NHS
West Cheshire
Clinical Commissioning Group

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

AGENDA

Formal Governing Body Meeting to be held in Public on Thursday 17th September 2015, at 9.00am in Tarvin Community Centre, Meadow Close, Off Crossfields, Tarvin, Chester, CH3 8LY

Item	Time	Agenda Item	Action	Presenter
	9.00	Welcome and **Open Forum**	-	Dr Huw Charles-Jones *GP Chair*
	9.15	Chairs Opening Remarks	I	Dr Huw Charles-Jones *GP Chair*
A	9.20	Apologies for absence	-	Dr Huw Charles-Jones *GP Chair*
B	9.22	Declarations of interests in agenda items	-	Dr Huw Charles-Jones *GP Chair*
C	9.25	i. Minutes of last meeting held on 16th July 2015 ii. Notes of the informal meeting held on the 13th August 2015 iii. Notes of the informal meeting held on the 26th August 2015	DR	Dr Huw Charles-Jones *GP Chair*
D	9.40	Matters arising/actions from previous Governing Body Meetings	D	Dr Huw Charles-Jones *GP Chair*
WCCCGGB/15/09/15	9.50	Clinical Senate Report	D	Dr Huw Charles-Jones *GP Chair*
WCCCGGB/15/09/16	10.05	Quality Improvement Committee Report	D	Paula Wedd *Director of Quality and Safeguarding*
WCCCGGB/15/09/17	10.20	Commissioning Delivery Committee Report	D	Chris Hannah Vice Chair/Lay Member Laura Marsh *Director of Commissioning* Gareth James *Chief Finance officer* Philippa Robinson *Interim Director of Operations*
10.35 BREAK				

Item	Time	Agenda Item	Action	Presenter
WCCCGGB/15/09/18	10.45	Audit Committee Report	D	David Gilburt *Lay Member* Gareth James *Chief Finance officer*
WCCCGGB/15/09/19	11.00	Remuneration Committee Report	D	Chris Hannah Vice Chair/Lay Member Clare Dooley *Head of Governance*
WCCCGGB/15/09/20	11.15	Chief Executive Officer's Business Report	I To follow	Alison Lee *Chief Executive Officer*
WCCCGGB/15/09/21	11.20	Governing Body Assurance Framework	DR	Alison Lee *Chief Executive Officer*
CONSENT ITEMS				
WCCCGGB/15/09/22	11.35	Clinical Commissioning Group Sub-Committee Minutes	I	Alison Lee *Chief Executive Officer*
WCCCGGB/15/09/23	11.40	Any Other Business **(to be notified to the Chair in advance)**	D	All
Date and time of next formal Governing Body meeting – Thursday 19th November 2015, at 9.00am in Neston Cricket Club, Station Road, Neston, Cheshire CH64 6QJ				

I – Information D – Discussion DR – Decision Required

* A consent agenda means that the items will be noted with no time for debate unless the chair is notified in advance of the meeting.

** Any other items of business should be notified to the Chair at least 48 hours in advance of the meeting.

NHS
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NHS West Cheshire Clinical Commissioning Group

Formal Governing Body Meeting

Thursday 16th July 2015, 9.00a.m.
Conference Rooms A and B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ

PRESENT

Voting Members:

Dr Huw Charles-Jones	Chair
Ms Alison Lee	Chief Executive Officer
Dr Andy McAlavey	Medical Director
Mr Gareth James	Chief Finance Officer
Ms Chris Hannah	Lay Member
Ms Pam Smith	Lay Member
Dr Jeremy Perkins	GP representative – Ellesmere Port and Neston Locality
Dr Steve Pomfret	GP representative – Rural Locality
Ms Fiona Reynolds	Interim Director of Public Health, Cheshire West and Chester Council

Non-voting Members:

Ms Paula Wedd	Director of Quality and Safeguarding
Mr Rob Nolan	Director of Contracting and Performance

In attendance:

Ms Clare Dooley	Corporate Governance Manager
Ms Debbie Smith	Public Engagement Manager
Ms Clare Jones	Governing Body and Committees Administrator

15/07	AGENDA ITEM	Action
	WELCOME AND OPEN FORUM	
	The Chair welcomed everyone to the meeting and noted that the meeting is held in public but is not a public meeting. Hardcopies of the agenda and minutes of the previous formal governing body meeting were made available for members of the public, and a full set of papers can be obtained from the Clinical Commissioning Group's website at www.westcheshireccg.nhs.uk It was noted that the first 15 minutes of the agenda is set aside for questions from members of the public and, to make best use of this time, it may be necessary to respond outside of this meeting to any individual points of detail that cannot be dealt with within the allotted time. There were eight members of the public in attendance at the meeting. One question has been raised by Mr Gus Cairns, relating to whether NHS West Cheshire Clinical Commissioning Group has an action plan to tackle health inequalities in its area; specifically Blacon, Lache, City Centre Chester and several Wards in Ellesmere Port. The Chair responded that the clinical commissioning group does not have a target for specific areas, and that this is	

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	work that will be delivered jointly with the Cheshire West and Chester Council through the Health and Wellbeing board. It was also noted that successful progression of the management of health inequalities will depend on sufficient commitment of time being given to the work to be undertaken, and that it may be necessary for the clinical commissioning group to ensure that this commitment is undertaken by all partners involved. Fiona Reynolds noted that reducing health inequalities and increasing healthy life expectancy are key priorities for the Health and Wellbeing Board, of which the clinical commissioning group is a member, and partnership working is being undertaken to address this issue. There were no further questions raised from the floor.	
	CHAIR'S OPENING REMARKS	
	The Chair made the following opening remarks: • Philippa Robinson was welcomed as the Interim Director of Operations, and will be in post until the clinical commissioning group completes recruitment for a permanent post holder. • The clinical commissioning group has also begun the recruitment process to replace the hospital doctor and governing body nurse roles, and thanks were offered to both of the current post holders for the work they have undertaken on behalf of the clinical commissioning group. • Dr Claire Westmoreland has resigned from the clinical commissioning group following a vote of no confidence from the Chester City GP Locality Network, and the clinical commissioning group respects Dr Westmoreland's decision. Dr Westmoreland has provided strong leadership in mental health and end of life care and will be missed by her colleagues in the clinical commissioning group, and is wished every success in the future. Dr Annabel Jones has been elected as the new chair of the Chester City GP Locality Network and will be joining the clinical commissioning group governing body. Dr Tony Bland was thanked for undertaken the interim post of chair while a new chair was elected. • The BBC Panorama programme aired an episode on the 13th July 2015, 'NHS: The Perfect Storm', and the Chair encouraged people to watch the episode if they had not already done so. The episode outlined the challenges faced by the NHS, caught between the increase in demand and the continually increasing financial pressure to produce efficiencies. The episode strongly resonated with the work that the clinical commissioning group and partners are attempting across the local Cheshire health economy, and also showed the scope of the challenges to be faced. • After returning from holiday in France, and visiting Chester city centre, the disparity between the lifestyles seemed very obvious, with the French and Mediterranean populations taking more time to eat, and sharing meals as families, which has led to a much healthier lifestyle. It will require a generational shift in lifestyle, within the local health economy, to create this lifestyle change here, and the clinical commissioning group will continue to progress this work through the West Cheshire Way.	

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	• The Chair attended a meeting at Chester University on the 15th July 2015, to discuss the plans to open a medical school in Chester by 2017, which is both ambitious and exciting, and there are a number of options for the type of model to be used. There is a growing realisation that the current undergraduate and post graduate training of doctors is overly academic, scientific and specialised, and is not producing doctors that thrive in a highly complex and uncertain, people and community focussed, NHS that is needed. The proposed Chester curriculum is imaginative and addresses a number of these challenges, and considers very different skills and values, and focuses on the value base needed for doctors of the future. If Chester University chooses, and is allowed by the General Medical Council, to develop a curriculum that is locally developed and meets local needs for the type of doctors we are looking for, for the future, then we need to support and get behind the university, and encourage them to take that route. In conclusion, it is important that the clinical commissioning group continues to communicate its ideas to partners and the local health economy, and that it starts to deliver change, through steady steps of progress.	
A	**APOLOGIES FOR ABSENCE**	
	Apologies were received on behalf of David Gilburt, Mike Zeiderman, Sheila Dilks, Laura Marsh and Dr Annabel Jones.	
B	**DECLARATIONS OF MEMBER'S INTERESTS**	
	There were no additional declarations of interest to be noted.	
C	**MINUTES OF PREVIOUS MEETINGS**	
	MINUTES OF LAST MEETING HELD ON 21ST MAY 2015 The minutes of the meeting held on 21st May were agreed as an accurate record of the meeting's proceedings, with the following amendments: • Page 1 – Present – Pam Smith to be included as present at the meeting. • Page 1 – In attendance: Mr Donald Reed to be amended to Mr Donald Read • Page 2, 2nd bullet point – "...reduction if fees…" to be amended to "...reduction in fees…" • Page 2, 6th bullet point – "..as wells as…" to be amended to "..as well as…" • Page 7, 1st paragraph – "...where concerns…" to be amended to "…where worries…" • Page 7, 4th bullet point – "…clinical commissioning croup..." to be amended to "…clinical commissioning group…" <u>Matters arising not covered under the action log</u> Page 7 – Quality Improvement Report – Nursing Homes – The possibility has previously been raised of including a clause within contracts, for care and nursing homes, that each home must display a contact number where families may raise worries relating to their family member. This has been discussed at	

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	the Nursing Home Forum and further discussions will take place between the clinical commissioning group and local authority to progress this issue. The minutes of the extraordinary meeting held on the 28th May were agreed as an accurate record, with the following amendment: • Page 3, second paragraph – "…and that amend… to be amended to "…and then amend…" <u>Matters arising not covered under the action log</u> There were no other matters arising.	**PW/FR**
D	**MATTERS ARISING/ACTIONS FROM PREVIOUS GOVERNING BODY MEETINGS**	
	• 15/05/01 – Clinical Senate report – Discussions on how to most appropriately reflect on the detail of the meetings has taken place and it has been agreed that, at the end of each clinical senate meeting, a greater effort will be made by members to identify recommendations and conclusions to be included within the resulting briefing paper to governing body. • 15/05/02 – Quality Improvement Committee report – Countess of Chester Hospital and Cheshire and Wirral Partnership NHS Foundation Trusts have been encouraged to improve their involvement of patients and patient family member in root cause analysis work. Improvement by both Trusts has been noted, and this issue will continue to be monitored to ensure that patients and their families are included in any incident's root cause analysis work. • 15/05/03 – Commissioning Delivery Committee report – Finance – The revised timescale for work relating to the reduction of the financial gap is scheduled to be discussed at the August 2015 informal governing body meeting.	**GJ**
08	**CLINICAL SENATE REPORT**	
	Dr Huw Charles-Jones provided an update to the meeting and noted that this report relates to the meetings on the 28th May and 25th June 2015. The May 2015 clinical senate meeting was interesting and innovative, and was led by the Youth Senate. The main focus of the meeting was in relation to mental health and the reduction of stigma surrounding mental health. The rise in the number of cases of self-harm reported at the meeting was alarming, although it was encouraging to hear of the work being undertaken between the paediatric department and Children and Adolescent Mental Health Service to address the issue. One of the main challenges identified is how to make GPs and GP practices less intimidating to young adults, and how to allow them to feel comfortable in that environment, and consider issues of confidentiality should the young person encounter friends or family during their visit.	

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	The June 2015 clinical senate meeting focused on Working Together to Improve Dementia Care and Support for People with Dementia and Family Carers, and was facilitated by Life Story Network. Life Story Network has been asked to produce a report on the information obtained from the meeting on how services could be improved and this will be provided to the governing body once it is available. The opportunity to talk with carers of dementia patients was both fascinating and distressing, and there was recognition that the motivation to improve services for patients is significant. The viewpoint from a patient/family member/carer's viewpoint was very powerful, and it will be important to share this message with GPs at Membership Council once the report from Life Story Network is received, to ensure that the clinical insight from the senate meeting is not lost. In response to questions and comments by Dr Steve Pomfret, Dr Jeremy Perkins and Alison Lee, the following points were noted: • The engagement from the young people involved was very positive and the insights they offered after the meeting were very striking. However, the issue of a comfortable environment at practices is important to young people and it may be appropriate to remind GP colleagues that a visit to the GP can often be a significant event for a young patient. It has been suggested that Healthwatch and the Youth Senate may wish to progress this issue together. • As a part of the Local Safeguarding Children Board, a group of young people that are a part of the Youth Parliament and Youth Senate have recently undertaken visits to a police custody suite, and they have identified a number of practical issues that had not previously been considered, i.e. the height of desks, etc. The clinical commissioning group has used this access to the Local Safeguarding Children Board to engage with young people and to ask them to be more involved and to consider visiting GP practices. Paula Wedd, Jenny Dodd and Kulvinder Hira will progress this issue outside of this meeting. • The June 2015 clinical senate meeting did not focus on local performance in relation to dementia diagnosis, as it was deemed that the focus should be on improving services for patients. **RECOMMENDATIONS** The governing body noted the issues discussed by the clinical senate and reflected on the recommendations, and will take these into account when making decisions.	**JD** **HCJ** **PW**
09	**QUALITY IMPROVEMENT COMMITTEE REPORT**	
	Paula Wedd noted that this report highlights issues of importance to be brought to the attention of the governing body. Although this report highlights areas of concern to the governing body, the quality improvement committee feels that it is important that positive items are also highlighted.	

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	The following key points were noted from the report: • Countess of Chester Hospital NHS Foundation Trust ➢ Serious Incidents – In March 2015, concerns were raised with the Trust in relation to a number of serious incidents, two of which were Never Events. The Trust's full report and action plan have been shared with the quality improvement committee and the committee was assured by the Trust's plan, but noted concerns in relation to the capacity of clinical leaders to deliver sustained changes in practice by all staff. A further Never Event was reported in May, which means that the Trust has had three incidents in five months. The quality and performance meeting will continue to monitor implementation of the action plan. ➢ Coroner's Ruling – The Coroner has requested more assurance in relation to a Regulation 28 Preventing Future Deaths Notice, and this will be shared with the quality improvement committee, once it is available. ➢ Hospital Intelligent Monitoring – the Trust has now been moved down to a Band 5, and a summary of the risks was provided. The formal alert issued by the Care Quality Commission in January, relating to the Trust being identified as an outlier for the number of women identified as having puerperal sepsis and other puerperal infections within 42 days of delivery, has now been closed. • Cheshire and Wirral Partnership NHS Foundation Trust ➢ Liaison Psychiatry – The impact that the new access and waiting time targets are likely to have in an acute setting was highlighted, as well as the impact this is likely to have on Countess of Chester Hospital due to the increase in patients attending at the Accident and Emergency Department. The intention is for commissioners to agree service development and improvement plans with acute providers, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services across acute settings, but these have not yet been agreed and the work is ongoing across programmes. ➢ Care Quality Commission Announced Visit – the Care Quality Commission is currently undertaking a number of unannounced visits in community settings, but there is currently no feedback available. Once the report is published it will be received by the quality improvement committee and any exceptions, and areas for improvement, will be identified to the governing body. ➢ GP Out of Hours – Further assurance is being sought as the service has not met a number of targets over a period of months, in relation to time taken to assess urgent calls. The service has identified that this links to NHS 111 determining the urgency required and this position should now improve as clinicians within the Out of Hours service have been given the ability to change the urgency level of a callers needs following a clinical review. • Wirral University Teaching Hospital NHS Foundation Trust – The quality improvement committee has received a summary of the elevated risks identified by the Care Quality Commission, which has caused the Trust to be downgraded to a Band 1, which represents the highest level of risk.	**PW** **PW**

15/07	AGENDA ITEM	Action
	NHS England Area Team and Wirral Clinical Commissioning Group are holding a follow up Quality Surveillance Group to review progress on the actions previously agreed. An update on progress and any exceptions will be provided once this is available.	**PW**
	• Nursing Homes – Previous discussions have taken place in relation to the identification of concerns within care homes and ensuring that sustained improvements are made. The clinical commissioning group and local authority continue to support sustained improvements and, in the case of the Willows Care Home, the Countess of Chester Hospital NHS Foundation Trust is supporting the learning and development of staff by sharing educational and dementia specialist resources.	
	• Infection Control – Clostridium Difficile – The year-end performance target was not achieved for 2014/15, due to the increase in the number of reported community cases. There is recognition nationally that there is a challenge to identify the root cause of cases within a community setting, and the national target has now been amended to take this in to consideration.	
	• GPs and Child Protection Case Conferences – GP attendance at initial child protection case conferences has achieved the expected standard throughout the year, although submission of reports by GPs for reviews of child protection case conferences has not achieved the required target during the last 4 quarters. Consideration is being given to the use of information technology facilities that will allow GPs to join case conferences remotely across West Cheshire and Vale Royal Clinical Commissioning Group areas.	
	In response to questions and comments by Dr Jeremy Perkins, Chris Hannah, Alison Lee, Dr Andy McAlavey and Dr Steve Pomfret, the following points were noted:	
	• Wirral University Teaching Hospital NHS Foundation Trust – The quality improvement committee will continue to monitor the risks identified by the Care Quality Commission, and how swiftly these issues are addressed. Consideration will also be given to the inclusion of a clinical commissioning group GP representative at future NHS England Quality Surveillance Group meetings relating to this issue, to ensure that West Cheshire patients that may use the Trust hospital are appropriately represented.	**PW**
	At the quarter 4 assurance meeting with NHS England, NHS England complimented Paula Wedd on her attention to detail, and the work she has undertaken, in relation to this issue. Thanks were also offered to Paula Wedd on behalf of the clinical commissioning group.	
	• Coroner's Ruling – Countess of Chester Hospital NHS Foundation Trust has been issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner following an inquest in May 2015 in relation to the death of a patient in July 2014, and has 56 days from receipt of the notice to reply to the Coroner. An update will be provided to the governing body once further details are available.	**PW**
	• Nursing Homes – Willows Care Home – The latest report from the Care Quality Commissioning identifies evidence of some improvements, but	

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	notes that the overall rating for the provider is 'Inadequate'. However, the report also notes that the standard of patient care is good. • Clostridium Difficile – the increase in the number of reported cases is mainly due to the increased identification of cases. There are a number of new healthcare acquired infections that are now being recorded more frequently and there is now a need to focus on more than the clostridium difficile and methicillin-resistant staphylococcus aureus bacteria. Each reported case of clostridium difficile is discussed at the serious incident review group and any learning is shared appropriately. It is important to ensure that the appropriate education and training is in place in relation to antibiotics and inappropriate prescribing, and significant work is currently ongoing within primary care. Work has not yet been undertaken to map the reported incidents to GP practices and to compare this with antibiotic prescribing levels. It was agreed that this may be beneficial and, as this is an issue that also relates to the wider community, it was agreed that Fiona Reynolds would undertake this work. **RECOMMENDATIONS** The governing body reviewed the issues and concerns highlighted and identified any further actions for the quality improvement committee.	**FR**
10	**COMMISSIONING DELIVERY COMMITTEE REPORT**	
	Chris Hannah introduced this item and noted the concerns in relation to the clinical commissioning group's financial position, particularly in relation to the projection for delivery of the planned year-end surplus. The commissioning delivery committee has announced its intention to monitor this issue closely, specifically in relation to efficiency savings, and a detailed report is expected for the next meeting in September 2015. However, there is positive news in relation to Vanguard and the finance associated with that work and, combined with the Prime Minister's Challenge Fund, there is some flexibility in relation to the delivery of transformational work, and this opportunity provides some potential to resolve issues currently being addressed. The clinical commissioning group has a clear vision on the work to be done and the focus will now be on ensuring that there is pace behind the delivery of this work. Rob Nolan provided an update to the meeting and the following points were noted: <u>Delivery – Transformation and Stabilisation</u> • The Vanguard bid value proposition for the implementation of the Multispecialty Community Provider in West Cheshire has been submitted, requesting £6.6million each year for the next three years. NHS England's Investment Committee is meeting during July 2015 to assess the submitted value propositions and it is unclear whether the clinical commissioning group will be required to submit any further information. Thanks were offered to staff in the clinical commissioning group and partner organisations that helped to ensure that the very short deadline for the submission of the value proposition was met.	

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	• Primary Care – Concern has been raised in relation to the data sharing agreements that will be imperative to the delivery of the Extended Hours service and this will be progressed by the senior management team, as a part of a number of other data sharing agreement concerns currently being managed. <u>Performance</u> Rob Nolan provided an update to the meeting and the following points were noted: • Accident and Emergency 4 hour target – The 4 hour waiting time has been achieved for the first two weeks of July 2015 and it is expected that the target will be achieved, although the levels of attendance at the accident and emergency department remain high. The implementation of the Discharge to Assess model is crucial to the achievement of accident and emergency performance on a consistent basis and a number of issues were considered at the committee, which are part of the final agreement with the Trust in their role as the lead for implementing the Discharge to Assess care model. Final discussions are taking place with the Trust and local authority to complete the agreement on the contract. <u>Finance</u> Gareth James provided an update to the meeting and noted that the main issues to be highlighted are: • As at the end of May 2015, there was a reported underspend of £545,000, which equates to two months of the planned year-end surplus. This position has been reported to NHS England and additional time has been set aside at the informal governing body meeting, in August 2015, to discuss how the 2015/16 positon will be reported to NHS England. • Early indications for months 2 and 3 shows spend is not as high as anticipated, although this does not mean that the target will be achieved. • Details of the plan to deliver the efficiency target were provided. It was noted that £2.7 million of the savings target is yet to be assigned to a programme, and further details were provided. In response to questions and comments from Dr Jeremy Perkins, Dr Andy McAlavey, Chris Hannah, Alison Lee, Dr Steve Pomfret, the following points were noted: • There remains concern in relation to the accident and emergency 4 hour target and this has been raised with the Countess of Chester Hospital NHS Foundation Trust. It is unlikely that the performance target will be achieved on a daily basis, but significant work has been undertaken to put processes in place to allow the target to be achieved and maintained. However, it was noted that the admissions to the Trust over the summer months are 20% above what was expected and work is underway to identify the source of this increase. Resilience planning is underway with Countess of Chester Hospital NHS Foundation Trust and partner organisations to manage winter pressures.	

15/07	AGENDA ITEM	Action
	• Discharge to Assess model – Engagement work is being undertaken as a part of the Countess of Chester Hospital NHS Foundation Trust's implementation plan, to ensure that GPs are aware of the expected admissions and recovery timescales that now apply to patient admissions to the Trust, and it is intended that clear guidance will be issued to community and primary care staff, and integrated teams in particular. It was agreed that an update on the progress of the model will be provided to the October 2015 commissioning delivery committee. It was also agreed that awareness of the model will be raised at the next Membership Council meeting in September 2015.	**PR** **HCJ**
	• Financial balance – It is intended that the clinical commissioning group will aim to deliver the financial balance for 2015/16, and to achieve a return to the NHS England business rules for the end of financial year 2016/17. The current financial position does not include any financial benefit that may come from being a vanguard site and further details were provided in relation to the vanguard position. The clinical commissioning group is not the only organisation facing financial challenges, as the local authority and provider organisations are also required to achieve significant efficiency savings, and the position of the local health economy will need to be considered as a whole and not individually. Governance issues in relation to shared responsibilities for releasing efficiency savings and other joint working are being undertaken through the West Cheshire Leadership Group meeting and there is now a feeling that all organisations are owning challenges collectively. It will also be important to ensure that leadership within each organisation provides clear communications and engagement to staff in relation to the need to adopt a collaborative way of working, and that this is also communicated to members of the public.	
	• Continuing Healthcare – Work is continuing to progress the reduction of backlog case reviews, although this is progressing at a slower pace than anticipated due to staffing issues. Steps have been taken to resolve this and to recruit additional staff. Progress to reduce the cases of Previously unassessed periods of care has been poor and an action plan has been agreed with North West Commissioning Support unit to plan to assess all restitution cases by September 2016. Cases where patients are alive have been prioritised, and there are 19 such cases within West Cheshire. This issue will continue to be closely monitored by the commissioning delivery committee. A serious process issue has been identified in relation to the use of incorrect documentation within the continuing healthcare service. This issue has not affected West Cheshire but significant potential implications have been identified for other local clinical commissioning groups. Further updates will be provided to the commissioning delivery committee as they become available.	
	RECOMMENDATIONS The governing body noted the key issues discussed and the decisions made at the commissioning delivery committee.	

15/07	AGENDA ITEM	Action
11	**CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT**	
	Alison Lee noted that the business report is provided for information, and the following points were highlighted from the report: • The clinical commissioning group has received the quarter 3 assurance meeting letter from NHS England, and the assurance assessment is recorded as "Assured". • The quarter 4 assurance meeting with NHS England took place on 25th June 2015 and it is anticipated that an update will be provided to the formal governing body meeting scheduled for September 2015. • Vanguard Bid – The clinical commissioning group submitted the vanguard value proposition document to NHS England on 30th June 2015, and this outlies the investment needed to develop a local multi-specialty community provider. After review by NHS England, the new models of care team has asked to work more closely with the clinical commissioning group to refine the proposition and a number of points have been clarified by that team, as outlined within this report. When comparing the West Cheshire proposition to those of other vanguard sites, West Cheshire is the only proposition that considers a patient from a 'cradle to grave" aspect and this has been positively received. However, this also makes it more challenging to articulate the impact of the work that will be undertaken. It will also be important to ensure that the balance between transformation and stabilisation is achieved, to obtain the best outcomes available. Work will be undertaken over the coming weeks on a draft to be submitted for review by NHS England, by the 3rd August 2015. • The Healthwatch Cheshire Annual Report 2014/15 has been included within the report, and this was also presented to the Health and Wellbeing Scrutiny Committee on the 15th July 2015. • Recruitment is currently underway for the governing body Hospital Doctor and Nurse Lead positions and interviews for the positions have been scheduled for the 22nd July 2015. In response to questions and comments from Chris Hannah, Dr Jeremy Perkins, Pam Smith, the following points were noted: • Future quarterly assurance letters from NHS England will be shared with the governing body in full, to ensure that governance is appropriate. • Concerns have been expressed in relation to management capacity during the stabilisation and transformation process, as there is clear evidence that staff are working extremely hard, with an increasing workload. Further consideration may be required in relation to "invest to save" work to ensure progress is achieved. Concerns have also been raised that increased scrutiny from NHS England in relation to finance will also have an impact on the clinical commissioning group's ability to progress the necessary stabilisation and transformational work. As a result, it is intended that a narrative will be included within the value proposition that will refer to this challenge. A review of programmed work will be undertaken to determine the workstreams that are the most efficient and beneficial for patients, and	

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	consideration will be given to ceasing those that have limited positive outcomes for patients. Work is also ongoing to pool resources across local organisations, which will assist with both efficiency and partnership working. A transformation team has been created locally across organisations, but for work is required to highlight the existence of the team. • The co-commissioning of primary care has been paused due to a delay in achieving membership council approval of the amendments of the constitution, but it is expected that this will be progressed within the next few months. **RECOMMENDATIONS** The governing body noted the contents of this report.	
12	**CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS**	
	Gareth James noted that a governance plan has been created to schedule an annual review of policies and governance documents and, as a part of this plan, three policies/governance documents were received for approval/ratification. The following points for noting from the documents were highlighted: • NHS West Cheshire Clinical Commissioning Group Constitution – Changes have been made to the document in relation to the Terms of Reference in relation to the Joint Committee for co-commissioning with NHS England, and paragraphs 4 and 5 outline how the joint committee will work, and further details were provided. • Conflict of Interest Policy – A significant piece of work has been undertaken by Clare Dooley, Head of Governance, and Mersey Internal Audit Agency in relation to this policy, and thanks were offered for their work. The revised document has been presented at Membership Council for ratification, and details of the amendments were provided. The policy was discussed and it was agreed that a number of scenarios will be posited, to test the robustness of the policy. The policy will also be brought to governing body on a quarterly basis, for review, and will be updated upon the clinical commissioning group's website, after each quarterly review. **RECOMMENDATION** The governing body approved/ratified the three policies/governance documents provided.	**GJ** **GJ**
13	**CLINICAL COMMISSIONING GROUP SUB-COMMITTEE MINUTES**	
	The governing body received and noted the significant issues arising from, and the minutes of, the sub-committees to the governing body and there were no issues to be raised.	

15/07	AGENDA ITEM	Action
14	**ANY OTHER BUSINESS**	
	There were no other items of business to be discussed.	
	DATE AND TIME OF NEXT FORMAL MEETING	
	Thursday 17th September 2015, at 9.00am, in Tarvin Community Centre, Meadow Close, Off Crossfields, Tarvin, Chester, CH3 8LY	

Minutes received by: _____

(Chair)

Date _____

NHS
West Cheshire
Clinical Commissioning Group

NHS West Cheshire Clinical Commissioning Group

Informal Governing Body Meeting

Thursday 13th August 2015, 2.30p.m.,
Conference Room D, 1829 Building, Countess of Chester Health Park,
Liverpool Road, Chester CH2 1HJ

PRESENT

Dr Huw Charles-Jones	Chair
Ms Alison Lee	Chief Executive Officer
Mr Gareth James	Chief Finance Officer
Mr David Gilburt	Lay Member
Ms Pam Smith	Lay Member
Ms Sheila Dilks	Lay Member
Mr Peter Williams	Hospital Physician Representative
Dr Steve Pomfret	GP representative – Rural Locality
Dr Jeremy Perkins	GP Representative – Ellesmere Port and Neston Locality
Dr Annabel Jones	GP Representative – Chester City Locality
Ms Laura Marsh	Director of Commissioning
Ms Paula Wedd	Director of Quality and Safeguarding
Ms Philippa Robinson	Interim Director of Operations

In attendance:

Ms Clare Dooley	Head of Governance
Ms Clare Jones	Governing Body and Committees Coordinator

	AGENDA ITEM	Action
2.30	**APOLOGIES FOR ABSENCE**	
	Apologies were received on behalf of Dr Andy McAlavey, Chris Hannah, Fiona Reynolds and Sarah Faulkner. Huw welcomed Peter Williams as the new Hospital Physician Representative and introductions were made by the governing body.	
2.35	**OPENING COMMENTS**	
	The Chair noted that there are no opening comments to be made and that the purpose of this meeting is to ensure that the governing body is aware of the clinical commissioning group's financial position, and the work being undertaken in relation to vanguard.	
2.45	**FINANCIAL RECOVERY PROPOSITION**	
	Gareth James provided the background to the present financial position, noting that it had been agreed previously with the governing body that an in-depth review of the financial position would be undertaken once quarter 1 financial data was available. A review of the financial outlook for 2015/16 was provided	

	AGENDA ITEM	Action
	and a draft financial recovery plan was presented to the meeting. The following points were noted: • A financial recovery plan will need to be submitted to NHS England by end of August 2015, and needs to demonstrate how the clinical commissioning group will achieve a sustainable financial recovery. The intention is for the clinical commissioning group to achieve financial balance for the end of this financial year, and to achieve the required financial surplus by the end of financial year 2016/17, although this has not yet been agreed by NHS England. If a recovery plan is not agreed, the clinical commissioning group will formally be in "turnaround" and this will have an impact on the assurance process with NHS England. • Performance against budgets to deliver the financial balance was outlined, and the significant risks were outlined. It will be necessary for all budgets to balance at a minimum, with an underspend required against some budgets. • Details of the non-recurrent funding spend was outlined and it was noted that this leaves approximately £3.1million to support the financial position. • Secondary care contracts – 2% activity growth was allowed for in the 2015/16 financial plan. However, there is a significant overspend in relation to unplanned admissions and further work is required in relation to this issue. • The additional capacity created by the winter monies provision has now ceased, although the impact of this additional capacity is not yet available. The increase in unplanned admissions is significant and further understanding of the why these admissions are occurring will be required. • The allocation of the clinical commissioning group's budget against programmes was raised, and whether this funding was being utilised in the best way for the local population, and where the clinical commissioning group benchmarked in relation to similar population demographics, as this could show that the current level of admissions may be appropriate. To ensure the finances are reflecting the local population requirements, conversations would be required with both the public and GPs to be realistic on where the funding should be focussed. There is best practice evidence and regional peer review elements that can also be utilised to consider the most effective and efficient use of funding, and further details were provided on the work already undertaken to ensure that a robust process is in place to guide this work. • Discussions took place in relation to the wards around the 'front door" of the acute trust, i.e. Medical Assessment Unit, which can be used to avoid breeching the 4 hour target by admitting patients, and for which the clinical commissioning group is charged admission costs, and it was noted that this is an area where further consideration would be beneficial. • Complex care is an area of significant risk and further details were provided. £2million has been allowed for growth in activity, but it was acknowledged that this sum may not be sufficient and further partnership working is required to ensure that this issue remains controlled. • The financial challenges faced by Countess of Chester Hospital NHS Foundation Trust are significant and details were provided. This is an	

	AGENDA ITEM	Action
	issue also being faced by other vanguard sites and underlines the need for a radical change in working, as this issue is likely to decline further if social care budgets continue to reduce. Another challenge to be faced is addressing health matters upstream, before they become clinical issues. It will be essential to have the involvement of Public Health in this work, although Public Health's current lack of involvement in meetings has been challenging. Papers were tabled that provided details of the high level plan of future work. This work includes looking at indicators, which has been completed in 3 ranges; 50%, 25% and 10%, and further details were provided. This work will also be completed in relation to the production of a Quality, Innovation, Productivity and Prevention (QIPP) plan, and will consider requirements for the next five years. Details were also provided in relation to each programme, although there remain some areas to be completed. The next stage of work is to prioritise the programmes and, if necessary, to shift the focus of the programmes that are being delivered, and further details were provided. The focus of work will now be to ensure that work is progressed at pace. Discussions took place in relation to focussing on specific programme areas where significant progress can be made and it was noted that it will be important to ensure that stabilisation and transformation are not treated as two separate entities, and that there is focus on ensuring the correct outcomes are achieved and that the correct metrics are in place to ensure outcomes are achieved. Gareth James noted that a lot of the work that the clinical commissioning group will try to do will focus negatively on Countess of Chester Hospital NHS Foundation Trust's finances, and this increases the risk that a contract with the Trust will not be signed. This was discussed and it was agreed that, if this is the best way forward for patient care, the clinical commissioning group's intentions will be made clear to the Trust, including the rationale behind this.	
4.10	**DRAFT VANGUARD VALUE PROPOSITION**	
	Laura Marsh provided the background to the Multi-Specialty Community Provider Value Proposition, noting that the most recent changes to the document are in relation to the financial section. The value proposition is in effect a business case that will be submitted to NHS England, to support the implementation of the new care model over the next three years, and is intended to describe the type of care model to be used, the health impact and the financial impact will be. The clinical commissioning group was already working towards the new care model but the additional funding will allow implementation to take place at a greater pace and scale than originally planned.	

	AGENDA ITEM	Action
	The care model builds on the strengths of existing general practice and covers all age cohorts, for both physical and mental health, and is inclusive of low to high risk patients. The model focuses on three key age cohorts: starting well, adults with long term conditions, and older people. Details were provided on the work being undertaken across these cohorts and the consideration being given to shifting down the pyramid of need to a greater focus on prevention. The foundation of the model will be GP practice teams working together as clusters, with each cluster supported by an integrated care team made up of community nurses, therapists, care co-ordinators, and social care and wellbeing co-ordinators. There is a focus on workforce development to provide the skills for clinicians to be empowered to improve their way of working as well as behavioural skills to support patients to set goals they are committed to achieving. The model proposes that the future workforce will change in terms of skills and setting but will not significantly increase in size instead building capacity within the local population to be more involved in their health care delivery. It will be important to ensure that community resource is in place, and that community engagement is supported, to ensure that the local population is encouraged/enabled to be involved. Consideration is being given to the possibility that the patient will have a care plan, based in the first person, i.e. I want, I feel, building on 'My aim is…'. The health impact of the Care Model has been led by Paula Wedd and Jenny Dodd, thinking across the three dimensions of quality; safer care, more effective care and improved patient experience, and further details were provided. Work is also ongoing to describe end to end service delivery models that include quality and safety standards agreed across multiple providers and a whole system commissioning for quality and innovation goal has been developed, which includes primary care, and this will be built upon by incentivising providers to perform against shared standards. The Cost and Activity section outlines that based on local planning assumptions and anticipated changes to the population, if the clinical commissioning group does not progress with the proposed transformation of the care model, there will be a need to deliver savings of approximately £120million. Work has been undertaken to look at growth assumptions, and to break down the impact of the care model on the number of emergency admissions going forward, year on year. It is expected that by 2017/18, efficiencies made will equate to a reduction in the number of beds required by approximately 2 wards. Work has also been undertaken in relation to the stratification of the population towards development of an alternative funding model in the longer term, but further work is required to ensure that all sectors have been incorporated. In response to comments and questions from Alison Lee, Sheila Dilks, Dr Annabel Jones, David Gilburt, Dr Jeremy Perkins, and Paula Wedd, the following points were noted: • There is no breakdown in relation to how the finance will be distributed between supporting the programme and providing additional services that	

	AGENDA ITEM	Action
	will be non-refundable, and are therefore a risk. The majority of the funding will be utilised on double running costs in the first 2 years, allowing existing clinicians to develop and implement the new care model while maintaining existing services in the short term. It will also support the recruitment of new staff within the health and care economy where it is clear what new roles are required to support development of additional skills and new ways of working. However, as the model continues to evolve over the next three years, there may be further new roles that may require support. A small amount of additional staffing will also be required to support the Multispecialty Community provider infrastructure. The monitoring of investment and non-investment funding will be tracked at project level and there will be a significant degree of rigour within the programme to ensure transparency. • Although domestic violence is not a long term condition, it has been included within this programme due to the potential to reduce costs downstream • The governance structure will be made clearer, to reflect that progress of this work will be reported through the commissioning delivery committee. • Wider discussions will be required in relation to the location of paediatric services, if these are not provided in a secondary care setting, as a number of specialities will only be sustainable once networking commences with other hospital trusts. • Details of the planning assumptions made have been included within the value proposition, which assumes realisation of 70% of the projected savings, and an attempt has been made to describe assumptions in the workings, where possible. • It will be important to ensure that, at the starting point, everyone, including GP practices, understands the assumptions made, what the ambition is, and is involved in the continued partnership working that will be required to progress this work. • Within the value proposition, the return on investment is 4:1 • The funding received by NHS England will be provided to the clinical commissioning group, • Discussions took place in relation to including staff experience and it was suggested that a Staff friends and family test could be utilised, and used as a baseline and trajectory. Laura Marsh noted that the draft vanguard value proposition has been forwarded to Sheena Cumiskey, Tony Chambers and Alison Lee, for comment, and it is intended to submit the plan on the 14th August 2015 unless any fundamental changes are identified. The Chair thanked all those who have been involved in the work and acknowledged the significant step forward this represents.	

	AGENDA ITEM	Action
5.00	**ANY OTHER BUSINESS**	
	The Chair noted that Sheila Dilks is retiring from the NHS, and thanked Sheila for the contribution she has made to the governing body, and clinical commissioning group as a whole, over that last few years. Sheila will be greatly missed and is wished a happy and enjoyable retirement.	
11.55	**DATE AND TIME OF NEXT (FORMAL) MEETING**	
	Informal Governing Body: Wednesday 26th August 2015, at 10.00am, in Conference Room A at the 1829 Building, Countess of Chester Health Park **Formal Governing Body:** Thursday 17th September 2015, at 9.00 a.m., in Tarvin Community Centre.	

Minutes received by: _____

(Chair)

Date _____

NHS
West Cheshire
Clinical Commissioning Group

NHS West Cheshire Clinical Commissioning Group

Informal Governing Body Meeting

Wednesday 26th August 2015, 9.30 am
Conference Room A, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester CH2 1HJ

PRESENT

Chris Hannah	Vice Chair (Meeting Chair)
Ms Alison Lee	Chief Executive Officer
Dr Andy McAlavey	Medical Director
Mr Gareth James	Chief Finance Officer
Mr David Gilburt	Lay Member
Ms Pam Smith	Lay Member
Dr Steve Pomfret	GP representative – Rural Locality
Ms Laura Marsh	Director of Commissioning
Ms Paula Wedd	Director of Quality and Safeguarding
Ms Philippa Robinson	Interim Director of Operations

In attendance:

Ms Clare Dooley	Head of Governance

	AGENDA ITEM	Action
9.30	**APOLOGIES FOR ABSENCE**	
	Apologies were received on behalf of Dr Huw Charles-Jones, Annabel Jones, Dr Jeremy Perkins, Sarah Faulkner, Dr Peter Williams and Fiona Reynolds.	
9.35	**FINANCIAL RECOVERY PROPOSITION UPDATE**	
	The Chief Finance Officer circulated an updated financial outlook. **<u>Recap on financial position</u>** • 2015/16 financial plan was £3.277M (1%) surplus and reasons for this were well documented and shared with partners. • The governing body insisted on a detailed review at quarter 1. • Month 3 position reported to NHS England was a deterioration in forecast (i.e. break even) and we immediately started a financial recovery process. • We need to develop plans to deliver business rules again by March 2017 and are currently planning financial balance as at March 2016 on path towards goal. • The outline financial recovery plan identified that in order to break even the CCG budgets would need to deliver underspends of £1.3M which has a significant element of risk.	

	AGENDA ITEM	Action

	Forecast
	
	• Month 4 financial position deteriorated due to, in the main, huge increase in unplanned admissions at COCH. An explanation of this has been formally requested from the Trust.
	• Month 4 forecast before QIPP (best/worst/likely) has been developed.
	• Significant difference between worst (+£7.4M) and likely (+1.7M)
	
	QIPP
	
	• There is a likely need for in-year savings of between £2M and £4M.
	• The current delivery plan has >50 initiatives with varying degrees of delivery but without an emphasis on projects that will release savings.
	• Governing body asked Chief Finance Officer and Director of Operations to re-prioritise and concentrate balance between the number of "big hitting" QIPP opportunities and maintain balance between short term stabilisation and longer-term transformation work.
	• Programme Delivery Group agreed to increase focus on the following areas:
	
	- Starting well – acute to community shift and maternity
	- Being well – acute to community activity shift, alternatives to elective care/referral management.
	- Ageing well – discharge to assess/acute to community shift and reducing emergency admission from nursing homes.
	
	• Programme managers have been tasked with developing outline project initiation documents to support the projects listed above (within 48 hours). Director level and clinical leads for each programme are being agreed.
	• The need to concentrate on these areas is supported by the better care, better value indicators.
	• Other areas are also being considered to develop savings within this year:
	  • Age-related Macular Degeneration
	  • Maximum utilisation of Hospital@home contract (18 beds)
	  • Procedures of limited clinical priority.
	  • Diagnostics undertaken with no further treatment.
	  • Others to be confirmed.
	• At this stage we do not have a detailed plan to share with the governing body. The Chief Finance Officer and Director of Operations described the process that is being followed and likely timescales.
	
	The governing body were asked to consider the position, impact of QIPP schemes, relationships with COCH and how we report to NHS England.
		PMs

	AGENDA ITEM	Action
	Discussion and action points:	
	• GJ provided an anecdotal update on the position of other local CCGs to put the West Cheshire financial outlook into context.	
	• Explanations and challenge in relation to the significant rise in unplanned admissions at COCH during the first quarter of the financial year (when compared to Q1 14/15). This was discussed at quality and performance meeting with the Trust and they have been asked to look into this further and feedback to the CCG by 4 September 2015. It was agreed to write to the Trust formally once a response is received to formally query unadvised changes to coding/thresholds.	**GJ**
	• It was agreed that further work is required to understand entry point pathways at the Trust.	**LM**
	• Future/Model Hospitals bid/work being led by the Deputy Chief Executive planned at COCH. We have not yet been engaged with this work and this needs to be raised at the next Strategic Leadership Group meeting on 9th September 2015.	**AL**
	• Assurance is to be provided to governing body from clinicians and managers that QIPP schemes are being progressed/delivered and reported to governing body with benefit timelines. Project initiation documents for all the proposed QIPP schemes are expected by Friday 28th August 2015.	**GJ**
	• Yield on delivery of schemes (£2M proposed) within 2015/16 financial year should be reported to NHS England to enable further support from them on further work required by the CCG on delivering a balanced position.	**GJ**
	• The proposed QIPP schemes were discussed: - Pricing of drugs for age-related macular degeneration procedures undertaken at COCH (potentially escalated compared to other CCGs) – it was agreed to develop a project initiation document for this issue to challenge this with the Trust.	**GJ**
	- Hospital@Home contract – it is essential to ensure full use of all 18 available beds and triangulation work has been undertaken in relation to financial loss implications. It was agreed a project initiation document will be developed on this QIPP scheme and a revision of the contract, following recent legal advice is also being progressed via the Director of Operations.	**GJ** **PR**
	- QIPP schemes for procedures of limited clinical priority and diagnostics undertaken with no further treatment need further data/development.	**GJ**

	AGENDA ITEM	Action
	- Elective Care – referrals and follow-ups (discussed at the informal governing body meeting on 13th August). Work to enable reductions will be undertaken with high referring practices immediately (and data also presented and highlighted at the Membership Council on 30th September).	**PR**
	- It was agreed to also provide project initiation documents for both Out of Hours and NWAS 111.	**PR**
	- It is essential to ensure to provide information from the successful project initiation documents (and QIPP schemes delivered) as part of commissioning intentions and contract documents for the next financial year.	**SMT**
	- A list of smaller savings from running costs to be produced by Chief Finance Officer.	**GJ**
	• Capacity and infrastructure issues within and across the clinical commissioning group to re-focus on delivery of stabilisation (QIPP schemes) and transformation (Vanguard) are being discussed/ monitored, and process proposals will be implemented with all managers and clinical leads immediately by the senior management team.	**SMT**
	• GJ will submit a revised financial recovery proposition by 4 September 2015. This will need to include a list of the firm intentions/proposals/QIPP schemes including the benefit timelines. This information will also be provided to the next Commissioning Delivery Committee on 10th September for further scrutiny.	**GJ** **GJ/PR**
	• A financial summit to be proposed with senior partners within the next few months to focus on position/plans/behaviours across the health economy.	**GJ**
11.55	**DATE AND TIME OF NEXT (FORMAL) MEETING**	
	Formal Governing Body: Thursday 17th September 2015, 9.00 a.m., at Tarvin Community Centre.	

Minutes received by: _____

(Chair)

Date _____

NHS
West Cheshire
Clinical Commissioning Group

West Cheshire Clinical Commissioning Group Governing Body

Action Log from the minutes of formal Governing Body meetings

Item	Action	Owner	End Date	STATUS
Meeting held on 15th January 2015				
Page 6 15-01-43	**Quality Improvement Committee Report –** alternatives to the use of fax machines to be considered by the ICT Strategy Committee	Laura March	September 2015	**Blue** To be put on agenda for next ICT Strategy Group. The next meeting has not yet been scheduled.
Meeting held on 21st May 2015				
Page 3 D	**Matters Arising – Finance -** A sub-group of CDC has been created and is now considering the financial position across the whole health economy. An update will be provided after the conclusion of Quarter 1.	Gareth James	August 2015	**Green** This issue was covered as a part of the financial discussion at the August 2015 governing body meeting.
Page 9 15/05/03	**Commissioning Delivery Committee Report - Finance –** Revised timescale for work relating to the reduction of the financial gap to be provided to governing body members.	Gareth James	July 2015	**Green** This issue was covered as a part of the financial discussion at the August 2015 governing body meeting.
Meeting held on 16th July 2015				
Page 4 15/05/02	**Matters Arising – Nursing Homes –** discussions are to be held to consider the possibility of including a clause within nursing home contracts stating that nursing homes must display a contact number where family or friends may report any worries they may have, in addition to the Care Quality Commission details.	Paula Wedd / Fiona Reynolds	September 2015	**Green** This requirement will be added when the care home contracts are renewed.
Page 4 15/07/08	**Clinical Senate Report – Dementia event** a. The Life Story Network report from the June meeting will be presented at the November 2015 governing body meeting.	Jenny Dodd	November 2015	**Blue** Update to be presented to November governing body meeting.
	b. The Life Story Network report from the June meeting will be shared with the membership council at the November 2015 meeting.	Dr Huw Charles-Jones	November 2015	**Blue** Update to be presented to November membership council meeting.
	c. Work to be undertaken to request that members of the Youth Senate become involved in visits to GP practices, to consider how the practices can be made more 'user friendly' for young people. This will be progressed by Paula Wedd, Jenny Dodd and Kulvinder Hira.	Paula Wedd	September 2015	**Amber** A verbal update will be provided to the September governing body meeting.

Item	Action	Owner	End Date	STATUS
Page 6 15/07/09	**Quality Improvement Committee** a. **Unannounced Care Quality Commission visits in community settings** – any areas for improvement will be identified to the governing body, following the publication of the report.	Paula Wedd	September 2015	**Green** This item has been added to the quality improvement committee workplan
	b. **GP Out of Hours Service –** Further assurance is to be sought in relation to the failure of the service to achieve targets for a number of months.	Paula Wedd	September 2015	**Green** Assurance is being pursued through the Quality Improvement Committee.
	c. **Wirral University Teaching Hospital** – i. An update on progress and any exceptions noted at the Quality Surveillance Group will be provided, once available.	Paula Wedd	September 2015	**Green** An update has been provided within the Quality Improvement Report
	ii. Consideration is to be given to the inclusion of a CCG GP rep. at future NHS England Quality Surveillance Groups around this issue.	Paula Wedd	September 2015	**Amber** A verbal update will be provided to the September governing body meeting
	d. **Coroner's Ruling –** Further details will be provided, once an update is available.		September 2015	**Green** This item has been added to the quality improvement committee workplan
	e. **Clostridium Difficile –** Mapping of reported cases to GP practices to be undertaken, to enable a comparison with antibiotic prescribing levels to be carried out.	Fiona Reynolds	September 2015	**Amber** A verbal update will be provided to the September governing body meeting
Page 10 15/07/10	**Commissioning Delivery Committee Report – Finance - Discharge to Assess model –** a. An update on progress will be provided to the commissioning delivery committee in October 2015	Philippa Robinson	November 2015	**Blue** For update at November governing body meeting
	b. Awareness of the model will be highlighted at the next meeting of the membership council.	Dr Huw Charles-Jones	November 2015	**Blue** For update at November governing body meeting
Page 12 15/07/12	**Policies and Governance Documents – Conflicts of Interest Policy** a. An update on the robustness of the policy, following the testing of a number of scenarios, will be provided	Gareth James	September 2015	**Amber** A verbal update will be provided to the September governing body meeting
	b. The policy will be reviewed by the governing body on a quarterly basis.	Gareth James	September 2015	**Green** This item has been added to the governing body workplan and will next be reviewed at the November 2015 governing body meeting.

Action Log from the minutes of informal Governing Body meetings

Item	Action	Owner	End Date	STATUS
	Meeting held on 16th April 2015			
2.	Consideration to be given to whether the Lay member for Audit and Governance is to write to NHS England in relation to financial position, after the review of the Quarter 1 position.	Gareth James	August 2015	**Green** This issue was covered as a part of the financial discussion at the August 2015 governing body meeting.
4.	Upon completion of the chronology, the Chair will provide a position/status briefing to the CCG membership.	Huw Charles-Jones	August 2015	**Green** This issue was covered as a part of the financial discussion at the August 2015 governing body meeting.
	Meeting held on 18th June 2015			
1.	Finance			
	c. Agreed amendments to detailed financial narrative to be made and circulated to governing body members	Gareth James	July 2015	**Green** This issue was covered as a part of the financial discussion at the August 2015 governing body meeting.
	Meeting held on 26th August 2015			
	Finance			
1.	Programme managers have been tasked with developing outline project initiation documents to support the projects listed above (within 48 hours).			**Green** This action is now complete
2.	It was agreed to write to the Trust formally once a response is received to formally query unadvised changes to coding/thresholds.	Gareth James	September 2015	**Green** A formal response has been sent to the Trust and this issue is on the agenda for the quality and performance meeting on the 17th September 2015
3.	It was agreed that further work is required to understand entry point pathways at the Trust.	Laura Marsh	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
4.	Future/Model Hospitals bid/work being led by the Deputy Chief Executive planned at COCH. We have not yet been engaged with this work and this needs to be raised at the next Strategic Leadership Group meeting on 9th September 2015.	Alison Lee	September 2015	**Amber** For verbal update at the September 2015 governing body meeting

Item	Action	Owner	End Date	STATUS
5.	Assurance is to be provided to governing body from clinicians and managers that QIPP schemes are being progressed/delivered and reported to governing body with benefit timelines.	Gareth James	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
6.	Yield on delivery of schemes within 2015/16 financial year should be reported to NHS England to enable further support from them on further work required by the CCG on delivering a balanced position.	Gareth James	September 2015	**Green** A revised financial recovery plan has been submitted to NHS England
7.	The proposed QIPP schemes were discussed: a. Pricing of drugs for age-related macular degeneration procedures undertaken at COCH – it was agreed to develop a project initiation document for this issue to challenge this with the Trust.	Gareth James	September 2015	**Green** A project initiation document has been developed
	b. Hospital@Home contract – It was agreed a project initiation document will be developed on this QIPP scheme and a revision of the contract, following recent legal advice is also being progressed via the Director of Operations.	Gareth James Philippa Robinson	September 2015	**Green** A project initiation document has been developed
	c. QIPP schemes for procedures of limited clinical priority and diagnostics undertaken with no further treatment need further data/development.	Gareth James	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
	d. Elective Care – referrals and follow-ups - Work to enable reductions will be undertaken with high referring practices immediately (and data also presented and highlighted at the Membership Council on 30th September).	Philippa Robinson	November 2015	**Blue** For update at November governing body meeting
	e. It was agreed to also provide project initiation documents for both Out of Hours and NWAS 111.	Philippa Robinson	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
	f. It is essential to ensure to provide information from the successful project initiation documents (and QIPP schemes delivered) as part of commissioning intentions and contract documents for the next financial year.	Senior Management Team	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
	g. A list of smaller savings from running costs to be produced by Chief Finance Officer.	Gareth James	September 2015	**Amber** For verbal update at the September 2015 governing body meeting
8.	Capacity and infrastructure issues within and across the clinical commissioning group to re-focus on delivery of stabilisation and transformation are being discussed/ monitored, and process proposals will be implemented with all managers and clinical leads immediately by the senior management team.	Senior Management Team	September 2015	**Amber** For verbal update at the September 2015 governing body meeting

Item	Action	Owner	End Date	STATUS
9.	GJ will submit a revised financial recovery proposition by 4 September 2015. This will include a list of the firm intentions/proposals/QIPP schemes including the benefit timelines. This information will also be provided to the next Commissioning Delivery Committee on 10th September for further scrutiny.	Gareth James Gareth James/ Philippa Robinson	September 2015	**Green** A revised financial recovery plan has been submitted to NHS England
10.	A financial summit to be proposed with senior partners within the next few months to focus on position/plans/behaviours across the health economy.	Gareth James	September 2015	**Green** This item is on the agenda for membership council in September 2015

Red	Outstanding
Amber	Ongoing/For update
Green	Complete/On Agenda
Blue	Update to future meeting

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1.	**Date of Governing Body Meeting:**	17th September 2015
2.	**Title of Report:**	Clinical Senate Committee Report
3.	**Key Messages:**	This report provides an overview of the business discussed and decisions made at the clinical senate committee meeting held on 18 June 2015
4.	**Recommendations**	The governing body is asked to: a. Note the issues discussed by the clinical senate b. Reflect on the discussions of the clinical senate and take these into account when making decisions
5.	**Report Prepared By:**	Jennifer Dodd Assistant Chief Officer

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

CLINICAL SENATE

PURPOSE

1. The clinical senate has been established by the governing body to provide clinical leadership and advice on the development of the clinical commissioning group's commissioning strategy. It is a multi-disciplinary group of clinical and non-clinical leaders from across the health and care community, bringing together commissioners and providers to discuss complex issues of policy and service redesign.

2. This paper provides an overview of the discussions of the clinical senate in June 2015.

BACKGROUND

3. The Clinical Senate held on Thursday 18 June was a workshop session facilitated by Life Story Network. The aim of this event was to bring together people using dementia services, family carers and the senior staff (clinical, professional and managerial), who are responsible for planning and delivering support and services to can work together to identify where it is essential to make improvements. The session was based on the principles of Experienced Based Co-Design (EBCD*): **capture; understand; improve the experience and measure the improvement*** and Theory U (***open mind; open heart and open will***).

4. This workshop was the final event in a process, led by NHS West Cheshire Clinical Commissioning Group and Cheshire West and Chester Council, to refresh the local Dementia Strategy. The final report on this process will be available at the end of September 2015.

PROCESS

5. The facilitated workshop asked those with lived experience of dementia (mainly as carers) to reflect on their experience, talk about their journey and share what would have been needed to improve the experience.

6. The process asked participants to:
   a. ***Focus on*** the lived experience (***both positive and negative***) of people with dementia and family carers / relatives using local general and specific dementia services and support;
   b. Engage with the ***experience*** and ***emotions*** of people using the service / family carers / relatives as they tell their story;
   c. Listen ***empathetically*** and ***generatively*** *(see Theory U)* to these experiences / emotions, ensuring that they are valued, acknowledged;

the emotional 'touch points' are accurately recorded, reflected back, owned by all; and that there is a genuine willingness to engage and creative a better future;

d. Use ***storytelling*** as a real way of ***empowering*** people using the services / family carers & relatives to work with local staff to ***identify real opportunities for improvement***, which will have a ***positive impact and outcome***;

e. **Commit to taking the necessary action**, review and measure the impact of this improvement.

f. In a departure from how the senate normally works the group broke into small groups and professionals sat with carers to listen to their story and map their journey. The content of these discussions were drawn out into "life story" maps that will be used to inform the final dementia strategy.

EVALUATION

7. The format of the Senate forced participants to go on an emotional as well as a professional journey. The value of this is reflected in the feedback from the participants.

Carers	Staff
"This was so therapeutic for me and quite honestly the first time I have been able to share good and bad experiences. A form of counselling really, but in a good way! My voice has been heard." *"Enriched real stories are the most powerful way to live the experience of people affected by dementia."* *"Thought provoking, informative and humbling."* *"It made me think about the things I just do each day. I found it powerful, challenging, upsetting and empowering."*	*"Made me consider how dementia impacts on the lives of [family] carers."* *"It has made me realise that our services only reach the tip of the iceberg. More detailed services are required."* *"This was a powerful way to ensure that we listen and don't assume."* *"Incredibly moving and powerful! Personalises the issues – makes you put the patient [person] and their family at the centre, something which is often overlooked."* *"Great opportunity to hear the real life experience. Lovely people in the group, very honest and emotional story."* *"Very powerful to hear the stories and what practical things we can do to improve their journey."* *"Really powerful!"* *"It was lovely to get time to investigate someone's story. To listen and ask questions."* *"Great to listen – busy days mean that listening is sometimes lost."*

Carers	Staff
Amazing just actually seeing it!" *"Most of all I hope that any information I shared can be used to inform future practice for the better."* *"Emotions underpin the experience!"* *"Such a positive experience with people, who are genuinely interested."*	*"Focusing on emotions is helpful to keep the person at the centre."* *"I was surprised by how much laughter there was as we drew out the map."* *"Just wonder how it will impact on the carer 'after' this morning. It would have been useful to have carer support information available for people to take away."* *"Makes you think of the emotional roller coaster ride and the impact that has on folk!"* *"Great way to understand the journey that the patient and carers go through!"* *"Good outline of the highlight/ summary points."* *"Highlights the gaps that there are - but also some themes coming through!"* *"Very reflective! I was blown away!"*
Some positive ideas shared to change the negative experience into positive."	*"Would have liked more time to forward plan."* *"The solution bit felt a bit rushed, but that was our fault!"* *"We didn't come to any firm conclusion on this."* *"Would like to feel that this discussion will be taken forward."*
"Totally listened to!" *"Everybody had the opportunity to share."*	*"Comfortable to contribute."* *"Good facilitation and excellent patient story."* *"I was able to amplify."* *"Keep it exactly the same!"* *"The workshop was much smaller than I had anticipated, but this enhanced the experience, I think!"* *"All had the opportunity to ask and reflect!"*
"More time!"	*"Allow more time for slippage!"* *"The key is not 'health' - it is 'health' as part of a network. Involve local council, education, commerce, emergency services, Age UK and the 3rd sector."* *"More time for focusing on the future."* *"More discussion time – more discussion between all involved."*

Carers	Staff
	"Nothing! Except a bit more space between the tables – listening would be better!" *"Keep it exactly the same."*

OUTPUTS

8. The process asked carers to consider what would have improved their experience and captured these to inform the re-writing of the west Cheshire dementia strategy.

9. **Pre-diagnosis**
   - Improved awareness for opticians to be alert to dementia-related problems
   - Consistent support from GPs to take carers' concerns seriously, be empathetic and not dismissive

10. **At diagnosis**
   - A follow up appointment with the GP to discuss concerns and ask questions
   - Signposting to resources by knowledgeable staff
   - Advice and support that is diagnosis specific – not just a generic Alzheimer's Society referral; one person was a carer for a man with Posterior Cortical Atrophy (PCA)
   - Clear information about dementia and the implications – but not too much at once
   - Pro-active questions and advice about Lasting Power of Attorney, Wills, Advanced Directives, financial planning

11. **On-going support**
   - A one-stop shop/single point of contact for information and advice – to save time and not have to keep repeating stories
   - Better integration between physical health/acute care and mental health services, e.g. Countess of Chester Hospital NHS Foundation Trust, GPs and Cheshire and Wirral Partnership NHS Foundation Trust
   - Care co-ordination – someone taking responsibility for multi-disciplinary working, especially when planning discharge from hospital. There are good models for looking after people with cancer – why can't this be the same for people with dementia and their carers?
   - Communication and information sharing, including medical records, between professionals
   - Activities that are based on individual preferences and what people enjoy, with support to take part
   - A directory of services (including care homes) that is kept up to date with contact details

- Improve the signage and care parking at hospitals – these problems add to the stress of a clinic appointment or hospital visit

12. **Support for carers**
    - Involving carers in planning and decision making and keeping them informed of developments
    - Peer support – not feeling alone, being able to share anxieties and coping strategies
    - Contingency planning for emergencies
    - Regular re-assessment of carers' needs as the dementia progresses – don't leave people just to get on with it

NEXT STEPS

13. The content of the workshop will be included in a final report, this will be prepared by Life Story Network and reflect all of the work that has been done to refresh the local dementia strategy. This report will be made available at the end of September 2015

RECOMMENDATIONS

14. The governing body is asked to:

    a. Note the issues discussed by the clinical senate

    b. Reflect on the discussions of the clinical senate and take these into account when making decisions

Jenny Dodd
Assistant Chief Officer
September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting 17th September 2015

2. Title of Report: Quality Improvement Report

3. Key Messages:

Following a number of incidents in which misidentification was identified as a recurring theme the Countess of Chester Hospital NHS Foundation Trust developed an improvement plan. The Trust Medical Director has identified additional clinical leadership capacity to support implementation of this action plan.

Practices have reported delays of up to 12 weeks in receiving letters following attendance of their patients at Adult and Elderly Mental Health outpatient clinics run by Cheshire and Wirral Partnership NHS Foundation Trust. The Trust has been requested to undertake an audit of current turnaround times of clinic letters and provide an action plan for improvement.

NHS England Area Team and local commissioners have been working together with Wirral University Teaching Hospital NHS Foundation Trust to address a number of concerns highlighted by the Care Quality Commission. The Trust have now provided sufficient evidence and assurance against the agreed actions to enable NHS England to close this enhanced surveillance process. Wirral Clinical Commissioning Group will continue to hold the Trust to account for delivery through their routine contract mechanisms.

A national Patient Safety Alert has been issued which requires agencies to address antimicrobial resistance through the implementation of an antimicrobial stewardship programme. The Public Health team from the local authority have funding to

promote best practice for antibiotics. Our medicines management leads are working with Public Health to discuss how this education should be targeted. The education will mainly be aimed at patients and the public; however it was identified that community pharmacies can also be used to promote best practice and reinforce messages. The Pharmaceutical Local Professional Network has been asked to support this.

4. Recommendations

The governing body is asked to review the issues and concerns highlighted and identify any further actions for the quality improvement committee.

5. Report Prepared By:

Paula Wedd
Director of Quality and Safeguarding

QUALITY IMPROVEMENT REPORT

PURPOSE

1. To provide information to the governing body on the quality of services commissioned by NHS West Cheshire Clinical Commissioning Group by identifying areas where performance falls below expected standards.

2. To seek scrutiny of the assurance provided by the quality improvement committee in relation to the risks and concerns managed by the committee that may impact on patient safety, experience and outcomes in this health economy.

3. The quality improvement committee identified the following issues to be brought to the attention of the governing body from its meeting on 13th August 2015.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Serious Incidents

4. Following a number of incidents in which misidentification was identified as a recurring theme the Trust developed an improvement plan. The committee reviewed the action plan and raised a concern about whether there was adequate capacity within the clinical leadership structure to deliver the changes. The Trust Medical Director and Director of Nursing have subsequently provided assurance that additional clinical leadership capacity is now in place to support implementation of the action plan developed to reduce incidents of misidentification.

Coroners Ruling

5. The Trust was issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner following an inquest in May 2015 in relation to the death of a patient in July 2014. The Coroner wanted more assurance about the robustness of processes for communicating information between departments along with processes for checking clinical suitability for the referred intervention.

6. The committee has received a copy of the Regulation 28 along with the Trust response to the Coroner and the Coroner has replied to note he is satisfied with the improvement plan.

Quality Impact Assessments of Trust Cost Improvement Plans

7. The National Quality Board requires commissioners to assure themselves that systems are in place to assess the impact on quality of provider cost improvement plans.

8. The Director of Quality and Safeguarding has been meeting with the Trust Director of Nursing and Director of Operations and Planning to scrutinise the existing processes that support quality impact assessments. The Trust has

now enhanced both the governance structures and documents supporting these processes. These amended processes were shared with the committee.

ONE TO ONE MIDWIFERY SERVICE

9. One to One Midwifery Service received an unannounced visit from the Care Quality Commission in June 2014 and did not meet Standard 17 regarding governance. One to One responded to this with an action plan and has been awaiting re-inspection as per Care Quality Commission policy. One to One believed that they were compliant against the action plan within a number of weeks of the inspection report being published and requested a re-inspection from the Care Quality Commission on a number of occasions but this did not take place.

10. One to One Midwifery Service did however receive a further unannounced visit from the Care Quality Commission on 13th April 2015. Publication of the report following this visit has currently been deferred by the Care Quality Commission. It has been confirmed that One to One Midwifery Service will receive a comprehensive Care Quality Commission inspection on 1st and 2nd December 2015 following which a report will be published.

CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

Adult and Elderly Mental Health Outpatient Clinic Letters

11. Practices have reported delays of up to 12 weeks in receiving letters following attendance of their patients at Adult and Elderly Mental Health outpatient clinics. The Trust have been requested to undertake an audit of current turnaround times of clinic letters and this will be reviewed at the next contract quality and performance meeting. The committee will be updated on the outcome of this review and subsequent plans for improvement.

WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

12. NHS England Area Team in conjunction with Wirral Clinical Commissioning Group convened a Quality Surveillance Group in February 2015 to review a number of concerns highlighted by the Care Quality Commission. Subsequent to this meeting further concerns regarding infection prevention control and organisational culture were escalated to NHS England, who convened a further extraordinary Quality Surveillance Group meeting in March 2015. The Director of Quality and Safeguarding represented this clinical commissioning group at these forums. The detailed findings from these meetings were shared with the committee and in summary the outcome from these meetings was an agreed set of actions that Wirral Clinical Commissioning Group supported by the Director of Commissioning Operations from Cheshire and Merseyside Area Team NHS England would oversee.

13. NHS England Area Team with Wirral Clinical Commissioning Group convened a follow up Quality Surveillance Group in August 2015 to review progress on these actions and the Director of Quality and Safeguarding represented this clinical commissioning group at this forum. The outcome from this meeting was that sufficient evidence and assurance was provided against the agreed actions to enable NHS England to close this enhanced surveillance process. Wirral Clinical Commissioning Group will continue to hold the Trust to account for delivery through their routine contract mechanisms.

COMMISSIONING FOR QUALITY AND INNOVATION SCHEMES

14. The committee received a detailed report showing the year end 2014-15 performance levels of both the Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust against the goals set in the commissioning for quality and innovation schemes. The committee noted areas of success and areas of non-achievement. Where goals have not been met payments have been withheld totalling £69,943 for mental health services and £37,516 for physical health services. For the Countess of Chester Hospital NHS Foundation Trust the proposed value reduction for non-achievement of goals is £322,000.

NURSING HOMES

Willows Care Home

15. In December 2014 the Care Quality Commission published an inspection report on the Willows Care Home that identified the need for improvements. The home developed an action plan in response to the findings of the Care Quality Commission inspection report. The governing body have previously been advised that following this report the Designated Nurse for Adult Safeguarding and Cheshire West and Chester Council have been contributing to the increased scrutiny of this home and they had reported progress in delivering improvements. In March 2015 the Care Quality Commission carried out an unannounced follow up visit and their latest report found evidence of some improvements but noted the overall rating for this provider is ‘Inadequate’. This means that it has been placed into ‘special measures’ by the Care Quality Commission. Services placed in special measures will be inspected again within six months.

16. The home have recently appointed a new deputy manager who has a lead role in quality improvement and feedback from visits by our quality manager notes evidence of sustained improvement in the care provided. Training by the deputy manager to the staff in relation to person centred care and care planning has been positively received by the staff. Cheshire West and Chester Council have established a learning and development programme which our two main secondary care providers are supporting.

Atherton Lodge Nursing Home

17. In September 2014 the Care Quality Commission published an inspection report on Atherton Lodge that identified the need for improvements. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group have been monitoring the home to establish if the improvements required are being delivered in a consistent way that is sustainable.

18. The Care Quality Commission has undertaken a further unannounced visit and published its findings on 10th August and the overall rating for this provider is 'Inadequate'. This means that it has been placed into 'special measures' by the Care Quality Commission. Services placed in special measures will be inspected again within six months. Cheshire West and Chester Council have now agreed a voluntary suspension of admissions with the owner/provider.

Crawfords Walk Nursing Home

19. The Care Quality Commission published the findings of their inspection visit in May 2015. The report identified the need for improvements. The provider submitted an action plan to the regulator to demonstrate how the required improvements will be achieved. The regulator issued clear timescales for completion of the required actions for improvement. Cheshire West and Chester Council and our quality manager both report evidence of sustained delivery against the improvement plan.

INFECTION CONTROL

Methicillin-resistant Staphylococcus aureus

20. There has been one case of Methicillin-resistant Staphylococcus aureus positive culture collected in May 2015 but this case has been fully investigated by the community infection control team and found to be unavoidable. This means that the zero target of avoidable Methicillin-resistant Staphylococcus aureus cases for 2015-16 has been maintained.

Clostridium Difficile

21. For 2015-16 the overall Clostridium Difficile breaches target for NHS West Cheshire Clinical Commissioning Group has been increased to a total of 78 with a decrease in post 48 hour breaches from 30 to 24 and an increase in pre 48 hour breaches from 31 to 54. These changes reflect the changing profile of the previous year with 74 breaches against a target of 61 in 2014-15. In May there were 3 pre-48 hour breaches and 1 post-48 hour breach during the month and in June there were 6 pre-48 hour breaches and 3 post-48 hour breaches bringing the total number of Clostridium Difficile breaches to date during the first quarter of the year (1st April 2015 – 30th June 2015) to 19 cases against a year-end plan of 78.

2015/16	Pre 48 Hour Quarter 1	Post 48 Hour Quarter 1	Year to date Quarter 1	Target
MRSA	0	0	0	0
C.Diff	13	6	19	78

22. The infection control team are working in partnership with local GP practices to ensure that inappropriate repeat specimens are not sent and have issued a best practice summary bulletin to all GP practices. The team are working proactively with post Clostridium Difficile patients for a least a month after the event to monitor for any relapses.

23. A working group has also been established in West Cheshire to implement a local action plan aimed at reducing anti-microbial prescribing in the community. The work aims to target localities with higher than average prescribing and is focused both on prescribers and the public. The work aims to support that which is being initiated at a sub-regional level by Public Health England.

ANTIBIOTIC STEWARDSHIP

24. Health Education England, NHS England and Public Health England has issued a Patient Safety Alert addressing antimicrobial resistance through the implementation of an antimicrobial stewardship programme. Our local antimicrobial resistance plan was discussed at the July meeting of the Infection Prevention and Control Network.

25. The Public Health team from the local authority have funding to promote best practice for antibiotics. Our medicines management leads are working with Public Health to discuss how this education should be targeted.

26. The education will mainly be aimed at patients and the public; however it was identified that community pharmacies can also be used to promote best practice and reinforce messages. The Pharmaceutical Local Professional Network has now been asked to support this.

27. The Community Infection Prevention and Control team met with GP prescribing leads to discuss clostridium difficile, including root cause analyses of the cases that have occurred this year, appropriate prescribing of antibiotics and implications of other prescribed medicines such as acid-suppressants.

28. The requirements for improvement in antibiotic prescribing set out in the Quality Premium have been discussed with GP prescribing leads. Monthly updates of progress will be shared with practices. Each practice will be given an individualised target.

NATIONAL SAFER STAFFING

29. It has been announced that the next steps in developing the National Safe Staffing guidance will be led by the new body, NHS Improvement, working with the Chief Nursing Officer. NHS Improvement will identify leads for each of the programmes: mental health, learning disability, urgent and emergency care, primary and community services and maternity.

30. To ensure the NHS is safely staffed the key principles of the national work will:

- take a multi-professional approach that takes into account all staff involved, not just nurses
- take into account that there are many care settings that are not in a hospital and span organisational boundaries
- remember that this is not just about filling rotas or looking only at numbers or input measures
- recognise that there is no one-size fits all approach for new models of care and the mix of staff we need
- ensure that future plans are underpinned by the need for career progression for non-registered staff, nurse retention and flexible working
- recognise that, other than in acute wards, there is as yet little research or evidence into what safe staffing looks like for other care settings

31. In line with these principles, NHS England has set out in more detail the next steps for delivering this important programme of work. These next steps are guided by the need to:

- improve experience of care for patients and staff.
- improve the effective and safe clinical outcomes of our patients.
- achieve an improved efficiency and productivity in every pathway of care and staffing guidance.

32. Once the work is complete the staffing guidance will be published by the National Quality Board taking into account the feedback from an oversight advisory group and independent reviews. The committee will consider the guidance and implications for our care providers.

GP QUALITY GROUP

33. The group has developed a process to ensure that opportunities for sharing learning from incidents are taken forward through education events or clinical alerts.

34. The group agreed that regular monitoring in relation to antibiotic prescribing will take place at the commissioning delivery committee, although highlights will also be provided to the GP quality group.

35. The group agreed to work collaboratively with NHS England monitor flu vaccination uptake and will identify actions to support practices with lower uptake rates.

ADULT SAFEGUARDING

36. As part of the 2014-15 audit plan Mersey Internal Audit Agency undertook a review of the arrangements in place in relation to safeguarding adults during February and March 2015. All public bodies including NHS organisations are required to develop robust arrangements to ensure that safeguarding becomes fully integrated into NHS systems.

37. The terms of reference for the audit were designed to demonstrate that there are appropriate systems in place in discharging our responsibilities in respect of safeguarding in line with the *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework (March 2013*).

38. The audit report concluded there was Significant Assurance and identified a small number of recommendations, which have been now developed into an action plan that will be monitored by audit committee.

RECOMMENDATIONS

39. The governing body is asked to review the issues and concerns highlighted and identify any further actions for the quality improvement committee.

Paula Wedd
Director of Quality and Safeguarding
September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th September 2015

2. Title of Report: Commissioning Delivery Committee Report

3. Key Messages: This report provides an overview of the business discussed and decisions made at the commissioning delivery committee meeting held on 10th September 2015. The key items for the governing body to note are:

- Work is ongoing to develop the governance for the Transformation and Stabilisation programmes with the introduction of the system-wide Transformation and Stabilisation Committees.

- Significant further work has been undertaken on the value proposition, particularly to develop the financial narrative. The document has now been re-submitted to NHS England to approve the requested investment (£5million in 15/16, £9million in 16/17 and £8million in 17/18) and initial feedback has been positive. A final decision regarding the funding is expected imminently.

- Note the work of the stabilisation delivery committee and that the systems resilience group demerges from the commissioning delivery committee and is reconstituted as the system resilience group under the acute hub of the stabilisation delivery committee.

- At the end of July 2015 it is forecast that the clinical commissioning group will deliver financial balance as at 31 March 2016.

- A financial recovery plan has been submitted to NHS England demonstrating a trajectory to deliver NHS England business rules by 31 March 2015.

- The committee noted the performance measures currently rated as red and asked for a more detailed recovery plan for these areas.

4. Recommendations

The governing body is asked to note the key issues discussed and the decisions made at the commissioning delivery committee.

5. Report Prepared By:

Philippa Robinson
Interim Director of Operations

Gareth James
Chief Finance Officer

September 2015

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

COMMISSIONING DELIVERY COMMITTEE REPORT

PURPOSE

1. This report provides an overview of the business discussed and decisions made at the commissioning delivery committee meeting held on 10th September 2015.

2. Details of the key issues discussed are provided in the following paragraphs.

DELIVERY REPORT

Transformation and Stabilisation

3. There is evolving governance for the transformation and stabilisation work streams through the introduction of the transformation and stabilisation committees. Membership of these groups is key to organisational ownership. However, there is a risk that key people will be attending multiple meetings. Further discussion on this has taken place at the Systems Leadership Group and a governance map is being prepared for this meeting.

4. Discussion regarding wider clinical commissioning group engagement in the proposed changes identified the need for lay members to be involved in the establishment of these new committees, particularly to review the impact on governing body sub-committees.

STABILISATION

4. The stabilisation to transform programme wishes to address, amongst other issues, the following:

   - How reliable are our current delivery systems?
   - Is care safe today?
   - What information can we use and share to help with real-time sense making and action?
   - How effective are we?

5. A key initiative is the development and use of project initiation documents which provide a system wide overview of the progress of all of these work-streams. Through this, we will build a long term financial model for West Cheshire. However, with any new delivery programme, there are issues which either need further clarification or greater detail.

6. From the NHS West Cheshire Clinical Commissioning Group perspective, it is imperative that the work streams being led by senior managers of Countess of

Chester Hospital NHS Foundation Trust, have significant input from clinical commissioning group leads to avoid duplication of effort. Within the clinical commissioning group, there already exists a number of groups (e.g.: medicines management, continuing healthcare) which the work streams listed below are in danger of replicating. However, the clinical commissioning group and the stabilisation delivery committee acknowledge this and are endeavouring to ensure that duplication does not continue.

7. The stabilisation work-streams are:

- Systems Resilience Group (Acute hub)
- Transitional and Intermediate care
- Continuing Healthcare Systems Alignment Group (Complex care)
- Maternity service
- Elective Care Working Group (Elective care hub)
- Infection control
- Palliative care
- Medicines Management
- Therapies

System Resilience Group

8. The commissioning delivery committee were supportive of the recommendation to de-merge the system resilience group from the commissioning delivery committee and to combine the group with the Acute Hub meeting. It was agreed that co-chair arrangements would be in place with Countess of Chester Hospital NHS Foundation Trust, with the co-chairs as the Trust's acute physician and the clinical commissioning group's Director of Operations. However, it has been agreed that an escalation policy must also be in place for the management of the group when the local health system encounters significant pressures.

Discharge to Assess Model

9. The discharge to assess model is contributing to the decrease in the length of stays in the acute trust, although it is too early to quantify the benefits gained and, therefore, assess the sustainability of projected efficiencies. Cheshire West and Chester Council, Countess of Chester Hospital NHS Foundation Trust and NHS West Cheshire Clinical Commissioning Group are currently undertaking joint working to agree the overall integrity of the financial model, and this work is anticipated to be completed by the end of September 2015.

TRANSFORMATION

10. The transformation committee and the multispecialty community provider programme board are to be merged to reduce the layers of reporting and ensure clinical time is released to focus on delivery. The structure beneath this committee is currently being reviewed.

11. Significant further work has been undertaken on the value proposition, particularly to develop the financial narrative. The document has now been re-submitted to NHS England to approve the requested investment (£5million in 15/16, £9million in 16/17 and £8million in 17/18) and initial feedback has been positive. A final decision regarding the funding is expected imminently.

12. The process of developing a system wide document, such as the value proposition, has highlighted that further work is required to ensure the full engagement of all partner organisations in both the care model itself as well as the proposed impact. It is recognised that both of these are iterative.

13. However, it is important that relationships continue to develop between organisations (clinically and managerially) to share ownership of the vision as well as the roadmap to realisation. In addition, the governance for final sign-off of such documents going forward will be written into the relevant terms of reference for the systems leadership forum and the governing body/boards it reports into.

FINANCIAL PERFORMANCE TO THE END OF JULY 2015

14. The committee received a Finance, Contracting and Performance report for the period ended 31 July 2015.

15. Key issues to escalate to the governing body:

- The 2015/16 financial plan planned for a £3.277 million (or 1%) surplus. Following a detailed review at the end of quarter 1, the governing body has agreed to change this forecast to break-even (financial balance as at 31 March 2016).

- As a result of this change in forecast the clinical commissioning group is part of year NHS England financial recovery. A financial recovery plan has been submitted demonstrating a trajectory to deliver NHS England 'business rules' by the end of financial year 2016/17.

- At the end of July there remains a significant element of risk within the revised financial forecast. It is currently forecast that further efficiencies of approximately £2 million will be required. However, the potential worst case year-end scenario is approximately £5.5 million worse than this.

- A quality, innovation, productivity and prevention (QIPP) plan has been developed to support this.

- The financial recovery plan, including QIPP plans will be shared with commissioning delivery committee members. Further details will be provided to the committee in October 2015.

PERFORMANCE AGAINST SECONDARY CARE CONTRACTS TO THE END OF JULY 2015

16. At the end of July 2015 there is an over performance against NHS contracts of £220,000. Within this position there is a significant pressure in relation to un-planned admissions at the Countess of Chester Hospital (pressure of £668,000). In the main, this relates to increases in the number of patients being admitted with pneumonia, urinary tract infections and broken hips, many with complications.

17. There has been a material increase between the first quarter of this year compared to the corresponding period from last year. This increase in activity has been raised formally at the quality and performance meeting with the trust. The trust agreed to lead on the work to understand this increase and agreed to a two week deadline to respond.

18. The committee considered the various contracting options available.

PERFORMANCE AGAINST AGREED PERFORMANCE MEASURES TO THE END OF JULY 2015

19. The committee reviewed performance against the recognised performance targets. The following areas are currently of concern (RAG rated as red):

- Diagnostic Tests; performance against this measure is breaching the 99% tolerance. The majority of breaches were in respect of echocardiography at the countess of Chester Hospital.

- Accident and Emergency; Accident and Emergency performance is not meeting the 95% target. This is monitored on a daily basis. Data for July and August has seen a significant improvement with performance above the 95%.

- Mixed Sex Accommodation; there have been 2 same sex accommodation breaches; 1 at Wirral University Hospital NHS Foundation Trust and 1 at Liverpool Heart and Chest Hospital.

- Electronic-Discharge; performance against this target is slightly improved but still not reaching the 90% target. Performance is monitored on a specialty basis at the monthly quality and performance meeting with the Countess of Chester Hospital NHS Foundation Trust.

- Mental Health – Dementia**;** The clinical commissioning group will not receive the figures calculated by a new denominator until September 2015. This is expected to improve performance by 5% which will still mean that performance is still short of the 74% target. Work is continuing with NHS England to implement their recommendations.

- Mental Health – Improving Access to Psychological Therapies; performance against both access and recovery measures is below target.

In particular, performance against the 52.3% recovery target was significantly under target in July. The challenges and problems of this service are topic of discussion for the mental health local enhanced service meeting in September.

20. The committee approved the new format of the performance report and asked for more detail on actions being taken to address the above performance issues.

CONTINUING HEALTHCARE, FUNDED NURSING CARE AND COMPLEX CARE PROGRAMME UPDATE

21. The committee received the monthly update covering the backlog of case reviews and progress against the agreed trajectory for dealing with the previously unassessed periods of care.

22. In addition, the committee were informed of a recent Parliamentary and Health Service Ombudsman decision to uphold a claim from a previously delayed continuing healthcare eligible status and backdate the full cost of the placement to August 2013.

23. The committee noted the significant potential future costs of these challenges and agreed that the implementation of a revised local NHS continuing healthcare commission policy is critical to mitigate the impact of cases such as this in the future.

24. The joint complex care committee (joint committee in common with Cheshire and Wirral clinical commissioning groups) has recommended a new business model for this service. This will be discussed in detail at the October commissioning delivery meeting.

RECOMMENDATIONS

20. The governing body is asked to note the key issues discussed and the decisions made at the commissioning delivery committee.

Philippa Robinson
Interim Director of Operations

Gareth James
Chief Finance Officer

September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th September 2015

2. Title of Report: Audit Committee Report

3. Key Messages: This report provides an overview of the key items of business discussed at the audit committee meeting held on 10th September 2015. The key items for the governing body to note are:

- The clinical commissioning group has recently undertaken a self-assessment of its financial governance arrangements as part of the NHS England Financial control environment assessment.
- Significant assurance has been received from internal audit in respect of commissioning support arrangements, provider contract management and safeguarding adults.
- Limited assurance has been received in respect of governance arrangements for personal health budgets.
- The committee received the annual audit letter from external auditors, Grant Thornton UK LLP for the year ended 31 March 2015.
- The committee noted that unqualified opinions were issued in terms of:
  - True and fair view of the reported financial position.
  - Regularity opinion; meaning that expenditure was incurred as intended by parliament.
  - Value for money opinion.

4. Recommendations	The governing body is asked to note the key items of business discussed at the audit committee at its meeting on 10 September 2015.
5. Report Prepared By:	Gareth James Chief Finance Officer

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY
AUDIT COMMITTEE REPORT

PURPOSE

1. The purpose of this report is to provide the governing body with an overview of the key items of business discussed at the audit committee meeting held on 10th September 2015.

BACKGROUND

2. As a formal committee of the governing body, the purpose of the audit committee is to:

   a) Provide assurance to the governing body that its systems of governance, risk management and internal control are effective and are being maintained across the organisation;

   b) Monitor compliance with the clinical commissioning group's constitution and other principal policies, including the group's policies on conflicts of interest, whistle blowing and counter fraud arrangements;

   c) Advise the governing body on internal and external audit services;

   d) Make recommendations to the governing body in respect of:

      - The schedules of losses and compensations;
      - The annual financial statements;
      - Suspension of standing orders;
      - The Scheme of Reservation and Delegation.

3. In addition to the normal updates on internal and external audit and counter-fraud, the following key issues were discussed at the September 2015 audit committee.

   - ***Financial control environment assessment***; the NHS England Chief Finance Officer recently wrote to all clinical commissioning groups launching a new initiative to support financial resilience and sustainability across commissioning organisations. Clinical commissioning groups have been required to self-assess against 18 financial governance criteria (ratings of excellent, good, moderate or improvement needed).

The audit committee reviewed the initial assessment made by the Chief Finance Officer which has been submitted to NHS England. West Cheshire Clinical Commissioning Group has been rated as requiring improvement in the following areas:

- Credibility of longer term financial planning.
- In-year financial performance

- ***Internal audit progress report***; the committee received updates on 4 internal audit reviews. Significant assurance was received in respect of the following areas:

  - Commissioning support contract management.
  - Provider contract arrangements.
  - Safeguarding adults.

  The review of arrangements in place for personal health budgets was given limited assurance meaning that there are weaknesses in the design and/or operation of controls in this area. This result was anticipated and Mersey Internal Audit Agency has been retained to undertake a piece of work to review current processes and support the design of robust governance arrangements. This is a joint piece of work with other local clinical commissioning groups.

- ***External Audit annual audit letter***; the committee received the annual audit letter from Grant Thornton UK LLP summarising key findings arising from their audit of the group's accounts for the year ended 31 March 2015. The committee noted that unqualified opinions were issued for this period in terms of:

  - True and fair view of the reported financial position.
  - Regularity opinion; meaning that expenditure was incurred as intended by parliament.
  - Value for money opinion.

RECOMMENDATIONS

4. The governing body is asked to note the key items of business discussed at the audit committee on 10 September 2015.

Gareth James
Chief Finance Officer
September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1.	**Date of Governing Body Meeting:**	17th September 2015
2.	**Title of Report:**	Remuneration Committee Report
3.	**Key Messages:**	This report provides an overview of the key items of business discussed at the remuneration committee meeting held on 16th July 2015. The key items for the governing body to note are: • Progress with actions from an internal investigation. • Standardisation of nurse clinical lead sessional payments. • Senior team remuneration return to NHS England. • A review of Director posts remuneration. • Chief Executive Officer and Chief Finance Officer remuneration benchmarking.
4.	**Recommendations**	The governing body is asked to note the contents of this report
5.	**Report Prepared By:**	Clare Dooley Head of Governance September 2015

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

REMUNERATION COMMITTEE REPORT

PURPOSE

1. The purpose of this report is to provide the governing body with an overview of the key items of business discussed at the remuneration committee meeting held on 16th July 2015.

BACKGROUND

2. As a formal committee of the governing body, the purpose of the remuneration committee is to:

   a) recommend to the governing body determinations concerning the remuneration, fees and other allowances for employees and for people who provide services to the clinical commissioning group and on determinations concerning allowances under any pension scheme that the clinical commissioning group may establish as an alternative to the NHS pension scheme.

   b) The membership council and governing body have also delegated the following responsibilities to the remuneration committee:

      i) recommending proposals for succession planning for governing body members.

      ii) oversight of the clinical commissioning group's arrangements for the appointment of senior, staff; ensuring that the selection and appointment processes are fair and transparent and conform with best practice.

      iii) induction for governing body members.

      iv) the remuneration of nominated practice representatives, and

      v) recommending the group's organisational development.

   c) Where the audit and remuneration committees' review or advise on matters which concern the functions of the membership council, both committees will report directly to the membership council on such matters.

REMUNERATION COMMITTEE – JULY 2015

3. The following key issues were discussed at the remuneration committee held on 16th July 2015:

a) **Internal Investigation Actions -** 12 recommendations were agreed by the remuneration committee in October 2014 in relation to a review of clinical leadership for the mental health local enhanced service. Discussion took place on progress of the actions, six of which had been completed. The remaining actions are being progressed as follows:

- a value for money review is being undertaken, to be completed by November 2015, when standard processes will be in place.
- a proposal for clinical leadership arrangements for the mental health local enhanced service which will be provided to the commissioning delivery committee in September for approval.
- job descriptions are in place for clinical leads.
- a programme management document has been authorised by the commissioning delivery committee and shared with programme boards.
- a policy for clinical leadership will be provided to the remuneration committee when the constitution is next updated in October 2015 for approval at the November 2015 membership council meeting.
- bespoke learning packages for clinical line managers is being progressed by the Assistant Chief Officer.

b) **Nurse Clinical Lead Sessional Payments** – a review to standardise the sessional payments for the two nurse clinical leads is being progressed through the clinical lead value for money review.

c) **Senior Team Remuneration return to NHS England –** the clinical commissioning group provided a response to NHS England following receipt of a letter from the Secretary of State relating to the remuneration of Very Senior Managers within the NHS. The letter and response were discussed by the committee and it was agreed that the response was accurate in that salaries conform to the national guidance. It is unlikely that there will be any subsequent issues arising for the clinical commissioning group. The letter vindicates the approach taken by the remuneration committee in relation to pay scales, and the work that has been undertaken in relation to benchmarking salaries with other clinical commissioning groups, and to NHS England guidance. Guidance had been sought in relation to which positions were included within the information request and the HR business partner confirmed the clinical commissioning group had been consistent with other organisations across the Cheshire and Merseyside footprint by including only the Chief Officer and Chief Finance Officer. It was also noted that the Interim Director of Operations post had not included within the return, as this post is currently filled by an interim consultant pending substantive recruitment, and unlikely to be in place for more than 6 months.

d) **Director Remuneration Review** – The Chief Executive Officer provided the context for a review of director post portfolios and remuneration. The review was undertaken following the redundancy of the Director of Partnerships in January 2015 and the redistribution of workload between the Director of Contracting and Performance, the Director of Quality and Safeguarding, and the Director of Commissioning, with no additional remuneration to reflect the increase in levels of responsibility and accountability. Further additional pressure and responsibility has been placed upon the directors of the clinical commissioning group, which include the increasingly challenging financial position and the co-commissioning of general practice. Revised job descriptions, to reflect additional responsibilities, for the Director of Operations, Director of Quality and Safeguarding, and Director of Commissioning / Transformation had been taken through the Human Resource Agenda for Change evaluation process.

e) The committee members acknowledged the reasoning behind the review but expressed concern relating to proposed increases to director salaries given the current financial position, the requirement for the clinical commissioning group to reduce running costs and the acknowledgement that a number of staff members will receive a 1% pay increase, while staff members earning over £54,000 will not receive a salary increase. An extensive discussion took place in relation to proposed increases to the salaries and the changes to salary banding levels. It was noted that the Agenda for Change evaluation process had been undertaken for other staff positions, however only the proposed changes to the director roles was brought to the committee for consideration.

f) It was agreed that the three director posts would be re-banded to Agenda for Change band 9 positions and salaries were confirmed for each post. It was also agreed that the notice period for the three posts will remain at 3 months. However, it was noted that there may be a risk of cost increases to the clinical commissioning group should Agenda for Change pay increments be re-instated in line with a national pay award. As the proposal had been evaluated through the formal Agenda for Change process, there was no requirement for this to be progressed to the governing body for approval/ratification.

g) **Chief Executive Officer and Chief Finance Officer Benchmarking –** the Chief Executive Officer declared an interest in this agenda item and left the meeting. Remuneration benchmarking work had been undertaken by the HR Business Partner for the Chief Executive Officer and Chief Finance Officer posts. As a result of clarity set out in letter from the Secretary of State in relation to senior managers pay, the only issue discussed by the committee was is in relation to a non-consolidated 1% salary payment currently received by both post holders. The four options outlined in the paper provided by the HR business partner were discussed and a 1% consolidated payment was agreed to

be a fair option as it would provide a reasonable consolidated increase in salary for both posts. However, the post holders would actually note a small reduction in their monthly salary as this payment becomes pensionable.

RECOMMENDATION

4. The governing body is asked to note the contents of this report.

Chris Hannah
Vice Chair / Lay Member
September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th September 2015

2. Title of Report: Chief Executive Officer's Business Report

3. Key Messages: This report provides an overview of important clinical commissioning group business which has not been provided in other papers to the governing body. Key issues raised are as follows:

- Quarter 4 assurance meeting with NHS England.
- An update on health and social care devolution across Cheshire and Warrington.
- An update on procurement of commissioning support services via the NHS England Lead Provider Framework
- An update on governing body positions.
- An overview on the Health and Care Innovation Expo held on 2nd and 3rd September 2015.

4. Recommendations The governing body is asked to note the contents of this report

5. Report Prepared By: Clare Dooley
Head of Governance
September 2015

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT

INTRODUCTION

1. This report provides an overview of important clinical commissioning group business which has not been provided in other papers to the governing body.

QUARTER 4 ASSURANCE MEETING WITH NHS ENGLAND

2. The quarter 4 assurance meeting with NHS England took place on 25th June 2015 and an overview was provided on the business discussed at the last formal governing body meeting. It was anticipated to receive formal confirmation of the outcome of this meeting in August however it has been decided at Board level within NHS England, that the confirmation of the annual assessments will be after they have gone to the Commissioning Committee of the NHS England Board. This meeting will take place during the third week of September 2015.

3. The annual national publication will follow the NHS England Commissioning Committee, however the emphasis has changed as the committee has the formal role of signing off the NHS England annual assessments of clinical commissioning groups. The annual assessment is of course a statutory requirement under the Health and Social care Act and so this is essentially an internal governance issue for NHS England but it does delay clinical commissioning groups receiving the annual assurance letter.

4. The annual assurance letter will be provided to the formal governing body meeting of the clinical commissioning group in November 2015.

HEALTH AND SOCIAL CARE DEVOLUTION

5. The three local authorities which make up the Cheshire/Warrington sub-region have submitted a devolution proposal to government that includes both economic and health and social care devolution.

6. The inclusion of health and social care was a fairly recent addition and the five clinical commissioning group Chief Executive Officers had the opportunity to review prior to submission. Collectively the clinical commissioning groups will be represented on the sub-regional management board where the devolution work will be progressed.

PROCUREMENT OF COMMISSIONING SUPPORT SERVICES

7. As previously reported to the governing body North West Commissioning Support Unit was not successful in securing a place on the NHS England Lead Provider Framework to provide commissioning support services.

8. The clinical commissioning group are therefore currently in the process of procuring a range of commissioning support services with the other North West clinical commissioning groups via the NHS England Lead Provider Framework.

9. A series of detailed specifications for these services have been produced and a range of prospective suppliers have already attended a series of supplier information days with clinical commissioning group representatives. Over 120 clarification questions on the specifications have also been received from the prospective bidders and the clinical commissioning groups have responded to these.

10. The clinical commissioning groups will receive bids from prospective bidders by the end of September 2015 and the timetable for the procurement will then proceed as follows:

Date	Description	Status
05/10/15 – 16/10/15	Evaluation	Work underway
05/10/16 – 07/10/15	Interviews	Work underway
27/10/15 - 05/11/15	Standstill Period	Work underway
16/11/15	Award of Contracts	Work Underway
17/11/15 – 01/03/16	Mobilisation	Not yet commenced

11. The clinical commissioning group governing body will be required to approve/ratify the decision of the successful supplier(s) however the date for this process/meeting are yet unknown and will be provided once the information is available.

12. Clinical commissioning groups have also already made decisions about services they want to bring back in-house and business cases for these services have been submitted and approved by NHS England. In-line with this process the TUPE transferring a number of staff from the North West Commissioning Support Unit is underway and are expected to be completed by 1st October 2015. However, the impact analysis (including financial projections) is still awaited to support this process.

13. A significant amount of time has been invested by members of the senior management team for this procurement process. The risk of not securing a successful supplier from this procurement process had been escalated to NHS England and we await confirmation from them in relation to a proposed action plan to mitigate this potential risk, which has been included on our governing body assurance framework.

GOVERNING BODY POSITIONS

14. A recruitment process has been undertaken to appoint to the Director of Operations post. Interviews (both technical and value based), along with a lunch with governing body members, took place on Monday 7th September 2015. A successful candidate was selected however at the point of producing this report the final recruitment checks have not been completed. An update on this appointment will be provided to the formal governing body meeting in November 2015.

HEALTH AND CARE INNOVATION EXPO EVENT

15. The Health and Innovation Expo event took place in Manchester on 2nd and 3rd September 2015. The clinical commissioning group and partners contributed to the "Vanguard" programme with sessions on self-care, system leadership as well as promoting our proposal on the NHS England stand. There were a number of stand-out presentations for me including Mark Britnell from KPMG on international health systems and Dr David Agus (from the United States of America) on a short guide to a long life.

RECOMMENDATION

16. The governing body is asked to note the contents of this report.

Alison Lee
Chief Executive Officer
September 2015

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting:	17th September 2015
2. Title of Report:	Governing Body Assurance Framework
3. Key Messages:	A risk management strategy was approved by the audit committee in February 2015. Operational risk registers were last updated by risk owners in August 2015 and the high level risks have been escalated to the 2015/16 governing body assurance framework. The audit committee discussed the proposed 2015/16 governing body assurance framework at the meeting held on 10th September 2015.
4. Recommendation:	The governing body are asked to: a) Approve the 2015/16 governing body assurance framework, as proposed by the audit committee at the meeting held on 10th September 2015. b) Agree that all high level risks on the assurance framework are provided at each formal governing body meeting.
5. Report Prepared By:	Clare Dooley Head of Governance

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

GOVERNING BODY ASSURANCE FRAMEWORK

INTRODUCTION

1. A proposed re-structure of risk management procedures was approved by the audit committee in February 2015. As set out in the report, operational risk registers have been realigned to provide governing body committee oversight.

OPERATIONAL RISK REGISTERS

2. The latest review and refresh of all operational risk registers was undertaken by risk owners in August 2015. The review included the addition of new risks, some re-scoring of current risks in-line with current pressures, archiving of risks which have been fully mitigated and some realignment of risks in-line with portfolio changes to risk owners (senior management team members).

3. The operational risk registers will be reviewed and refreshed again in October 2015. High level risks from the operational risk registers will then be reported, as set out in the risk management report, to committees of the governing body in October and November 2015.

2015/16 GOVERNING BODY ASSURANCE FRAMEWORK PROCESS

4. 14 high and medium level risks, as scored by risk owners, have been escalated from operational risk registers to the proposed 2015/16 governing body assurance framework.

5. The audit committee discussed the proposed assurance framework at the meeting held on 10th September 2015. The committee also recommended that all high level risks on the assurance framework are shared with the governing body at each formal meeting.

CHANGES TO THE GOVERNING BODY ASSURANCE FRAMEWORK SINCE 2014/15

6. A summary of changes made to the 2015/16 governing body assurance framework (since the 2014/15 framework) are provided on the framework (attached). An indicator is provided on changes to scoring (arrows to highlight increase, decrease, or score unchanged).

7. 3 new risks have been included to the framework in relation to:

- corporate governance processes (risk 2)
- procurement of commissioning support services via the NHS England Lead Provider Framework (risk 3)
- Failure to agree contracting mechanisms to support delivery of the West Cheshire way (risk13).

8. An overview of risks archived since the 2014/15 governing body assurance framework are provided below.

a) Risk 2 - Failure to operate within the running cost allowance risk has been archived by the Chief Finance Officer as the previously agreed reduction for 2015/16 has been delivered.

b) Risk 9 - Failure to ensure the smooth transfer/transition of services back to the clinical commissioning group from Commissioning Support Unit and failure to agree a service level agreement for 2014/15. This risk has been archived by the Chief Finance Officer as a new risk has been included on the 2015/16 governing body assurance framework (risk 3) in relation to procuring commissioning support services from a new provider via the NHS England Lead Provider Framework.

c) Risk 14 - Failure to agree a work programme to deliver on behalf of the clinical commissioning group and failure to assess impact of public health re-commissioning services on the clinical commissioning group. This risk has been archived by the Director of Commissioning.

d) Risk 15 - Failure to ensure safe and cost effective use of medications across the health economy. This risk has been archived by the Medical Director following a review of the medicine management risk register, increased mitigated assurance and reduced scoring of this overarching risk to the organisation.

RECOMMENDATIONS

9. The governing body are asked to:

a) Approve the 2015/16 governing body assurance framework, as proposed by the audit committee at the meeting held on 10th September 2015.

b) Agree that all high level risks on the assurance framework are provided at each formal governing body meeting.

Clare Dooley
Head of Governance
September 2015

WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY ASSURANCE FRAMEWORK 2015/16

Risk No	Sponsor	Objective Description & Risk Type	Risk Description	Impact Rating	Positive Assurance on Key Controls to the Governing Body	Likelihood Rating	Risk Score	Changes/ comparison to 2014/15 Framework	Gaps in Control and Assurance	Residual Impact	Residual likelihood	Residual Risk Score	Partnership Issues
		Corporate Objective	What are the principle risks that could prevent the Clinical Commissioning Group from achieving this objective *(Types of Risk include clinical, financial, reputation, statutory, target)*	1 to 5	Evidence to the Governing Body that the organisation is reasonably managing its risks and that objectives / projects are being delivered by describing what controls / systems the Clinical Commissioning Group has in place to assist in securing delivery	1 to 5	sum		Where the controls / systems / assurances have either not yet been put in place or are yet to be fully effective. What needs to be done				Where the management of risk and delivery of objectives is dependent upon other organisations
5	2	4	6	7	8	10	11		15				16
FINANCE AND GOVERNANCE													
1	Chief Finance Officer	To ensure financial sustainability for the health economy	Failure of the CCG to deliver financial duties; This risk is underpinned by several more detailed risks on the finance and governance risk register. ***(Statutory & Financial)***	5	The development of a financial recovery proposition. Development of stabilisation committee and workplan. Reprioritising of delivery plan with a bias on patient experience and efficiency. Discussion at commissioning delivery committee, formal and informal governing body meetings.	4	HIGH 20	↑ Increased score and updated narrative	Lack of detailed Quality, Innovation, Productivity and Prevention (QIPP) plan. Confusion and cross-over between stabilisation and transformation . In-year financial pressures (e.g. unplanned admissions).	5	4	HIGH 20	Collaborative work with local health partners is key to the delivery of financial duties for 2015/16 and subsequent years. The joint work under stabilisation is crucial.
2	Chief Finance Officer	To continue to develop the effectiveness of the organisation	Failure to embed systems and processes of good governance. ***(Statutory, Reputational & Clinical)***	5	Internal and external audit opinions. Risk management is embedded throughout the organisation. Membership agreement to constitution and conflicts of interest policy. Robust mechanism for declaring and publishing declarations of interest.	2	HIGH 10	NEW RISK	Aligning CCG governance to wider strategic leadership with partners. Ongoing engagement from membership. Uncertainty of arrangements for co-commissioning of primary care.	5	2	MED 10	Strategic leadership and primary care.
3	Chief Finance Officer	To continue to develop the effectiveness of the organisation	Failure to secure appropriate and cost effective commissioning support services from the NHS England Leader Provider Framework. ***(Statutory, Reputational & Financial)***	3	Significant amount of time invested by the CCG management team. Secondment of project managers to support the transition. Agreement of full business cases for in-housing of specific service lines.	3	MED 9	NEW RISK	Uncertainty of suitability of providers from the Lead Provider Framework. Timeframes for transition and the ability of new providers to deliver within agreed financial envelope.	3	2	MED 6	Joint approach with Cheshire and Merseyside CCGs to the procurement process. Close working with NHS England.
4	Chief Finance Officer	To continue to develop the effectiveness of the organisation	Failure to embed sound systems of information governance; including the compliance with the national IG toolkit and management of patient confidential data. ***(Statutory, Reputational & Clinical)***	5	CCG is fully compliant with Information Governance Toolkit and systems and processes have been agreed to manage and process patient confidential data. Working closely with North West Commissioning Support Unit to ensure all actions to comply with Information Governance toolkit are being implemented across the CCG. Commissioning support services, and successor organisation will continue to be reviewed on a quarterly basis. Data sharing agreements signed by all local partners.	3	HIGH 15	- Gaps in controls updated	Commissioning from the lead provider framework. Potential implications of a new model of care. IPC for learning disabilities. The ability to demonstrate the effectiveness of the delivery plan.	5	3	MED 15	Collaborative work with local health and social care economy via the strategic leadership group.
QUALITY AND SAFEGUARDING													
5	Director of Quality and Safeguarding	To commission safe, effective care that continues to improve patient experience	Failure of commission safe, effective and harm free care from Providers. ***(Statutory, Clinical and Targets)***	5	Quality requirements in contract. Commissioning for Quality and Innovation Schemes. Quality and performance meetings. Advancing Quality. Serious incident performance monitoring. Clinical engagement meetings. Insights and intelligence from user surveys. Insights and intelligence from Patient Advice and Liaison Service (PALS), incidents, claims and complaints. Insights and intelligence from patients and public engagement. Quality Improvement Committee. CCG Governing Body quality improvement/ performance report. National Institute for Clinical Excellence (NICE) quality standards. Quality Surveillance Group.	3	HIGH 15	- Controls and gaps in control updated.	Closer integration with performance reporting. Sharing of incident information across commissioners. Fragmented commissioner roles. Increase focus on no/low harm incident reporting. Limited capacity to monitor quality of care in smaller provider contracts such as nursing homes and hospices.	5	2	MED 10	Countess of Chester Hospital NHS Foundation Trust. Cheshire and Wirral Partnership NHS Foundation Trust. Partners4Health. Nuffield Health. Cheshire West and Chester Council 1:1 midwifery
6	Director of Quality and Safeguarding	To commission safe, effective care that continues to improve patient experience	Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children ***(Statutory, Clinical and Targets)***	5	Local Children Safeguarding Board and Business Plan, Safeguarding Children Policy, Quality and performance meetings with Providers. Safeguarding Assurance Framework received from Providers identifying levels of compliance with these standards. Exceptions in assurance against these standards are escalated to Quality and Performance meetings Routine reporting to Quality Improvement Committee and Governing Body. Annual report to Quality Improvement Committee. Designated nurse and doctor in post including looked after children function. Early intervention services developed to progress outcome from previous Ofsted inspection. GP attendance and reporting to case conferences. Staff training levels. Unannounced Care Quality Commission inspection into children safeguarding and looked after children January 2014 identified areas of good practice. Care Quality Commission report received February 2014 and action plan now complete.	3	HIGH 15	- Unchanged	Publication of action plans in response to two recently commissioned serious case reviews.	5	2	MED 10	Working with new commissioners of children's services to adopt shared safeguarding assurance framework methodology

WEST CHESHIRE CLINICAL COMMISSIONING GROUP

Risk No	Sponsor	Objective Description & Risk Type	Risk Description	Impact Rating	Positive Assurance on Key Controls to the Governing Body	Likelihood Rating	Risk Score	Changes/ comparison to 2014/15 Framework	Gaps in Control and Assurance	Residual Impact	Residual likelihood	Residual Risk Score	Partnership Issues
7	Director of Quality and Safeguarding	To commission safe, effective care that continues to improve patient experience	Failure to ensure robust arrangements are in place for the safeguarding of adults at risk ***(Statutory, Clinical and Targets)***	5	Executive representation at Local Adult's Safeguarding Board. Clinical Commissioning Group led contracts contain commissioning standards for Safeguarding. Safeguarding Assurance Framework received from Providers identifying levels of compliance with these standards. Exceptions in assurance against these standards are escalated to Quality and Performance meetings. Routine reporting to Quality Improvement Committee and Governing Body. Collaborative working e.g. Care Quality Commission inspections. Annual report to Quality Improvement Committee. Designated nurse in post working in partnership with providers and local authority. Investigation and monitoring of safeguarding concerns in care homes in collaboration with local authority safeguarding adults team. System in place to report concerns about care homes to GPs. Adult safeguarding training in primary care.	3	HIGH 15	▬ Unchanged	Limited capacity to monitor quality of care in smaller provider contracts such as nursing homes and hospices.	5	2	MED 10	
COMMISSIONING AND OPERATIONS (STABILISATION AND TRANSFORMATION)													
8	Director of Commissioning/ Director of Operations	To lead the development of a shared vision for the health and social care economy	Failure of partner organisations to align their plans with the clinical commissioning group commissioning intentions 2016/17. Failure of the clinical commissioning group to deliver its intended efficiency gains. ***(Statutory & Clinical)***	5	Robust quality and performance (contractual) meetings in order for effective engagement with stakeholders. Other high level engagement includes the Clinical Senate, Health and Wellbeing Board, West Cheshire Strategic Leadership Group, Stabilisation Committee and Transformation Committee.	3	HIGH 15	▬ Refreshed controls and gaps in controls narrative.	Establishment of robust and approved governance arrangements by all local health economy partners to deliver detailed programme and project plans with pre-determined qualifiable outcomes.	5	2	MED 10	Supporting the formal mechanisms (Strategic Leaders Group) and seek external critical friend support.
9	Director of Commissioning/ Director of Operations	To lead the delivery of the stabilisation and transformation plans using the knowledge and experience of patients, clinicians and managers to improve care.	Failure to deliver the transformation and stabilisation programmes with special emphasis on the Vanguard New Model of Care (MCP) aligned to the commissioning intentions. ***(Statutory, Reputational, Financial & Clinical)***	5	We will use local evidence and national benchmarking to inform any assumptions to underpin delivery of strategic objectives. Implementation of approved and detailed programme and project plans with owners of each key workstream identified, agreed milestones, monitoring arrangements in place to ensure accountability of these workstream owners. Approved governance structure and systems to support the delivery of these programme/project processes.	3	HIGH 15	▬ Refreshed controls and gaps in controls.	Development of a sophisticated impact model that will also track the achievement against programmes. Develop improved mechanisms for sharing learning across with neighbouring localities as well as Vanguard peers. Understanding the impact of failure to deliver programmes against other workstreams already being undertaken.	5	2	MED 10	Agree system wide deliverables against system wide outcome measures.
10	Director of Operations	To commission safe, effective care that continues to improve patient experience	Failure to provide high quality funded nursing care, continuing health care and complex care within agreed timeframes and against criteria the CCG has determined within its financial envelope. ***(Clinical & Reputational)***	4	Adult safeguarding lead. Care Quality Commission registration. Development of joint care home contract with local authority. Robust quality monitoring and performance and intelligence from patient advice and liaison service (PALS), incidents, claims and complaints. Insights and intelligence from patients and public engagement. Continuing Healthcare Service transfer from North West Commissioning Support Unit to South Cheshire Clinical Commissioning Group took place on 1st February 2015. CCG Joint Committee and Operational Groups now established to manage risks and provide assurance. Reports (as a programme) provided to Stabilisation Committee, Commissioning Delivery Committee and Governing Body.	4	HIGH 16	▬ Refreshed controls and gaps in controls narrative.	lack of agreed criteria for eligibility. Adequate provision for additional costs in CCG balance sheet. Progressing outstanding assessments and claims in residual backlog.	4	4	HIGH 16	Service hosted by South Cheshire CCG for Cheshire and Wirral CCGs.
11	Director of Commissioning	To lead the development of a shared vision for the health and social care economy To ensure financial sustainability for the health economy	Failure to maximise opportunities for co-commissioning, in particular with NHS England on Specialised Services and Primary Care and with other neighbouring Clinical Commissioning Groups ***(Statutory, Reputational & Clinical)***	4	We have developed, agreed and ratified the infrastructure for co-commissioning with NHS England for primary care services.	3	MED 12	▬ Unchanged	Need to ensure we have sufficient resources, financial and staffing capacity, to maximise the opportunity to deliver co-commissioning.	4	3	MED 12	Working with NHS England on the implications of full delegation.
PRIMARY CARE													
12	Medical Director	To work effectively with our members To commission safe, effective care that continues to improve patient experience	Failure to improve primary medical services/GP quality by transforming services with health economy partners. ***(Clinical, Reputational & Targets)***	4	Monitor progress through established GP Quality Group. System-wide primary care commissioning quality and innovation scheme implemented. Prime Minister's Challenge Fund workstreams. Engagement with members via Membership Council and GP Network meetings. Annual practice visits with GP Chair and Medical Director. Development of co-commissioning arrangements with NHS England.	3	MED 12	▬ Updated controls and gaps in controls.	Contractual mechanisms and financial incentives to enforce transformation agenda (currently with NHS England).	4	2	MED 8	-
CONTRACTING & PERFORMANCE													
13	Chief Finance Officer	To lead the development of a shared vision for the health and social care economy. To commission safe, effective care that continues to improve patient experience.	Failure to agree contracting mechanisms to support delivery of the west Cheshire way. ***(Statutory, Reputational, Clinical and Financial)***	4	Shared strategic vision (the West Cheshire Way). Agreed contracts for 2015/16. Agreement of commissioning intentions by end of September 2015. Future contracting models support via Vanguard programme.	3	MED 12	NEW RISK	Lack of commissioning intentions. Lack of evidence why certain activities have been undertaken (local and national benchmarking). Financial position needs alignment to the local health needs.	4	3	MED 12	Vanguard programme (MCP) and strategic leadership group.
14	Chief Finance Officer / Director of Operations / Director of Quality and Safeguarding	To commission safe, effective care that continues to improve patient experience.	Failure of to deliver against agreed performance and quality indicators ***(Reputational, Clinical, Financial and Targets)***	4	Reports to commissioning delivery committee. Scrutiny at quality and performance meetings. Governance arrangements to support stabilisation agenda.	3	12 MED	↑ Increased score and updated controls, gaps in controls and partnership issues.	Monitoring current performance effectively against specific targets for diagnostic tests, A&E, mixed sex accommodation, e-discharge, dementia and improving access to psychological services. Integration of performance management across the CCG.	4	3	12 MED	Strategic leadership group.

NHS
West Cheshire
Clinical Commissioning Group

1.	**Date of Governing Body Meeting:**	17th September 2015
2.	**Title of Report:**	Minutes of Governing Body Sub-Committees
3.	**Key Messages:**	To provide an overview of business and actions/decisions made by the sub-committees of the governing body.
4.	**Recommendations:**	The governing body is requested to receive and note any significant issues arising from, and the minutes of, the sub-committees.
5.	**Report Prepared By:**	Clare Jones Governing Body and Committees Coordinator

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

MINUTES OF GOVERNING BODY COMMITTEES

PURPOSE

1. To provide the governing body with the minutes which record the decisions of sub-committees established by the governing body, which have an influence on the governing body business.

BACKGROUND

2. This report provides a format for the governing body to consider the work of all the various sub-committees that work on its behalf. The intention of this report is to highlight some of the key issues raised and actions undertaken by the different sub-committees. Where available, approved meeting minutes are available via the hyperlink beside each meeting title.

GP LOCALITY NETWORKS

Chester City Locality GP Network

3. There are no approved minutes available since the last update.

Rural Locality GP Network – minutes

4. Major issues and actions from the June 2015 meeting included:
   - A verbal update was provided by Brio Leisure and it was noted Brio Leisure is the leisure provider with Cheshire West and Chester Council and has been so for the past 4 years. Brio Leisure have recently been offered a 15 year contract to offer sport and fitness services along with an integrated wellbeing contract
   - A presentation was received from Brightlife, a programme led by Age UK Cheshire and it was noted this particular project is one of 15 across the country with funding of £5.12m over 5 years from April 2015.
   - An update was provided on the new primary care team structure, outlining project managers and the Clusters they will be linking to.
   - The Network unanimously agreed to trial, until March 2016, the suggested meetings structure. To retain Locality Network meetings but on a less frequent basis and to support Cluster meetings and Cluster Lead meetings. This will in turn support Primary Care Cheshire (PCC) and help develop an infrastructure that will sustain the changing face of primary care.
   - Commissioning Lead Updates were provided from Clinical Leads
   - An e-Lloyd George Service proposal update was provided

Ellesmere Port and Neston Locality GP Network – minutes

5. Major issues and actions from the June 2015 meeting included:
   - An update was provided on the new primary care team structure, stating project managers and which Clusters they will be linking to.
   - All PMCF updates will be given at every opportunity through Clusters, Networks and Project Managers as well as other forums.
   - The new proposal to makes best use of existing forums and allow some funding to take forward Cluster meetings was summarised. A vote took place at the meeting, in principle, and any exceptions within or changes to this vote will be notified electronically within 10 days of the meeting. Great Sutton Wearne and McAlavey were to be contacted outside of the meeting.

CLINICAL SENATE

6. An update of the June 2015 meeting is contained within the Clinical Senate report. The report from the June 2015 meeting is scheduled to be received at the end of September 2015 and will be included within the November 2015 update.

QUALITY IMPROVEMENT COMMITTEE – minutes

7. An update of the August 2015 meeting is contained within the quality improvement report. The minutes from this meeting will be available for the November 2015 meeting.

COMMISSIONING DELIVERY COMMITTEE

8. An update of the September 2015 committee meeting is contained within the commissioning delivery committee report. The minutes from this meeting will be available for the November 2015 meeting.

REMUNERATION COMMITTEE

9. An update of the July 2015 committee meeting is provided within the remuneration committee report.

RECOMMENDATION

10. The governing body is requested to receive and note any significant issues arising from, and the minutes of, the sub-committees.