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WEST GLOUCESTERSHIRE PRIMARY CARE TRUST

**Notes of the PCT Public Board meeting
held on Thursday 17th November 2005 at 9.30 am
at Highnam Business Centre**

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| Present: | Hugh Annett Ahmed Bham Liz Boait (Chair) Stephen Golledge Derek Harbottle Mark Hendry Anny Reid Mike Roberts Susanne Noblett Fred Simpson Mike Theelke | Director of Public Health Non-Executive Director Non-Executive Director Chief Executive Non-Executive Director Non-Executive Director Non-Executive Director Chair of Professional Executive Committee Professional Executive Committee member Non-Executive Director Director of Finance |
| In attendance: | Amanda Fisk John Ford Jenny Kirkby Ann McCluskey Sarah Robinson | Director of Performance and Corporate Development Director of Service Delivery Personal Assistant to Director of Performance and Corporate Development Director of Human resources and Organisational development Assistant Director Corporate Development |
| Also present: | John Hale – Rebecca Potts – | Member of the Public PPI Forum |

136/05 APOLOGIES FOR ABSENCE

Apologies were received from Jan Marriott, Director of Clinical Development.

137/05 MINUTES OF THE MEETINGS HELD ON THURSDAY 15th SEPTEMBER 2005

These were agreed as an accurate record.

138/05 MATTERS ARISING

There were no matters arising.

139/05 CHAIR'S REPORT

Liz Boait welcomed those present at the meeting.

Liz presented her report and explained that changes in non-Executives responsibilities have led to the process of appointing a new Vice-Chair. Liz confirmed that Fred Simpson had kindly volunteered to take on the additional responsibility of Vice-Chair and the Board approved this change for the remainder of the life of West Gloucestershire PCT. Liz also thanked Mark Hendry who had been Vice-Chair since 2002. Liz highlighted that all non-Executive lead roles were accessible on our website.

Liz also confirmed that the Appointments Commission had recently reconfirmed the terms of office for herself, Derek Harbottle and Mark Hendry.

Liz reported that the PCT would be assessed on Improving Working Lives (IWL) Practice Plus validation during week commencing 28th November 2005. It was noted that Liz, and Ann McCluskey (Director of Human Resources and Organisational Development) had already met with the assessors and that we would hear in early January if the PCT has achieved Practice Plus Status.

Liz highlighted the launch of the Smoke Free Gloucestershire Vision on 5th October, and encouraged members to sign up to the vision statement.

The Board noted the contents of the report.

140/05

PROFESSIONAL EXECUTIVE COMMITTEE (PEC) CHAIR'S REPORT

Mike Roberts presented his report highlighting the presentation of the PEC Clinical Strategy to Board members at a recent PEC/Board Development Session. He explained to members that the Clinical Strategy which has been developed by the Professional Executive Committee sets out the key objectives in the areas of unscheduled or urgent care, chronic disease management and outpatients and diagnostics. The strategy will guide future planning.

Mike confirmed to the Board that Dr Chris Nancollas has tendered his resignation from the PEC due to practice workload pressures. Due to the current organisational changes the PCT will not be recruiting to fill the vacancy. Liz Boait confirmed that she had written to Chris thanking him for his contribution and work on behalf of the Board.

Mike reported that the Primary Care Centre and the Accident and Emergency department at Gloucestershire Royal Hospital are now working more closely together and that a review of clinical protocols, for the management of patients presenting to the A&E department that are suitable for treatment within the primary care sector is about to begin. Mike confirmed that the two week pilot of the Practice Nurse Facilitator was a success with the redirection of 32 patients, most back to their GP practice, at a saving of £61 per patient. Derek Harbottle enquired if the Practice Nurse Facilitator post was going to continue and Mike confirmed that they were currently looking for a team of people who could do this work on a rota. Fred Simpson asked how patients perceived this when they arrived at A&E and then diverted back to their GP practice. Mike reported that there is a degree of flexibility depending on where they have travelled from and what time it was.

Lastly, Mike reported that the Hucclecote practice had put in a request to the PEC to change their boundary. The reasons for this are that the practice has reached capacity and all alternatives for expansion have been explored and found not to be practicable. The PEC, in acknowledgement of the consultation undertaken with other practices who would take up any patients are no longer able to receive their care from the Hucclecote practice, approved the change. Mike recorded that it was a positive change that more practices were coming to the PEC to request advice or consultation with the PCT about such issues.

The Board noted the contents of the report.

141/05 CHIEF EXECUTIVE'S REPORT

Stephen Golledge presented his report.

Stephen highlighted the NHS Organisational Development programme and noted that it continues to be a slow and gradual process with Avon, Gloucestershire and Wiltshire Strategic Health Authority still not knowing their boundaries ahead of consultation on the number of PCTs. No further work towards planning for a Gloucestershire PCT could take place at this stage as it would be seen as pre-empting the outcome of the consultation.

Stephen reported that the Older People's Mental Health Services consultation document was expected soon although actual publication date was not yet determined. He confirmed that there was a possibility that the Board Development Session on 15th December may have to be changed to incorporate a short public meeting to discuss the consultation due to the tight timescales.

The Board noted the contents of the report.

142/05 AUDIT COMMITTEE

Derek Harbottle presented the report from the Audit Committee held on 6th October. He alerted the Board to the publication of the NHS Audit Committee Handbook 2005 and notified the Board that the Audit Committee will review the Handbook and bring revised Terms of Reference to the Board.

Derek summarised the key points of discussion at the Audit Committee including data quality, progress on the audit plan for 2005/06, new audit evaluation tools and the outcome of the QOF spot check process. It was noted that the internal audit plan on target to achieve 66% of the annual total by the end of December.

The Board noted the contents of the report.

143/05 ANNUAL AUDIT LETTER

Derek Harbottle presented the Annual Audit Letter from the Audit Commission to the Board. He emphasised that the letter was addressed to all members of the Board and requested that they note the recommended action in paragraph 7 that the Board should undertake. He highlighted that the letter confirmed an unqualified opinion on the accounts with the exception of the PCT not meeting the statutory duty to achieve financial balance. Liz Boait confirmed that it was critically important for the Board to observe these actions, particularly reviewing deviation from the financial plan. Liz stated that any variances from the financial plan should be discussed in the public arena.

Mike Theelke commented on the difficulty in signing off the accounts in time as mentioned in paragraph 11, however a list of actions had been agreed as outlined in paragraph 12. The positive messages in paragraphs 30, 38 and 43 were highlighted by Derek.

Members attention was drawn to the revised Audit Fee proposed by the Audit Commission.

The Board noted the contents of the Audit Letter and approved the audit fee tabled under Appendix 3.

144/05 CHARITABLE FUNDS COMMITTEE

Liz Boait presented the report asking the Board to receive the draft minutes of the Charitable Funds Committee meetings held on 27th October and 28th July 2005,

together with the Annual Accounts and Annual Report for the financial year ending 31st March 2005, and the Annual Report for the year ending 31st March 2004.

Liz circulated to members a leaflet which will hopefully encourage more people to donate to the Charitable Funds. Liz will ensure members get sufficient copies.

The Board received the draft minutes and adopted the accounts and Annual Report for 2004/05 and the Annual Report for 2003/04. Members also approved the amendments to the registration in Annex 4.

145/05 INTEGRATED GOVERNANCE COMMITTEE

Amanda Fisk presented the report from the Integrated Governance (IG) Committee and asked the Board to receive the draft minutes of the inaugural meeting held on 22nd September 2005.

Amanda confirmed that Fred Simpson was appointed as Chair of the Integrated Governance Committee.

Susanne Noblett identified an error in the minutes of 22nd September 2005 – Alex Harrington should be recorded as “PEC Member” and not a non-Executive Director.

Liz Boait highlighted that the Integrated Governance Committee is a sub-committee of the Board and its critical role in part was to give assurances to the Board and the Public on the PCT’s governance arrangements.

Amanda reminded members that representation on the group was from non-Executive Directors, PEC members and clinical members. Members discussed the cross connections between the IG Committee, the PEC and the Board and it was noted that there was representation from the PEC, Audit Committee and the Board to ensure a flow of communication across the governance structure. Fred Simpson questioned how the Clinical Governance Steering Committee would now operate and it was noted that this was under review as part of the evolving process of the development of the PCT’s governance structure.

Ahmed queried the Integrated Governance Committee communication channels and asked the PEC to oversee the working processes of the new committee in picking up issues early on. It was noted that the current Risk Register shows all the clinical and non-clinical risks covered in the Assurance Framework, which captures and identifies more explicitly the high risks for the organisation. Further work would be undertaken on the Risk Register over the next few months.

Mark Hendry highlighted that complaints was not featured on the structure chart. Amanda agreed to amend and re-issue to members.

The Board noted the report of the Integrated Governance Committee their draft minutes and noted the development of the Risk Register.

146/05 CLINICAL GOVERNANCE ANNUAL REPORT

Stephen Golledge asked members for their comments on the Clinical Governance Annual Report for 2004 – 05 presented in the form of a fold up report in the papers.

Liz Boait stated that the report should be on the website and also record an author on the end of the report.

Fred Simpson enquired whether by using measures or targets next years report would show achievements over the previous year. Hugh Annett explained that the report is structured around the Healthcare Commission Standards for Better Health format.

Ahmed Bham queried where the opportunity is for patients to have a say and to feed into the document. Stephen confirmed that patients could formally comment through the Patient and Public Involvement process, patch networks, Health Forums and complaints routes.

Anny Reid highlighted the importance of clinical supervision and reported that from talking to Health Visitors, she was concerned that they are not doing as well as they should be in this respect. John Ford reported that this was at the front of Jan Marriott's agenda and assured members that annual appraisals are being rolled out. Susanne Noblett gave members some background information pointing out that Health Visitors could opt in or out of clinical supervision.

The Board noted the contents of the report.

147/05

PERFORMANCE REPORT

Nicki Millin presented the monthly performance report. Nicki summarised the key outlying areas of performance as at September 2005. Due to an administrative error at North Bristol NHS Trust a patient had waited for over 17 weeks for an outpatient appointment.

The Gloucestershire Ambulance Service NHS Trust continued to fail to meet the Category A target. Mike Roberts raised a query about performance in meeting GP urgent calls versus "blue light" or Category A targets. Mike considered that the GP community were requesting ambulances under the Category A target due to difficulties in achieving GP urgent call outs within the required timescale. However this had not resulted in a decreased number or improved performance in GP urgent call outs. The Gloucestershire Ambulance Trust remains under a Performance Improvement Plan with the Strategic Health Authority and are starting to use Emergency Care Practitioners to triage calls which will help to meet targets.

In relation to waiting times it was noted that the Gloucestershire Hospitals NHS Foundation Trust continued to reduce the numbers of patients waiting over 6 months (inpatients) and over 13 weeks (outpatients) as the end of December target date approached. However the situation remained tight with considerable attention being paid by GHNHSFT and the PCT.

During October 2005, GHNHSFT had not met the 4 hour maximum wait time target in A&E. The situation was improving but continued to be closely monitored.

Nicki noted that there had been a deterioration in the number of delayed transfers of care. This was due to the de-registration of Great Western Court following an inspection visit.

In relation to the graphs of supporting data in Appendix 1, Derek Harbottle queried the absence of route of admission for non electives and trends analysis. Ahmed Bham was also concerned that we knew the reasons for changes or increases in activity in A&E and for non elective admissions. It was agreed that graphs showing the route of non elective admission, for example by Ambulance, through A&E or through the Acute Admissions Unit, and historical trend analysis would be incorporated into the graphs. Amanda Fisk confirmed that she and Nicki would undertake this piece of work and share with Derek Harbottle and Ahmed Bham ahead of the next Board meeting.

The Board noted the contents of the report and the actions being undertaken to maintain and improve performance.

FINANCE REPORT

Mike Theelke presented to the Board the financial position of the PCT as at 31st October 2005.

Mike reported that the PCT is showing an overspend of £748,000 at the end of September and a "best case" forecast overspend of £450,000. The "worst case" forecast overspend of £2,180,000.

Fred Simpson queried if it was the worse case scenario whether activity levels would stay as they are. Mike drew members' attention to Annex 2 the Summary of GHNHSFT contract showing the forecast variance in activity for both for the best and worst case.

Mike explained that the non NHS provider budgets charges to date are overspent by £711,000 and is forecast overspend by £1,018,000 in 2005/06. The key areas of pressure are Private Sector Placements (£1,058,000); Mayfield Trust (£143,000) and Nursing Home Placements (£461,000) offset by savings on Long Term Care Payments (£444,045) and Continuing Care Equipment (£191,000). The PCT has agreed additional protocols with Cheltenham and Tewkesbury (the lead PCT on Private Sector Placements) on the placing of new clients. The forecast has deteriorated steadily in the first half of this year, and between month 6 and month 7 by £158,000.

Mike reported that the PCT has calculated that the forecast overspend for prescribing is £200,000 including an overspend of £187,000 on central drug costs. The PCT is experiencing zero rolling growth as at September 2005. Mike referred to Annex 3 – Practice Prescribing Budgets 2005/06 - and explained that due to price changes the budget would continue to reduce in the short term.

Mike drew members attention to Annex 5 showing the Financial Recovery Plan (FRP) actual savings against the target. Mike confirmed that following discussions with the Strategic Health Authority (SHA) about capital IT schemes, there would be a significant benefit of about £2M across the 3 PCTs. Further detail would follow in the full FRP report but Mike highlighted that the FRP position has improved.

Nationally, it is still anticipated that there will be a significant cash shortage this year. The PCT's cash limit has been 'topliced' nationally by £2million to support this. In addition the Department of Health have indicated that there will be an incentive scheme set up for cash brokerage whereby organisations offering up surplus cash will receive it back next year plus interest. It is anticipated that this will bring more cash into the NHS Bank to support organisations with cash shortfalls.

Mike reported that he and Stephen Golledge had met recently with the Chief Executive and Director of Finance of the SHA to discuss the wider financial position. Each organisation in the Strategic Health Authority's boundary is being set a "control total" to achieve in order to deliver financial balance in aggregate for the SHA. The control totals are not yet finalised, but it has been indicated that West Gloucestershire may be expected to achieve a £0.5M surplus as its contribution.

FINANCIAL RECOVERY PLAN PERFORMANCE MONITORING REPORT

Amanda Fisk presented the paper and explained that the fifth Challenged Organisation meeting had been held with the SHA on 8th November 2005.

Amanda drew members attention to the assessment of FRPs for all challenged organisations across AGW, using criteria to establish whether the FRP will deliver recurrent and in-year financial balance. A paper submitted to the AGW Public Board meeting on 3rd November 2005 showed an overall assessment of the West

Gloucestershire PCT FRP as “green”. West Gloucestershire PCT is the only challenged organisation which has secured the approval of the SHA on their FRP.

At the 8th November 2005 meeting progress against the actions identified in the letter following the meeting on the 8th October was reviewed. At this meeting, the FRP was reviewed in the context of further slippage of approximately £700K being used to offset some of the risks in delivery of the schemes. In addition the proportion of schemes classified as “green” had increased to 78%.

Stephen Golledge explained that a Challenged Organisation meeting would not be held in December but the usual information report would be shared with the SHA.

Fred Simpson emphasised that the FRP work needed to be continued with the same rigour. Amanda explained that the PCT was not being complacent and that it was acknowledged that there is a lot more to be done to achieve financial balance.

John Hale raised a query at this point about the relationship between private providers and the PCT and the community hospitals. John considered that local people wanted the PCT to make any decisions and not future, different organisations. Liz Boait assured John that the PCT was determined to see the community hospitals work through and should be in existence long enough to reach the decision making stage.

The Board noted the contents of the report.

150/05

COMPLAINTS QUARTERLY REPORT

Debbie Townsend presented the complaints summary for the period 1st September to 30th September 2005.

Debbie confirmed that 51 complaints have been received or carried over from the previous quarter, compared to 26 received in the same period last year. Out of this number 15 complaints related to the out of hours service. It was noted that several complaints had also been received from the prison with 15 complaints received between 1st April and 30th September 2005.

It was noted that the Healthcare Commission had become responsible for the second or final stage of the NHS complaints procedure, and was still experiencing a considerable backlog. In relation to future complaints arrangements, draft regulations were still anticipated later in the year.

Rebecca Potts for the PPI Forum commented that the Forum received feedback from members of the public and enquired whether there was any way to feed that information back to the PCT as they were not mentioned in the report. Liz advised that a channel should be in place. Amanda Fisk agreed to consider this with Jan Marriott and report back to Rebecca.

The Board members noted the contents of the report.

151/05

GLOUCESTERSHIRE PARTNERSHIP NHS TRUST FOR FOUNDATION TRUST STATUS

Sandra Betney, Director of Finance and Julie Soutter, Assistant Director (Planning and Performance) made a presentation in support of the application for NHS Foundation Trust status. Copies of the Public Consultation document had been made available to Board members prior to the meeting, and were also available on the day. The presentation was in two parts. Firstly the achievements of the Partnership Trust so far were set out, in particular noting that the Trust had achieved 3 star status in each of the three years of its existence. Board members were reminded of the national policy for all NHS Trusts to achieve Foundation status by 2008. The purpose of achieving Foundation status at the Gloucestershire Partnership NHS Trust (GPT) lay in strengthening links with service users, carers

and wider communities, with members of staff being actively involved and engaged. The public consultation would run for three months and staff would automatically become members. The second part of the presentation focused on the proposed constitution, membership and governance arrangements. It was pointed out that there would be 6 public constituencies from which members would be drawn, based on existing parliamentary boundaries. The key dates for the application following the three month public consultation were outlined; the application would need to be submitted to the Department of Health by the 9th December 2005 and a decision by the Secretary of State was anticipated in January 2006. If successful the Foundation Trust would "go live" from 1st April 2006.

Following the presentation Stephen Golledge confirmed that each of the Gloucestershire PCTs was currently receiving presentations to Boards and PECs. It had been agreed that all the comments would be submitted to Cheltenham & Tewkesbury PCT who would respond to the Gloucestershire Partnership NHS Trust on behalf of the three PCTs. This was in recognition of the lead commissioning role for mental health and learning disability services played by Cheltenham & Tewkesbury PCT.

The ensuing discussion raised a number of queries and comments as follows:-

- i. Fred Simpson enquired about the learning for GPT from the Gloucestershire Hospitals NHS Foundation Trust. Sandra Betney confirmed that much valuable advice had been received, particularly around the constitution and financial modelling aspects of the application process. GPT had also learnt how important it was to achieve clarity on the role of governors in the new constitution, but also realised this was difficult given the responsibility of governors to decide this aspect themselves. The main difference between the two Foundation Trust applications was the large number of members which had been achieved at an early stage by GHNHSFT. There is currently less interest in GPT Foundation Trust membership, which could reflect a lack of understanding in the wider community about the difference between the two Foundation Trusts. However the strength of GPT lay in the existence of current Patient and Public Involvement networks which they would use and build on as part of a wider membership network.
- ii. Hugh Annett raised concerns about possible under representation of hard to reach groups, for example the prison. It was confirmed that GPT had developed a whole strategy covering just membership which included dealing with the challenges of connecting with hard to reach communities, and using the existing communities of carer and user networks, for example in learning disability services. The application form had also been adapted for use with different client groups and in different communities.
- iii. Stephen Golledge acknowledged the national policy imperative for all NHS Trusts to move towards Foundation Trust status, and in this context enquired about the medium term strategy for a relatively small organisation serving a Gloucestershire community, and in the context of potential links with the Avon and Wiltshire Partnership Trust (AWP). Sandra Betney clarified that the Strategic Health Authority has supported the Gloucestershire Partnership Trust moving ahead to Foundation Trust status first, out of the two specialist Mental Health and Learning Disability Trusts. However at the time when AWP will be due to apply for Foundation Trust status, both organisations will need to reconsider the options for a single Avon, Gloucestershire and Wiltshire – wide Foundation Trust. What was clear was that GPT would not have to lose Foundation Trust status if both organisations were combined. Therefore the medium term strategy was based on GPT as a Foundation Trust having a stronger position from which to embrace broader strategic objectives for a larger, specialist and more financially viable Trust in the future. In relation to the financial position Sandra Betney confirmed that GPT had examined the 5 year financial projection and as part of Monitor's assessment would need to demonstrate breakeven in 2005/06 and recurrent

balance within the next 4 to 5 years. As part of its application process GPT would be stating that it was on the margins of financial viability, and Monitor would evaluate these risks as part of the assessment phase before the Secretary of State for Health makes a decision on the application. Therefore the minimum commitment required from PCTs was to fund inflation and the developments set out in the Service Development Strategy was.

- iv. Following on from the conversation about financial viability for the whole health community, Liz Boait raised the issue of the current cost of private placements and the desire of the community to repatriate patients into Gloucestershire in order to free up resources for investment in county services. In response Sandra Betney confirmed that the Trust was keen to engage and help, but was not in a position to take on high levels of risk to manage activity if the private placements budget did not reflect current levels of expenditure. However GPT is jointly responsible for a county-wide solution and was keen to discuss a phased approach to the transfer of responsibility, and budgets, within an agreed risk management process.
- iv. Mike Roberts asked how GPT would ensure that there was not an imbalance between the views of members from particular constituencies directing support, services and resources away from areas of greatest need. Julie Soutter confirmed that it was the responsibility of the governors to challenge the Board on mechanisms for needs assessment and equity of resources, and this would act as a safeguard.
- vi. Ahmed Bham, building on Hugh Annett's comments previously, reiterated concerns about under representation of hard to reach groups and the approach to the involvement of minority communities. The assurance was given that the governance arrangements would support co-option, and this could be exercised to ensure appropriate inclusion of hard to reach groups. The approach to involve minority communities has evolved through informal and personal interaction with small groups and the development of different models for involvement to meet the needs of specific groups.
- vii. John Ford acknowledged the complexity in ensuring access to resources based on assumptions for service reconfiguration. It was vital that the expectations of commissioners and GPT on the priorities and resource allocation in response to service reconfiguration was set out clearly. It was acknowledged that this was the territory of the Service Development Strategy which contained assumptions into the future for each care group based on levels of activity, demography, current resources and expectations from reshaping of services. A group of commissioners from all the PCTs had been meeting monthly to draw up these assumptions and agreement was anticipated, to meet the timescales of the Foundation Trust application.
- viii. Mike Roberts emphasised the importance of clinical engagement in the PCTs, which was now in transition to practice based commissioning. The commissioners for the future for mental health and learning disability services would therefore be groups of practices and a constructive dialogue with GPs would be required. This was acknowledged as a relevant and important point and the Service Development Strategy was considered to be the first step on this path. The legally binding contract between commissioners (currently PCTs) and the Foundation Trust would clarify expectations and assumptions for all parties.
- ix. Susanne Noblett requested that some reference to maternal deaths in the adult mental health category be made, given the high level of risk and actual suicides amongst young mothers. It was acknowledged that the list of services in the consultation document was not the full list of services provided, and that this was an important category of need.

Liz Boait thanked Sandra Betney and Julie Soutter for the presentation. Following their departure the Board agreed that Amanda Fisk would capture the discussion through the minutes and with the approval of the Chair and Chief Executive draft a letter incorporating the comments from the PEC on 3rd November 2005, and the PCT Board, and submit to Cheltenham & Tewkesbury PCT to incorporate in their response on behalf of the Gloucestershire PCTs.

152/05 HEALTHCARE COMMISSION'S ANNUAL HEALTH CHECK

Sarah Robinson updated the Board on the Standards for Better Health draft declaration for the Healthcare Commission.

Sarah reported on the "insufficient assurance" reported for each of the following standards:-

C4b (staff and visitors kept safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised), C4c (all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed), C4e (to ensure that the prevention, segregation handling, transport and disposal of waste is properly managed) and C9 (a systematic and planned approach to the management of records).

Sarah highlighted that where there is insufficient assurance declared, the PCT has submitted an action plan with the draft declaration detailing what will be done to achieve evidence of compliance.

Derek Harbottle asked what will happen where we declare insufficient assurance in March 2006. Amanda Fisk explained that this is a new system for the PCT and the Healthcare Commission and that we will find out about the scoring in due course.

The Board noted the work programme and timetable for the final declaration and approved the internal working arrangements.

153/05 BUSINESS PLAN AND ASSURANCE FRAMEWORK 2005/06

Amanda Fisk presented the Business Plan and Assurance Framework 2005/06, updated to the end of October 2005.

Amanda restated that the Business Plan was based on 3 elements:-

- National targets (Public Service Agreement targets for the NHS and Social Services)
- Standards for Better Health
- Financial Recovery Plan (which forms part of a separate paper to the Board)

The Business Plan is set out in section 1 – National Targets, section 2 – Standards for Better Health and is supported by the Assurance Framework.

Liz Boait commented that the documents contained a lot of information and asked how often they would be reported to the Board. Amanda confirmed this would be quarterly.

Fred Simpson considered the business plan to be a good format.

The Board noted the contents of the Business Plan and progress to date against the key milestones and approved the Assurance Framework. The

Board also noted the ongoing performance management arrangements for the 2005/06 Business Plan.

154/05 LOCAL DELIVERY PLAN 2006/07 TO 2008/09

Amanda Fisk presented the Local Delivery Plan to members and explained the key drivers for 2006/07 as:-

- The PCT Strategic Service Direction 2005 to 2008 Meeting the Challenges Ahead.
- The PEC Clinical Strategy.
- The 7 key targets for the NHS in 2005/06 identified by Nigel Crisp.
- Choosing Health.
- The Workforce Development Strategy.
- PCT reconfiguration
- Policy changes such as Choice, the move towards practice based commissioning and Independent Sector procurement.
- The requirement to achieve Foundation Trust contract and provider Trust Service Level Agreements in stated timescales.

There was wide ranging discussion about the opportunity to include voluntary organisations as providers in the Local Delivery Plan. It was concluded that it was a direction of travel but not a priority for this financial year due to the financial position.

Amanda highlighted that the county level Strategic Commissioning Group (SCG) had initiated the county level LDP process which would link with the 3 PCTs.

The Board members considered the level of engagement by the Board, PEC and GPs and it was agreed that more time would be spent on this subject at the forthcoming Board & PEC Development Session on 24th November 2005.

The Board noted the contents of the Local Delivery Plan and endorsed the process underway to secure a balanced LDP for the PCT and its successor PCT for the period 2006/07 to 2008/09.

155/05 CAPITAL & ESTATES REPORT

Mike Theelke updated the Board on the progress of the PCT's Capital and Primary Care Estates Programmes.

Mike confirmed that Churchdown Surgery have now obtained outline planning permission for their plans from Tewkesbury Borough Council. More work is needed on the development of an affordable design solution, and a business case and financial appraisal should be with the PCT in time for the next Capital & Estates sub-group on 6th December.

Mike reported that tenders received for the works to the Lydney hot water system are in excess of the initial estimates of the consultants. They are currently being reviewed by the Estates Shared Service but additional resources may need to be made available. A set of costed works are currently awaiting consideration by the Capital & Estates sub-group although these may have to be reconsidered if the Lydney scheme requires additional funds.

Liz Boait asked why there was no update on the Westgate Street initiative. Mike confirmed that West Gloucestershire PCT are not leading on it and that we were a small partner in the initiative. It was agreed to bring updates to the Board when there was any relevant news.

It was agreed that a list of planned schemes would be listed on future reports.

Mike brought to the attention of the Board the Framework Agreement for Professional Advice (Construction) Appointments.

The Board noted the contents of the report and approved the adoption of the Framework Agreement.

156/05

SECOND ANNUAL REPORT ON SANDHURST LONG TERM FOLLOW-UP STUDY

Hugh Annett presented the Second Annual Report on the Sandhurst Long Term Follow-up Study of the health of local residents following a major chemical incident in 2000.

Hugh explained that the statistical power of such a study would be low due to the small numbers of residents involved and the lack of information about exposure. Lack of statistical power is a common occurrence in small studies of exposure incidents and reduces the ability of researchers to draw robust conclusions.

Hugh reported that the Project Team commenced work on revising the study protocol but encountered further difficulties with designing a study with sufficient statistical power. Further expert advice was obtained. The Steering Group discussed the issues and it was decided that although the study was statistically weak there was sufficient benefit to be obtained to justify continuing the study.

The study protocol has been redrafted to include all previous control groups within a new enlarged study population. A new appropriate control group is being identified within the county with the help of expert independent advice. The revised protocol will be submitted both for local ethical approval and to the national committee for monitoring flagging studies submitted under section 60 of the Health and Social Care Act (2001).

Fred Simpson asked if the PCT had a litigation implication from the study and Hugh reported that it did not.

The Board noted the contents of the report.

157/05

DATES FOR 2006

Liz Boait presented to members Public Board meeting dates 2006.

The Board agreed the 2006 dates.

158/05

DATE OF NEXT MEETING

The next full Board meeting will be held on Thursday, 19th January 2006, 9.30 am in the Board Room at Highnam Business Centre. A public meeting may be held on 15th December 2005, 9.30 am to discuss Older People Mental Health Services.