementation of the Strategy.

Members welcomed the Strategy. Mrs Kerr said that she was pleased to see emphasis placed on social justice and believed that the Strategy presents challenges to the Board as a commissioner of services.

Mrs McAndrew advised that, through the work of PHA Health Improvement, the Board had been approached by a number of community and voluntary organisations wishing to look at the delivery of services within their community. She emphasised that it was about empowering the community to promote health and social wellbeing. She said that it would be important for the Board to examine the potential implications for a number of commissioning decisions to demonstrate its commitment to bridge inequalities and social justice.

Dr C Harper said that the view of the PHA Board was that the commitment to health improvement and reducing inequalities should be clearly stated throughout the Commissioning Plan and not just within the Health and Wellbeing section.

Following discussion, the Community Development Strategy was **APPROVED** by members.

The Chair thanked Mr O'Neill for his attendance and Mr O'Neill withdrew from the meeting.

53/12 REGIONAL CHILD PROTECTION COMMITTEE (RCPC) REPORT – 1 APRIL 2010 – 31 MARCH 2011

The Chair welcomed Mr Tony Rodgers, Assistant Director, Children and Families, and Mr Martin Quinn, Safeguarding Officer, to the meeting.

Mr Rodgers advised the meeting that the Regional Child Protection Committee (RCPC) had been established in late 2009 to replace the legacy Area Child Protection Committees. It was noted that the RCPC had been established as an interim arrangement to ensure that a regionally co-ordinated approach to child protection was

maintained pending the implementation of the Safeguarding Board for Northern Ireland (SBNI). Mr Rodgers commented that the RCPC was required to produce an annual report as prescribed by the Co-operating to Safeguard Children Guidance (2003).

Mr Rodgers explained that the RCPC is a multi-professional multi-agency Committee and emphasised that, although social services staff in the HSCB and Trusts had responsibility for child protection services, a multi-disciplinary approach to this work was essential. In terms of accountability, Mr Rodgers confirmed that the RCPC and its chair were accountable to the HSCB which constituted the Committee. He added that RCPC members were also accountable to the agencies they represented and that these agencies in turn were responsible for taking any action which fell within their respective remits.

Mr Rodgers advised that the RCPC report outlined how it had conducted its business throughout the year and reflected reports submitted by the sub-groups, Trust Child Protection Panels. The report also highlighted key activities, including a statistical analysis of child protection activity, carried out during the year by the RCPC.

Members commended Mr Rodgers and Mr Quinn on a comprehensive report.

Following this discussion, members **NOTED** the RCPC Annual Report for the period 1 April 2010 – 31 March 2011.

54/12 CONSIDERATION OF PROPOSED PHARMACY FEES FOLLOWING CONSULTATION

The Chair welcomed Mr Joe Brogan, Assistant Director of Integrated Care, Pharmacy & Medicines Management, to the meeting.

By way of introduction, Dr S Harper briefly provided background to this issue. He explained that, since 2005/06, the DHSSPS and the representative group of pharmaceutical contractors (CPNI) had been in dispute regarding the overall financial package available to community pharmacy linked to the development of a new community pharmacy contract.

Dr S Harper advised that this had resulted in two judicial reviews being taken by the pharmaceutical contractors against the DHSSPS and the HSCB with respect to elements of reimbursement. He indicated that the first judicial review had found in favour of the applicants with a compensation package being negotiated as the mechanism for payments was deemed to be unlawful. The second judicial review found in favour of the applicants but no financial penalty had been imposed on the DHSSPS/HSCB, as the payment process was not deemed to be unlawful.

Mr Brogan pointed out that in December 2011, the HSCB wrote to CPNI proposing that the global sum would be subject to 0% growth (linked to Doctors Dentists Review Body) and remain at £51.4 million. Members' attention was drawn to the CPNI response. In summary, Mr Brogan said, that no material issues had been raised which affected the fees calculation.

However he said that legal advice sought by the Board had confirmed that the HSCB had a statutory obligation to consult on fees on an annual basis and, after consideration of responses received during that consultation, could form a conclusion on fees and proceed to apply that decision.

Mr Brogan drew members' attention to the fee model which had been proposed. He said that, given past experiences in respect of pharmaceutical payments and the recent judicial reviews, this matter would be sensitive.

In response to a question from Mr McKeever, Dr S Harper confirmed that the Board was in regular contact with CPNI representatives.

Mr Cummings said that he had also been involved in the negotiations with CPNI and added that, as offers made to CPNI had been rejected, the HSCB had very little choice but to proceed with the community pharmacy fees it had proposed.

Mrs Skelly said that it would be important to ensure that, should the Board approve the proposal before it, there would not be any detrimental effect on rural communities.

Responding, the Chief Executive pointed out that, of the £8 million investment announced by the Minister in March, £4 million would be targeted at rural and deprived areas, with £1.3 million specifically for rural pharmacies. He referred to a pilot project that would initially look at 73 pharmacies across Northern Ireland and which would determine the range of services required for a rural population. The Chief Executive said that £2 million, of the £8 million, had been earmarked for compliance issues.

Mrs Skelly thanked the Chief Executive for clarifying the issue. She said that it would be important to ensure that patient involvement in this work would be paramount and added that the PCC would be happy to assist as necessary.

Following this discussion, members **APPROVED** the community pharmacy fees as set out in the paper before the Board.

55/12 LCG APPOINTMENTS

Mr Bloomfield advised members that HR processes had now been completed in respect of a further General Dental Practitioner for the Western LCG and two Local Government members for the Western and Southern LCGs.

Therefore, he said, in accordance with Schedule 1, section 7 of the Health and Social Care (Reform) Act (NI) 2009, the following appointments are proposed:

- Cllr Bronwyn McGahan – Local Government member – Southern LCG
- Cllr Eamon McAuley – Local Government member – Western LCG
- Dr Ciaran Mullan – General Medical Practitioner member – Western LCG

Members **APPROVED** the appointments of Cllrs McGahan and McAuley and Dr Mullan.

It was noted that the Chief Executive would now write to the DHSSPS seeking approval to these appointments.

56/12 MINUTES OF GOVERNANCE COMMITTEE ON 1 DECEMBER 2011

Mr Leach gave a brief summary of the minutes of the Governance Committee meeting held on 1 December 2011.

57/12 LOCAL COMMISSIONING GROUP MINUTES

Members **NOTED** the minutes of the Local Commissioning Groups.

58/12 DATE AND VENUE OF NEXT MEETING

The next meeting of the Health and Social Care Board will take place on Thursday 26 April 2012 in the Boardroom, HSCB, 12/22 Linenhall Street, Belfast BT2 8BS.

59/12 ANY OTHER BUSINESS

(i) 'Connecting for Health'

The Chair sought approval for the Chief Executive to visit Copenhagen as part of a delegation on the 'Connecting for Health' initiative.

Members **APPROVED** this request.

(ii) Research and Development

Mr McKeever sought clarification as to the process involved in initiating research into specific health conditions.

Dr C Harper explained that this would fall within the remit of the Research & Development Division within the PHA and undertook to provide Mr McKeever with the relevant contact details.

60/12 RESOLUTION TO GO INTO CONFIDENTIAL SESSION

The Board **APPROVED** a resolution to go into Confidential Session to consider a number of confidential items of business.

Statement to HSC Board Members

29th March 2012

Presenting on behalf of Independent Health and Care Providers - IHCP

Hugh Mills Chief Executive

Accompanied by Janet Montgomery, Hon Secretary

Independent Health and Care Providers (IHCP) wish to thank the Chair and members of the Board for granting us this opportunity to address you at your meeting today. This is the first time we have addressed the Board and the decision to make our request is not taken lightly. We believe that Board members should be in receipt of all the appropriate information before reaching your decision on the proposal contained in the paper being considered under item 9 on your agenda. Indeed the lack of information within this paper conveyed to Board members following our representations is a matter of significant concern given the legal requirements associated with your decision today.

The Board is required to set care home tariffs (known as 'the Regional Rate') each year. **The Board is legally obliged to ensure that the Regional Rate is sufficient so as to ensure that quality services are procured, that the rate is fair and that it is affordable.** IHCP is of the opinion that Board officers have failed to pay adequate regard to these legal obligations.

FAIRNESS

In November 2011 IHCP presented an independent analysis conducted by PricewaterhouseCoopers titled 'Social Care in Northern Ireland – A better future for us all'. In section 5 this study analysed NI independent care home fees and costs. You will note in the graph provided from page 38 of the report that in comparison with a range of benchmarks the current fees were below the actual cost of care by between 7% and 21%. IHCP representatives therefore believe **the current rate does not meet the test of fairness.** Board officers have rejected this independent evidence and surprisingly there is no reference to it in the paper they have tabled. They have also failed to undertake any other enquiry into the actual costs. Without knowing what the actual costs of care are, the Board is not able to determine what a fair fee rate is. We strongly believe that it is inequitable for the Board to set the Regional Rate at a level which is significantly below the actual costs.

Furthermore the proposed 2.5% increase does not meet current inflationary increases. Our analysis of pay inflation is 3.5% based on 1% for NIC and 2.5% increase in the Minimum Wage in Oct 2011 and a further 1.9% (11p to bring to £6.19) scheduled for Oct 2012. Many providers in the sector are forced to offer pay at or close to the Minimum Wage and therefore pay inflation in the sector is dictated accordingly. These are statutory obligations placed on providers in 2011 and are causing a significant strain on resources. There has been no pay uplift by many providers for over two years. Cost pressures in the non-pay categories range from 5% to over 30% in energy costs. In the circumstances, were the proposal to be adopted, the gap between the Regional Rate and the actual cost will continue to grow.

QUALITY

There is an obvious connection between the Regional Rate, the quality of the care that homes can provide and the sustainability of the sector. Board members will be aware of the closure of one major provider last year. This was due to a number of factors including lower occupancy levels and the rate of fees paid. IHCP has informed the Board of recent evidence from RQIA (in the form of 'failure to comply' notices being placed on care homes) of falling standards of quality. It is not apparent that Board officers have paid any attention to this evidence. There is no mention of these aspects in the

paper you have received and **we have received no assurance that the reasons for this fall in quality are under investigation.**

Members are reminded that the independent care sector now provides the vast majority of social care for the most vulnerable groups of adults in our society. Providers strive to meet and exceed quality requirements so those in our care receive a good level of service and we require sufficient funding to ensure that this is achieved.

AFFORDABILITY

Affordability is a relevant consideration. **However, Board officers are placing an improper level of regard to affordability, to the exclusion of the other legally required considerations.** We understand the need for Board members to meet their financial stewardship responsibilities and recognise that funds have to be allocated appropriately. The PwC Report referred to above also found 'that care home places can be provided at a lower cost in the independent sector compared to the statutory sector'. Therefore the sector is well able to demonstrate value for money.

In response to the request to contribute efficiency savings our members have reported to us many examples of increased efficiency as well as coping with increased dependency of residents. Increased dependency of new admissions as well as existing residents has meant that more staff time is spent on the delivery of personal care which impacts on the capacity to provide activities and stimulation for residents. As an illustration of the impact of increased dependency a home manager reported recently that when she started working in a 25 bed care home 6 years ago there were 3 residents who required assistance with feeding; today she has 12 who require assistance. Regrettably our members report that there is reluctance of Trust staff to recognise increased dependency issues with adequate resources.

Apart from the resources available to the Board from the DHSSPS, the Departments of Work and Pensions and Social Security also contribute through pensions and other benefits to the costs of each resident in care homes. We estimate that the contribution which will be applied from 1st April will result in an approximate 5% increase in pensions and benefits resulting in extra resources available to the Trusts. This would equate to approximately an extra 1% that could be applied to the fees. This has been applied in Scotland providing an increase in total of 2.75% on already higher rates for care. A similar approach in NI would enable the Board to add the extra 1% and therefore be able to afford a 3.5% increase in fees.

CONSULTATION

Finally, Board officers have failed to consult properly on the proposal. We learned last Friday that the recommendation to the Board would be a 2.5% increase. We don't expect a formal 12 week public consultation process but at least sufficient time to test proposals with our members in a considered manner.

CONCLUSION

In conclusion we must ensure that Board members are aware that you have little option if you are to meet your legal obligations but to reject the proposal as presented. As an alternative proposal, in order to discharge your legal duties, we request that the Board

1. **Engages with an open mind with IHCP and the care home sector on the setting of a Regional Rate for the year 2012/13 based on the true economic costs of care**
2. **Applies the available funds of 3.5% increase in fees as an interim uplift on care home fees pending a full and proper review of the fee rates for the year 2012/13.**

Thank-you for hearing our representation on this important issue for our residents and members.

Figure 5.1: %shortfall of tariff compared to indicative costs