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 March 2016, at 9.00am in The Groves Sports and Social Club, Chester Rd, Ellesmere Port CH66 2NZ

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	Minutes of last meeting held on 21st January 2016	DR	Dr Huw Charles-Jones *GP Chair*
D	9.30	Matters arising/actions from previous Governing Body Meetings	D	Dr Huw Charles-Jones *GP Chair*
WCCCGGB/16/03/45	9.35	Senate Report	D	Dr Peter Williams *Hospital Doctor Member*
WCCCGGB/16/03/46	9.45	Quality Improvement Committee Report	D	Paula Wedd *Director of Quality and Safeguarding*
WCCCGGB/16/03/47	10.05	2016/17 Financial Budget	D	Gareth James *Chief Finance officer*
WCCCGGB/16/03/48	10.25	Finance, Performance and Commissioning Committee Report	D	Chris Hannah Vice Chair/Lay Member Lee Hawksworth *Director of Operations* Laura Marsh *Director of Commissioning* Gareth James *Chief Finance officer*
10.45 BREAK				
WCCCGGB/16/03/49	11.00	Audit Committee Report	D	Ken Morris *Lay Member* Gareth James *Chief Finance Officer*

Item	Time	Agenda Item	Action	Presenter
WCCCGGB/16/03/50	11.10	Chief Executive Officer's Business Report	D	Alison Lee *Chief Executive Officer*
WCCCGGB/16/03/51	11.25	Nurse Revalidation	D	Sarah Faulkner *Nurse Representative*
WCCCGGB/16/03/52	11.40	2015/16 Governing Body Assurance Framework	I	Gareth James *Chief Finance officer*
CONSENT ITEMS				
WCCCGGB/16/03/53	11.45	Clinical Commissioning Group Policies and Governance Documents	DR	Gareth James *Chief Finance Officer*
WCCCGGB/16/03/54	11.50	Clinical Commissioning Group Sub-Committee Minutes	I	Alison Lee *Chief Executive Officer*
WCCCGGB/16/03/55	11.55	Any Other Business **(to be notified to the Chair in advance)**	D	All
Date and time of next formal Governing Body meeting – Thursday 19th May 2016, at 9.00am at Tarvin Community Centre, Meadow Close, Off Crossfields, Tarvin, Chester, CH3 8LY				

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
West Cheshire
Clinical Commissioning Group

NHS West Cheshire Clinical Commissioning Group
Formal Governing Body Meeting
Thursday 21st January 2016, 9.00a.m.
Rooms A&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 Pam Smith	Lay Member
Mr David Gilburt	Lay Member
Ms Sarah Faulkner	Nurse Representative
Dr Annabel Jones	GP representative – City Locality
Dr Steve Pomfret	GP representative – Rural Locality
Ms Laura Marsh	Director of Transformation
Ms Paula Wedd	Director of Quality and Safeguarding
Ms Philippa Robinson	Turnaround Director

In attendance:

Gill Frame	Independent Chair, Cheshire West and Chester Local Safeguarding Children Board
Geoffrey Appleton	Independent Chair, Cheshire West and Chester Local Safeguarding Adults Board
Ms Clare Dooley	Head of Governance

16/01	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. It was noted that hard copies 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. The first 15 minutes of the agenda are 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. A concern was raised by Mr Gus Cairns in relation to Countess of Chester Hospital NHS Foundation Trust reporting breaches against the 62 day waits for cancer. The Chair responded that this issue is noted within the Finance, Performance and Commissioning Committee report, and details were provided on the work being undertaken to address this issue.	

16/01	AGENDA ITEM	Action
	Although performance improved during September 2015 the target of 85% was not achieved and the main area for concern continues to be the Cheshire and Merseyside Cancer Network reallocation policy, which is currently under review and impacts upon the Trust's reporting figures. A contributory factor has also been the pressure from emergency admissions at the Trust and, subsequently, a number of cancer operations have been cancelled as a result of this pressure. The decision to cancel these operations was serious and any resulting impact of this decision is awaited. It was noted that the decision to cancel operations also affected other specialities at the Trust and the Trust and clinical commissioning group continue to monitor performance on a daily basis.	
	CHAIR'S OPENING REMARKS	
	The Chair noted that, due to the number of items on the agenda to be discussed at today's meeting his opening comments would be brief. The Chair advised that due to the current clinical commissioning group financial position, there is a separate finance paper on the agenda, which contains a number of important issues for discussion. The Chair reflected that the NHS, as a whole is experiencing difficult times, and our local NHS is no exception to this. However, during challenging times, and when people are under pressure, it is easy to forget what the NHS is about; it is about caring for people in our community, it is not about trying to please the Department of Health or NHS England. It is important that we constantly ask ourselves about the decisions we are taking in the best interests of the people of West Cheshire. We can only do this by continuing to place patients at the very centre of our decision making and ensuring that we continue to listen to the clinical voice. The Chair closed his opening remarks by noting that our double helix of managers and clinicians has served us well and transformed the way we work. There is a danger that we slip back into the "command and control" methods that have blighted the NHS for years, and we should resist this. If we do not, we may make decisions that seem attractive in the short term, but will ultimately not serve the people in this area well. In simple terms we need to remember our team charter, and stick to our values.	
A	**APOLOGIES FOR ABSENCE**	
	Apologies were received on behalf of Chris Hannah, Dr Jeremy Perkins, Dr Peter Williams, Lee Hawksworth and Fiona Reynolds.	
B	**DECLARATIONS OF MEMBER'S INTERESTS**	
	• David Gilburt declared an interest, as a Non-Executive Director at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, in relation to agenda item WCCCGGB/16/01/34.	

16/01	AGENDA ITEM	Action
	• Dr Huw Charles Jones declared an interest in relation to NHS 111 within agenda item WCCCGGB/16/01/34. • Sarah Faulkner declared an interest in relation to NHS 111 within agenda item WCCCCGGB/16/01/34.	
C	**MINUTES OF FORMAL GOVERNING BODY MEETING HELD ON 19th NOVEMBER 2015**	
	The minutes of the formal governing body meeting held on 19th November 2015 were accepted and signed as an accurate record.	
D	**MATTERS ARISING/ACTIONS FROM PREVIOUS GOVERNING BODY MEETINGS**	
	• Senate dementia event (June 2015) – Laura Marsh advised a report had been provided by Fiona Reynolds, Interim Director of Public Health, and confirmed that Fiona plans to attend the February finance, performance and commissioning committee to provide a further update (the 2 actions on the governing body tracker were closed). • Voluntary suspension of admission of patients to Sutton Beeches – monitoring to take place via the quality improvement committee. Paula Wedd confirmed monitoring is taking place at the quality improvement committee (the action was closed on the governing body action tracker). • Contingency planning by the Countess of Chester Hospital NHS Foundation Trust in relation to the planned junior doctor's strike. Gareth James confirmed this issue was discussed at the last quality and performance meeting with the Trust, and confirmed an action plan was in place, which provided assurance to the clinical commissioning group (the action was closed on the governing body action tracker).	
32	**SENATE REPORT**	
	The Chair presented a report from the Senate meeting held in November 2015, in Dr Peter Williams' absence. The Chair reflected that this was the first Senate meeting since the development session in September 2015. Dr Williams opened the November Senate meeting to set out how it would continue to develop in the future. There is a real desire to hear the patient voice at Senate meetings, and whilst maintaining the core membership, other clinicians and senior managers across the health economy will be invited to attend based on meeting topics. There is now also a stronger focus on future meetings agenda planning. The Senate is not a decision making body and there was discussion on the commitment for members to take back recommendations to their own organisations in relation to implementing actions that are agreed at Senate meetings.	

16/01	AGENDA ITEM	Action
	There was a multi-agency discussion on winter planning at the meeting and optimising capacity and maintaining quality standards of Care Homes was a recurring theme throughout the session. Alistair Jeffs, Head of Commissioning People at Cheshire West and Chester Council presented the "Let's Talk" consultation on the budget cuts at the local authority. The consultation is now closed but comments can still be put forward to council representatives. In response to comments and queries raised by governing body members the following were noted: • It was agreed that expanding/enabling the patient voice, through powerful real life stories at the Senate would continue to be pursued by the Head of Communications and Engagement and the Organisational Development Manager. • The style of the Senate report to the governing body needs to be developed further to provide a flavour of the debate at the Senate rather than a formal business report. • The Senate members were clear that the difficult financial position of the NHS is similar/equal to the challenges that are faced, and were presented, by the local authority. • Further discussion and development is required to improve the influence of Senate, to avoid it being a discussion group, and to make real efforts towards influencing decision making across the local health economy. ***The governing body noted and reflected on the issues discussed by the Senate.***	
33	**QUALITY IMPROVEMENT COMMITTEE REPORT**	
	The Director of Quality and Safeguarding, Paula Wedd, introduced the paper. Paula advised that clinical commissioning group managers are continuing discussions with partners about quality issues during pressured times for the local health system and she offered thanks to staff and provider Trust colleagues. Paula highlighted the following issues from the report: • There have been 2 cases of MRSA at the Countess of Chester Hospital NHS Foundation Trust since September 2015. • The Countess of Chester Hospital NHS Foundation Trust has shown its commitment to hearing the voice of patients by investing in a new text system to collect Friends and Family test information.	

16/01	AGENDA ITEM	Action
	• The Care Quality Commission has issued their report following an inspection at Cheshire and Wirral Partnership NHS Foundation Trust. It was a good report following a review of 14 core services. An "outstanding" rating was received for inpatient learning disability services, which is a significant improvement, given the issues that have been previously highlighted to our governing body about these services. There is a list of "must do" issues that the Trust has to address in the report, with a significant amount of specific detail behind these. The clinical commissioning group will use some of the detail from the report and include them in our quality schedule for monitoring with the Trust in 2016-17. • Sutton Beeches Care Home provides respite care through a contract with the local authority. They also provide a number of beds as part of our discharge to assess process. The Countess of Chester Hospital NHS Foundation Trust and GPs have worked hard with care home staff and improvements are now in place in relation to medication administration and Sutton Beeches is starting to take admissions again on a phased basis. A review of implementing a new service at Sutton Beeches needs to take place (between the clinical commissioning group, Cheshire West and Chester Council and Cheshire and Wirral Partnership NHS Foundation Trust). • Following other Care Quality Commission inspections the Willows Care Home have seen positive improvements to services. Atherton Lodge Care Home has moved to "needs improvement", from a previous rating of "inadequate". • The primary care commissioning for Quality Innovation (CQUIN) scheme is different from other incentive schemes previously implemented. In 2015/16 practices have put effort into establishing systems to change care delivery models. This work will continue in 2016/17. • Medicines Management quality improvement work is ongoing, with particular emphasis on antibiotic resistance by looking at individual prescribing practices. Innovative projects are being developed to improve Improving flu vaccination rates and flu prophylaxis. • Ofsted inspection – the Chair of the Local Safeguarding Adults Board and the Chair of Local Safeguarding Children's Board are attending the governing body today, and the Ofsted inspection report has now been published. Paula thanked Anne Eccles and Berenice Astbury for all their hard work during the Ofsted inspection process. In response to comments and queries raised by governing body members the following were noted:	

16/01	AGENDA ITEM	Action
	• Regulation 28 issued by the Coroner to the Countess of Chester Hospital NHS Foundation Trust in relation to a patient who had fallen. The clinical commissioning group does not yet have the full details on this issue and will therefore be provided at a future governing body meeting.	**PW**
	• Safer staffing issues from the Care Quality Commissioning inspection report at Cheshire and Wirral Partnership NHS Foundation Trust is in relation to community staff based over several sites, service areas and localities. Safer staffing levels are easily reported for acute trusts, however providing this information accurately for community services is a national issue and will require further work by the Trust. We are following up through the quality and performance meetings with the Trust the particular issue of safer staffing in our physical health community teams.	
	• The National Institute for Clinical Excellence guidance on pneumonia care is an area for further discussion and implementation, in-line with the evidence base. We need to expedite developing near patient testing as part of Vanguard programme. A clinical commissioning group programme manager has met with health scientists in relation to work we can do on front-line testing in primary care. It was agreed that the Medical Director will provide an update on this work to the next governing body meeting.	**AMc**
	• We have identified that we need to undertake a whole system review approach of Falls Services and this has been discussed with head of joint therapies at the Countess of Chester Hospital NHS Foundation Trust and feedback will be provided, once available, on this work by the Director of Quality and Safeguarding.	**PW**
	• The Care Quality Commission can close Care Homes that fail to improve following a rating of "inadequate". In respect of the West Cheshire Care Homes the clinical commissioning group can agree a voluntary suspension to admissions and a directive for specific improvements to be addressed which we monitor before they are allowed to take any future admissions. All Care Homes have agreed to this approach to date. Dependent on the specific issues raised at Care Homes we will closely monitor improvements and processes before it can re-open.	
	The governing body reviewed the issues and concerns highlighted and identified further actions for the quality improvement committee.	
34	**FINANCIAL PERFORMANCE AT END OF DECEMBER 2015**	
	The Chief Finance Officer, Gareth James provided a brief background on this report.	

16/01	AGENDA ITEM	Action
	Since changing the financial forecast (from surplus to break-even) at month 3 he had reported that there is risk within the forecast of between £2 and £3 million. This has been consistently reported to both NHS England and the governing body. The issues creating the financial pressures have been discussed on many occasions; secondary care (un-planned admissions and critical care) and complex care packages. The governing body considered several mitigating actions at the informal governing body meeting in December 2015. These mostly relate to applying more rigour to enforcing contractual levers. The revised financial forecast factors in the part-year impact of these mitigations. This results in a lower potential financial gap of £1.269 million. Appendix A of the report details that, at the end of month 9, it is forecast that this risk will be mitigated further and break-even will be delivered. There remains a significant level of risk. The biggest risk is the dispute with NHS England about funding (for activity at the Countess of Chester Hospital NHS Foundation Trust) relating to specialised critical care activity. This will be discussed in more detail in part 2 of the governing meeting and would have been escalated on the risk table if known prior to writing the report. The Chief Finance Officer reported that the anticipated funding in respect of charge exempt overseas visitors has been reduced from £1.4M (received in 2014) to £800K. The Chief Finance Officer has lodged a formal query with NHS England to understand how/why this has occurred. The two issues above increase the level of financial risk to approximately £3.2M. The Chief Finance Officer is in negotiation with NHS England to understand the governance behind their funding decision and we have made representations on this to NHS England. In response to comments and queries raised by governing body members the following were noted: • The issues highlighted are material decisions at this point in the financial year and it is not easy to absorb these. The governing body provided support to the Chief Finance Officer in challenging the position with NHS England. • Slippage from the transformation fund are likely (£900K detailed in the report) and at time of writing the report the Chief Finance Officer was confident there would be further slippage, however not enough to reach a break-even position. • We have requested twice that NHS England formally confirm to us the position in relation to the two issues reported to the governing body. However, we have not yet received this in writing. We have exhausted our own capabilities and there is little we can do further at this stage other than being clear with NHS England that their decisions are impacting on our bottom-line.	

16/01	AGENDA ITEM	Action
	• The Chief Finance Officer confirmed a formal letter to NHS England will be sent this week, asking them to confirm in writing the position on the two issues set out and that the clinical commissioning group may need to escalate further is a response is not received. An audit trail of our correspondence/governance with NHS England is robust in relation to the two issues. • The Chief Finance Officer noted that the 2016/17 financial position includes 3.05% growth in allocation. However, this comes with many more commitments for the clinical commissioning group, for example an inflation of contracts and GPIT budget commitments. • The Chief Finance Officer will present the budget and financial plan for 2016/17 at the next formal governing body meeting. ***The governing body noted the financial position to the end of December 2015 and the significant level of risk underpinning the financial forecast.***	**GJ** **GJ**
35	**FINANCE, PERFORMANCE AND COMMISSIONING COMMITTEE REPORT**	
	The Turnaround Director presented the following areas from the report: • Elective care – a review of commissioning in-line with the policy on procedures of limited clinical value is taking place with the Countess of Chester Hospital NHS Foundation Trust, focussing on the out-patient system and GP referrals. • The NHS 111 mobilisation plan (appended to the report) was discussed at the finance, performance and commissioning committee and the implementation/go-live date of 1 April 2016 for West Cheshire has been agreed. • Daily reporting of local system metrics via the Alamac system (as described at paragraph 13 of the report). This reporting forms the basis of activity information all partners use on a daily basis. • The long term financial model (working with local health economy partners) is nearing conclusion, and it was reported there is approximately 3 days of work required before the model can be shared across the health economy for agreement and implementation. In response to comments and queries raised by governing body members the following were noted: • It was agreed that completion of the long term financial model work is essential and a discussion across the health economy on the implementation of this is required as soon as possible. Time is also required for a discussion on the Better Care Fund budget alignment with partners on the pooled budgets.	

16/01	AGENDA ITEM	Action
	The Director of Transformation presented the following items from the report: • The first quarter of Vanguard funding has been received and plans are in progress to track delivery against this funding. • A performance dashboard is in progress for the programmes, which will monitor success as well as process measures. This will evolve over time using vital engagement intelligence with the population as well as measures from clinicians across the health economy. • A Head of Communications and Engagement Officer has now been appointed and commenced in post. The importance of this role is bringing together and leading the communications and engagement expertise across the health economy in relation to the Ne care Model programme was noted. • The next iteration of the value proposition (for 2016/17 funding) will be submitted to the NHS England New Models of Care Team on 8th February 2016. • A quarterly review meeting with the NHS England New Models of Care Team is planned for early February 2016 to assess achievement against the strategic milestones set out within the 2015/16 value proposition it has been acknowledged that by their nature some of the projects will take time to impact on the outcomes. In response to comments and queries raised by governing body members the following were noted: • It was agreed that evidence of success should be provided to the governing body. The Director of Transformation highlighted a few of the projects already underway which are making an impact: a) The 'Daily Mile' project - 5 schools are launching this project in 2016. b) The paediatric acute to community shift – a GP cluster has been established to shape the model which will enable more children to be seen in community. c) Self-care progress – Self Management courses and one to one coaching programmes are up and running. d) The "year of care" project on holistic care planning on an individual's conditions and identifying support for patients to set their own goals is underway. e) Ageing Well Programme – the piloting of pharmacists, and the recruitment of speech and language therapists and dieticians to work with the integrated teams is underway. A physiotherapist to work with the ambulance service to help avoid admissions from those who have fallen is also being implemented.	

16/01	AGENDA ITEM	Action
	• A West Cheshire Way e-newsletter on progress and successes within the programmes has been developed and is circulated to all partners. • It was agreed that awareness of success is important, however further detail on projects that are not working as well should be reported, including decisions made on actions to mitigate issues, including whether or not projects should be stopped. • The impact of the open access to physiotherapy project on referrals to hospital has had a demonstrable impact and we need to make sure this type of information is more visible. It was also agreed that the Director of Transformation will link highlight reports and dashboard in her paper to future governing body meetings. The Chief Finance Officer presented the following performance issues from the report: • The finance, performance and commissioning committee considered the performance report at the end of September 2015 and discussed the areas where performance falls below target, these are consistent with previous reporting periods. • An action plan is in place to address the 62 day cancer waiting times with the Countess of Chester Hospital NHS Foundation Trust. • The accident and emergency 4 hour target will not be achieved for quarter 3 of 2015/16 and an action plan to address this is required. • The committee asked for a simple action plan to address meeting the mental health targets (improving access to psychological therapies and dementia diagnosis rates). • A verbal update was provided to the committee on the number of breaches against both the 18 week referral to treatment target and the 52 week wait target, following the issue of refreshed guidance. Following a formal contract query, an action plan has been agreed with the Trust and this will be reviewed again at the quality and performance meeting on 28th January 2016. • At the time of writing the report there were 25 patients waiting in excess of 52 weeks (a large number of these are related to "patient choice"). Contractual penalties will be invoked for these breaches. ***The governing body noted the key issues discussed and the decisions made at the finance, performance and commissioning committee and noted the change of direction of this report in order to make it more dynamic and operationally aligned to key areas of delivery within the West Cheshire Way.***	**LM**
36	**AUDIT COMMITTEE REPORT**	
	David Gilburt, Chair of the audit committee, highlighted the following issues discussed at the audit committee meeting held on 10th December 2015:	

16/01	AGENDA ITEM	Action
	• Assurance in relation to the significant amount of work being undertaken to submit evidence for the information governance toolkit. • Significant assurance received from internal audit colleagues in relation to the clinical commissioning group's financial reporting systems and processes. ***The governing body noted the key items of business discussed at the audit committee held on 10th December 2015.***	
37	**LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15**	
	The Chair welcomed Geoffrey Appleton, Independent Chair of the Local Safeguarding Adults Board to the meeting and Geoffrey highlighted the following areas from the 2014/15 Annual Report: • The Local Safeguarding Adults Board has had a statutory role since 1st April 2015. • Paula Wedd, Director of Quality and Safeguarding (West Cheshire Clinical Commissioning Group) is a member of the Board and chairs a sub-committee. • Helen Wormald, Adult Safeguarding Nurse (NHS West Cheshire Clinical Commissioning Group) also attends the Board. • Strong partnerships have been developed with the local authority scrutiny panel • The report format will change focus for 2015/16 to include performance reporting, in conjunction with guidance from Paula Wedd. • A section is included on modern day slavery, and there is a conference anticipated in 2016, preparation for this will take place in collaboration with the Chair of the Health and Well Being Board. • A joint development day between the Local Adults Safeguarding Board and Local Children's Safeguarding Board members will take place on 22nd January 2016, on future joint/shared working. • The Board is working more closely with the Police and Crime Commissioner. In response to queries and comments received from governing body members the following points were noted: • Agreement on the good quality, style and content of the report was provided from a number of governing body members. • The domestic violence strategy is in draft and being developed, although it is not the finished version the Board are known to be ahead of other boroughs in this regard. • Language will be changed in future Local Safeguarding Adults Board annual reports to reflect the Care Act. Paula Wedd, Director of Quality and Safeguarding at NHS West Cheshire Clinical Commissioning Group is working on the suite of performance measures and benchmarking data	

16/01	AGENDA ITEM	Action
	• From a transformation perspective projects to address domestic abuse have been included in our Vanguard programme value proposition, which will strengthen community ownership. • NHS England has provided assurance that this Local Safeguarding Adults Board is operated at a considerably high standards and rates exceptionally highly compared to other Boards. The Board is the only one nationally to undertake annual awards ***The Chair thanked Geoffrey Appleton for presenting the Local Safeguarding Adults Board 2014/15 Annual Report to the governing body.***	
38	**LOCAL SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT 2014/15**	
	The Director of Quality and Safeguarding, Paula Wedd reminded the governing body that at the last meeting we had our own (clinical commissioning group) adults and children's safeguarding annual reports. Paula introduced, Gill Frame, Independent Chair of the Local Safeguarding Children's Board, who presented the following highlights from the 2014/15 Annual Report: • A detailed executive summary was provided to the governing body, a full version of the report is available on the Local Safeguarding Children Board website. • The report shows that robust governance, accountability and reporting mechanisms are in place. • A child death overview panel has now commissioned an independent chair and has seen significant changes in how this now operates. • There are a number of pan Cheshire work programmes (across clinical commissioning group boundaries), such as children sexual exploitation, children missing from home and female genital mutilation. • A review of work programmes in 2014/15 is set out from page 11 onwards highlighting what has been achieved, what has been less successful and the impacts of programmes on children on young people. The main focus of the work described is focussed on child sexual exploitation and domestic abuse/neglect. • Audits and practice learning reviews have taken place using evidence based assessment tools. • The Local Safeguarding Children's Board website has been completely revamped and access to training via the website is now much easier. • Further detail at the back of the report is provided on future priorities (towards 2019). • Two serious case reviews have taken place in 2014/15, one is due for publication in February 2016, and both review action plans are being progressed, which includes sharing learning from the reviews with staff via briefing communications. • An Ofsted review has taken place and the Local Safeguarding Children's Board had received good feedback on partnership working.	

16/01	AGENDA ITEM	Action
	In response to comments and queries raised by governing body members the following were noted: • Agreement on the good quality, style and content of the report was provided from a number of governing body members. • The established "early help offer" and co-location of teams is working well. Sharing information is enabling some initial implementation of the team around the family intervention model, which needs further development in 2016/17 as part of transformation programmes. • Concern was raised in relation to cuts in local authority budgets and the Local Safeguarding Children's Board need to understand how this will affect future programmes of work. In March 2016 a new model of care on one collective approach (one front door) will be launched. • Partnership working is taking place between the local authority and GPs on attendance at child case conferences including to pursue technology (e.g. Skype) as different options/solutions for different practices. ***The Chair thanked Gill Frame for presenting the Local Safeguarding Children Board 2014/15 Annual Report to the governing body.***	
39	**CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT**	
	Chief Executive Officer, Alison Lee highlighted one area specifically from the paper provided to the governing body. The next stage of work for the clinical commissioning group, in-line with the national Five Year Forward View is to submit our 1 year commissioning plan and agree the geography for the 5 year sustainability and transformation plan with NHS England. This footprint will potentially be on a wider footprint than the current structure of single NHS organisations across Cheshire and Merseyside. As part of the process to agree the footprint, there are 25 questions we are required to consider by 29th January 2016. As part of the clinical commissioning group's system leadership role NHS England are asking us where/how we would want future NHS organisations to operate. In response to comments and queries raised by governing body members the following were noted: • Wirral Hospital Teaching NHS Foundation Trust executives have clearly indicated a preference to work closely with West Cheshire (clinical commissioning group and provider Trust), however the intentions of NHS Wirral Clinical Commissioning Group are, as yet, unclear. • A Cheshire, Warrington and Wirral footprint has previously been established (alliances by predecessor primary care trusts), and a Cheshire and Merseyside footprint (a strategic health authority footprint between 2002 – to 2006) has also been in place. Some Cheshire clinical commissioning groups refer towards Manchester and Stafford therefore	

16/01	AGENDA ITEM	Action
	these approaches is not straightforward to implement. It is anticipated that Halton and Warrington may consider joining a Liverpool (mid Mersey) footprint. • Around 90% of patient contact happens in primary care and there are some specialist services that patients already "travel to" for best care. The NHS need to ensure sophisticated conversations and communication processes take place to ensure the best care options are clearly set out with the public. • From the discussion a Cheshire, Warrington and Wirral footprint/alliance was agreed. The decision will ultimately be made by NHS England, however the views of NHS Chief Executives will be taken into consideration at an event to take place on 29th January 2016. It was agreed that the senior management team would discuss this further, having heard the governing body's preference, in advance of responding to NHS England at the meeting on 29th January 2016. ***The governing body noted the contents of the report and agreed a preferred option (Cheshire, Warrington and Wirral alliance) to report to NHS England on the sustainability and transformation plan footprint.***	**AL**
40	**GOVERNING BODY ASSURANCE FRAMEWORK**	
	The Chief Finance Officer noted that the governing body assurance framework is provided to each formal governing body meeting as it is important to provide assurance to the governing body that risks are identified and being managed. David Gilburt noted that the financial break-even position scoring within the framework needs to be increased, and this was agreed by governing body members. ***The governing body noted the information provided on the governing body assurance framework.***	**GJ**
41	**CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS**	
	The Chief Finance Officer advised that 2 policies (Serious Incidents Policy and Learning and Development Policy) were provided for ratification by the governing body, as proposed by the committees outlined in the covering paper. ***The governing body approved/ratified the two policies provided.***	
42	**SUB-COMMITTEE ANNUAL REPORTS**	
	The annual report was reviewed and it was agreed that the report will be amended to clarify that Alison Lee "attends" the remuneration committee meeting, and is not a member of the committee. ***The governing body noted the sub-committee annual reports.***	**CD**

16/01	AGENDA ITEM	Action
43	**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.	
44	**ANY OTHER BUSINESS**	
	There were no other items of business to be discussed.	
	DATE AND TIME OF NEXT FORMAL MEETING	
	The next meeting will take place on Thursday 17th March 2016 at 9.00am. **POST MEETING NOTE:** **The venue for the formal governing body meeting on 17th March has changed. The meeting will now take place at the Groves Sports and Social Club, Chester Road, Ellesmere Port, CH66 2NZ.**	

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 17th September 2015				
15/09/D Page 3	**Conflicts of Interest Policy** – Off-line testing will be undertaken and an update on the robustness of the policy, following the testing of a number of scenarios, will be presented at the next audit committee meeting.	Gareth James	March 2016	**Green** Complete
Meeting held on 19th November 2015				
15/11/25 Page 7	**Quality Improvement Report -** Advancing Quality – This issue is to be considered as an item for a future meeting of the Senate.	Paula Wedd	March 2016	**Green** This issue is being progressed outside of the governing body meeting
15/11/27	**Chief Executive Officer's Business Report** - The full ECIST report for accident and emergency services, including intermediate care, is awaited by the system resilience group.	Lee Hawksworth	March 2016	**Green** Complete
Meeting held on 21st January 2016				
16/01/33 Page 6	**Quality Improvement Report** a. Regulation 28 – Full details are to be shared with the governing body, once available.	Paula Wedd	March 2016	**Green** Complete (contained within Quality Improvement Report for March GB meeting)
	b. Medical Director to provide an update on National Institute for Clinical Excellence guidance on pneumonia care to the next governing body meeting.	Andy McAlavey	March 2016	**Amber** For update March 2016
	c. Feedback to be provided on whole system review of Falls services, once available.	Paula Wedd	March 2016	**Green** Complete (Joint Therapies Manager and Director of Nursing at CoCH have agreed that inpatient falls should be considered as a part of the falls workstream.)
16/01/34 Page 8	Financial Performance at end of December 2015 a. Formal letter to be sent to NHS England requesting confirmation in relation to two issues previously identified to the governing body.	Gareth James	March 2016	**Green** Complete
	b. Budget and financial plan for 2016/17 to be presented at March 2016 governing body.	Gareth James	March 2016	**Green** Complete (included on March GB agenda as item 2016/03/47)

Item	Action	Owner	End Date	STATUS
16/01/35 Page 10	**Finance, Performance and Commissioning Committee Report** – Director of Transformation to link highlight reports and dashboard in future reports to the governing body.	Laura Marsh	March 2016	**Green** Complete (included in the FPCC report for March GB meeting)
16/01/39 Page 15	**Chief Executive Officer's Business Report –** Having heard the governing body's preference, the senior management team is to further discuss a Cheshire, Warrington and Wirral footprint/alliance, in advance of responding to NHS England at the meeting on 29th January 2016.	Alison Lee	March 2016	**Green** Complete
16/01/40 Page 16	**Governing Body Assurance Framework –** The financial break-even position scoring within the framework is to be increased.	Gareth James	March 2016	**Blue** For update May 2016
16/01/42 Page 16	**Sub-Committee Annual Reports –** The report is to be amended to reflect that the Chief Executive Officer attends at the remuneration committee meeting and is not a member of the committee.	Clare Dooley	March 2016	**Green** Complete

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 March 2016
2.	**Title of Report:**	Senate Report
3.	**Key Messages:**	This report provides an overview of the business discussed at the West Cheshire senate meeting held on 28th January 2016. There was also a presentation and discussion on the work that has been undertaken on the long-term financial model for the West Cheshire health and care economy. The meeting was attended by Sir Sam Everington, Chair of NHS Tower Hamlets Clinical Commissioning Group. Sir Sam shared his experience of transforming the provision of primary care in Tower Hamlets.
4.	**Recommendations**	The governing body is asked to note the issues discussed by the senate.
5.	**Report Prepared By:**	Karen Warren Organisational Development Manager

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

SENATE REPORT

PURPOSE

1. The West Cheshire senate has been established by the governing body to provide 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 discussion that took place on the work that has been undertaken in West Cheshire to develop a shared long-term financial strategy and the discussion with Sir Sam Everington, Chair of NHS Tower Hamlets Clinical Commissioning Group, on addressing the behaviours of change required to support the delivery of the West Cheshire Way.

CONTENT

Long Term Financial Position

3. Tim Welch, Director of Finance from Cheshire and Wirral Partnership NHS Foundation Trust, presented an update on the collaborative work that had been undertaken across West Cheshire to develop a shared long-term financial strategy for the health and care system. This is needed to support the development of a new sustainable model of care and will ensure that the full financial impact of decisions are understood and the continued development of the value proposition is supported.

4. Sustainable success will be delivered if the needs of our population can be met at a cost that is less than or equal to the available funding. Changes in cost or income, without fundamental changes to the way care is provided, will not deliver a sustainable solution. Tim observed that we need to be more open and share information, build on existing models of care and incorporate all providers including primary care.

5. The system finance model has been developed around understanding demand and actively increasing commissioning through the system. The meeting attendees looked at the initial outputs of the new system and talked about the two main drivers for increased costs; namely the demands in pressure and the increase in costs.

6. Tim confirmed that in order to assess the impact of service changes we will need to get better at defining outcomes and measuring impacts. In summary, we need to be clearer on what difference we are making and if it is worth doing. The next steps are to complete the draft model to share with partners and to regularly update the live version of the document. Further long term financial planning sessions will be scheduled for the senate meeting to ensure our partners across the health economy are linked into the planning and delivery of financial stability.

Motivation and Responses to Change - Presentation by Sir Sam Everington

7. Sir Sam Everington works as a GP in Bromley by Bow in London and is the chair of Tower Hamlets clinical commissioning group. Under his chairmanship the clinical commissioning group was awarded clinical commissioning group of the year by the Health Service Journal in November 2014. The judges praised the group's 'strong leadership, especially around clinical leadership, while retaining patient focus'. Sir Sam was invited to speak at the Senate in his capacity as a senior advisor to Simon Stevens in support of developing the Five Year Forward View new care models.

8. Sir Sam gave a summary of his career to date. Starting out as a welder, he then became a barrister and then trained as a doctor. Sir Sam became involved in the campaign for changing junior doctors' hours in 1989 and advised at the time the workforce was exhausted, emotionally distressed and depressed after typically working 84 hour weeks. Sir Sam reported that at that time consultants were angry that he and his colleagues were bringing these issues to light and were particularly frustrated that the fight for change was being played out in the media. Sir Sam recently supported his son in the recent junior doctors strike and so continues to campaign in support of colleagues.

9. Sir Sam talked to the group about some of the changes Tower Hamlets have made to services and gave an example of a maternity review which is to be launched there next month. Tower Hamlets has shown that low risk births are safer to have in the community rather than in hospitals. The group discussed how a shift into primary care will need a massive change in skill mix, how it would be useful to get pharmacists into practices and how health care assistants can be trained up to better use their skills. Sir Sam encouraged everyone to start thinking outside the box.

10. The group asked how mental health fits into the Tower Hamlets plans and Sir Sam advised there are now phycologists in all their practices and confirmed social prescribing also links into mental health. The group discussed the shortage of palliative care specialists and how this can have very poor outcomes. Sir Sam suggested palliative care specialist nurses need to share their skills and experience with the rest of the care teams to help them to develop a wider skill set. He also talked about how skype is very useful and can be used day or night to help end of life patients in particular.

11. The group talked about promoting self-management in schools, how there is a need to drive up the health agenda there and how healthy living needs to be included as part of the curriculum. Sir Sam talked about how he was involved in introducing the fit note and how we need to be encouraging patients to stay at work with statistics showing people who work are fitter than those who don't.

West Cheshire Way Behaviours of Change Workshop Sessions

12. The format of the espresso sessions was used at the senate meeting as it had been successful at a team event in December 2015. The meeting attendees were split into groups, with a mix of partner representatives in each group and asked the following four questions. Each group had ten minutes to give their feedback and suggestions in response to each of the questions, working with a facilitator to record their responses and then moved around to the next question.

- How do we expect people's responses to change to impact on the progress of our Vanguard work - positives and challenges?
- How do we overcome challenging behaviours and embrace the positive behaviours?
- How do we build, embed and embrace a culture of change, across the West Cheshire health economy, strategically and operationally?
- How do we make people feel included and consulted?
    - Patients?
    - Public?
    - Staff?

13. The groups worked and engaged really well and there was a great sense of energy and enthusiasm in the room. Sir Sam decided to stick with one question, chaired by Dr Peter Williams and so saw four different responses to the question 'how do we expect people's responses to change to impact on the progress of our Vanguard work – positives and challenges?'.

14. The espresso session responses are detailed in Appendix A but the main overriding theme was that people felt they and their teams did not have the space and time for reflection in order to influence and input to plans, something which needs to be factored into the delivery of the West Cheshire Way. An action plan will be developed in response to the espresso session feedback which will be issued to the senate attendees for consideration. A future session will be planned to agree how the action plan will be implemented across the health economy.

Sir Sam's Reflections

15. Sir Sam reflected on the summaries and key themes from the espresso sessions and encouraged the group to think about equality and encourage patients to take more responsibility for their health. He talked about managing difficult people and patient experience.

CONCLUSIONS

16. Following the update from Tim Welch regarding the long term financial position it is important that we keep those updates linked into the senate meetings to ensure all partners are updated and receive the same message.

17. Following the behaviours of change sessions and advice from Sir Sam it is important that we develop an action plan for implementation across the health economy to demonstrate our commitment to delivering against feedback people have taken the time to give us, to maintain the momentum of progress on the delivery of the West Cheshire Way and to build in opportunities, in this forum and others, to give people the time and space to reflect, comment and support our collective plans to put the West Cheshire patient at the centre of their care.

RECOMMENDATION

18. The governing body is asked to note the issues discussed by the senate.

Dr Peter Williams
Hospital Doctor Member

March 2016

Espresso Session Feedback

How do we expect people's responses to change to impact on the progress of our Vanguard work – positives and challenges?

Group 1

- Biggest change – more personal responsibility
- The spectrum of change
- Early adopters
- Late adopters
- Do people know what the changes will be?
- You can't sell it to the people with staff by-in are staff addicted to
- Will it be perceived as possible
- Initial reactions are crucial
- What's in it for them

Group 2

- Are they aware of the changes?
- What are the benefits?
- Have we described the change?
- What's in it for me?
- Have we given staff time to change?
- The message to staff – staff need headspace
- Too busy to change – more of the same
- Quick wins needed

Group 3

- Who are the stakeholders:
- What is the message to different groups
- Communicate well "win – win"
- You will be treated holistically
- Re-define the healthcare contract and more self-care
- Expect a medic and don't get one
- GPs are reactive – champions and leaders are needed

Group 4

- Small group effects DoFs, GPs, Legals
- Role definitions will be important
- Professional barriers
- Title – Task
- Patient Expectations
- Outcomes must be good
- Good stories are essential
- Patients should expect not to have to walk into the surgery

How do we build, embed and embrace a culture of change across the West Cheshire health economy, strategically and operationally?

Group 1

- Identify the audience – tailor it accordingly

Strategic	Operational
• Ownership Clear single voice consistent purpose • Courage to change • Hearts and minds!	• Ownership • Involvement to help shape • Consult, engage, involve • Help understand the "purpose"

Group 2

- Clear purpose – defined from engagement / needs
- "Why" do we need to? – isn't it already happening!?

Strategic (outcomes)	Operational (output)
• Clear message / purpose • We've been here before • Comms/education • "Do with" not "do to" • Whole place based • Effective leadership!	• Clear message / purpose • Resilience for constant change – another new model • Comms/education

Group 3

- Clear message / purpose and consistent (blur the line between these)

Strategic	Operational
• Empowering change and space to change • Acknowledge success • Planning for change • Demonstrate the need for change	• Ownership / buy in • Doing it • Understand the purpose – it's for the better • Space to reflect / review • Co-designing the approach • Champions on the group / spreading the word

Group 4

- Is there a difference
- Single / clear message!

Strategic	Operational
• Leadership – shared • Innovation (strategic and at scale) • Sustainability • Comms – better navigation and education for change • Celebrate success and share it! • Future proofing	• Innovation (implement) • Sustainability • The "have a go approach"

How do we make people feel included and consulted in particular Patients, Public and staff?

Group 1

- It's about people and making sure they feel engaged
- Reflection has to be built in
- Make it memorable and about ownership and co-production young advisors and commissioners , co design is important
- Make it relevant, quick and responsive – be brave with the Diabetes target
- Creative approaches, as well as existing models used by other industries

Group 2

- Social Media
- Spend more
- Advertising experts
- Speak to people
- Build relationships with providers
- Use large employer locally – Vauxhall, Airbus
- Build relationships with schools – 'reflect' get schools to tell us what works
- Stop making assumptions

Group 3

- Stop consultations – setting questions, frames the answers
- Look at commissioning cycle to get public involved earlier
- What's important to you, not what you want, the answer might be very different cover/include family safety/lifestyle
- Example from drug services, using peer etc.

Group 4

- Staff have a particular role and vital to understand and deliver change
- Need "bought in staff" to lead change
- Lego – passionate and bought in to product
- We are stakeholders in this process
- Use other orgs to teach us: MFS
- Real time responses: texts
- Don't get bogged down in detail
- NHS staff as ambassadors for change

During this time of change how do we overcome challenging behaviours and embrace the positive behaviours?

- Need to be better at sharing "evidence" innovation or here's the evidence
- Have to get much better at sharing what we are doing and share positive quickly
- How do you out run rumour and gossip
- Listening and talk as crucial skill
- Fear has to be overcome
- Understanding own contributions and those of others some negativity has to be listen to
- Reflection to have to build in to how we work – hold the mirror
- Clear standards of behaviour
- Values and behaviours and principles
- Not tolerating from outset
- Skills to challenge behaviours needed
- How to deal with disruptors
- Can we learn from private sector
- Build com-petition to be the best
- Go with coalition of the willing
- Deal with the planes that are in the air first
- Inspiring change – traditional ways – got to go and inspiration – need to be better at this
- Have to embrace the positive
- Seek it out
- Find champions – front line and patients
- Have to accept some people can't change
- Those who launch whole squadrons might be a problem
- Statistical neighbours - important

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting 17th March 2016

2. Title of Report: Quality Improvement Report

3. Key Messages:

- West Cheshire is implementing 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 initiatives being led at a sub-regional level by Public Health England.
- The Countess of Chester Hospital NHS Foundation Trust has been issued with a regulation 28 Preventing Future Deaths notice by the Coroner in relation to concerns about the reliability of mattress sensors used to alert staff about a person who is at risk of falls.
- The most recent information published on hospital mortality rates shows that the Countess of Chester Hospital NHS Foundation Trust Mortality ratios are in line with national expectations.
- Cheshire and Wirral Partnership NHS Foundation Trust have taken action in response to the Care Quality Commission report that identified staffing levels in the community physical health teams "required improvement." The Trust report that they have recruited additional posts into community nursing.
- The report from the Ofsted inspection of the Cheshire West and Chester services for children in need of help and protection, children looked after and care leavers has been published and the services have been rated as good.

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

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

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 11th February 2016.

INFECTION PREVENTION CONTROL

Clostridium Difficile

4. For 2015/16 the overall Clostridium Difficile breaches target for West Cheshire CCG 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 to reflect the changing profile of the previous year.

5. The total number of Clostridium Difficile breaches during the first three quarters of the year (1st April 2015 – 31st December 2015) was 53 cases against a plan of 78.

2015/16 Totals	Pre 48 Hour	Post 48 Hour	YTD	Objective
C.Diff	32	21	53	78

6. A working group has 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 initiatives being led at a sub-regional level by Public Health England.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Care Quality Commission

7. The Care Quality Commission has just completed a planned visit to the Trust. We provided intelligence to the Care Quality Commission in relation to positive practice and the concerns highlighted to this governing body over the last 12 months.

8. The report will be shared in full with the committee when it is published and any exceptions and positive assurance will be presented to the governing body.

Regulation 28

9. In October 2015 the Trust was issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner. The concern related to the use of falls prevention sensors. The Coroner heard that on the day of the fall the mattress alarm failed to sound and nursing evidence was given to the effect that failures of mattress alarms were not exceptional.

10. The Trust has provided an action plan to the Coroner which the committee has seen and includes the following actions:

    - Perform scoping exercise to review what equipment is currently used within the Trust in relation to falls prevention with a view to streamlining the current variety of equipment in use.
    - Introduce additional training to ensure that staff utilise appropriate falls prevention measures for the individual patient and are aware of pre-use safety checks to be undertaken prior to employing such equipment.

11. In February 2016 the Trust was issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner in relation to the quality of the discharge information to primary care. The Trust now has 56 days to respond to the Coroner with an action plan. More detail will be provided to the committee in relation to the Coroners concerns when the action plan has been received.

National Safety Standards for Invasive Procedures

12. The committee were advised that a set of national standards for invasive procedures had been published by NHS England. The document sets out the key steps necessary to deliver safe care for patients undergoing invasive procedures and allow organisations delivering NHS-funded care to standardise the processes that underpin patient safety.

13. The committee and the governing body have previously been advised of a number of surgical Never Events that have occurred in the Trust over the last 12 months that relate to invasive procedures.

14. The Trust has invested significant time in identifying all the services and locations where invasive procedures are undertaken. This includes all surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within the organisation. It includes procedures such as: invasive cardiology procedures; endoscopic procedures; interventional radiological procedures; thoracic interventions such as bronchoscopy; biopsies and other invasive tissue sampling. The scoping identified 26 areas outside the main theatre hub which undertake invasive procedures.

15. The Trust has audited practice in all these locations against the standards and has produced a high level gap analysis along with clear recommendations of priority areas for developing practice in line with the standards. Progress against this plan will be monitored through the Quality and Performance Contract meeting.

Family and Friends Test

16. The Trust's response rate in the national Family and Friends Test has been below national average. The Trust has now invested in a text system to supplement paper and website options as a means of improving response rates and the response rate in January 2016 is now in line with national average.

Mortality rates

17. The Trusts most recent report on mortality to their Board of Directors dated December 2015 shows that all mortality indices are within expected range against national benchmarks.

Commissioning For Quality and Innovation Scheme Performance

18. The Trust is reporting a challenge in achieving goals related to reducing length of stay due to pressures in the discharge to assess system that prohibits their ability to discharge patients who are fit for discharge. This concern has been escalated to the Chief Finance Officer and Director of Operations. The proposed actions from these discussions will be presented to the Finance, Performance and Commissioning Committee.

CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

Care Quality Commission Inspection

19. The governing body were advised at the last meeting of the positive outcome from the Care Quality Commission Inspection of Cheshire and Wirral Partnership NHS Foundation Trust. At the last Quality and Performance meeting in December 2015, the Trust were asked to provide assurance of actions being taken to address the areas identified in the inspection as "requiring improvement." The Trust reported that they had already taken action in relation to staffing levels within the community physical health teams. The

meeting was given assurance that seven posts had been recruited into the community nursing teams, with an additional five posts being recruited into in January 2016.

20. The Trust has acknowledged that high sickness levels are causing real pressure on teams' responsiveness. They are addressing this by providing senior management support directly into these teams and working with individual team members to develop their potential to 'step-up' within the team. Staffing levels is now a standing agenda item on the Quality and Performance meeting and will continue to be closely monitored.

Adult Attention Deficit Hyperactivity Disorder

21. The committee were alerted to a concern relating to the Trust's proposed prescribing practice for Adult Attention Deficit Hyperactivity Disorder which included a shared care arrangement with GPs. There were concerns that proposals fell outside of British National Formulary guidance.

22. The committee asked the Integrated Provider Hub to seek further assurance about the governance of these proposals the meeting were assured that changes had been made to the prescribing element of the pathway to bring it in line with guidance.

23. The Integrated provider Hub have requested that the Consultant from the Trust who is leading this work attends the March 2016, Mental Health Local Enhanced Service meeting to share the pathway amendments with GPs.

PARTNERS4HEALTH

24. It had previously been reported to the committee that Partners4Health had led a review of the clinical pathways used in their service and they provided assurance that they had engaged with other local providers to get consensus on these. The committee were subsequently advised that there were some challenges getting consensus for the respiratory pathways from the Countess of Chester Hospital NHS Foundation Trust.

25. The committee asked for this to be escalated to the Trust Medical Director for resolution. This issue was discussed at the Quality and Performance meeting with the Trust and the Trust Medical Director has been tasked with reporting back to that meeting. The committee will be briefed on the outcome of this escalation.

ONE TO ONE MIDWIVES

26. The Care Quality Commission undertook a planned comprehensive inspection of One to One (North West) on 1st and 2nd December 2015. The full report is expected to be published in early 2016.

27. One to One Midwives did not report any serious incidents in relation to West Cheshire residents during November, December 2015.

CARE HOMES

Sutton Beeches

28. Sutton Beeches is part of the West Cheshire "Discharge to Assess" scheme and less complex patients are discharged from the Countess of Chester Hospital NHS Foundation Trust to sixteen beds at Sutton Beeches for up to three weeks. The Care Home provides fourteen respite beds in addition to these sixteen beds.

29. The committee were advised that following a number of medication related incidents that the local authority agreed a voluntary suspension of admissions to the care home from the hospital. Actions have been taken to develop best practice in the administration of medication with the support of both Cheshire and Wirral Partnership NHS Foundation Trust and the Countess of Chester Hospital NHS Foundation Trust.

30. The initial phased opening to admissions was halted in January due to an isolated medication incident. On review of the incident and concerns raised by the GP's relating to safe practice a decision was taken that the GP's would transcribe all medication for residents on admission to the discharge to assess beds and admissions resumed.

31. The community services manager from Cheshire and Wirral partnership NHS Foundation Trust has been meeting with the Manager of Sutton Beeches to ensure the agreed support from the District Nurses is also being provided.

32. Cheshire West and Cheshire Council committed to ensuring that they commission safe services from Sutton Beeches and that it is effective in continuing to support the capacity pressures within health and social care in delivering the discharge to assess model.

Mental Healthcare UK

33. Mental Healthcare UK are an independent provider of specialist mental health services caring for adults within independent hospitals and residential services across England & Wales focused on rehabilitation and support.

34. Mental Health Services are delivered from a number of independent hospital, satellite homes and a residential home. Denbighshire County Council has currently imposed a suspension of admissions to this provider.

35. The Cheshire and Wirral Continuing Health Care team have commissioned care from this provider and an urgent plan to review individuals that are placed with this provider is in place. Any concerns identified as a result of the reviews will be acted on.

Atherton Lodge Nursing Home

36. The governing body has previously been advised that there had been long standing safeguarding and quality concerns relating to this provider. As a provider they had shown an ability to respond well initially to feedback but then had struggled to sustain those improvements over longer periods. As a consequence there had been a voluntary suspension to admissions in place.

37. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group have continued to support and monitor the quality of care in the home over the last 12 months. Commissioners are now assured by evidence presented at visits that under the leadership of a new manager the improvements have been sustained. The voluntary suspension was lifted in February 2016 and the monitoring visits will continue. Visiting health professionals have also provided assurances of the significant sustained improvements.

Saint Cyrils

38. St Cyril's Rehabilitation Unit is a purpose-built facility providing twenty inpatient beds and two transitional one bedroom bungalows for individuals who require specialist rehabilitation and management programmes.

39. An inquest has been opened by the coroner into the death of a person placed there from outside the West Cheshire area. The Coroner has confirmed the inquest will be held between March and June 2016. The Coroner has had detailed information from our Designated Nurse for Adult Safeguarding and local police.

40. The Care Quality Commission has recently conducted an unannounced visit out of hours. The findings and report are not yet published.

41. There have been a number of key staff changes within the provider and group and our Designated Nurse for Adult Safeguarding will continue to undertake visits to seek assurance that changes in practice have been sustained.

PRIMARY CARE QUALITY

GPs and Child Protection Case Conferences

42. The Cheshire West and Chester Local Safeguarding Children Board continue to monitor the initial and review child protection case conference information.

Table 1: GP attendance at initial child protection case conferences and submission of reports to initial and review child protection case conferences

	% of Initial Child Protection Case Conferences with GP attending	% of Initial Child Protection Case Conferences with report submitted	% of Review Child Protection Case Conferences with report submitted
Quarter 4 2014 / 15	67% (12 out of 18 conferences)	67% (12 out of 18 conferences)	54% (28 out of 52 conferences)
Quarter 1 2015 / 16	41% (11 out of 27 conferences)	100% (27 out of 27 conferences)	57% (21 out of 37 conferences)
Quarter 2 2015 / 16	29% (7 out of 24 conferences)	88% (21 out of 24 conferences)	39% (13 out of 33 conferences)
Quarter 3 2015 / 16	22% (9 out of 41 conferences)	76% (31 of 41 conferences)	50% (23 out of 46 conferences)

43. Table 1 demonstrates activity over the last four quarters in West Cheshire. Attendance at initial child protection case conferences has met the expected standard of 25% in three of the four quarters, having fallen for the first time this quarter. Submission of reports for initial child protection case conferences has met the expected standard of 75% for the last 3 quarters. Submission of reports for review child protection case conferences has not met the required standard of 75% at any time during the last 4 quarters.

44. When analysed the main reasons for not returning reports has been internal practice systems have not been in place to prompt a GP to complete a review report. The committee will be briefed at its next meeting on the outcome of the February Practice Managers meeting as the Designated Nurse and an Independent Child Protection Chair were invited to discuss the reporting timeframes, volume of work and options for streamlining the process. This meeting will also progress the option to hold the initial case conferences in the practice buildings with the highest number of case conferences.

Primary Care Commissioning

45. The committee received an update on the progress of the primary care commissioning for quality and innovation scheme 2015/16 at the end of quarter three. Three GP clusters had not met the target milestones; however assurance was given that all clusters are on track to achieve the milestones in quarter 4.

46. The committee were advised that work is ongoing to secure agreement on the goals for the 2016/17 commissioning for quality and innovation scheme. These developments are being discussed at GP network meetings and monthly cluster leads meetings. Updates will be given to the GP quality group as this work progresses.

47. Key performance indicators have been drafted for those practices who are currently receiving additional funding in their contract via personal medical services. These are now to be shared with the practices to negotiate a position that can be agreed from April 2016 for one year.

GP Patient Experience Survey Results

48. The committee were informed that the January 2016 results from the GP patient experience survey have been published. The GP Patient Survey measures patients' experiences across a range of topics, including:

- Making appointments
- Waiting times
- Perceptions of care at appointments
- Practice opening hours
- Out-of-hours services

49. The GP Patient Survey provides data at practice level using a consistent methodology, which means it is comparable across organisations and over time. A report summarising movement over the past 2 years at a clinical commissioning group level and showing performance by practice is provided here.

50. The results of the surveys are discussed during practice visits, which provides an opportunity to share improvement plans and to share best practice from other surgeries.

51. The committee has asked the primary care team to triangulate information from the survey with Care Quality Commission reports and present this information back to the committee.

CHILDREN'S SAFEGUARDING AND CHILDREN IN CARE

Serious Case Review 01 / 2014 Child A

52. This review was undertaken following an incident that resulted in Child A sustaining an injury that later required a surgical intervention. The Serious Case Review report is completed and was endorsed by the Local Safeguarding Children Board meeting on 8th June 2015.

53. At the time of the last update the police investigations into the circumstances of the case had concluded and the Local Safeguarding Children Board were in the process of making contact with the parents via the social worker to ascertain the parent's involvement in the final report.

54. The planned community impact assessment has been completed and a multi-agency meeting agreed the actions of the respective representatives. A further meeting was arranged between the Chair of the Serious Case Review Panel, Local Safeguarding Children Board Business Manager, Children's Social Workers and the respective Head Teachers to ensure that full consideration was given to sharing the report with Child A and the siblings and the potential impact of the publication for the children.

55. A plan of action has been agreed and the Local Safeguarding Children Board is now in a position to proceed to publication. The report will be submitted to the National Panel and Care Quality Commission will be notified of the publication date. A statement has been prepared and endorsed by partners, including the Clinical Commissioning Group in readiness for publication. In agreement with all partners the Local Authority Communication Team will co-ordinate media response.

56. The action plan for Child A is progressing and the Local Safeguarding Children Board is now in a position to proceed to publication at the end of March 2016.

Serious Case Review 01 / 2015 Child B

57. This review was commissioned following the death of a young person in care. The Serious Case Review report is completed and was endorsed by the Local Safeguarding Children Board at its meeting on 18th November 2015.

58. A meeting of the Serious Case Review Team took place in February 2016 to develop the Action Plan; this has been shared with all relevant partners and was endorsed by the Local Safeguarding Children Board on 7th March 2016. Action plan progress will be overseen by the Local Safeguarding Children Board Audit and Case Review Sub-Group.

59. A new date for the postponed inquest is still to be confirmed. As a consequence the Review Panel, in consultation with the family, have agreed that the report will be published in line with the Coroner's findings. The Care Quality Commission will be notified of the publication date once it has been confirmed.

60. Child B's parents both have a copy of the report. The Care Quality Commission will be notified of the publication date once it has been confirmed.

Cheshire West and Chester Unannounced Ofsted Inspection of Children's Services November 2015

61. The Ofsted inspection of the Cheshire West and Chester services for children in need of help and protection, children looked after and care leavers concluded on 17th December 2015. The final report was published in February 2016 is available here.

62. The summative judgment is that Children's services in Cheshire West and Chester are good with ratings of :

- Children who need help and protection is rated as Good
- Children looked after and achieving permanence is rated as Good
- Adoption performance is rated as Outstanding
- Experiences and progress of care leavers is rated as Good
- Leadership, management and governance is rated as Outstanding

63. The inspection also reviewed the effectiveness of the Local Safeguarding Children Board and rated this as Good. The clinical commissioning group is a statutory partner of the Local Safeguarding Children Board, we make a financial contribution to this and are required to attend Board meetings and chair sub groups of that board. This rating is a measure of successful partnership working.

64. The Local Authority has thanked all partner agencies for their input during the inspection.

Child Protection - Information Sharing Project (CP-IS)

65. The committee were advised of a national project to implement a standard mechanism to share child protection information across all health providers and local authorities.

66. Progress in Cheshire has been slow and in order to expedite implementation the NHS Standard Contract now requires providers to co-operate fully and must take all reasonable steps towards the implementation of the Child Protection - Information Sharing Project.

67. The lack of progress locally with the project was escalated to the Local Safeguarding Children Board following the submission of a report by the Designated Nurse Safeguarding Children. It has been agreed that Cheshire West and Cheshire and East Cheshire Local Authority representatives and local health provider representatives will meet to agree how this will be taken forward locally. The work will be supported by NHS England. The committee will be kept updated on progress.

Goddard Inquiry/Independent Inquiry into Child Sexual Abuse

68. In June 2015 a letter was sent to all Chief Executive Officers in NHS Trusts by Lowell Goddard, Chair of the Independent Inquiry into Child Sexual Abuse. It was recirculated to Trusts and Clinical Commissioning Groups by NHS England in December 2015. The letter lays out the Chairs expectation on the issue of retention and information and records held by organisations, and those organisations for which we are responsible, or which are affiliated to our organisations. The expectation is that there is no premature destruction of files or records that may later become required as evidence. The letter also includes the Terms of Reference for the Inquiry.

69. NHS England continues to work with the Department of Health to elicit clear guidance on the retention of records. Extended retention of records will have financial implications for organisations. National workshops are planned to ensure that organisation has systems and processes in place to fulfil the requirements of the Goddard Inquiry.

Children in Care Health Assessments

70. Our Designated Nurse for Children in Care has highlighted to the committee that there has been an improvement in the number of looked after children with an up to date health assessment. The percentage of children with an up to date Health Assessment for quarter three was 83.2% and up to date dental check was 73.2%. Although this remains slightly lower than our statistical neighbour and nationally, the performance is better than quarter 2 and all of the previous year. The current longest wait outside of the annual review time period is three months past the due date.

71. The Countess of Chester NHS Foundation Trust provides the initial health assessments which are done by a paediatrician and they deliver a high compliance rate.

72. Cheshire and Wirral Partnership NHS Foundation Trust are not delivering against their requirement to provide review health assessments in a timely way. This has been escalated to the Quality and Performance Contract meeting and a formal request has been made for an improvement plan giving evidence of the actions taken to improve performance and mitigate the risk of non-delivery of a timely service to children. Some of the challenges are caused by late requests from social care for the review health assessments but we have an escalation process in place to support the Trust when this occurs and they need to use it effectively and take swift action to address late requests.

73. There has been a positive impact on the number of 16+ Care Leavers with an up to date Health Plan following the appointment of a new 16+ children in care post by Cheshire and Wirral Partnership NHS Foundation Trust in July 2015. The percentage with an up to date Health Plan in place for quarter 2 was 64% and for quarter 3 69.5%. The Review Health Assessment Pathway has been reviewed and there is a clear process in place to offer young people who

decline to have a Health Assessment an alternative approach to engaging with an identified lead health professional.

74. The Designated Nurse Children in Care will continue to monitor the timeliness of all health assessments for Children in Care and report progress and potential risk to the committee.

RECOMMENDATIONS

75. 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
March 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

Date of Meeting:	17th March 2016
Title Of Report:	2016/17 Financial Budget
Key Messages:	• NHS West Cheshire Clinical Commissioning Group will begin 2016/17 with an annual budget of £332.939 million including a £5.206 million running cost allowance. • Budgets have been set following both national guidance and local planning assumptions. • The 2016/17 financial budget has been set with a planned year-end deficit of £4.829 million (1.5% of total allocation). • In addition there is currently a gap between available resource and likely spend of approximately £11.558 million. This is reflected as a negative budget (previously described as Quality, Innovation, Productivity and Prevention gap)
RECOMMENDATIONS:	The governing body is asked to agree the 2016/17 financial budget;
Report Prepared By:	Gareth James Chief Finance Officer

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP GOVERNING BODY

FINANCIAL BUDGET 2016/17

INTRODUCTION

1. NHS West Cheshire Clinical Commissioning Group will begin 2016/17 with a total programme (or healthcare) £327.733 million with an additional running cost allowance of £5.206 million. The programme allocation includes allocation growth of £9.694 million (3.05%). The running cost allocation has been reduced for 2016/17 by £193,000 (3.57%).

2. A further non-recurrent allocation of £1.133 million has been anticipated in respect of the following:

   2.1 2015/16 quality premium funding (£338,000), and:
   2.2 2016/17 charge exempt overseas visitors allocation (£795,000).

3. The governing body is, therefore, asked to approve a base budget in the amount of £332.939 million; made up as follows:

Description	£m
Recurrent programme allocation b/fwd	318.039
Growth in allocation	9.694
Total 2016/17 programme budgets	**327.733**
2015/16 running cost allowance	5.399
2016/17 reduction in running costs	(-)0.193
Total 2016/17 running cost allowance	**5.206**
Total 2016/17 financial budget	**332.939**

4. Appendix A analyses the budget across recognised budget headings. It is important to note that the 2016/17 financial budget is a 'snapshot' as at 1 April 2016 and will be subject to change during the financial year.

5. Programme budgets have also been developed. These are provided at Appendix B. The assumptions underpinning the allocation of budget between programmes will require further agreement with programme managers. Approximately £6.4 million remain described as 'other' and is yet to be allocated across programmes. This relates to running costs and contingencies.

BUDGET SETTING METHODOLOGY

6. The 2016/17 financial plan and, therefore, financial budget has been developed following application of national inflation and efficiency rules and local finance and activity planning assumptions.

7. The clinical commissioning group will begin 2016/17 with a recurrent deficit of £5.989 million. The following amounts have contributed to the deficit and have been factored in to the 2016/17 financial budget:

Description	£m
2015/16 underlying recurrent position carried forward.	(-)2.814
2015/16 Outturn	
Secondary care contracts	(-)1.998
Complex care	(-)0.728
Primary care enhanced services and CQUiNs	(-)0.224
Community Equipment	(-)0.225
Total recurrent deficit	**(-)5.989**

8. A fundamental principle for 2016/17 budget setting has been to fund the recurrent impact of previous commissioning decisions including the impact of the over-performances against secondary care contracts and the complex care budget. £4 million has been factored into the recurrent deficit described above.

9. The 2016/17 financial budget also includes £8.572 million for expected increases in activity and costs based on intelligence from a local modelling tool. A further £3.754 million 'must do' investments are also accounted for.

NHS ENGLAND BUSINESS RULES

10. NHS England mandate the following 'business rules' for all clinical commissioning groups:

- Delivery of at least a 1% surplus as at 31 March 2017.
- Protection of 1% recurrent funding for non-recurrent use ('headroom').
- Agreement of a contingency of at least 0.5% of total funding.

11. The 2016/17 budget plans for a deficit and, therefore, does not comply with the business rules (see above). Further guidance from NHS England requires clinical commissioning groups, as a minimum, to plan for the same year-end position as 2015/16 (which would be break-even for NHS West Cheshire Clinical commissioning Group). In addition, 1% of funding has not been set aside for non-recurrent use. Complying with this rule would increase the group's planned deficit by approximately £3.3 million.

12. Appendix A reflects that a contingency of £1.666 million (0.5%) has been allowed for in the 2016/17 financial budget.

SECONDARY HEALTHCARE

13. A budget of £254.826 million has been set for secondary healthcare contracts. This reflects anticipated activity growth of approximately 3.2% over and above 2015/16 out-turn. The following inflation and efficiency requirements have been applied:

- Inflation of 3.1%.
- National efficiency requirement of (-)2.0%.
- Additional contribution for clinical negligence scheme for trusts (CNST) 0.7%.

14. In short, this should mean that the same level of activity, with a similar case mix, should be approximately 1.8% more expensive than the previous year. However, the exact impact of the national tariff inflation/deflation will need to be monitored during the financial year based on actual activity.

15. The financial impact of the mitigations from both stabilisation and transformation programmes is yet to be netted off this budget.

PRIMARY CARE PRESCRIBING

16. During 2015/16 the primary care prescribing budget delivered an efficiency saving of approximately £1 million. This efficiency has been consolidated in the 2016/17 prescribing budget which has been calculated as follows:

Description	£m
Recurrent budget carried forward	40.578
Inflation @4%	1.623
Efficiency @2%	(-)0.811
2016/17 budget	**41.592**
Made up as follows:	
Practice budgets	40.877
Other prescribing budgets	0.513
Innovation fund	0.202
2016/17 budget	**41.592**

17. An additional savings target has been levied against the prescribing budget of £1.8 million. This will have the effect of reducing year-on-year expenditure by £1 million.

NON-RECURRENT FUNDING AND INVESTMENT

18. As described above, the 2016/17 financial plan should set aside 1% of recurrent funding for non-recurrent, or one-off, use. The NHS West Cheshire Clinical Commissioning Group plan does not comply with this requirement. This decision will continue to be challenged by NHS England prior to the agreement of the final 2016/17 plan in April.

19. A 'value proposition', or business case has been submitted to NHS England New
Models of Care team for continuation of the non-recurrent Vanguard funding to support the transformation of how healthcare is provided in West Cheshire. This funding is yet to be notified and has, therefore, not been anticipated on the 2016/17 budget.

20. Appendix A reflects that the 2016/17 annual budget anticipates non-recurrent funding in respect of the following:

    20.1 2015/16 quality premium (based on performance to the end of December 2016 - £338,000, and,

    20.2 2016/17 charge exempt overseas visitors allocation (based on 2015/16 funding) - £795,000.

21. During 2016/17 the following non-recurrent investments will be required:

Description	£m
Continuing healthcare risk pool	0.330
Prime Minister's challenge fund repayment	0.500
Transformation funding carried forward	1.645
Total	**2.475**

CONTINGENCIES (RESERVES)

22. In line with principles of sound financial management, organisations are expected to create reserve budgets to provide cover for an appropriate assessment of risk. Further guidance from NHS England mandates all clinical commissioning groups to set aside a contingency of at least 0.5% of funding.

23. NHS West Cheshire Clinical Commissioning Group will, therefore, begin 2016/17 with recurrent contingencies of £1.666 million. The Chief Finance Officer will closely monitor the use of contingencies with regular reports to the finance, performance and commissioning committee throughout the financial year.

24. An additional sum of £250,000 has also been set aside in respect of the uncertain pressures relating to specialised services where the commissioning responsibility transfers to clinical commissioning groups from April 2016 (see investments in paragraph 28).

2016/17 INVESTMENTS

25. An additional £3.754 million has been set aside for new investments. This is in respect of items previously funded separately (now in clinical commissioning group baselines) and new costs resulting from previous decisions and can be analysed as follows:

Description	£m
Recurrent costs of Prime Minister's challenge fund	0.137
Child and adolescent mental health and eating disorders	0.691
GP IT	0.663
Mental health 'parity of esteem' budget	0.713
Specialised critical care activity	1.300
Specialised	0.250
Total investments	**3.754**

26. The NHS England five-year forward view included a clear expectation that spend on mental health services will increase, at least, in accordance with clinical commissioning group allocation growth. An additional budget of £713,000 has, therefore, been included in the 2016/17 annual budget. The process to govern the investment of this budget will be managed by the programme assurance board, and, therefore, in collaboration with local partners.

RUNNING COSTS

27. NHS West Cheshire Clinical Commissioning Group will begin 2016/17 with an allowance of £5.206 million, representing a reduction of £193,000 (3.57%) from the previous year.

28. Regular updates will be provided to the finance, performance and commissioning committee on progress against the running cost target.

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP)

29. Following the implementation of national guidance and local planning assumptions, the 2016/17 financial plan includes an efficiency requirement of £11.558 million. In short, this means that if not delivered, NHS West Cheshire Clinical Commissioning Group will deliver a deficit of approximately £16.4 million.

30. As at 1 April 2016, the QIPP target will be reflected as a negative budget within the 2016/17 financial budget.

BETTER CARE FUND

31. Appendix A reflects a Better Care Fund budget of £5.909 million. The total fund contributions for 2016/17 for NHS West Cheshire Clinical Commissioning Group will be £15.905 million with the balance being within other budgets. In-year performance against the total fund will be reported to the governing body.

NEXT STEPS

32. Following governing body approval of the 2016/17 financial budget, budget holders will be required to formally accept budgets. Further adjustments might be made to the budget to reflect actual year-end performance.

33. Programme managers will also be required to accept their programme level budgets with performance, including delivery of programme level QIPP targets monitored by programme delivery group.

34. Financial performance will be reported to the finance performance and commissioning committee and governing body on a monthly basis.

RECOMMENDATIONS

35. The governing body is asked to agree the 2016/17 financial budget.

Gareth James
Chief Finance Officer
March 2016

West Cheshire Clinical Commissioning Group
2016/17 Financial Budget

Description	Recurrent Budget	Non Recurrent Budget	Total Budget
Primary Care:			
Enhanced Services	1,910	0	1,910
Primary Care CQUINs	2,541	0	2,541
Clinical Leads	785	0	785
GP IMT	807	0	807
PMCF	0	500	500
Primary Care Vanguard	0	1,645	1,645
Prescribing	41,390	0	41,390
Prescribing - Innovation Fund	202	0	202
Prescribing - medicines management	944	0	944
Home Oxygen	303	0	303
Sub-total - Primary Care	**48,882**	**2,145**	**51,027**
Secondary Care:			
NHS contracts	189,690		189,690
Ambulance Services	7,908		7,908
Mental Health and Community Services	45,018		45,018
Private Providers and NCA's	2,412		2,412
Orthopaedic budget	5,259		5,259
GP led Urgent Care Unit	1,936		1,936
111	931		931
Winter Pressures	1,672		1,672
Sub-total - Secondary Care	**254,826**	**0**	**254,826**
Advancing Quality	**198**	**0**	**198**
Complex Care			
Care in the Community	27,010		27,010
CHC - Risk Share Pool	0	330	330
Sub-total - Complex Care	**27,010**	**330**	**27,340**
Joint Commissioning			
Better Care Fund	5,909		5,909
Safeguarding	89		89
Looked after Children	103		103
Re-ablement	1,485		1,485
Grants to Voluntary Organisations	1,956		1,956
Community Equipment	634		634
Sub-total - Joint Commissioning	**10,176**	**0**	**10,176**
Running Costs	**5,206**		**5,206**
NHS Property Services	**20**		**20**
Contingencies	1,666		1,666
QiPP Progarmmes:			
Stabilisation	-4,350		-4,350
Transformation - Vanguard	-7,208		-7,208
Anticipated Income:			
Charge Exempt Overseas Visitors		-795	-795
Quality Premium		-338	-338
Sub-total - Contingencies	**-9,892**	**-1,133**	**-11,025**
Total Operating Cost	**336,426**	**1,342**	**337,768**
Resource Limit	332,939		332,939
Total CCG (-)Surplus/Deficit	**3,487**	**1,342**	**4,829**

West Cheshire Clinical Commissioning Group

2016/17 Financial Budget - Programme Area

Description	Recurrent Budget £000	Non Recurrent Budget £000	Total Budget £000
Stabilisation			
Urgent care	56,224	0	56,224
Intermediate care	17,521	0	17,521
Complex care	23,344	330	23,674
Planned care	98,981	0	98,981
Medicines mangement	47,397	0	47,397
Sub-total - Stabilisation	**243,467**	**330**	**243,797**
Transformation			
Starting well	13,254	0	13,254
LTC	8,094	0	8,094
Ageing Well	31,289	0	31,289
LD	4,970	0	4,970
Mental health	21,473	0	21,473
Primary Care	6,346	2,145	8,491
Sub-total - Transformation	**85,425**	**2,145**	**87,570**
Other Areas	**7,534**	**-1,133**	**6,401**
Total Operating Cost	**336,426**	**1,342**	**337,768**
Resource Limit	332,939	0	332,939
Total CCG (-)Surplus/Deficit	**3,487**	**1,342**	**4,829**

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th March 2016

2. Title of Report: Finance Performance and Commissioning Committee Report

3. Key Messages

This report provides an overview of the business discussed and decisions made at the finance, performance and commissioning committee meeting held on 3rd March 2016. The key items for the governing body to note are:

- NHS 111 will go live across West Cheshire on the 31st March and the clinical commissioning group has in place and is delivering a local implementation plan.

- The clinical commissioning group led a system-wide Urgent Care Recovery Week in response to the current urgent care pressures, during February 2016

- The penultimate version of the operational plan was submitted on 2nd March 2016. The final submissions date is the 11th April 2016 and will require committee and governing body sign off.

- A jointly-agreed Better Care Fund plan was submitted on 2nd March 2016. The plan was approved by the Health and Wellbeing Board and will required committee and governing body sign off.

- The committee received assurance following the quarterly review meeting between West Cheshire Way and the NHS England national team in February 2016 and the subsequent receipt of the second tranche of the vanguard funding for 2015/16.

- The value proposition 2016/17 was submitted on 8th February 2016 and a decision by the NHS England Investment Committee is expected on 14th March 2016.

- NHS West Cheshire Clinical Commissioning Group is part of the NHS England 'local turnaround' process.
  After 10 months of the financial year it is forecast that the clinical commissioning group will deliver financial break-even (or balanced budget) as at 31 March 2016.

At the end of December 2015 the clinical commissioning group is currently rated as red, or failing to achieve, the following measures:

- 18-week referral to treatment.
- Referral to treatment excessive waiters.
- Diagnostic tests.
- Cancer waiting times.
- Accident and Emergency waiting times.
- Emergency ambulance response times.
- Hospital acquired infections; Methicillin-resistant Staphylococcus aureus
- Electronic discharge
- Dementia diagnosis

A draft 2016/17 financial plan has been submitted to NHS England. The draft plans for a 2016/17 year-end deficit of £4.8 million. This will only be realised following delivery of an efficiency programme of £11.5 million.

4. Recommendations

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

5. Report Prepared By:

Lee Hawksworth - Director of Operations

Laura Marsh - Director of Commissioning

Gareth James - Chief Finance Officer

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP GOVERNING BODY

FINANCE PERFORMANCE AND COMMISSIONING COMMITTEE REPORT

PURPOSE

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

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

STABILISATION DELIVERY REPORT

3. The committee was provided with assurance on:

   a. **Urgent care:**
   Regional escalation calls with NHS England have continued, varying from daily to twice weekly. The region as a whole experienced operational and performance challenges throughout February and early March 2016, with most areas in a similar position to West Cheshire and Countess of Chester Hospital NHS Foundation Trust, with major issues around:

   - High number delayed transfer of care
   - Low number weekend patient discharges
   - High number of medically optimised patients

   b. **NHS 111 mobilisation plan for NHS West Cheshire Clinical Commissioning Group:** NHS 111 will go live across West Cheshire on the 31st March 2016. The clinical commissioning group has put in place and is delivering a local implementation plan. This includes engagement with patients, practices and providers; raising awareness of the impact and practical elements of the changes

   c. The clinical commissioning group led a system-wide response to the current urgent care pressures, called the **"Urgent Care Recovery Week".** The team that designed and delivered urgent care week included:

   - Cheshire and Wirral Partnership NHS Foundation Trust
   - Countess of Chester Hospital NHS Foundation Trust
   - NHS West Cheshire Clinical Commissioning Group
   - Cheshire West and Chester Council
   - Partners for Health

During the week the team delivered new initiatives and approaches including:

- Ward-based falls prevention initiative
- Urgent care communication and marketing plan
- Hospital consultants at accident and emergency department front door
- Social care ward sweeps
- GP ward rounds
- GP telephone review of ward-based patients
- Nursing home daily telephone triage
- Integrated neighbour teams – acute patient review conference calling
- Extended weekend transport
- Extended GP early visiting

The outcomes of the week have been audited and recommendations made. This will be shared across the health and social care economy, with the operational plan including the key recommendations.

d. **System resilience group** activity and actions:

- Reinvestment of 2015-16 Ambulance Fines: The system resilience group agreed that this would be reinvested (£230,000) in acute-based care provided to support / during the period of exceptional pressure.

- Intermediate Care Pathways: the system resilience group approved the implementation of a shadow Accountable Care Organisation model. This gives The Countess of Chester Hospital NHS Foundation Trust the operational lead in the management of step down intermediate care service providers, the bed base and ownership of the related key performance indicators. This will be underpinned by a comprehensive memorandum of understanding across relevant providers, commissioners and co-commissioners.

e. The **clinical commissioning group stabilisation programme**. This has identified the 6 pathway areas which will focus on the delivery of quality and the £6million financial challenge i.e. quality, innovation, productivity and prevention, across West Cheshire during 2016-17. The generic pathway areas are:

- Urgent care
- Elective care
- Medicines management
- Mental health
- Complex care

These pathways and supporting initiatives will complement those identified within the multi-specialty community provider value proposition. Each pathway will be led by a clinical commissioning group programme manager and a clinical lead. Delivery will be underpinned by a process of wide engagement on pathway challenges and initiatives. Support from the

right care programme and the advisory board will also ensure we focus down on the appropriate speciality-level pathways, with initiatives that have proven outcomes.

f. **Clinical commissioning group membership council**: The meeting was utilised to engage members in the designing of pathway-focussed initiatives and solutions to deliver the quality and financial challenge across West Cheshire. The pathways were:

- Urgent care
- Elective care
- Medicines management

Priority areas within each pathway were identified to be taken forward and will be included within the clinical commissioning group's operational plan 2016-17.

g. The development of the clinical commissioning group's **operational plan** has been underway since late January 2016. The plan included elements of the membership council engagement workshop. The penultimate version of the operational plan was submitted on 2nd March 2016, including 2016-17:

- Activity plans
- Financial plans
- Operational plan narrative

The final operational plan submissions date is the 11th April 2016 and will require committee and governing body sign off. Beyond this, stabilisation transformation planning submission is required during June 2016. As such, the clinical commissioning group must agree the makeup of the planning footprint.

h. **Better Care Fund:** A jointly-agreed (NHS West Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group and Cheshire West and Chester Council) Better Care Fund plan was submitted on 2nd March 2016, outlining our joint 2016-17 plans. The plan was approved by the Health and Wellbeing Board and included:

- A pooled budget of £15.905million is utilised in 2016-17 (assuming minimum pooling stays at 2015/16 figure of circa£24.309million);

- Budget areas and services that support the joint commissioning intentions across NHS West Cheshire Clinical Commissioning Group and Cheshire West and Chester Council.

- Better Care Fund templates for return (received 25th February 2016, for submission on 2nd March 2016). This is the final submission and will require committee and governing body sign off.

4. The committee was asked for decisions on the following:

    a. **Extension of the Early Visiting Service**: the committee approved extension via Primary Care Cheshire and Cheshire and Wirral Partnership NHS Foundation Trust.

    b. **Establishing Drug Rebate Governance**: the committee agreed to the establishing of an internal governance process to assess new, proposed drug rebates. This will allow the clinical commissioning group to accept and reject rebate proposals from pharmaceutical companies, opening a new revenue stream for the clinical commissioning group, where agreed and appropriate.

TRANSFORMATION DELIVERY REPORT

5. The committee was assured as a result of the quarterly review meeting between West Cheshire Way and the NHS England national team in February 2016 and the subsequent receipt of the second tranche of the vanguard funding for 2015/16. This meeting also provided an opportunity to reflect on some key successes/progress to date, including:

    a. Sir Sam Everington's visit – inspiring local GPs, practice nurses and others in the potential transformed future of primary care

    b. Developing primary care clinical leadership between the clinical commissioning group, Local Medical Committee and Primary Care Cheshire

    c. Ongoing development of relationships at senior leader level through the Renuma work at systems leaders group

    d. Initial launch of the West Cheshire Way and the ongoing launch reaching out to the local population to raise awareness, particularly through social media

    e. Significant progress made on self-care including training peer champions and feedback from those who have completed self-management courses.

    f. Identification of need to formally capture patient stories as an additional mechanism for measuring success (informally these stories have been powerful in creating clinical engagement).

    g. Identification of need going forward to focus on enhancing relationships between primary and secondary care medics as well as developing an integrated nursing workforce across primary/community/specialist nurses.

6. The value proposition 2016/17 was submitted on 8th February 2016. A review and summarisation process is being undertaken by NHS England New Care Models national team for consideration and a decision by the NHS England Investment Committee on 14th March 2016.

7. The committee were provided with the programme level highlight reports, available here, as well as a summary of some of the key issues within each of the programmes. Members agreed this was useful in enabling them to understand more fully the content and progress of the programmes. The need to bring together the Countess of Chester Hospital NHS Foundation Trust with the clinical commissioning group and the local authority in relation to Starting Well was noted, as an opportunity to clarify commitment to a shared vision and delivery of the associated milestones or to collectively agree whether an alternative approach was needed.

8. The impact of aligning the GP networks to the three programme areas was noted as being supportive, both for practices in terms of a greater understanding of the new care model and the constituent interventions and for the programme/project managers in ensuring greater clinical input and ownership.

9. Although the work done on collating the overall programme outcome measures in the dashboard was recognised as valuable, the need to create a small subset of measures that could act as a temperature check for the success of the care model and to support clinical engagement was agreed. Dr Sivananthan from Cheshire and Wirral Partnership NHS Foundation Trust is leading this work. A copy of the dashboard is available here.

10. It was noted that significant progress has been made with the Long Term Financial Model and a deadline of end of February 2016 had been set for agreeing the underlying assumptions.

11. The NHS England national team have developed a framework for each care model, which provides a useful reference guide for sites but will also be used to support roll out across the wider NHS.

12. The committee noted that due to the risk of the full value proposition financial ask being unavailable, a prioritisation process is being undertaken using an agreed prioritisation tool and ensuring involvement of all partner organisations.

FINANCE, CONTRACTING AND PERFORMANCE REPORT

13. The Chief Finance Officer provided an update covering the following themes:

    1.1 Financial performance as at 31st January 2016.
    1.2 Performance against agreed performance targets at the end of December 2015.
    1.3 Update of the financial outlook for financial year 2016/17.

FINANCIAL PERFORMANCE AS AT 31ST JANUARY 2016

14. Following the change of the 2015/16 financial forecast at the end of quarter 1 (June 2015), NHS West Cheshire was placed into 'local turnaround' by NHS England. As part of this process a financial recovery plan has been submitted

demonstrating that the clinical commissioning group will deliver financial balance as at 31st March 2016 and return to surplus by 31st March 2017.

15. After 10 months of the financial year it is forecast that the clinical commissioning group will deliver financial break-even (or balanced budget) as at 31 March 2016. The themes underpinning this forecast are consistent with previous months:

    3.1 Significant rise in the cost of secondary care (urgent care) and complex care expenditure.
    3.2 Delivery of approximately £1 million prescribing efficiencies.
    3.3 Receipt of £1.3 million funding in respect of specialised respiratory critical care funding to fund spend within the group's contract with the Countess of Chester Hospital.
    3.4 Non-delivery of 2015/16 Quality, Innovation, Productivity and Prevention (QIPP) target.
    3.5 Non-recurrent slippage against transformation funding.

16. It was reported to the committee that the level of risk underpinning the reported financial position is reduced although year-end financial balance will only be delivered following a significant level of non-recurrent mitigation.

PERFORMANCE AGANST AGREED PERFORMANCE MEASURES AS AT 31ST DECEMBER 2015

17. The committee received an update on performance against agreed performance measures. There has been a reduction in the number of measures that are currently rated 'red'. However, performance against the following measures continues to be a concern.

    5.1 Referral to treatment; both 18-week and excessive waiter measures.
    5.2 Diagnostic test.
    5.3 Cancer waiting times; 62-day target.
    5.4 Accident and emergency 4-hour waiting target.
    5.5 Emergency ambulance handover times.
    5.6 Hospital acquired infection; Methicillin-resistant Staphylococcus aureus.
    5.7 Electronic discharges.
    5.8 Dementia diagnosis.

18. The committee was also provided with a series of actions being taken to improve performance against these measures. Following discussions, the committee requested milestones for improvement and details of the improvement trajectories submitted by the trust to NHS Improvement.

19. Many of the deteriorations in performance can be linked to the significant level of pressure in the West Cheshire urgent care system and the resulting bed occupancy with the Countess of Chester Hospital NHS Foundation Trust. The trust is robustly challenged on areas of poor performance at the monthly quality and performance meetings. It is anticipated that shared learning from the recent 'urgent care week' will have a positive impact on many of these targets.

20. Performance against the 18-week referral to treat and, in particular, the number of excessive waiters continues to be a concern. An improvement plan was agreed with the Countess of Chester Hospital NHS Foundation Trust following the material deterioration in performance in October 2015. Performance to the end of December 2015 reflects that this improvement plan is not being delivered, in the main, due to the number of cancelled elective operations resulting from the pressures the hospital is currently under compounded by recent industrial action.

21. As agreed by the governing body, the clinical commissioning group is imposing the contractual penalties in respect of poor performance in these areas (covered by schedule 4 of the NHS contract). At the end of January, after adjusting for ambulance turnaround and Accident and Emergency performance, the total penalty is £454,000.

FINANCIAL OUTLOOK FOR 2016/17

22. A draft 2016/17 financial plan has been submitted to NHS England. Following the application of national inflation and efficiency rules and local financial and activity planning assumptions there is a planned deficit of approximately £4.8 million for the year-ended 31 March 2017. The clinical commissioning group's allocation will increase by £9.694 million (3.05%). However, this is offset with a greater level of mandated investment.

23. The draft plan is, therefore, not consistent with the trajectory outlined in the financial recovery plan which planned for a 0.5% 2016/17 year-end surplus. A revised recovery plan will be required to be submitted following the agreement of the 2016/17 plan.

24. The current planned deficit will only be achieved following the delivery of £11.5 million of efficiency savings. This is currently allocated between programmes as follows:

    12.1 £7.2 million savings from the development of the new care model (transformation programme), and
    12.2 £4.3 million from the stabilisation programme.

25. The draft financial plan does not, therefore, comply with all of the NHS England 'business rules'. In particular, the plan will not allow for the following:

    13.1 1% planned surplus
    13.2 1% non-recurrent headroom;

26. There is a significant level of challenge within the above quality, innovation, productivity and prevention (QIPP) target. The governing body will be asked to consider several financial scenarios prior to sign-off of the 2016/17 financial plan and, therefore, annual budget.

RECOMMENDATIONS

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

Lee Hawksworth - Director of Operations

Laura Marsh - Director of Transformation

Gareth James - Chief Finance Officer

March 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th March 2016

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 3rd March 2016. The key items for the governing body to note are:

- NHS West Cheshire Clinical Commissioning Group remains on course to be level 2 compliant with version 13 of the NHS information governance toolkit as at 31 March 2016.
- Internal audit provided significant assurance following the review of arrangements to manage serious untoward incidents and high assurance for the monitoring of quality of commissioned services.
- The committee approved both the internal audit plan and the ant-fraud work plan for 2016/17.

4. Recommendations The governing body is asked to note the key items of business discussed at the audit committee at its meeting on 3rd March 2016.

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 3rd March 2016.

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. The committee was chaired by Interim Audit Committee Chair, Ken Morris, who will provide support until the end of May 2016. The committee expressed thanks to David Gilburt who has chaired the committee since October 2012.

4. The key issues discussed at the March 2016 audit committee are summarised in paragraphs 5 to 15.

INFORMATION GOVERNANCE

5. The committee received an information governance update from the North West Commissioning Support Unit. The clinical commissioning group is currently on course to remain level 2 compliant with version 13 of the national information governance toolkit as at 31 March 2016.

6. With effect from 1 March 2016 information governance support will be provided by Midlands and Lancashire Commissioning Support Unit following the NHS England lead provider framework exercise.

INTERNAL AUDIT

7. Mersey Internal Audit Agency provided an update on progress towards completion of the annual internal audit plan. Significant assurance was provided on the clinical commissioning group's processes for managing serious untoward incidents and high assurance was provided in relation to how the group fulfils its responsibilities in monitoring the quality of commissioned services.

8. In addition, the committee received an opinion on the clinical commissioning group's assurance framework. The following opinion was issued:

   The organisation's assurance framework is structured to meet the NHS requirements, could be more visibly used by the governing body and clearly reflects the risks discussed by the governing body.

9. The committee also approved the 2016/17 annual internal audit plan. This plan has previously been discussed with the Chief Finance Officer and agreed with the group's senior management team.

10. An interim Director of Audit opinion was also provided. The final opinion will be issued following the completion of outstanding work to complete the 2015/16 internal audit plan.

EXTERNAL AUDIT

11. Grant Thornton, the clinical commissioning group's external auditors, provided a verbal update on the interim audit of the 2015/16 annual accounts which is nearing completion.

12. In addition, an update was provided on the process that is being undertaken to appoint clinical commissioning group external auditors from April 2017. The audit committee will act as an 'audit panel' during this process. The Chief Finance Officer will present a report to the committee following the sign-off of the accounts.

13. The committee also received a report which benchmarks NHS West Cheshire Clinical Commissioning Group's 2014/15 annual report with reports from other clinical commissioning groups. The Chief Finance Officer noted that this report was helpful and would be used to inform the production of the 2015/16 annual report.

COUNTER FRAUD

14. The committee received and approved the anti-fraud services work plan for 2016/17 covering the following areas:

    13.1 Strategic governance advice; including the review of the clinical commissioning group's code of conduct.
    13.2 Inform and Involve; awareness of the NHS anti-fraud agenda.
    13.3 Prevent and deter; proactive exercise to minimise potential fraud risk.
    13.4 Hold to account; undertaking of investigations within legal requirements.

15. The Chief Finance Officer noted that the 2016/17 fraud plan currently allows for the minimum level of anti-fraud work. This will potentially be increased when primary care budgets are full delegated to the group.

RECOMMENDATIONS

16. The governing body is asked to note the key items of business discussed at the audit committee on 3rd March 2016.

Gareth James
Chief Finance Officer
March 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th March 2016

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

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:

- Progress and proposed actions in relation to the clinical commissioning group's financial turnaround position.
- An overview of developments on the sustainability and transformation plan footprint.
- An overview of the discussion at the West Cheshire Strategic Leadership Group meeting on 9th March 2016
- An overview of the revised NHS England assurance process;

4. Recommendations The governing body is asked to:

- note the contents of this report;
- agree the actions in relation to financial turnaround;
- discuss the progress on the sustainability and transformation plan footprint.

5. Report Prepared By: Clare Dooley
Head of Governance
March 2016

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.

CLINICAL COMMISSIONING GROUP FINANICAL TURNAROUND

2. The clinical commissioning group received a report from the Turnaround Director, which was presented to the finance, performance and commissioning committee in February 2016.

3. Provided below is the clinical commissioning group's response to the report, which was presented to the finance, performance and commissioning committee in March 2016. This response, now the Turnaround Plan, has recommendations and actions we need to take to improve our performance.

4. The tTurnaround Plan summarises our priorities for 2016/17 that will form the basis of our delivery plan, the financial context within which we are operating and a section on delivering successful turnaround drawn from international best practice with actions that respond to the leadership challenges identified in Turnaround Director's turnaround report. It then outlines actions in five areas:

   a) Clinical leadership
   b) Programme management
   c) Performance management
   d) Communication
   e) Capacity, capability and governance

5. This quote from McKinsey captures where we are at as a clinical commissioning group; we know what our problems are - we just have to turn them around:

"It's not enough simply to bring these tactics to bear, of course; executing them well is the other half of the battle." McKinsey management consultants

Stabilisation priorities

6. There is a sense of urgency within stabilisation programmes. Unless we implement changes soon we will not be able to deal with the pressures in the health and social care system. Our priorities are:

- Sustainable urgent care and improved intermediate care services to support effective discharge from hospital.
- Better management of complex care packages.
- Efficient and effective planned care (outpatients, day cases and operations).
- More effective prescribing and help patients manage medications better.

Transformation Priorities

7. These priorities will be the focus for work in 2016/17. The required £15million savings target will need to be found from these programmes.

    - Starting Well: Support children and young people to get the best start in life.
    - Being Well: Focusing on prevention, early detection and self-management.
    - Ageing Well: Supporting frail and vulnerable people whatever their age.
    - Transform care for people with mental health and people with learning disabilities.
    - Transform the model of care for people accessing General Practice.

The financial challenge

8. The West Cheshire health economy has been financially challenged for a number of years and the level of financial risk has been growing for the last two financial years.

9. Most areas of spend have increased as a result of changes to our population and improved access to health services. However, the two main areas causing financial pressure are secondary care contracts and continuing healthcare (more complex individual care packages):

    - Expenditure with NHS providers has been growing by £8 million per year.
    - The cost of complex care packages has grown by 37%, or £10 million, since financial year 2013/14.

10. We started 2015/16 with a plan to deliver a £3.6 million surplus but due to the, continued financial impact of pressures outlined above we are now aiming to deliver a break-even position (or balanced financial budget). This will be delivered with a number of actions that will impact on our finances into 2016/17.

What is the underlying position?

11. We will begin financial year 2016/17 in ‘recurrent financial deficit’ meaning that we are committing to spend more than our allocation and that financial balance has been delivered with non-recurrent, or one-off, measures. Put simply, on 1 April 2016 we will need to fund ongoing expenditure of approximately £6.8 million just to stand still. This does not take accounts of any new costs that will materialise during the new financial year.

What is our forecast position for 2016/17?

12. National guidance requires all clinical commissioning groups to deliver at least a 1% surplus. However, due to the underlying financial position described above and the anticipated continued growth in healthcare costs, we will agree a financial plan to break-even as at 31 March 2017.

13. After application of national inflation and efficiency rules, and agreed local planning assumptions, our plan will include an efficiency requirement in excess of £15 million.

14. Some of the key factors causing this efficiency requirement can be summarised as follows:

- Expected increase in costs resulting from changes to our population and access to healthcare of £8.6 million.
- Net impact of inflation and efficiency rules is estimated to be £4 million.
- £2 million of spend that was previously funded separately.
- New mandated investment in mental health services £0.7 million

Our longer term financial forecast

15. Our allocation will increase by £43 million over the next 5 years. However, based on local modelling assumptions, the increasing cost of healthcare means that total efficiencies of greater than £60 million will be required over this period in order to return to financial balance. The size of the financial challenge is reflected in the following table:

Description	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Forecast Expenditure	330,196	348,706	354,786	360,397	365,207	369,860
Forecast Funding\Allocation	323,382	332,884	339,551	346,298	353,495	366,434
Shortfall	**6,814**	**15,822**	**15,235**	**14,099**	**11,712**	**3,426**

16. We are working with local partners to develop a joint financial model that will represent a ‘single version of the truth’. As part of this approach there will be system wide agreement of local planning assumptions.

ACTION: The long term financial model is to be presented by Directors of Finance with system leaders in March 2016.

Delivering Successful Turnaround

17. We will set **clear turnaround targets** in terms of what we require from each programme. Setting a well-defined stretch target is the single tactic most tied to success. Indeed, 90% of programmes that lack such a target, fail. We need to involve the whole organisation and set clear, widely communicated aspirations and targets. Turnaround targets will include outcomes on quality and patient experience as well as financial savings.

18. Successful turnarounds require **strong leadership**. It is crucial that both the Chief Executive Office, GP Chair and Medical Director as clinical leaders are more closely involved in the turnaround programme. There should be weekly updates at executive team and monthly updates at the finance, performance and commissioning committee. We will also ensure wider communication to members and partners of the importance of the turnaround programmes starting with the membership council in February 2016.

19. We will create a **clear structure and plan for turnaround** that includes the 10 "service priorities" outlined above (elective care, urgent care, prescribing etc.) but also enablers such as strengthening clinical leadership, robust programme and management, rationalising decision-making process etc. Each programme needs to have clear leadership and be as distinct and self-contained as possible to avoid confusing overlaps.

20. We will create **energy for change**. We need a good narrative to explain the case for change, challenges and opportunities ahead and the impact for individuals. It is an emotional piece asking people to change cherished routines and habits and embrace a different future. This is crucial for our GPs and that the GP Chair is particularly good at it.

21. Each programme and project will be dependent on good ideas along the way. Keeping front line staff involved and engaged will ensure a flow of ideas. It doesn't require unusual levels of creativity or the input of the latest innovation guru. We need to emphasise that practical, small-scale solutions are as useful as big ideas.

22. We need to tackle negative energy by making sure that successes, big and small are visible, by eliminating bureaucracy and making sure that decision-making processes are seen as fair. Each programme/project needs to describe what health and health care will look like at points along the journey, for example the projected halfway mark. This will help front line staff see the way forward and feel personally involved and accountable for change.

ACTION: The GP Chair to write a change narrative for turnaround and use at senate and membership council.

ACTION: Each project to identify what will be different for staff, public and patients at an interim point and at project completion.

Clinical Leadership

23. There is a constant refrain that we hear both within the clinical commissioning group and in partner organisations that we have to allow clinicians to lead. There is clear evidence that involving front line staff in design and delivery of change will enhance success. There is less evidence, from a long history of clinical leadership in commissioning, that this has made a difference. The role of clinical leadership in clinical commissioning groups has evolved and is well described in a recent report from Hays. Changes include:

From:	**To:**
Leading in pathway design or clinical networks within their area of expertise	Leading on service transformation often beyond own area of expertise
Influencing and engaging colleagues	Influencing and engaging across a broader range of stakeholders. Leading teams
Inputting patients' views and needs	Systematically assuring that patients' views and needs are driving decision making

24. Clinical leadership is a precious resource. We have to think about where clinical leaders focus time and energy. A national study from The Kings Fund and The Nuffield Trust found that **the sustainability of clinical involvement in commissioning was at risk** due to waning levels of GP leader engagement in clinical commissioning groups, potential problems in the recruitment and retention of leaders, and significant pressures on GPs' time.

25. The development of Primary Care Cheshire as well as other organisations such as the Local Medical Committee and Partners for Health has meant that we are all drawing from a fairly small pool of GPs who are interested in, or feel able to undertake leadership roles.

26. There are two pieces of work that need to be done. Firstly, to encourage more GPs to take on leadership roles and give younger/newer GPs support and training to do this. Secondly, we need to review our current clinical leadership arrangements and do this collaboratively with other GP leadership organisations and clinical leads from both Cheshire and Wirral Partnership NHS Foundation Trust and the Countess of Chester Hospital NHS Foundation Trust.

ACTION: Develop a plan for engaging more GPs into leadership roles, and review our leadership arrangements (suggested starter for ten questions outlined below) and produce a set of recommendations by the end of March.

- **Where is the emphasis of our strategy and what does this mean in terms of prioritising your clinical leaders' limited and expensive time?**

- **What are managers best placed to do, and what can only clinical leaders do?**

- **Who do you have among your clinical leaders, and what are their strengths and motivations?**

- **How do you make best use of these given the work you need to get done?**

- **Are the jobs doable, both in terms of time and range of areas that are covered? What is most important for them to deliver?**

- **How will they link with other roles – in particular management? Does everyone understand this? Is everyone clear about where accountability and authority lies?**

Programme Management

27. We need the Programme Management Office to be the centre of turnaround delivery. The turnaround review has identified that the majority of projects being undertaken by the clinical commissioning group do not have project plans with clear savings targets.

28. It is critical that we get a balance between being able to account for the savings we have to deliver and not strangling the system, particularly clinical leadership, with red tape and bureaucracy.

29. Overall we have to separate our internal processes where we hold programmes to account from the wider leadership, ownership and buy-in to change which needs to be clinically led.

30. Recommendations are that the following need to be in place, to be critiqued by the Chief Finance Officer and Programme Office Manager and a response provided to the Senior Management Team.

    ACTION: Each programme (under transformation and stabilisation) must complete a project initiation document or business by the 15th of March that:

    a. **Set out the clinical commissioning group budget attributable and explicitly devolved to each programme – what we already spend and what additional investment, if any, we are making.**

    b. **Identify a financial and activity savings target against it and state whether this is evidence based or innovation. Wider benefits realisation in terms of improved outcomes and patient experience must also be clear**

c. **Beneath this should be projects with milestones, metrics and key performance indicators that give us assurance that the project is underway and an analysis of risk of delivery**

d. **A trajectory of when we think changes to outputs and outcomes will be achieved**

ACTION: The transformation programmes need to articulate a convincing case for change for the new model of care and demonstrate what forecast spend is being avoided.

ACTION: Stabilisation programmes that are addressing financial and quality deficits require an analysis of root causes, and issue resolution through working with clinical staff.

ACTION: Formal programme assurance meetings to run every week. Our programme delivery group will undertake this function and meets every Tuesday.

ACTION: Each programme to be reviewed by Directors at programme delivery group and specific actions agreed to populate a weekly update on progress.

ACTION: The Chief Finance Officer to Chair programme delivery group supported by a Programme Office Manager servicing the meetings. This is already in place but needs reinforcing and communicating so that people understand the importance of this meeting.

ACTION: The roles and responsibilities of the programme officer manager, programme support coordinators and the two programme support administrators need reviewing and clarifying as soon as possible.

ACTION: Once roles and responsibilities are clear the substantive appointment to programme officer manager needs to be made.

ACTION: Programme Office Manager holds a master file of agreed/proposed/deleted programmes/projects and progress updates on all projects.

Performance Management

31. It is widely recognised that what gets measured, gets done. This simple statement lies at the heart of why we are not executing our plans as effectively as possible. We must improve our ability to hold programmes and our staff to account for delivery of programmes.

32. Elements of this are included within the programme management section above but goes beyond this.

ACTION: Accountability for each programme and project must be clear. Effective change programs are led by clinical staff, with strong support and organisational leadership by the management team. Management accountability must be clear with a named individual accountable for each programme and project.

ACTION: Staff must have a clear, manageable set of performance objectives related to the programmes they are charged with delivering. The capacity and capability work outlined below will help identify any skill and knowledge gaps we have within the organisation which should be translated into an individual's personal development plan.

ACTION: The weekly programme assurance meetings do not replace regular one to ones which should take place with line managers, reviewing organisational and personal objectives.

System Communication

33. The programme office should make sure that progress and deliverables from both transformation and stabilisation are visible to stakeholders.

ACTION: Key messages from weekly updates at programme delivery group should be reinforced in all interactions with providers and stakeholders:

a. Member GP practices should be updated through GP network meetings, practice management meetings and membership council

b. Patients and the public should be updated via local authority scrutiny committee, the governing body meetings, health and wellbeing board and patient participation groups.

ACTION: A significant proportion (up to 50%) of governing body meetings, development sessions and finance and performance committees should be devoted to our stabilisation and transformation plans.

Organisational Capability, Capacity and Governance

34. The clinical commissioning group has recently undertaken a review of capacity, capability and governance. A number of new posts have been recruited to, to support the significant agenda that we are facing. Key changes that have been made are as follows:

- Substantive appointment of a director of operations.
- Transferring the programme management office to the chief finance officer's portfolio

- A number of interim/fixed term appointments have been made. These are important in giving us flexibility and additional capacity and need to be better understood across the organisation.

35. In addition to the revised structure, we have retained the services of an experienced turnaround director. Part of this role will be to support the continued review of capacity and capability.

36. Across West Cheshire a systems leadership group has been established to take on a shared approach to managing the sustainability of the health and care economy across all statutory organisations. The membership of the committee includes Chairs, Chief Executive and Medical Directors from the clinical commissioning group, Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust as well as the Director of Social Care and Council Leader from Cheshire West and Chester Council. This group has oversight of the two key work programmes; 'stabilisation' and 'transformation'.

37. The governance arrangements underpinning the clinical commissioning group's decision making need revising. The current committee structure overloads the business of finance and performance and commissioning committee and the sub-reporting structures are unclear, particularly around levels of decision-making. Whilst the transformation and stabilisation committees are useful in terms of collaboration and updating people they are not an effective way of ensuring programme delivery

    ACTION: Head of Governance to set out a list of interim/fixed term posts by department with clear end dates described

    ACTION: The Turnaround Director, supported by the Head of Governance to conduct a rapid assessment of the capacity and capability of staff involved in our change programme.

    ACTION: The Turnaround Director to review and propose revisions to governance arrangements (with a particular focus on finance, performance and commissioning committee and its sub-committees) by the end of March 2016. Hopefully most of the changes will be at sub-committee level so not to require a re-write of the constitution.

38. The finance, performance and commissioning committee is discussed the NHS West Cheshire Clinical Commissioning Group Turnaround Plan, noted the findings of capacity and capability interviews conducted with staff and agreed the actions proposed to address the issues raised by the interview process and the other turnaround actions

WEST CHESHIRE STRATEGIC LEADERS GOUP

39. Simon Holden, Director of Finance at the Countess of Chester Hospital NHS Foundation Trust, and Gareth James, Chief Finance Officer at NHS West Cheshire Clinical Commissioning Group co-presented the draft health economy long term financial model. The purpose of the presentation and following discussion was to sign off the first phase of this work and understand any further outstanding issues. From the discussions at the meeting the next steps were agreed to:

- Strengthen the shared understanding of the West Cheshire health and social care system architecture (governance framework) arrangements. To adopt a governance model from another area (e.g. Salford, Morecambe Bay, Yeovil or West Wakefield). Proposals on this would be presented April strategic leaders meeting.

- Generating the collaborative sustainability and transformation plan within the timescales set by NHS England. Identify leads from each organisation to work backwards from the submission deadline to produce the document.

- Long term financial model (based on Payments by Results) next steps and describe the mechanisms for the quickest/safest way to potentially merge all the local health system budgets (and plans), and the implications of doing this.

- Test/confirm our stabilisation and transformation priorities are the right programmes. Provide the numbers/costs of high areas of spend, to agree how they will be delivered (on a whole population based approach). This will be presented to the next strategic leaders group meeting.

SUSTAINABILITY AND TRANSFORMATION PLAN

40. As in previous years, the clinical commissioning group will be required to produce an individual operational plan for 2016/17. This plan will be taken to finance, performance and commissioning committee in April 2016.

41. In addition, every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.

42. As part of this, local leaders will be required to set out clear plans to improve health and wellbeing, transform the quality of care delivery, and deliver sustainable finances.

43. The guidance also outlines nine ‘must dos’ for every local area in England in 2016/17, agreed by the leading health bodies in England. These include:

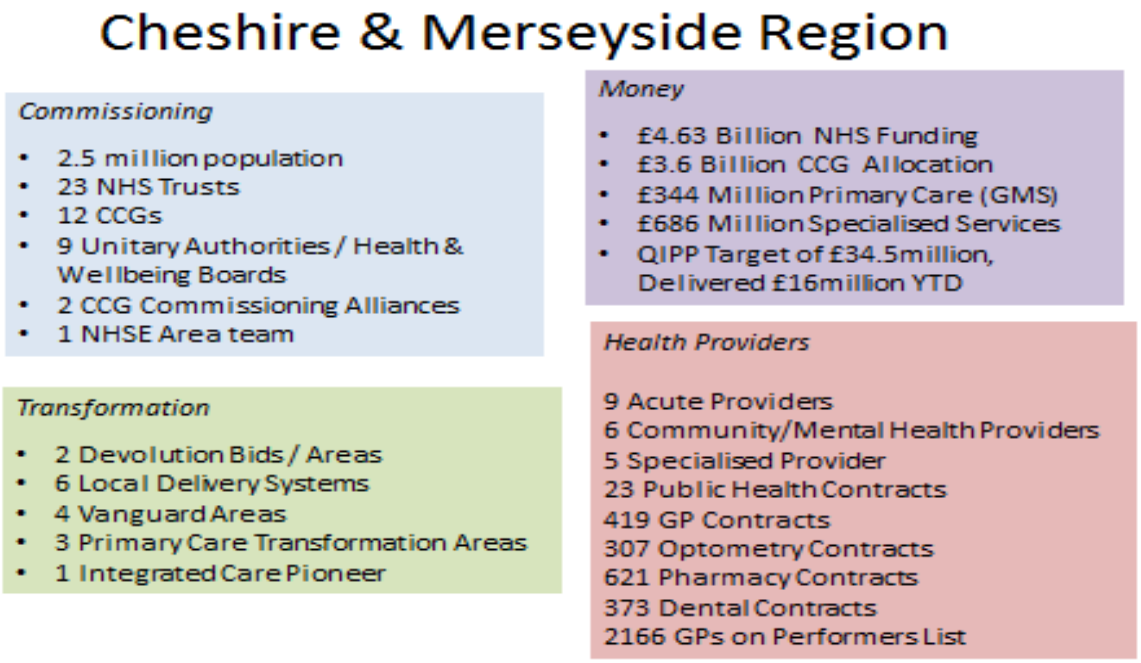
- returning the system to financial balance;

- introducing a local plan to address the sustainability and quality of general practice;
- reducing waiting times for Accident and Emergency, cancer and mental health;
- improving quality – particularly for organisations in special measures.

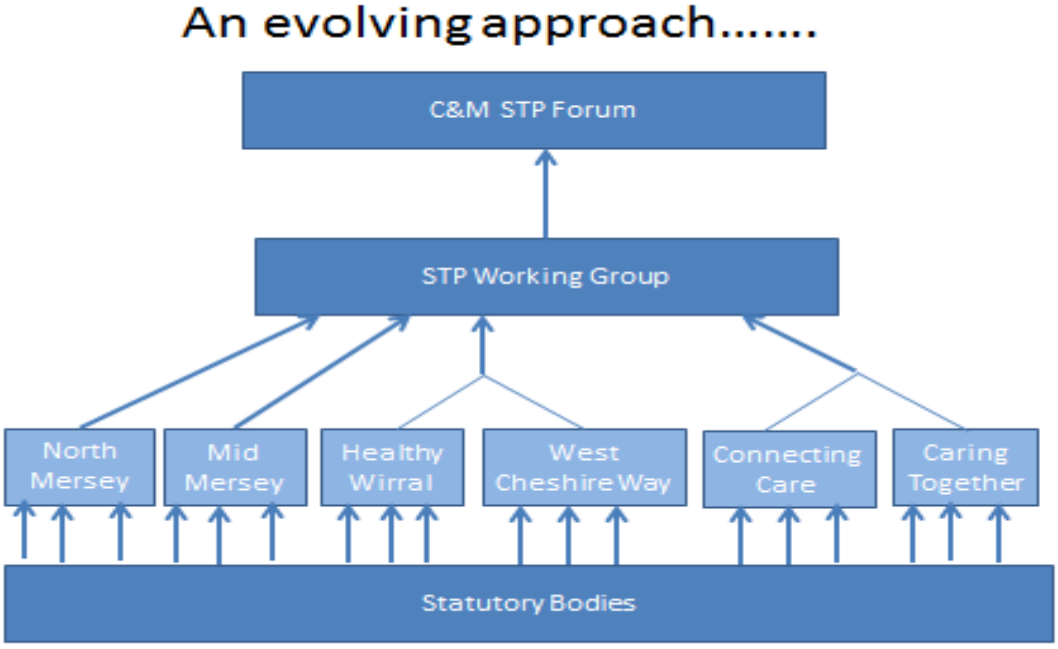
44. Similarly to the clinical commissioning group's approach, NHS England have stated that now is the time to stabilise hospital performance and finances so we can give the NHS a firm footing to make the necessary improvements. This stability and £1.8 billion of funding in the Sustainability and Transformation Fund will help providers be more positive about improving performance, particularly in Accident and Emergency, and balancing the books as they plan for the future.

45. We also need to look seriously at what can be done to realise the long-term improvements needed at a local level and to get on with making changes happen so that patients can rely on strong and sustainable services.

46. The first step in developing what is already shorthanded to a Sustainability and Transformation Plan is to agree the "footprint" over which the plan is to be developed. A planning event was held in involving 43 organisations across Cheshire and Merseyside including clinical commissioning groups, providers, Local Authorities, NHS England, etc. The group reached a decision that the Sustainability and Transformation Plan footprint would be across Cheshire and Merseyside, involving the following:



47. The governance to support development and implementation of the plan is at an early stage of development with an early draft of governance arrangements as follows:



48. The governing body may wish to note that the one Sustainability and Transformation Plan for Cheshire and Merseyside will be underpinned by what are known as Local Delivery Systems. Whilst there will be opportunities to consider working across a wider area when this makes sense for the health and health services our patients use, at the moment our Local Delivery System is the West Cheshire Way, our "vanguard" footprint.

49. The clinical commissioning groups across Cheshire and Merseyside have established a small Sustainability and Transformation Plan working group with 4 accountable officers (from Wirral, Liverpool, St Helens and East Cheshire) leading the development plans.

50. There is an acknowledgement that in the absence of a larger steering group, the working group will need to establish an "all Cheshire and Merseyside partner forum" to present the draft plan and address key decisions prior to statutory governing body sign-off.

NHS ENGLAND ASSURANCE PROCESS

51. From April 2016, a new approach to clinical commissioning group improvement and assessment will replace the current assurance arrangements. More details can be found in an engagement document which has been published.

Creating a headline assessment from the five components of assurance

52. The assurance oversight group has agreed that clinical commissioning group component assurance assessments will be aggregated to a headline assessment only once in 2015/16, for the annual assessment. The group also agreed to retain the approach of the lowest of the component ratings providing the headline rating. However, local NHS England teams may provide a case for a clinical commissioning group to move up one rating level.

53. The case would be approved / not approved at regional consistency checking and brought to assurance oversight group for national moderation of the decision. The case for moving the headline assessment up one rating level would include evidence of the direction of travel of the clinical commissioning group over the year and the level of confidence this gives NHS England in the clinical commissioning group's ability to manage its risk and deliver its responsibilities. Weightings are not being given to any of the components.

2015/16 assurance year end timetable

54. The Government's mandate to NHS England requires them to publish the clinical commissioning group annual assurance report by June 2016 with the following milestones:

- Mid-April – early May — annual assurance assessments
- Early to mid May — regional consistency checking

- Week commencing 23 May assurance oversight group/national moderation

55. Some adjustments to the process will be necessary, given the availability of important insight:

- The most up-to-date data available will be Month 11, due to be published on 14 April 2016. However the year end assessment isn't based solely on current performance, but should consider the clinical commissioning group's performance during the year, trends over time, the clinical commissioning group's general direction of travel and the level of risk it would be carrying in to the next year.

- The 360 degree stakeholder survey results will be available from 29th April 2016. If NHS England local teams believe the results would have a significant bearing on conversations with some clinical commissioning groups, they may wish to arrange a later meeting for those, or carry out a two-stage assessment, covering the well led component separately.

- Finance component assessments will be carried out before clinical commissioning group annual accounts have been signed off. If material issues subsequently emerge during the final accounts and audit processes, a further review should be carried out. This may result in the revision of the finance component assessment and, where relevant, other components and the headline assessment. If a further review is required, it should immediately be flagged to regional and national finance and assurance teams, to ensure that any changes can be moderated and incorporated.

RECOMMENDATIONS

56. The governing body is asked to:

- note the contents of this report;
- agree the actions in relation to financial turnaround;
- discuss the progress on the sustainability and transformation plan footprint.

Alison Lee
Chief Executive Officer
March 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting: 17th March 2016

2. Title of Report: Nursing and Midwifery Revalidation Assurance Report

3. Key Messages:

- The requirement for Nursing and Midwifery Council registrants to undertake revalidation every 3 years takes effect from 1st April 2016.
- Revalidation is the responsibility of the individual registrant and there are no mandated requirements on employers.
- Providing support for Nursing and Midwifery Council registered employees to revalidate is good employment practice and the minimum that our staff should expect.
- In the absence of confirmation that a registrant meets the requirements of revalidation, their registration will be suspended for a minimum of 6 weeks.
- The clinical commissioning group has taken steps to ensure that all directly employed nurses and midwives have support to complete revalidation.
- The clinical commissioning group has ensured that general practitioners, practice managers and their staff are aware of and have access to support for revalidation.
- The clinical commissioning group fully meets all the NHS England criteria for revalidation.

4. Recommendations The governing body is asked to:

a. To approve the assurances and actions taken to implement revalidation.
b. To approve the approach to shared staff, general practice clusters, providers and agencies.

5. Report Prepared By: Sarah Faulkner
Lead Nurse

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

NURSING AND MIDWIFERY REVALIDATION ASSURANCE REPORT

PURPOSE

1. The purpose of this report is to provide assurance to the governing body on preparation for Nursing and Midwifery Revalidation requirements taking effect from 1st April 2016.

2. Revalidation supports the objective to commission safe, effective care that continues to improve patient experience.

CONTEXT

3. In January 2014 the Government published "Hard Truths: the Journey to Putting Patients First" in response to the Mid Staffordshire NHS Foundation Trust public enquiry. At that time a commitment was made to review and strengthen regulation of the nursing profession.

4. The Nursing and Midwifery Council has responded in part by changing the requirements for nurses and midwives when renewing their registration. From 2016, all registered nurses and midwives, regardless of their role, must undergo a formal revalidation process every three years.

5. The purpose of nursing revalidation is to improve public protection by ensuring that nurses and midwives are fit to practice. It is being supported by a revised Code of Professional Conduct published in March 2015.

6. The new requirements to be completed every three years prior to revalidation are:

    a. A minimum of 450 practice hours.
    b. 40 hours of continuing professional development relevant to the scope of practice, 20 hours of which must be participatory learning.
    c. Five pieces of practice related feedback.
    d. Five written reflections on the Code of Professional Conduct, continuing professional development and practice related feedback.
    e. Confirmation from a third party on satisfactory compliance with the requirements, either a line manager who is a registered nurse / midwife or a Nursing and Midwifery Council approved alternative where they are not.

7. The requirements apply to every part of the register for which a nurse or midwife is registered and it is the responsibility of the individual to know their revalidation date and make arrangements to comply.

8. The Nursing and Midwifery Council has written to all registrants to inform them of the requirement to revalidate and the steps that must be taken to comply. A comprehensive programme of communication using a range of media has been used in the last 6 months to raise awareness across the board.

9. Failure to revalidate will result in removal from the register for a minimum of 6 weeks after revalidation is subsequently completed and submitted. During this time the registrant cannot undertake the duties and responsibilities of a registered practitioner.

10. Resources to support individuals and employers in implementing revalidation are available on http://revalidation.nmc.org.uk/ .

11. Providing support for Nursing and Midwifery Council registered employees to revalidate is good employment practice and the minimum that staff should expect and the governing body is asked to consider the assurances within this report and approve the actions taken to date as positive assurances against the NHS England implementation review criteria.

BACKGROUND

12. In August 2015, NHS Cheshire and Merseyside conducted an audit of the state of readiness of clinical commissioning groups in their area. The audit checked compliance against:

    a. Knowledge of registrant's revalidation dates.
    b. Identification of the first group of staff to support through revalidation.
    c. Whether staff in the first cohort (from April 2016) had had individual meetings with line managers to agree support and preparation
    d. Identification of confirmers and professional reviewers for registrants due to revalidate in the first cohort.
    e. Identification of a lead member of staff to oversee implementation of revalidation and deal with any cases where revalidation is not successful.
    f. Arrangements to assist registrants in recording practice hours / continuing professional development and reflection and feedback.
    g. Evidence of engagement with staff in preparation for revalidation, such as events and communications.
    h. The board or governing body being informed about revalidation and progress made in implementation.

13. Risks identified for NHS West Cheshire Clinical Commissioning Group at the time included :

    a. Arrangements for registered nurse / midwife reviewers and confirmers.
    b. Arrangements for assisting registrants in recording practice hours and continuing professional development.
    c. The lead nurse role on the governing body was designated to oversee the process and was in transition from one post holder to another.

d. The governing body had not received assurance on preparation for revalidation.

14. There are five employment scenarios in relation to revalidation of nurses and midwives. These are nurses and midwives who are:

a. Directly employed by the clinical commissioning group.
b. Seconded to the clinical commissioning group from a primary employer.
c. Employed by GP practices within the three West Cheshire areas.
d. Employed by providers from whom the clinical commissioning group commissions services.
e. Employed by agencies.

NURSES AND MIDWIVES EMPLOYED WITHIN NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

15. There are four senior nurses employed directly by the clinical commissioning group, of whom two must be registered with the Nursing and Midwifery Council as a requirement of their role. Revalidation dates are in June 2017 and December 2018.

16. There are six registered nurses and midwives seconded to the clinical commissioning group from a primary employer. Three are required to be registered, including the designated nurses for child and adult safeguarding and the lead nurse on the governing body (revalidation date September 2016).

17. All clinical commissioning group's nurses and midwives are aware of the revalidation requirement, have registered with the nursing and midwifery online revalidation portal and know their revalidation date.

18. Registered nurses and midwives employed directly or seconded to the clinical commissioning group have access to the Nursing Times online revalidation tool, and to a senior registered nurse (the governing body lead nurse) for professional review and Confirmation.

19. Secondees who work the majority of their hours with the primary employer are expected to undertake revalidation with that employer.

20. There is no requirement for a specific policy or procedure to be created in relation to revalidation of clinical commissioning group registered nurses and midwives. It is appropriate to include references to the requirement for revalidation within employment policies and procedures relating to professional registration checks.

NURSES AND MIDWIVES EMPLOYED BY GP PRACTICES

21. As general practitioners are employers in their own right it is their responsibility to ensure that their staff are registered with the appropriate professional body. This does present challenges for small practices in terms of access to professional reviewers and confirmers.

22. The clinical commissioning group lead for GP practice nurses has provided a programme of briefing events for practice nurses and has emailed every practice nurse to encourage them to register with the nursing and midwifery revalidation portal, and to identify their revalidation date. All practice nurses within the NHS West Cheshire Clinical Commissioning Group area have access to the Nursing Times online revalidation tool.

23. GPs and practice managers have been briefed on the requirement for revalidation and have been advised to consider the risks in terms of staff who may choose to retire rather than revalidate, or who do not meet the requirements for revalidation.

24. Arrangements are in place to provide a trained professional reviewer/confirmer for each clinical commissioning group GP cluster, where required.

NURSE AND MIDWIVES EMPLOYED BY PROVIDERS AND AGENCIES

25. Providers, whether they are independent (such as nursing homes) or NHS providers, carry their own responsibility for ensuring that the nursing and midwifery staff they employ are registered. Whilst the clinical commissioning group cannot dictate how revalidation is implemented by independent or NHS employers, the arrangements for it will be incorporated into NHS provider and nursing and care home quality reviews.

26. Agencies providing nursing and midwifery staff must demonstrate robust arrangements for revalidation and registration checks if they are to remain on the national procurement framework.

RECOMMENDATIONS

27. The governing body is asked to:

    a. To approve the assurances and actions taken to implement revalidation.
    b. To approve the approach to shared staff, general practice clusters, providers and agencies.

Sarah Faulkner
Governing Body Lead Nurse
March 2016

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

GOVERNING BODY REPORT

DATE OF GOVERNING BODY MEETING:	17th March 2016
TITLE OF REPORT:	Clinical Commissioning Group Policies and Governance Documents
KEY MESSAGES:	This report provides one clinical commissioning group policy / governance document for governing body ratification.
RECOMMENDATIONS:	The governing body is asked to approve / ratify the policy / governance document.
REPORT PREPARED BY:	Clare Jones Governing Body and Committees Coordinator

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS

INTRODUCTION

1. One clinical commissioning group policy/governance document is provided to the governing body for approval/ratification.

POLCIES AND GOVERNANCE DOCUMENTS

2. As a part of the clinical commissioning group's governance process, a governance plan was created to schedule an annual review of policies and governance documents. Provided below is the policy/governance document for ratification. A hyperlink to the document is provided and the table summarises the oversight (i.e. which sub-committee has scrutinised the report), along with details of when the document has been previously considered by the governing body. Also included is the name and contact details for the lead officer from the clinical commissioning group for the policy.

No	Document	Oversight	Previous Governing Body Ratification Date	Lead Officer
1.	Complaints Policy and Standard Operating Procedure	Quality Improvement Committee	April 2014	Paula Wedd Director of Quality and Safeguarding 01244 385272 paula.wedd@nhs.net

RECOMMENDATION

3. The governing body is asked to approve/ratify the policy / governance document provided.

Gareth James
Chief Finance Officer

March 2016

NHS
West Cheshire
Clinical Commissioning Group

1.	**Date of Governing Body Meeting:**	15th January 2016
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

GOVERNING BODY

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 – minutes

3. Major issues and actions from the December 2015, January and February 2016 meetings included:

- Prime Minister's Challenge Fund Update
- Elective Referral Analysis
- Commissioning for Quality and Innovation schemes 2016
- Cheshire Care Record
- Update on issues and developments around Countess of Chester Hospital NHS Foundation Trust, provided by the Trust's Chief Executive Officer and Medical Director
- Network involvement with the West Cheshire Way – Starting Well
- Primary care representation at the Joint Provider meetings
- Commissioning for Quality and Innovation schemes 2016
- Sir Sam Everington's visit and next steps
- Procedures of Limited Clinical Value
- New Colorectal pathways pilot

Rural Locality GP Network – minutes

4. Major issues and actions from the December 2015, January and February 2016 meetings included:
   - Elective Referral Data
   - Acute Visiting Service – North West Ambulance Service
   - Commissioning for Quality and Innovation schemes 2016
   - Prime Minister's Challenge Fund Update
   - Cluster Leads Meeting
   - Cheshire Care Record
   - GP Involvement in The West Cheshire Way – Ageing Well
   - New Colorectal Pathway pilot
   - Sexual Health and Health Checks

Ellesmere Port and Neston Locality GP Network - minutes

5. Major issues and actions from the December 2015, January and February 2016 meetings included:
   - Cheshire Care Record
   - Prime Ministers Challenge Fund Update
   - Primary Care Cheshire Update
   - Elective Referral Analysis
   - New Services – ophthalmology and DVT
   - Commissioning for Quality and Innovation schemes 2016
   - New Colorectal Pathway pilot
   - Network Involvement in West Cheshire Way – Being Well
   - Elective Care Analysis
   - Joint Provider meeting learning event

SENATE – report

6. An overview of the January 2016 Senate is contained within the senate report.

QUALITY IMPROVEMENT COMMITTEE – minutes

7. An update of the February 2016 meeting is contained within the quality improvement report. The minutes from this meeting will be available for the May 2016 meeting.

FINANCE PERFORMANCE AND COMMISSIONING COMMITTEE – minutes

8. An update of the March 2016 committee meeting is contained within the finance performance and commissioning committee report. The minutes from this meeting will be available for the May 2016 meeting.

AUDIT COMMITTEE – minutes

9. An update of the March 2016 committee meeting is provided within the Audit Committee report.

REMUNERATION COMMITTEE

10. No further meetings have taken place since the last update was provided.

RECOMMENDATION

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