Present:
Huw Charles-Jones Chair & GP representative – City
Andy McAlavey Vice Chair & GP Board Member
Alison Lee Chief Operating Officer (Interim)
Gareth James Director of Finance (Interim)
Jeremy Perkins GP Representative Ellesmere Port and Neston
Laura Millard GP Representative City
Steve Pomfret GP Representative Rural
Rachel Hopwood Non Executive Advisor
David Clark Non Executive Advisor
Sam Jeffery Practice Manager Representative

In Attendance:
David Parry Head of Estate Strategy and Investment
Laura Marsh Head of Commissioning
Christine France Minute Secretary

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<th>05/11</th>
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<tr>
<td>A</td>
<td>APOLOGIES FOR ABSENCE</td>
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<tr>
<td></td>
<td>There were no apologies.</td>
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<td>B</td>
<td>DECLARATIONS OF MEMBERS INTERESTS</td>
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<td>Huw Charles-Jones, Andy McAlavey, Jeremy Perkins, Laura Millard and Steve Pomfret declared an interest as partners in practices who are potentially affected by the new development in item 10 (Northgate).</td>
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<td>C</td>
<td>WELCOME</td>
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<td>Huw informed the board that he had attended a Commissioning Conference in London yesterday. Andrew Lansley, Secretary of State for Health, was the opening speaker and confirmed some of the changes announced by the Government in response to the Future Forum report He confirmed that consortia would be known as clinical commissioning groups to reflect wider clinical involvement. The composition of the board will change with secondary care hospital clinician and a nurse as Board members but neither can be employed by a local provider due to a conflict of interest as the Consortium will hold the contract for these organisations. Managing conflicts of interest was a message repeated throughout the day. We expect further guidance to come on this issue. There was a discussion on clinical senate and Huw got a sense from Andrew Lansley that this might be a wider geographical area than the senate our Consortium is already running but the panel suggested that this might be local health economy size which would fit with ours.</td>
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Huw also spoke with a number of private sector organisations who could provide services to the consortium, particularly in niche areas. Huw gave the example of a company based in Chester that provides health checks and data analysis work for several Primary Care Trusts. This would be an area worth exploring for us if we were struggling to carry out health checks.

10 FULL BUSINESS CASE INTEGRATED CARE CENTRE: NORTHGATE

David Parry introduced the Full Business Case for the proposed integrated care centre at Northgate and confirmed that the Board Paper outlined how the strategy for Northgate has been discussed and approved on a number of occasions, but confirmed that the development would only succeed with full support from the Consortium and requested Board approval in accordance with the board paper recommendation.

David confirmed that the case had brought together a number of comprehensive workstreams and had been developed with involvement from four Consortium Member practices and individual GPs; Tony Bland, Iain Minshall and Bernard Mills. The case had taken into account issues, concerns and suggestions received from other Consortium Members in GP network meetings.

David confirmed that subject to approval by the Consortium Board, the business case would then be shared with the Primary Care Trust Board at their meeting on 6th July. In addition the Business Case was also being shared with the Strategic Health Authority to ensure endorsement to proceed, in accordance with recent delegated authority directives.

Assuming approvals to proceed, David confirmed that legal contracts would be exchanged with the Developer requiring a number of conditions to be fulfilled, prior to entering into a formal contract to construct. The pre-conditions include full planning approval, agreed detailed design and specifications, District Valuer support and legal contracts agreed. The current programme indicates that these conditions will be fully addressed by January 2012, enabling construction to commence in February 2012 with overall completion date identified as April 2013. David would bring back to the Board confirmation or to raise any issues arising from the four conditions and the legal process in due course.

Huw asked what level of detail has been shared with the Countess of Chester Hospital and Cheshire and Wirral Partnership Trust and how confident are they that they can deliver the savings they have committed to? Laura responded that she had met with Tim Lynch Director of Operations, initially to discuss the high level services being considered for the integrated care centre. This was followed by a discussion with the Divisional General Managers. Laura has since sat down with managers for all the services on the list and they worked through the services and activity levels. The managers were comfortable with the type of services and level of activity talked about.
Rachel asked how will it save money putting Countess staff in a different working place. Laura responded that the intention would be to rationalise some of the services provided at the Countess site. Rachel then asked if the Countess committed to closing wards. Laura responded that the services we are discussing are not ward based but outpatient clinics and it is up to the Countess internally what they do to respond to different care pathways and models of care.

Alison commented that Laura has engaged with many different colleagues from the Countess of Chester and suggested that the Primary Care Trust Board obtains a formal response from them on their views of the Northgate development along with a formal response from Cheshire and Wirral Partnership. If the two local Foundation Trusts could not formally commit to the development then the Consortium and Primary Care Trust would then need to work up a different procurement model.

Alison stated that it is crucial that a full version of the business case is shared with partners as quickly as possible after this meeting. David and Laura Marsh confirmed that this would be done.

Jeremy commented that this increases pressure on us to start reorganising services immediately. There will be a financial burden on us and the Consortium will have to pick up the shortfall as we don’t have a good record of redesigning hospital services. These were comments from the Ellesmere Port and Neston Locality Network. Steve commented that the Rural Locality Network were uncomfortable with just moving some hospital services to a new building.

Jeremy referred to letters he had received from two GPs, expressing their concerns over safe transport options for patients and access to parking. Jeremy will forward the letters to Laura for her to respond.

Andy expressed concern about the £1.3m funding required to support the development recurrently and that this might increase. What potential is there to make Quality Innovation Productivity and Prevention savings by having the development in place? Laura responded that there is potential. The Primary Care Trust has talked about developing alternatives to hospital care for a number of years but delivery had not happened due to a lack of space within primary and community health centres and clinics. The models developed for the business case indicate an estimated saving of between £500,000 and £2.7million by delivering alternative services in a community rather than hospital setting.

Laura Millard commented that the City Network Locality are relatively supportive of the development. Laura had visited Garden Lane Medical Centre who are the nearest practice who would be affected by the development. The practice had asked will there be support if they lost patients and needed to make changes to their services. Alison responded this question would need to be put to the Primary Care Trust as they hold
primary care contracts, which will ultimately be the responsibility of the NHS Commissioning Board.

Gareth commented that a large proportion of Quality Innovation Productivity and Prevention is about growth over the next few years and that new innovative service need to be in place to respond to the increasing demands of an ageing population and new drugs and treatment, for example.

The Board debated “ownership” of the project and following a lengthy debate recommended that the project should be driven by the Consortium with support from the PCT around the primary care services that will be delivered in the building.

Huw asked a question about the potential Quality Innovation Productivity and Prevention savings outlined in the board and queried why the Obstetrics and Gynaecology projected savings are so large? Laura responded these are maternity cases who are brought in and assessed, admitted and then discharged within a few hours. Huw asked if the Countess accept that this is inappropriate?, Laura responded yes, they agree that this is not good for pregnant women to be brought into the hospital for this and that alternative pathways could be developed. Huw commented this will be a significant proportion of the service’s income. Sam commented that there is a quality issue here, some ladies have gone into the Countess eight or nine times during their pregnancy and the practice does not know any detail. Laura Marsh informed the Board that clinicians had not yet involved in these discussions. Laura Millard expressed her concerns about this lack of clinical engagement and asked that this be rectified as the project progresses.

The Rural and City Locality Networks were supportive of the development and Ellesmere Port Locality Network were supportive of practices being included but were against the intermediate tier services. Alison asked that we capture the network views in our response to the Cluster, along with our decision today.

Gareth informed the Board that the financial risk, for the development, needs to be put into context, the cost savings are less than 1% of what we are spending at the Countess so it is not a huge financial risk.

Rachel commented that it sounds from Jeremy’s feedback that some extra work needs to be done with the Ellesmere Port locality to understand their view not to sign up to the development.

Jeremy commented that it is interesting to hear the difference in views from Rural to Ellesmere Port and Neston. Steve responded that the difference is due to the wide geographical spread of the rural area so travelling to different locations is less of an issue for practices and patients in the rural area.
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<th>Network Locality Chairs</th>
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<td>The Board approved the Business Case including the proposed investment in primary and community care and the development of the intermediate tier as an opportunity to support the delivery of the Quality Innovation Productivity and Prevention programme for the longer term. The Locality Chairs will summarise the views of their localities and forward to Alison to assist with response to the Cluster.</td>
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Minutes received by: ____________________________
(Chairman)

Dated: ____________________________
West Cheshire Health Consortium Board  
Action List

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<tr>
<th>Meeting Held on 16th June 2011</th>
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<tr>
<td>A full version of the Business Case to be shared with Partners.</td>
<td>David Parry and Laura Marsh</td>
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<tr>
<td>Respond to letters from Ellesmere Port GPs</td>
<td>David Parry and Laura Marsh</td>
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<td>A summary of the Locality Networks views to be produced and forwarded to Alison Lee.</td>
<td>Locality Network Chairs</td>
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