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 November 2016, at 9.00a.m. in the Lecture Hall, Education and Training Centre, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL

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 15th September 2016	DR To follow	Dr Huw Charles-Jones *GP Chair*
D	9.35	Matters arising/actions from previous Governing Body meetings	D To follow	Dr Huw Charles-Jones *GP Chair*
WCCCGGB/16/11/83	9.45	GP Network Chair Update	Verbal	Dr Steve Pomfret *GP Representative – Rural* Dr Jeremy Perkins *GP representative – Ellesmere Port and Neston* Dr Annabel Jones *GP Representative – Chester City*
WCCCGGB/16/11/84	9.55	Senate Report	D	Peter Williams *Hospital Physician Representative*
WCCCGGB/16/11/85	10.05	Primary Care Committee Report	D	Laura Marsh *Director of Commissioning*
WCCCGGB/16/11/86	10.20	Quality Improvement Committee Report	D	Paula Wedd *Director of Quality and Safeguarding*

10.40 BREAK				
WCCCGGB/16/11/87	10.50	Finance, Performance and Commissioning Committee Report	D	Chris Hannah *Vice Chair* Laura Marsh *Director of Commissioning*
WCCCGGB/16/11/88	11.15	Pre-operative Medical Optimisation	DR	Laura Marsh *Director of Commissioning*
WCCCGGB/16/11/89	11.35	Audit Committee Report	D	Kieran Timmins *Lay Member*
WCCCGGB/16/11/90	11.45	Chief Executive Officer's Business Report	DR	Alison Lee *Chief Executive Officer*
CONSENT ITEMS				
WCCCGGB/16/11/91	12.00	Clinical Commissioning Group Policies and Governance Documents	DR	Alison Lee *Chief Executive Officer*
WCCCGGB/16/11/92	12.05	Clinical Commissioning Group Sub-Committee Minutes	I	Alison Lee *Chief Executive Officer*
WCCCGGB/16/11/93	12.10	Any Other Business **(to be notified to the Chair in advance)**	D	All

Date and time of next formal Governing Body meeting – Thursday 19th January 2016, at 9.00am in Rooms A & B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL

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 15th September 2016, 9.00 a.m.
Frodsham Community Centre, Fluin Lane, Frodsham, WA6 7QN

PRESENT
Voting Members:

Dr Huw Charles-Jones	Chair
Ms Alison Lee	Chief Executive Officer
Dr Andy McAlavey	Medical Director
Mr Gareth James	Chief Finance Officer
Ms Chris Hannah	Lay Member
Mr Kieran Timmins	Lay Member
Dr Jeremy Perkins	GP representative – Ellesmere Port and Neston Locality
Dr Steve Pomfret	GP representative – Rural Locality
Ms Fiona Reynolds	Interim Director of Public Health, Cheshire West and Chester Council
Ms Laura Marsh	Director of Transformation
Mr Lee Hawksworth	Director of Operations
Mrs Paula Wedd	Director of Quality and Safeguarding
Ms Clare Dooley	Head of Governance

In attendance:

Ms Clare Jones	Governing Body and Committees Coordinator

16/09	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, although the first 15 minutes of the agenda are set aside for questions from members of the public. 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 Chair noted that this meeting of the governing body will be the last to take place away from the Countess of Chester Health Park. This decision has been taken due to limited attendance by members of the public and availability and cost of external venues, and consideration is being given to the possibility of 'web-casting' future meetings. Four questions had been received prior to the meeting from Mr Gus Cairns, in relation to Sustainability and Transformation Plans, as follows: • ***Why are all negotiations on Sustainability and Transformation Plans excluding Patient Stakeholders?*** • ***Why have the end of June Draft Reports not been published yet?***	

16/09	AGENDA ITEM	Action
	• ***Will patient and public stakeholders see the October submissions before they are sent to NHS England for their appraisal?*** • ***Have you seen the NHS England Statement sent out Saturday 27th August 2016 which says community stakeholders should be included in planning for the Sustainability and Transformation Plans and who is more of a stakeholder than Patients?*** The Chair noted that this is a very relevant question on the inclusion of patients and the public in consultations, and it is beholden upon the governing body to ensure that consultation is undertaken appropriately. The Chair provided the following response to the questions raised: As set out in the NHS Shared Planning Guidance, published in December 2015 (and in guidance issued to local areas since), the success of Sustainability and Transformation Plans will depend on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors and local government. The national bodies responsible for the development of the programme have asked for robust local plans for genuine engagement as part of the Sustainability and Transformation Plan process. All local Sustainability and Transformation Plan areas should therefore now be having conversations with local people and stakeholders to discuss and shape their Sustainability and Transformation Plan proposals – understanding what matters to them, and explaining how services might be improved. We expect that these conversations will gain pace over coming months and we want as many people as possible to be involved. While formal consultation (if required) is not expected to take place until the next stage of the process, we have been clear that dialogue with local people is essential throughout the process and will be taken into account in an assessment of the plans. Each organisation within the Sustainability and Transformation Plan collaboration retains their usual duties to engage local people on any new proposals. With regard to publication, please note that Sustainability and Transformation Plan proposals are currently at a draft stage, but, as above, it is expected that all local leaders will be talking to the public and stakeholders regularly as it is vital that people are able to shape the future of their local services. No changes to the services people currently receive will be made without local engagement and, where required, consultation. There are longstanding assurance processes in place to make sure this happens. All footprints will submit an updated plan in October, with further formal public engagement and consultation taking place from this point, as appropriate. However, we are aware that many footprints are already publishing patient-facing summaries as part of their engagement programme. A copy of the clinical commissioning group's response will be provided to Mr Cairns, who was unable to attend at today's meeting.	

16/09	AGENDA ITEM	Action
	CHAIR'S OPENING REMARKS	
	The Chair provided an update on the selection process to appoint a new GP Chair for the clinical commissioning group, noting that a whole day assessment session had been held in August 2016 for the four potential candidates, which also involved partner organisations and stakeholders. Following the assessment session, one candidate withdrew as a result of their personal reflections on the day, and two other candidates withdrew in order to support the final candidate, whom they felt was the strongest candidate for the role. Subsequently, a full GP membership ballot is being undertaken at the September Membership Council meeting, for a 'Yes' or 'No' vote to support the final candidate's selection to the role of Chair. The Chair noted that the questions raised by Mr Gus Cairn had prompted him to reflect on public engagement in the structural reorganisation of the NHS through the Sustainability and Transformation Plan, and the importance of public debate and challenge on this issue. It can sometimes feel that the public nature of this meeting can inhibit debate and discussions of sensitive issues by the governing body. We have recently seen in Vale of York Clinical Commissioning Group and St Helen Clinical Commissioning Group what happens when a clinical commissioning group makes the significant decision to restrict access to services to reduce spending, which has also raised the question of what public debate had taken place before this decision was made, and how much challenge had been raised by each organisations clinicians and lay members. The current NHS financial position is too severe for services to continue in the same form, and rapid and radical change is required. The Sustainability and Transformation Plan considers this, although this is very political and contentious. As the plan is not being discussed on a national scale, debate will be required on a local footprint and the governing body will have a significant role in leading the public and clinical engagement and debate. The organisational changes required to modernise health and social care provision, regardless of funding issues, are medium term and will not help current in-year financial issues being experienced. In the short term, there are three possible solutions. Either the NHS receives additional funding and the country starts to restore health funding to European levels, or we proceed more slowly by prolonging waiting times, or we reduce activity within services by restricting the level of services offered across the local health economy. It is unlikely that additional funding will become available to the NHS, we cannot extend waiting times due to Constitutional targets that must be achieved, and therefore the third option appears to be inevitable. This is reflected in the papers for today's meeting, especially the Finance, Performance and Commissioning Committee Report which contains details relating to Procedures of Limited Clinical Priority, and it is vital that, as a governing body which includes clinicians and lay members, that we reflect on the potential restrictions on the local health services offer. We need to ensure that there is appropriate public discussion and debate around these issues.	

16/09	AGENDA ITEM	Action
	The Chair reminded the meeting that the clinical commissioning group's Annual General Meeting is scheduled to be held on the 28th September 2016, at 2.45pm – 4.30pm,	
A	**APOLOGIES FOR ABSENCE**	
	Apologies were received on behalf of Sarah Faulkner, Peter Williams, Pam Smith and Dr Annabel Jones.	
B	**DECLARATIONS OF MEMBER'S INTERESTS**	
	Dr Steve Pomfret declared an interest in agenda item WCCCGGB/16/09/77 - Finance, Performance And Commissioning Committee Report, in relation to Primary Care Procurement.	
C	**MINUTES OF FORMAL GOVERNING BODY MEETING HELD ON 21ST JULY 2016**	
	The minutes of the formal governing body meeting held on 21st July 2016 were accepted as an accurate record of the meeting. The minutes of the extraordinary governing body meeting held on the 26th May 2016 were accepted as an accurate record of the meeting.	
D	**MATTERS ARISING/ACTIONS FROM PREVIOUS GOVERNING BODY MEETINGS**	
	Matters Arising from the minutes of 21st July 2016 • Page 4 – Update on Item 2016/05/58 – Dr Andy McAlavey noted that discussions have taken place with Primary Care Cheshire in relation to the company's Chair position continuing to operate on a rolling monthly basis. There has been no indication that this position has changed and Dr Steve Pomfret confirmed that this issue was not raised at the Primary Care Cheshire monthly meeting. A number of concerns have now been noted in relation to this issue and it was agreed that the three GP Network Chairs will progress this with network members at upcoming GP Locality Network meetings. Alison Lee noted that the minutes of the July 2016 meeting have been expanded to included greater narrative detail, following a recommendation made by PricewaterhouseCoopers' capability and capacity review of the clinical commissioning group. However, it is important to ensure that an appropriate balance is maintained within the minutes, and Alison requested comments and thoughts on the new style used. Chris Hannah agreed that more detail on items debated is now captured, however this should remain a work in progress as there is additional work that can be undertaken, i.e., ensuring that key messages within the reports are not	**SP/JP/ AJ**

16/09	AGENDA ITEM	Action
	duplicated within the minutes, while retaining sufficient context for the details of the debate. Paula Wedd noted that, having not been present at the previous meeting, she felt that the minutes captured sufficient information and discussion to provide an understanding of the issues discussed and challenges raised. **Action Log** • **16/09/66 – Senate Report** - *HCJ and PWi to meet to discuss the future of the senate meeting*. The Chair confirmed that a meeting has been arranged with Peter Williams and Alison Lee for the 20th October 2016, to progress this issue. • **16/09/67.b – Quality Improvement Report** - *Discussions to be held re. ensuring sufficient staff are focussed on issues of care homes and this is to be raised at the Care Homes Quality Group meeting*. Fiona Reynolds confirmed that this issue has been raised, and that Sarah Faulkner has been invited to attend at the Care Home Quality Group meeting.	
75	**GP Network Chair Update**	
	The Chair explained that the purpose of this item is to connect the work undertaken at GP Locality Network meetings more fully in to the governing body. The GP Network Chairs provided an update and the following points were noted: • The GP locality networks have aligned their meeting agendas to ensure consistency of discussions across the networks. • Recent discussions at the network meetings have included the election of the new clinical commissioning group GP Chair, the ongoing work being undertaken on the Financial Recovery Plan, and the Sustainability and Transformation Plan, where concerns have been raised in relation to GP workloads and the sustainability of primary care within the Cheshire and Merseyside footprint, as there is a lack of confidence that GPs will have the ability to influence decisions that are to be made at a higher level. The lack of rigor around Primary Care Cheshire as an organisation has also been considered, although no clear next steps have been identified. The decision to restrict prescribing around Procedures of Limited Clinical Priority discussed and it was noted at the Rural locality meeting that GPs did not feel that GPs or clinical leads should be involved in determining restrictions and that this should be decided in agreement with professionals and the public. Urgent care and the use of the Consultant Connect service has been well received, and an update by the community care team manages was provided in relation to intermediate care. Countess of Chester Hospital NHS Foundation Trust has instigated high intensity therapy wards, and patients are filtered out to primary care teams. As a consequence, the Trust is discharging patients with high needs without discussion with the primary care team around the patient's needs.	

16/09	AGENDA ITEM	Action
	The Chair noted that it had been raised at the quarterly assurance meeting with NHS England that the clinical commissioning group continues to have support and 'buy-in' from primary care, and it is positive to note that financial recovery process continues to be a discussion item at locality networks. Gareth James noted that the financial position is not discussed in detail at every locality network meeting, but the issue is discussed and Laura Marsh confirmed that members of the clinical commissioning group's executive team attend at each locality network meeting, and any key issues from the financial recovery plan are highlighted. It was also noted that the integrated teams attend at the Rural locality network meetings and is has been suggested that this participation is considered for the Chester City and Ellesmere Port and Neston locality network meetings. Alison Lee advised that NHS England was very positive at the quarterly assurance meeting in relation to the clinical commissioning group's engagement with member practice, and acknowledged that this engagement can be challenging to achieve. Going forward, the locality networks will be the place where the integration of primary care and community services will be progressed in partnership with Cheshire and Wirral Partnership NHS Foundation Trust. It has been proposed that representatives from Cheshire and Wirral Partnership NHS Foundation Trust are invited to attend at the locality network meetings and it has been agreed that Laura Marsh will progress and manage this. Alison Lee advised that it is positive to see the locality networks' awareness of the Sustainability and Transformation Plan. Dr Andy McAlavey advised that a recent meeting had been held to discuss the Sustainability and Transformation Plan, which also included the Chairs of the network localities and representation from the GP federation. There was challenge on how service improvements in primary care can be achieved, given the significant level of workload currently being experienced by GPs, and further details were provided. Discussions also took place in relation to the GP's role and how they can be involved with this ongoing work, and the development of an Accountable Care Organisation. The Chair noted that, although there had been a focus on the development of the Accountable Care Organisation, there is also a need to understand how this evolution will affect GPs and future workforce planning. The Chair noted that there are no recommendations for this item, although it is important to note the engagement of networks and the positive feedback received from NHS England. It is also important to note the inclusion of the integrated teams within the Rural network.	**LM**
76	**QUALITY IMPROVEMENT COMMITTEE REPORT**	
	Paula Wedd introduced the paper and noted that Fiona Reynolds will present the highlights from the Director of Infection and Prevention Control Annual Report 2015-16, which is now completed as a part of the local authority Public Health requirement.	

16/09	AGENDA ITEM	Action
	Fiona Reynolds noted that the annual report highlights the positive and proactive work being undertaken locally between the Cheshire West and Chester Council's Public Health team, NHS West Cheshire Clinical Commissioning Group, Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust, and the following points were noted: • In 2015 flu vaccination for 5-7 year old children and the uptake in Cheshire West and Chester was 63.4% for 5-6 year olds and 62.4% for 6-7 year olds, against a national expectation that 40-60% of children would be vaccinated. • There were a total of 24 community outbreaks in care homes across West Cheshire. Partnership working is now more focussed on outbreak prevention and staff and management understanding of this issue has greatly improved. As a result, it is expected that a higher level of reporting will be experienced, although this is classed as a positive step forward. • Although there were no flu outbreaks reported in Cheshire West and Chester during winter 2015-16, work is continuing on flu prevention for winter 2016-17. • There is a focus on joint working in relation to reducing antimicrobial resistance across the local health and social care economy, to identify gaps in good practice. Public Health England has recently developed its Antimicrobial Resistance strategy, which includes improving prescribing and stewardship of antibiotics, and this will be a focus of future partnership working across West Cheshire. Jeremy Perkins queried the position of West Cheshire GP practices in relation to prescribing of antibiotics and Fiona Reynolds provided additional details, noting that local performance is positive when compared to national data, although there remains room for improvement. Alison Lee noted that the annual report was very positive and queried whether there has been any learning to identify why there were no reported outbreaks during winter 2015-16, and whether this learning can be used for future planning. Fiona Reynolds responded that the collaborative partnership working is believed to have contributed significantly to managing winter outbreaks, as has the preventative work undertaken with care homes and their staff. Alison Lee identified that the overall staff flu vaccination levels, locally, could still be improved and queried how staff uptake levels can be improved. Fiona Reynolds acknowledged that staff vaccination levels continue to be a challenge, but work is ongoing to improve this, especially within primary care, and further details were provided. Paula Wedd highlighted that there is a need to ensure that patients who are unable to attend at their local pharmacy are still able to access flu vaccinations, and that there is an appropriate response from primary care when a patient requires prophylaxis, and that both these issues are addressed. Fiona Reynolds responded that discussions have taken place with NHS England in relation to patients who are unable to access pharmacy services and it has been concluded	

16/09	AGENDA ITEM	Action
	that these patients are unlikely to be housebound patients that are not in receipt of some type medical care, and will therefore have an alternative access to vaccinations, although this will continue to be monitored. With regard to those patients requiring antiviral medication, this issue is being progressed with the Local Medical Committee and discussions are underway with NHS England in relation to how this will be funded. The following points were highlighted from the remainder of the report: • A Quality Impact Assessment Policy has been created that requires programme managers to complete a Quality Impact Assessment for each project, to identify whether there is any potential for a negative effect when implementing the project, and further details were provided. Steve Pomfret queried whether quality impact assessments are also completed by providers and Paula Wedd responded that the Medical Director and Director of Nursing from each Trust are expected to sign-off any quality impact assessment undertaken by their organisation. However, by having the clinical commissioning group also undertake this process, this may make the clinical commissioning group a better critical friend to its providers. Chris Hannah identified that, where providers are undertaking quality impact assessments, there is a need for the clinical commissioning group to be sighted on the provider's internal process and Paula Wedd acknowledged that there is more work to be undertaken to ensure the appropriate processes are in place across organisations. Laura Marsh noted that work on the Accountable Care Organisation and integrated provision may provide the opportunity to influence work around provider quality impact assessments and what information the provider documentation should contain. It was agreed that the members of the senior management team that attend at the quality and performance meetings with both the Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust will discuss the inclusion of quality impact assessments on the agenda for each meeting. • Countess of Chester Hospital NHS Foundation Trust ➢ The Trust commissioned an independent review of its neonatal service from the Royal College of Paediatrics and Child Health and The Royal College of Nursing, and the final report is expected to be completed by the end of September 2016. ➢ A number of never events have been reported by the Trust, and the Trust's Medical Director has been requested to produce a thematic report to identify whether there is any correlation between the events and incidents being reported.	**GJ/PW /LM/ LH**

16/09	AGENDA ITEM	Action
	Chris Hannah queried whether there is any additional information available on what conclusions are being reached in relation to the increase in the number of reported never events, and what work is being undertaken to address this. Paula Wedd responded that it is usual for a report on a never event or serious incident to take a number of months to be completed, which is why a thematic report has been requested in the interim. Current available information appears to indicate that, on a number of occasions, incidents have occurred as a result of non-adherence to appropriate pathways and processes that have been put in place to ensure surgical safety. Andy McAlavey confirmed that a number of recent incidents have taken place when a surgical procedure has been undertaken outside of a theatre setting and work is now required to ensure that those procedures also adhere to pathways and processes applied to theatre settings. Paula Wedd confirmed that a challenge around this issue was raised at the clinical commissioning group's quality and performance meeting with the Trust, where the Trust's Medical Director agreed to undertake a thematic review of the events and incidents, as a whole, which will then be provided to the quality improvement committee, once available. • One to One Midwives – Following a court hearing in July 2016, the winding up petition let by Wirral University Teaching Hospital has now concluded and all parties have reached a settlement agreement. • Care and Nursing Home**s** ➢ Crawfords Walk Nursing Home **–** Cheshire West and Chester Council, supported by the clinical commissioning group, applied a breach in contract in June 2016, which resulted in suspension of admissions to all houses in Crawfords Walk. Quality monitoring visits take place on a weekly basis to monitor improvements and, while improvements continue, further improvement is still required. ➢ Atherton Lodge – Cheshire West and Chester Council, supported by the clinical commissioning group, applied a breach in contract in July 2016, which resulted in suspension of placements at the home. The Care Quality Commission undertook an unannounced inspection at the home in August 2016 and the report is expected to be published on the 15th September 2016. The local authority and the clinical commissioning group meet weekly with the new manager and owner to monitor improvements and sustainability at the home. • Primary Care ➢ Work is continuing to develop the primary care dashboard and the dashboard continues to be shared and progressed with member practices. ➢ Following the commissioning of a new provider of primary care services by NHS England in March 2016, GP practices have been reporting that the new service is not adequate, with particular concerns relating to lengthy delays in practices receiving hard copy records for new patients and details were provided of the potential serious quality and safeguarding risks that may arise should the new provider fail to fulfil	

16/09	AGENDA ITEM	Action
	their contractual duties. The Chair of the clinical commissioning group, the Director of Quality and Safeguarding, and the Local Medical Committee have escalated this issue to NHS England but this issue remains unresolved. ➢ Child Protection Case Conferences – The quality improvement committee has received a detailed update on the work being undertaken in relation to GP contractual obligations in relation to attendance and report submissions for initial child protection case conferences. A joint meeting with the Medical Director, Named GP Safeguarding Children and the Designated Nurse Safeguarding Children has taken place to progress concerns around this issue and further details were provided. Chris Hannah expressed concern that the Countess of Chester Hospital NHS Foundation Trust did not meet the any targets within the Advancing Quality – Year end Position 2015/16, and therefore did not receive the financial incentives associated with these targets. Paula Wedd provided the background to this issue, noting that this issue had been raised regularly at the quality and performance meetings with the Trust, although there is no identifiable reason for the continued failure to achieve the annual targets. There has been a lack of clinical ownership and leadership to progress the achievement of the targets and it is believed that a failure to ensure that data is recorded appropriately to show the outcomes achieved is a contributing factor to the continual failure to achieve the Advancing Quality targets. It has been agreed that the Advancing Quality targets will no longer be used and, within the Quality Schedule for the Trust, three key measures have been agreed locally. Kieran Timmins queried whether there is an emerging concern in relation to care homes and the number of homes currently under suspension of admissions. Paula Wedd responded that there is concern around this issue, although it is positive that these issues have been identified and are being addressed. Lee Hawksworth provided details of work being undertaken through programmes in relation to care homes, as this is a current area of focus the clinical commissioning group. Laura Marsh noted that this is a challenging area and longer term, proactive, work is being undertaken, which includes having falls and dementia champions, and integrating care and nursing home staff more fully with community and primary care staff. The governing body: a. received the Director of Infection Prevention and Control Annual Report b. noted the positive practice in developing a Quality Impact Assessment process to support the clinical commissioning group Financial Recovery Plan c. reviewed the issues and concerns highlighted and identify any further actions for the quality improvement committee d. noted the update on the role of primary care in child safeguarding e. noted the recent increased engagement with the clinical commissioning group from our local population through the Complaints and Patient Advice and Liaison Service	

16/09	AGENDA ITEM	Action
77	**FINANCE, PERFORMANCE AND COMMISSIONING COMMITTEE REPORT**	

Dr Steve Pomfret declared an interest in this item, in relation to Primary Care Procurement.

The Chief Finance Officer provided an overview on finance and performance issues and the following points were noted:

- At the end of Month 4, the clinical commissioning group is forecasting a year end deficit of £4.586 million, which has been revised to include the increased funded nursing care costs. There is a potential shortfall of £6.3 million against the financial recovery plan and details of the risks were provided.

- Details were provided of a letter received from NHS England, in relation to a financial stock-take to be undertaken in relation to the Month 5 reporting cycle, which is in addition to the work already required to provide data to NHS England. As a part of the stock-take, Chief Finance Officers are being requested to sign a declaration to confirm that clinical commissioning groups have undertaken all possible steps to ensure the robustness of the year-end forecast and risks have been reviewed in detail. This declaration has not yet been signed, as the current forecast is not judged to be final, and support is being sought from the governing body in the recommendations that this is amended during Month 6.

  Kieran Timmins queried whether there are any emerging details in relation to the Month 4 report and Gareth James responded that the financial data is reviewed on a weekly basis and identified risks are included within the report, with a particular risk noted in relation to non-Countess of Chester Hospital NHS Foundation Trust contracts, where there is a need to implement a similar level of rigor with those Trusts, moving forward.

  Alison Lee queried which other Trusts are impacting on the financial position and Gareth James confirmed that these are Wirral University Teaching Hospital NHS Foundation Trust, Mid Cheshire Hospitals NHS Foundation Trust and Warrington and Halton Hospitals NHS Foundation Trust. Wirral University Teaching Hospital NHS Foundation Trust is the largest risk, and further details were provided on the work being undertaken through the financial recovery plan to address this.

  Steve Pomfret queried whether the length of time a patient is waiting for an appointment at Countess of Chester Hospital NHS Foundation Trust is impacting on the patient's choice to take an appointment at another Trust through the Choose and Book system and Gareth James responded that the data for the first quarter does not support this position, although this may be a risk further in to the financial year.
  Laura Marsh noted that patients will continue to have choice in relation to where they have their appointment, although the implementation of the revised Procedures of Limited Clinical Priority policy can be expected to have an impact on activity and further details were provided.

16/09	AGENDA ITEM	Action
	The Chair noted that appropriate triage of patients and consultant advice prior to referral of a patient to the Chooser and Book system will also have an impact on ensuring that patients are treated appropriately and effectively and Lee Hawksworth provided details on the work being undertaken within the elective care programme to progress this work. • Financial savings of £530,000 have been achieved against an in-year target of £561,000. However, as approximately 80% of the total planned savings are scheduled to be delivered during the second half of the financial year, and this remains as a risk for the clinical commissioning group. Alison Lee noted that, following a meeting of the system leaders group, there is a need for clarity in relation to what financial savings are expected to be delivered within the second half of the financial year, to enable a clearer view of what savings or efficiencies are expected to be achieved each month. Gareth James confirmed that work can be undertaken to produce simplified headlines for each month's expected delivery, to enable a clearer view to be shared. Chris Hannah acknowledged that it is important that additional pipeline savings are identified to bridge the potential financial gap and this issue is scheduled to be discussed in detail at the finance, performance and commissioning committee meeting in October 2016, which will provide additional clarity in relation to a medium term view of the financial position, going forward. The Director of Commissioning highlighted the following points from the financial recovery delivery update: • An overarching programme delivery tracker report has been created to provide a sufficient level of data on the latest position against each programme. An overarching dashboard has also been created, to be utilised in conjunction with the tracker report, to provide oversight of the impact of delivery of the programmes on performance targets and metrics, and it has been agreed that this will be combined with the performance dashboard from 1st October 2016. • Medicines Management Consultation – a significant piece of work has been completed with the support of the Communication and Engagement team, who proactively consulted with the public to understand the impact of stopping the prescribing of treatments for 'over the counter' treatments and medicines for short-term, minor ailments. The committee discussed the responses received from the public around the consultation, the majority of which were in favour of stopping the prescribing of the treatments, and therefore the committee agreed that recommend that, subject to ratification by the governing body, the clinical commissioning group cease to offer the treatments on prescription as of 1st October 2016. In relation to the stopping prescribing of gluten free food, a smaller margin of	

16/09	AGENDA ITEM	Action
	respondents were in favour of ceasing prescribing, the majority in favour was 49% against 41% opposing it, with the remaining 10% undecided. Kieran Timmins noted that a number of respondents would be directly affected by the stopping of prescribing for these treatments and queried whether the clinical commissioning group actively tracks this information. Laura Marsh responded that this information is tracked, where provided. Alison Lee noted that the report states that "Respondents were largely in favour of stopping prescribing treatments for 'over the counter' treatments and medicines for short-term, minor ailments." and queried whether the percentage of those if favour is known. Andy McAlavey confirmed that over 80% of respondents were in favour of stopping prescribing, and Laura Marsh confirmed that the Communication and Engagement team had ensured that the public was made aware of the details of which medications would be affected by the consultation process. • Procedures of Limited Clinical Priority – the committee discussed the commissioning policy currently in place and ensuring that there is a focus and adherence to the policy. However, due to financial pressures, it has been agreed that the clinical commissioning group will work with other clinical commissioning groups across Cheshire and Wirral to jointly undertake public consultation on further amendments/refinements to the policy. The consultation will have a range of options available for public response, although it was highlighted that it is equally important that discussions are also undertaken with clinicians to obtain their views and opinions on the options offered. Subject to governing body approval, it is proposed that the consultation process is launched during September 2016, ideally in partnership with Merseyside clinical commissioning groups. Lee Hawksworth acknowledged that discussions with clinical leads had been challenging at times, but that it was important that these discussions had taken place, and a response is expected by the 16th September in relation to a review of the procedures and options proposed. It was also noted that the clinical leads from Wirral have requested that some procedural areas are removed from the consultation document. Chris Hannah noted that it is important that the consultation and engagement with the public is undertaken on as wide a footprint as possible, at least across Cheshire and Wirral but preferably across Merseyside, to present a consistent and unified policy across the footprint, although it was acknowledged that the consultation may end with clinical commissioning groups may selecting different options based on their financial positions. • Primary Care Commissioning Committee – the committee considered a proposal for the creation of a primary care commissioning committee, from October 2016, to ensure that there is an appropriate focus on primary care and primary care quality and performance issues, and further details were provided. The creation of this committee will also support the move to full delegation proposed for 1st April 2017. The committee recommends that	

16/09	AGENDA ITEM	Action
	the governing body supports the recommendation to create a separate Primary Care Commissioning Committee with effect from October 2016. • Primary Care Escalation and Support Proposal and Best Practice – following in-depth discussion at the committee meeting, the committee has recommended that the governing body ratifies the escalation and support process for primary care, as outlined within the report. The governing body: a. Noted the business discussed and decisions made at the finance performance and commissioning committee meeting held on 1st September 2016. b. Reviewed and challenged the progress of the priority Financial Recovery Programmes of work. c. Approved/ratified the proposal to publicly consult on changes to the Procedures of Limited Clinical Priority policy currently known as the 'Commissioning Policy' in conjunction with Cheshire and Wirral clinical commissioning groups d. Approved the recommendations/outcomes from the public consultation on over the counter medicines and gluten free products, and agreed implementation from 1st October 2016. e. Agreed to support the Chief Finance Officer in the decision to sign the declaration required by NHS England as a part of the Month 6 financial position. f. Approved/ratified the proposal to create a Primary Care Commissioning Committee from October 2016. g. Approved/ratified the primary care escalation and support proposal and best practice.	
78	**CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT**	
	The Chief Executive Officer provided an overview of important clinical commissioning group business which has not been provided in other papers, and the following points were highlighted: • NHS England and NHS Improvement have published a Strengthening Financial and Performance Accountability in 2016/17 document, which identifies NHS providers and clinical commissioning groups that have been placed in financial special measures. The document contains a paragraph that outlines a range of interventions that can be applied under the new special measures regime, which includes the creation of an Accountable Care Organisation, should a clinical commissioning group be disbanded, and further details were provided. • NHS England Recovery Checkpoint and Assurance meetings – Alison thanked staff members involved with the work associated with the assurance and checkpoint meetings required by NHS England, which can be challenging.	

16/09	AGENDA ITEM	Action

- NHS England Application of Formal Directions – the clinical commissioning group has received formal notification of Directions applied to the organisation by NHS England. The formal directions focus on three key areas:
  - Improvement plan – it is disappointing to note that the clinical commissioning group has been directed to produce another improvement plan by the 28th September 2016, which will be undertaken by the Associate Director of Policy and Planning.
  - Financial recovery plan – work will continue on the financial recovery plan, and NHS England is looking to see evidence of the oversight and governance provided by the governing body, and continual engagement of member practices.
  - New appointments to the executive team and the next tier of management – this is to ensure that any changes are identified and reported to NHS England, and further details were provided.

  It is unlikely that the clinical commissioning group will get out of formal directions during this financial year, although it is anticipated that additional clinical commissioning groups will enter formal directions in the coming months.

- Cheshire and Merseyside Sustainability and Transformation Plan – it has been acknowledged that engagement with the public will be vital to the progression of the plan and this work will be led by Midlands and Lancashire Commissioning Support Unit across the wider footprint, with support from the Communication and Engagement team, locally.
  There are four themes which are consistent across Cheshire and Merseyside, which are demand management, unwarranted variation, streamlining back office functions and ways of working, and further details were provided.

Kieran Timmins queried whether there is a need for a mechanism for approval of the improvement plan by the governing body and Alison Lee responded that there is, i.e., whether the entire governing body should be required to provide input, whether approval is delegated to the senior management team, or whether lay members could provide alternative support.
This issue was discussed and it was agreed that approval of the improvement plan will be delegated to the Chief Executive Officer and Chief Finance Officer.

Chris Hannah noted that the plan is not new, but is rather a progression and integration of existing plans in to a consolidated document, and there is a high degree of confidence from NHS England in relation to the viability of the plan. However, it is important to note that the time taken up by providing assurance to NHS England and meeting the evidentiary requirements is disproportionate to the amount of time available for staff to then undertake the work required for progression, and capacity continues to be a challenge to the delivery of these plans.

16/09	AGENDA ITEM	Action
	The governing body: a. Noted the contents of the report; b. Confirmed receipt, and approved the associated actions required by the clinical commissioning group in relation to the formal directions issued by NHS England; c. Ratified the Cheshire and Merseyside Transforming Care Plan d. Delegated approval of the combined improvement plan to the Chief Executive Officer and Chief Finance Officer.	
79	**GOVERNING BODY ASSURANCE FRAMEWORK**	
	The Chief Finance Officer noted that the governing body assurance framework is a significant document for the clinical commissioning group and has been developed by directors, although the risk owners underpin this work. There have been no changes to the reporting of assurance since the July 2016 governing body meeting. However, all departmental risk registers have been updated by risk owners, in-line with the clinical commissioning group's risk management strategy schedule. The paper provides an overview of the process to align the governing body assurance framework to the NHS England Improvement Assessment Framework and the clinical commissioning group's improvement plan from November 2016. The governing body noted the governing body assurance framework as at 9th September 2016 and agreed the proposed realignment of the document from November 2016.	
80	**CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS**	
	The Chief Finance Officer advised that one policy is provided for ratification by the governing body, as proposed by the committee outlined in the covering paper. The governing body approved/ratified the one policy provided.	
81	**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.	
82	**ANY OTHER BUSINESS**	
	There was no other business to be discussed.	

16/09	AGENDA ITEM	Action
	DATE AND TIME OF NEXT FORMAL MEETING	
	The next meeting will take place on Thursday,17th November 2016, at 9.00 am, Lecture Hall, Education and Training Centre, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL	

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 21st July 2016				
16/07/D	**Matters Arising - Item 2016/05/59 – External Auditor Re-procurement Panel –** An update on the progress to re-procure external auditors will be provided to the September meeting of the governing body.	Gareth James	November 2016	Complete An update is included within the Audit Committee Report
16/07/66	**Senate Report –** HCJ and PWi to meet to discuss the future of the senate meeting.	Huw Charles-Jones / Peter Williams	November 2016	Verbal update to be provided to November 2016 meeting.
16/07/67	**Quality Improvement Committee report** a. Governing body to be briefed on outcome of external review of CoCH neonatal unit.	Paula Wedd	November 2016	The report is now scheduled to be shared during November and the governing body will be briefed on the findings of the external review, once available.
	b. Discussions to be held re. ensuring sufficient staff are focussed on issues of care homes and this is to be raised at the Care Homes Quality Group meeting.	Fiona Reynolds	September 2016	Complete
Meeting held on 15th September 2016				
16/09/D	**Matters Arising – Item 2016/05/58 – Primary Care Cheshire** – a number of concerns have now been noted in relation to Primary Care Cheshire's Chair position being operated on a rolling monthly basis and it has been agreed that the three GP network Chairs will progress this issue at the upcoming GP Locality Network meetings.	Steve Pomfret/ Jeremy Perkins/ Annabel Jones	November 2016	Verbal update to be provided to November 2016 meeting.
16/09/75	**GP Network Chair Update** – Representatives from Cheshire and Wirral Partnership NHS Foundation Trust community services to be invited to attend at GP Locality Network meetings.	Laura Marsh	November 2016	Verbal update to be provided to November 2016 meeting.

Item	Action	Owner	End Date	STATUS
16/09/76	**Quality Improvement Committee report – Quality Impact Assessments** – Members of the senior management team to discuss the inclusion of quality impact assessments on the agendas for the CoCH and CWP quality and performance meetings.	Gareth James/ Paula Wedd/ Laura Marsh/ Lee Hawksworth	November 206	Complete This issue has been raised at the quality and performance meetings with both Trusts. Consensus has been reached that QIAs from CCGs and Trusts need to be shared across the health economy, to ensure there is a shared understanding of risks. PW is progressing this work through a bespoke QIA summit.

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 November 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 22nd September 2016. The meeting focussed on two patient stories and the clinical commissioning group's savings plan. The first patient story identified the continued, and possible extended need for Care Coordinators to support patients, their carers and families through the healthcare system to provide information updates and coordinate the delivery of care through one point of contact wherever possible. The second patient story highlighted the need for multi-disciplinary teams to support patients with complex needs who are trying to navigate their own way through the healthcare system and are not being treated holistically as a result. Details of the clinical commissioning group's savings plan were confirmed and the need for staff and public engagement in its delivery recognised.
4.	**Recommendations**	The governing body is asked to note the issues discussed by the Senate.
5.	**Report Prepared By:**	Karen Warren Organisational Development Manager November 2016

Alignment of this report to the clinical commissioning group's corporate objectives	
Corporate objectives	**Alignment of this report to objectives**
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	This report confirms the delivery of Our Savings Plan to the Senate attendees and that discussions took place regarding the engagement of the plan and the savings to be made.
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	The patient stories detailed in the plan demonstrate areas where we, as a healthcare system need to improve our provision of care. Details of follow up actions are detailed in the report.
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	This report confirms discussions took place at the Senate about how changes to patient culture and people taking responsibility for their own health are important aspects of realising our savings plan.
We will commission integrated health and social services to ensure improvements in primary and community care	The patient stories detailed include aspects of primary, secondary and community care which will be addressed.
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	Senate meetings keep a regular focus on patient stories to ensure we focus on improving the delivery of effective care.
We will develop our staff, systems and processes to more effectively commission health services	The patient stories detailed in the Senate report have been circulated within the clinical commissioning group to build their awareness of the specific experiences of care and how we need to improve. This will inform their commissioning decisions in future.

Alignment of this report to the governing body assurance framework			
Risk No	**Risk Description**	**Assurance / mitigation provided by this report**	**Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)**
7.	To lead the development of a shared vision for the health and social care economy	This report confirms the engagement of the Senate attendees with the patient stories told and their desire to make improvements across the health economy. Follow up actions will ensure changes are made as a result of the patient stories presented at the Senate meeting.	No amendment to the risk is proposed but we need to continue to work to increase the attendance at the Senate meetings. Each of our partners is represented but the numbers of people attending could be improved. Senate meetings in 2017 will be developed around the clinical aspects of the sustainability and transformation plans, led by Dr Peter Williams.

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

SENATE REPORT

INTRODUCTION

1. The West Cheshire Senate provides 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, providers and our partners to discuss complex issues of policy and service redesign.

2. This paper provides an overview of the September Senate meeting which gave the attendees the opportunity to hear two patient stories and discuss how poor instances of care could be addressed and improved, and to receive an overview of the clinical commissioning group's savings plan which had recently been published.

CONTENT

Patient Stories

3. This report talks about one of the patient stories in detail.

4. The first patient story was introduced by Brian Green, the clinical commissioning group's Head of Quality and Safety. Brian introduced and welcomed Lucinda to the meeting who came to talk about her grandfather, Reg's experience of care in West Cheshire. Reg's length of stay in the Countess of Chester and Ellesmere Port hospitals was 110 days. As Lucinda addressed the attendees at the Senate meeting, Reg was in the Coronary Care Unit at the Countess of Chester Hospital and medical care had been withdrawn. He was comfortable but would not return home. Sadly, Reg passed away on 25th September.

5. Lucinda reported to the group that "some of what you hear will make you feel proud and some of what you hear will make you feel uncomfortable". Lucinda had not contacted the clinical commissioning group to make a complaint about Reg's care but had contacted us to say "if you think you are commissioning integrated care, you're not" and 'to hold up a mirror to the healthcare economy to show that we have a long way to go'. Lucinda works for a clinical commissioning group and so has knowledge and experience of healthcare systems which informed her observations.

6. Reg was originally discharged from the Countess of Chester Hospital but was readmitted on the 1st June 2016. After two weeks he was moved to Ellesmere Port Hospital which Lucinda originally felt was being inappropriately used for older people who did not warrant a bed at the Countess of Chester Hospital but were unable to go home. Following a recent visit with Karen Rees and Brian Green she now feels the hospital is a good asset and offers a lot of things that she was unaware of when her grandfather was admitted. Lucinda suggested a welcome pack would be useful for patients and their families to tell them about the care and services available at the hospital.

   Update: The Countess of Chester Hospital report the welcome pack is 80% complete and is being led by one of the senior nurses at Ellesmere Port Hospital. The pack is expected to be ready for distribution by the end of November 2016.

7. Lucinda suggested there should be a performance chart on what matters to patients about how patients and families feel. She talked about measuring performance against the 6Cs (care, compassion, courage, communication, commitment and competence) as part of core practice and advised she had seen examples of staff showing care and compassion and also examples of staff not showing this.

   Update: The Friends and Family test asks patients and their relatives if they have been satisfied with their care. These results are published monthly and are displayed outside the ward area. The Discharge to Assess team also complete a questionnaire with patients and their relatives, prior to discharge. This incorporates questions about their care and ensures discharge plans are in place. The results of the questionnaires are reported on the Friends and Family boards.

8. Lucinda reported she had spent a lot of time talking to health professionals and felt they should be using their time and skills more efficiently. She suggested time could be saved by using Care Navigators to contact and update patients and their families with progress. “A Care Navigator does not need to understand all the various systems they just need good people skills.”

9. Reg was discharged home on a Sunday and Lucinda felt there were some good aspects of his discharge and some that were not so good. She reported that double handed carers four times a day felt like Piccadilly circus at the house and talked about healthcare professional’s use of jargon such as “I’m from Rapids” which people with no experience of healthcare might find confusing.

10. Lucinda said “I don’t get that sense of care” and proposed a seventh ‘C’ of ‘culture’. She recognised the difficulty of measuring our performance against that measure and asked “how do you demonstrate a feeling?”.

11. Lucinda suggested patient coordinators would be very useful to support carers and family members in navigating the healthcare system which can be very challenging and recognised that the people in these roles would save time for more senior staff. Brian confirmed that although there are Care Coordinators in community healthcare, they are not yet working in hospital settings.

    Update: There are plans to have Care Coordinators at Ellesmere Port Hospital and there is a Care Co-ordinator working in the Discharge to Assess Hub who is responsible for the co-ordination of admissions and discharges.

12. Steve Pomfret talked about how families are not encouraged to be involved in patient care when they are in hospital and suggested the system needs to work more with families to encourage them to get involved in the day to day care of patients. Lucinda reported staff were trying to do things for her grandfather that he was able to do himself, such as offering to help him shave when they should have been encouraging him to do as much as he could.

13. Mahesh Odiyoor confirmed there are Care Coordinators in place in mental health services who were introduced following a significant incident involving a patient and who have worked well. There are also Care Coordinators in place for the physical health integrated teams.

14. The group discussed patient reported outcome measures and the difficulties in measuring compassion. It was agreed gathering compliments and complaints is a good way to measure progress and it would be good for patients and families to complete a daily view of their care which could then be fed back to staff at their performance reviews.

    Update: The Countess of Chester Hospital has confirmed all complaints, lessons learned and compliments are shared with the relevant individuals and wider staff groups as soon as they are received. Nursing care of all patients is reviewed on a daily basis using the Meditech care plan system.

Our Savings Plan

15. Alison Lee and Dr Huw Charles-Jones provided an update on the clinical commissioning group's savings plan which shows solutions to making savings across the healthcare economy. The group discussed how to get as much engagement around the plan as possible. Alison advised she had taken part in radio interviews and lots of information has been circulated via social media. The group agreed it is as important for staff to engage in the details of the plan, as it is the public.

16. Huw advised the initiatives detailed in the savings plan have been identified to improve patient care and in some instances also make financial savings. A focus on both aspects of the delivery of care is important to modernise the NHS and make it better. It was agreed a big part of making progress is about

changing patient culture, allowing and supporting patients to take more responsibility for themselves.

17. Alison advised the plan had been sent to Practice Managers and Patient Participation Group Chairs. The CCG's Communication and Engagement team circulated the plan to all appropriate groups.

CONCLUSIONS

18. It was agreed patient experience should be kept as a regular item for future Senate meetings and was suggested follow ups to our patient stories could be brought back to review progress on specific cases. The group agreed it would be useful for feedback from clinical groups attached to the sustainability and transformation plan could be linked into Senate meetings and this will be factored into the plans for the meetings next year.

19. Huw reflected on the importance of a quality culture system that builds in compassion and suggested it would be worth having something included in Senate meetings to pick up on good examples. Huw thanked both of our guests for their efforts in sharing their stories and the group for their feedback.

RECOMMENDATION

20. The governing body is asked to note the issues discussed by the Senate.

Dr Peter Williams
Hospital Doctor Governing Body Member

November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

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

2. Title of Report: Primary Care Committee Report.

3. Key Messages:

- The clinical commissioning group is required to spend a total of £3 per head, (£780,000 total for the population of West Cheshire Clinical Commissioning Group), as a one off non-recurrent investment, commencing in 2017/18. This funding is from within existing allocations and can be invested over two years as determined by the clinical commissioning group and included within the GP Forward view return due by 23rd December.

- The Committee were informed about the recurring funding available from 2016/17 for developing the provision of the extended hours service

- The committee were updated regarding progress with the procurement of Frodsham Medical Practice. The contract will be a three plus two year Alternative Provider Medical Services Contract, commencing on 1 April 2017.

- The Wellbeing Service will be procured in 2016/17 to include provision of Self Management courses and peer coaching

- NHS England (Cheshire and Merseyside) will receive funding over the next 4 years to support vulnerable General Practices. The clinical commissioning group has been asked to advise NHS England which practices could benefit from this support.

- The Committee were updated on developments in the use of the primary care dashboard in relation to the Escalation and support policy.

- NHS England provided an update on the management of significant concerns in relation to delivery of services by Primary Care Service England.

4. Recommendation

The governing body is asked to note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 19th October 2016.

5. Report Prepared By:

Laura Marsh
Director of Commissioning
November 2016

Alignment of this report to the clinical commissioning group's corporate objectives

Corporate objectives	Alignment of this report to objectives
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	**The report provides an update on primary care commissioning decisions in a joint commissioning context with NHS England.**
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	**The report provides an update on our primary care quality performance and approach to reduced variation in standards of care.**
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	**The report provides an update on procurement of the Wellbeing service/**
We will commission integrated health and social services to ensure improvements in primary and community care	**The report provides an update on implementation of GP Forward View.**
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	**n/a**
We will develop our staff, systems and processes to more effectively commission health services	**n/a**

Alignment of this report to the governing body assurance framework

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
1	Delivery of financial duties	The report provides an update on required financial investment.	No change
2	Delivery of planned deficit.	n/a	No change
11	Delivery of NHS constitutional targets	The report provides an update on primary care quality performance.	No change

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

PRIMARY CARE COMMITTEE REPORT

INTRODUCTION

1. The Primary Care Committee met for the first time on 19th October 2016. This report provides an overview of the business discussed and decisions made at the committee meeting.

2. The Committee supported the proposed Terms of Reference which have been approved by the Membership Council.

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

4. The Committee noted that the Clinical Commissioning Group still intends to take on full delegation for primary care commissioning from 1st April 2017.

IMPLICATIONS OF PLANNING GUIDANCE

5. The clinical commissioning group is required to spend a total of £3 per head, (£780,000 total for the population of West Cheshire Clinical Commissioning Group), as a one off non-recurrent investment, commencing in 2017/18. This funding is from within existing allocations and can be invested over two years as determined by the clinical commissioning group.

6. This investment is designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time and secure sustainability of general practice.

7. Clinical commissioning groups are required to provide plans outlining their approach by 23rd December 2016 as part of their GP Forward View plan. The existing Primary Care Strategy will be developed to become the Forward View Plan.

8. A paper will be brought to the December 2016 primary care commissioning committee setting out the future plans for agreement. This will include asking the committee for a decision on the timing of providing the £3 per head funding to member practices. The Committee agreed that it is likely we will look to backload the investment to 2018/19 due to the financial position of the Clinical Commissioning Group although this needs to be reviewed in light of the developing plans for 2017/18.

9. The primary care commissioning committee meeting in December 2016 will sign off the GP Forward View Plan before submission on the 23rd December 2016.

EXTENDED HOURS SERVICE

10. The Committee were informed about the recurring funding available from 2016/17 for developing the provision of the extended hours service.

11. NHS England has recently confirmed the ongoing funding arrangements for the enhanced GP extended hours that were funded by the GP Access Fund in 2015- 16. The GP Access Fund scheme was formerly known as the Prime Minister's Challenge Fund and NHS England intend to enable the Prime Minister's Challenge Fund 1st and 2nd wave organisations to continue with the provision of this service and support its 7 day NHS agenda. This funding is being offered to these former Prime Minister's Challenge Fund sites this financial year (pro rata) and in full next financial year (2017-18).

12. The funding from NHS England via the GP Access Fund scheme is dependent upon patients being offered '195 hours per week over and above core hours and any Direct Enhanced Services.' However there is some flexibility in provision not being limited to doctor and nurse hours only. It is therefore suggested that services will include Phlebotomy and dressings clinics, Physiotherapy First service, Wellbeing service, Mental Health Assessment and support service.

13. The allocation for 2016/17 is £1.2million (part year effect) and for 2017/18 (full year effect) equates to £1.8million.

14. The intention is to continue to consult with GP practices, patient participation group Chairs, Healthwatch and other stakeholders and gain their views regarding the proposals to extend hours.

15. The GP Forward View Plan to be submitted on 23rd December 2016 will include our intentions regarding delivery of extended access within West Cheshire.

PROCUREMENT

16. The committee were updated regarding progress with the procurement of Frodsham Medical Practice. It was noted that the service specification had been developed jointly by the Clinical Commissioning Group and NHS England. In addition to the core contract there is a requirement that bidders will provide three services in conjunction with the other GP practices and integrated care team within the Princeway cluster; the acute same day appointment service, the all day visiting service and the care homes service.

17. The contract will be a three plus two year Alternative Provider Medical Services Contract, commencing on 1 April 2017.

18. The Committee noted that for any future GP practice procurements they would be required to sign off the service specification which would enable the opportunity to ensure alignment with the primary care strategy.

19. The Wellbeing Service will be procured in 2016/17 to include provision of Self Management courses and peer coaching to commence on 1st April.

GP RESILIENCE PROGRAMME

20. NHS England (Cheshire and Merseyside) will receive funding over the next 4 years to support vulnerable General Practices; £716,000 in year 1(2016/17) with £358,000 in each of the following 3 years to the end of March 2020.

21. It is the national view that the same approach should be used by clinical commissioning groups that helped identify practices to be part of the Vulnerable Practice Scheme in 2015/16. Practices will also be able to self-refer into the programme.

22. The clinical commissioning group has been asked to advise NHS England which practices could benefit from this support. The committee agreed that to achieve this, the clinical commissioning group should utilise the following indicators;

    a. Significant changes in performance on primary care dashboard
    b. Care Quality Commission rated as Requires Improvement with a number of key domains rated as requires improvement.
    c. Practice results on GP Survey 'Ease of Getting Through on the Phone' (% Not Very Easy and % Not Easy at All)
    d. Practice results on GP Survey 'Would You Recommend Your Practice to Someone Moving into The Area?' (% No Probably Not and % No, Definitely Not)
    e. Practice have experienced difficulty in recruiting/replacing staff

GP QUALITY

23. The Committee were updated on the primary care dashboard. The dashboard gives practices the ability to determine if they are performing above or below their peers, and whether they have improved or deteriorated from the previous year. The thematic areas that are monitored are as follows:

    a. Planned Activity (including outpatients, follow-ups and procedures of limited clinical value)
    b. Emergency Activity (including admissions, accident and emergency attendances and acute visiting service usage)
    c. Primary Care Quality (including Care Quality Commission status, GP Survey, Friends and Family Test, Datix and Safeguarding)
    d. Primary care commissioning for quality and innovation scheme (achievement of key performance indicators to increase the number of vulnerable patients who are assessed as frail and have a care plan in place) e) Clinical quality (including flu vaccinations, falls and screening as well as childhood immunisations,)
    e. Medicines Management (including number of items, cost and usage of antibiotics).

24. The primary care escalation and support policy was signed off by the Governing Body in October and following discussion with GP Networks has now been fully implemented. This has enabled practice performance to be linked to the financial recovery plan, for example where practices are outliers for elective activity they are being encouraged to implement the referral support mechanisms (e.g. use of the virtual basket) as part of their action plan.

25. An issue has been raised via the GP quality group that Significant Event Analysis is not always being consistently reported to the clinical commissioning group by GP practices or shared with internal practice colleagues in order to foster improved quality and safety. As a result Dr Riley, Clinical Lead for Primary Care Quality is focusing on sharing learning from thematic areas of patient safety incidents, particularly relating to issues with process, omission and administration and a summary version of the NHS England Incidents Policy that has been circulated to all practices.

26. Following an OJEU procurement process NHS England awarded a contract for Primary Care Support services to Capita which commenced on 1st September 2015. Primary care Support Services provide a range of back office functions to primary care contractors. Historically the service was provided from a number of sites across England and there was a high level of variation in the support services offered and how they were delivered. The service therefore required significant modernisation and transformation to provide a nationally consistent service within a defined cost envelope.

27. Significant progress has been made to a more rationalised service but this has not been without issue or incidents. NHS England primary care commissioners, local service users and local representative committees have all expressed a range of concerns about the approach.

28. NHS England has attempted to established regular monthly oversight and management processes to oversee the operational performance and transformational changes to the service and to review and hold Capita to account for operational performance and their transformation plans. Due to a lack of progress these have escalated to daily performance meetings.

29. NHS England has recently commissioned an assurance review to look at the interfaces between Primary Care Services England and local stakeholders to ensure that robust mechanisms exist for the feedback and resolution of local issues and promote more proactive communications. In addition a team of NHS England subject matter experts have been appointed to work even more closely alongside the Capita team to help advise, provide necessary business knowledge and more quickly identify and resolve issues.

PRIMARY CARE ESTATES

30. The application process for the Estates and Technology Transformation Fund has now been through the first round of review with NHS England. All of the West Cheshire projects have made it to the next round and we will be advised of the next steps over the coming weeks. The funding request submitted to the Estates and Technology Transformation Fund comes to a total of £27,940,000.

31. Discussions with NHS England support our suggested plan of some projects being transformational, some being improvements and others being NHS Property Services customer capital.

32. The clinical commissioning group meet with Cheshire West and Chester Council, Countess of Chester Hospital NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and NHS Property Services to ensure that all our estates work better together to maximise space and maintain funding in the public sector.

RECOMMENDATIONS

33. The governing body is asked to note the business discussed and decisions made at the Primary Care Commissioning committee meeting held 19th October 2016.

Laura Marsh
Director of Commissioning
November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1. Date of Governing Body Meeting 17th November 2016

2. Title of Report: Quality Improvement Report

3. Key Messages:

- The Countess of Chester NHS Foundation Trust has completed a thematic review of non-compliance with the National Safety Standards for Invasive Procedures and the Trust has developed an action plan with targeted actions to reduce the number of incidents reported.
- Crawfords Walk was closed for admissions temporarily and following a number of improvements it is now open.
- NHS West Cheshire Clinical Commissioning Group has reviewed all of the residents in Atherton Lodge who receive funded nursing care payments and plans are in place to move all these residents with nursing care needs by December to new homes.
- GP attendance at Child protection Case Conferences in the last 6 months has declined. GPs are meeting the requirement to submit reports for initial child protection case conferences. Action needs to be taken in a number of practices to improve the number of reports submitted for review conferences.
- We have a statutory duty to ensure children in care have up to date health assessments and we are working with partners to ensure this is done in a timely way.
- The national Transforming Care for People with Learning Disabilities programme of work requires us to have close oversight of the care of people in an inpatient facility.

4. Recommendations The governing body is asked to:

a. review the issues and concerns highlighted and identify any further actions for the quality improvement committee
b. improve the position that to date 6 out of 16 governing body members have completed the training and at 37.5% this is below the expected 80% compliance rate
c. note the actions to improve the timeliness of the health assessments completed for children in care
d. note the local programme of work with regard to transforming care for people with learning disabilities

5. Report Prepared By: Paula Wedd
Director of Quality and Safeguarding

Alignment of this report to the clinical commissioning group's corporate objectives

Corporate objectives	Alignment of this report to objectives
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	**This report highlights variations in practice that impact on patient safety and actions to mitigate risk.**
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	
We will commission integrated health and social services to ensure improvements in primary and community care	
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	
We will develop our staff, systems and processes to more effectively commission health services	

Alignment of this report to the governing body assurance framework

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
5	**Failure of commission safe, effective and harm free care from Providers**	**This identifies how:** ***risk to the delivery of neonatal services is being mitigated through changes in the delivery of critical care services to high risk babies** ***risk to the consistent performance against the national safer surgery practice guidelines is being managed by the Countess of Chester Hospital**	**No change**

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
6	**Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children**	**This report identifies how escalation process across partners have delivered an improvement in the number of children in care with an up to date health assessment**	**No change**
7	**Failure to ensure robust arrangements are in place for the safeguarding of adults at risk**	**This report identifies how risk in care homes is being mitigated through closure to admissions and close surveillance.**	**No change**

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 a number of issues to be brought to the attention of the governing body from its meeting on 20th October 2016.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Neonatal services

4. In July 2016 the Trust temporarily changed the admission arrangements for the neonatal unit to focus predominantly on lower risk babies, who are born after 32 weeks. This decision was taken with the support of the regional Cheshire and Merseyside Neonatal Care Network.

5. The Trust had a Care Quality Commission inspection in February 2016 and the results published showed no concerns about the outcomes for babies cared for in this unit. Nevertheless, there has been an increase in neonatal mortality rates for 2015 and 2016 compared to previous years in babies with high dependency needs. In light of this the Trust has commissioned an independent review of their neonatal service from the Royal College of Paediatrics and Child Health and The Royal College of Nursing, which was completed by the end of September.

6. The Trust had advised that this report was due in October and would be shared rapidly upon receipt by Trust directors with the Director of Quality and Safeguarding from the clinical commissioning group and NHS England who commission the service. The Trust has now advised that this will be shared in November. The findings of the review will be shared with the committee and the governing body will be briefed on the outcome of the report.

Never Events

7. Since May 2016 the Trust has reported three Never Events. In addition to these surgical related Never Events the Serious Incident Review Group had observed a rise in surgery related incidents. As a consequence the Trust Medical Director was asked by the Director of Quality and Safeguarding for a single action plan articulating the quality improvements needed to deliver consistently against the national safer surgery practice guidelines.

8. The Trust provided this thematic review and associated action plan, and it was shared in full with the committee. The Trust Medical Director will be asked for updates on progress against this action plan at the contract Quality and Performance meetings.

9. The document identified the main findings from a thematic review of non-compliance with the National Safety Standards for Invasive Procedures and the committee received assurance that there are targeted actions in the following areas:

    a) Governance and audit - continue to audit compliance with the World Health Organisation Safer Surgery processes
    b) Documentation of invasive procedures - work underway with regard to electronic consent processes
    c) Workforce - develop and support staff with regular multi-disciplinary training that promotes teamwork and includes clinical human factors
    d) Scheduling and list management - further work is required to document the process for the listing of procedures
    e) Procedure verification and site marking – this practice will be extended to include anaesthetic block sites
    f) Safety briefing/pre-list briefing – focus on the presence of the whole theatre team during safety briefing/pre-list briefing
    g) Prevention of retained foreign objects – ensure documentation to record the counting of instruments and swabs is sufficiently robust across all clinical areas

Mortality Reviews

10. The Trust has an established mechanism for reviewing all in hospital deaths which is led by their Medical Director. As part of this process the Medical Director identifies patients that the clinical commissioning group need to review relating to decisions made by primary care both in hours and out of hours to refer the patient to hospital and care homes to call ambulances. The clinical commissioning group Medical Director has established a process for these commissioning lead reviews to take place in a timely way. The learning from these reviews will be shared with the committee.

Incident Management

11. The committee were informed that the Trust has been unable to respond in a timely way to requests for information about incidents reported by primary care and this has been escalated for resolution to the contract Quality and Performance meetings.

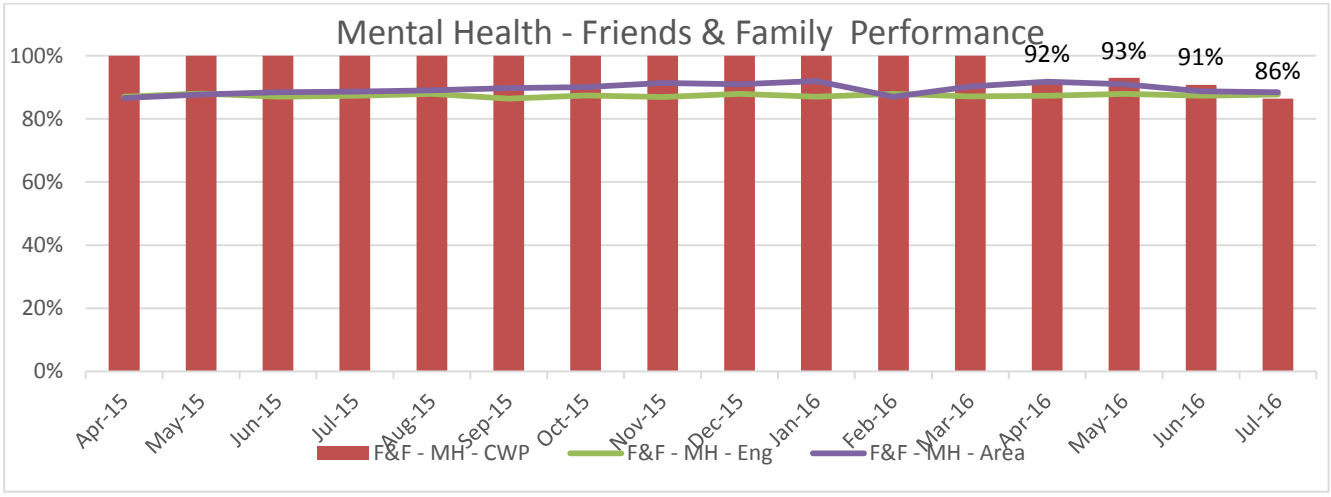
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

Friends and Family Test

12. Due to the flexibility organisations have over the degree and frequency of promotion of the Friends and Family test survey in mental health services there is no target for response rates. However the quarter one results for the Trust were very low at a response rate of 1% and the committee were assured that this was explored at the contract Quality and Performance meeting. Since the committee met the latest figures for August 2016 show an encouraging increase in the response rate to 2.8%, which is higher than the England average.

13. The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

14. The April to July 2016 results for the Cheshire and Wirral Partnership NHS Foundation Trust showed a decrease in those service users who would recommend the service to family and friends. The committee were advised that this trend will be monitored closely in the next quarter and will be discussed at the next contract Quality and Performance meeting. Since the committee met the latest figures for August 2016 show an increase in the percentage of service users who would recommend the Trust from the previous quarter, and at 92.4% was above the national average of 87.9%.



BRITISH PREGNANCY ADVISORY SERVICES

15. British Pregnancy Advisory Services hold a standard one year NHS Standard Contract covering 11 commissioners across the Cheshire and Merseyside area, including NHS West Cheshire Clinical Commissioning Group. In April 2016, NHS Halton Clinical Commissioning Group, in partnership with NHS Liverpool Clinical Commissioning Group, was asked by NHS England (Cheshire and Merseyside) to undertake a thematic review of serious incidents relating this service.

16. This report was reviewed by the NHS West Cheshire Clinical Commissioning Group Serious Incident Review Group and the clinical lead for maternity services in October 2016. The Committee were advised that this group were requesting further assurance in respect of the report findings, recommendations and action plan from NHS Halton Clinical Commissioning Group who are the lead commissioner on our behalf.

17. The Care Quality Commission also completed an unannounced inspection of British Pregnancy Advisory Services on 9th June 2016, although the final report has not yet been published. The committee have asked for an update at their next meeting.

CRAWFORDS WALK NURSING HOME

18. This is a large care home which is part of the BUPA care home group, with capacity to deliver care to over one hundred and thirty residents. The Care Quality Commission report that following their visits in September 2015, March and May 2016 that improvements have been made. However their inspectors are not yet assured that the improvements being undertaken are sustainable. The published report July 2016 rated the care home as requires improvement across all 5 domains and is not meeting all of its regulated activities.

19. In June 2016 Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group applied a breach in contract resulting in suspension of admissions to Crawfords Walk. There is evidence of sustained improvements in three of the four houses and the suspension of admissions has now been lifted in those three houses. A voluntary suspension remains in place for the one remaining house.

20. Quality monitoring visits by Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group are continuing. The visits monitor improvements by testing the sustainability of the assurances being provided.

ORCHARD MANOR

21. Orchard Manor is a care home owned by Fordent Properties Ltd. They are registered to provide both residential and nursing care for up to 90 residents, divided into six units. Three of the units provide general nursing care and three units for dementia care.

22. In May 2016 Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group applied a breach in contract resulting in suspension of placements for Orchard Manor. The local health and social care partners provided support and mentoring to the home manager and staff.

23. A phased lifting of the suspension was introduced in July 2016 and they are accepting a limited number of admissions per week.

24. Continued quality monitoring visits are in place, undertaken by Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group to monitor improvements and sustainability.

ATHERTON LODGE

25. Atherton Lodge is a care home owned by Par Nursing Ltd. They are registered to provide both residential and nursing care for up to 40 residents.

26. In July 2016 Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group applied a breach in contract resulting in suspension of placements.

27. NHS West Cheshire Clinical Commissioning Group reviewed all of the residents who receive funded nursing care payments and plans are in place to move all these residents with nursing care needs by December to new homes.

28. The Care Quality Commission has yet to confirm Atherton Lodge's future registration activity.

CHESTER LODGE

29. Chester Lodge is a care home owned by Heathbrock Ltd. The home provides residential and nursing care for up to 40 people. In July 2016 a safeguarding enquiry under section 42 of the Care Act 2014 commenced. Cheshire West and Chester Council, supported by NHS West Cheshire Clinical Commissioning group agreed with the owner to suspend admission of placements whilst this investigation is still on-going.

30. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group are supporting the current manager and Clinical Lead to review the improvements required to provide assurances relating to people who are at risk of falling and sustaining injury.

CHILDREN'S SAFEGUARDING AND CHILDREN IN CARE

Serious Case Review 01 / 2014 Child A

31. The committee were advised that the multi-agency action plan for Child A is nearing completion. The Local Safeguarding Children Board will be writing to all partners to ask for information about the impact of the Serious Case Review on practice and any single agency actions/changes implemented in light of the learning from these reviews.

32. The committee received an update on the actions and learning that has taken place in the GP practice involved in this Serious Case Review. This includes a review of their Did Not Attend Policy - non-attendance to the practice as well as non-attendance at hospital appointments has been included. Plus identification of looked after children has been improved in the practice and timely follow up of registration with a GP is ensured when a child / family moves from the practice.

Serious Case Review 01 / 2015 Child B

33. The Serious Case Review report was published in August 2016. The actions plan is progressing and is overseen by the Local Safeguarding Children Board Audit and Case Review Sub-Group.

34. This review took place following the death of Bryony (pseudonym). A post mortem found that Bryony had died from an overdose. There were no suspicious circumstances surrounding her death.

35. The independent review of mental health services that was commissioned by the Coroner has been completed and the Local Safeguarding Children Board Business Manager has circulated this to all interested parties in the case. There is no new learning to that which is contained with the Serious Case Review report.

36. The review was complex. The learning for health partners and other agencies included:

    a) The need for all professionals to be familiar with the principles of Risk and Vulnerability, and have means to assess their work with children and families (for example the Risk and Vulnerability Matrix).
    b) Risk assessment, risk management and safeguarding practice should adopt a 'Think Family' approach across Children's and Adult's Social Care.
    c) Practitioners need to consider the needs of Young Carer's that particularly addresses risks and vulnerabilities.
    d) Professionals need to be aware of the links between self-harm and suicide in young people.
    e) We need to listen to the voice of the child.

f) Information sharing in relation to the notification of children in care placements, both across the health economy and with wider partnership agencies needs to be improved.

37. The Local Safeguarding Children Board will shortly be writing to all partners asking for information about the impact of the Serious Case Review on practice and any single agency actions/changes implemented in light of the learning from the review. Progress updates will be provided to the committee.

Safeguarding Children Training – Governing Body level training

38. *'Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document Third edition: March 2014'* requires that all governing body members must have a level of knowledge equivalent to all staff working within the healthcare setting (level 1) as well as additional knowledge based competencies by virtue of their governing body membership.

39. A training package was made available to all governing body members from July 2016 for completion by 31st August 2016. A reminder and extension date of 31st September 2016 was circulated. The committee wants to alert the governing body that to date six out of sixteen governing body members have completed the training and at 37.5% this is below the expected 80% compliance rate.

GPs and Child Protection Case Conferences

40. The committee was updated on the completion of the collaborative work undertaken by the Named GP Safeguarding Children and four GP practices to review the format of the GP child protection case conference report template. While the template format remains the same it now contains prompts in each box to trigger thought and to support GPs to provide a better quality report. Lead GPs and practice managers have been alerted to the change and the template is available via the Local Safeguarding Children Board website.

41. At the time of the report to the committee it was not possible to report on quarter 2 data on attendance at initial child protection case conferences and submission of reports for initial and review child protection case conferences. This data is now available. Table below demonstrates that during quarter 2 we have seen a further decline in attendance at initial child protection case conferences, and while the submission of reports for initial case conferences has met the 75% compliance standard, the submission rate for review child protection case conferences has reduced to 54%. Following the changes to funding to support GP attendance at case conferences the 3 local GP Networks supported the commitment for practices to provide reports to all child protection case conferences. The data shows that this commitment is not being met.

42. The data continues to be shared with the Local Safeguarding Children Board. The reason for the decline in attendance at initial child protection case conferences, as reported by the GPs has been brought to the attention of the Local Safeguarding Children Board Quality Assurance sub-group.

Table to show 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 3 2015 / 16	22% (9 out of 41 conferences)	76% (31 of 41 conferences)	50% (23 out of 46 conferences)
Quarter 4 2015 / 16	31% (11 out of 35 conferences)	80% (28 out of 35 conferences)	55% (35 out of 64 conferences)
Quarter 1 2016 / 17	11% (2 out of 18 conferences)	72% (13 out of 18 conferences)	59% (36 out of 61 conferences)
Quarter 2 2016 / 17	6% (1 out of 18 conferences)	78% (14 out of 18 conferences)	54% (28 out of 52 conferences)

Children in Care

43. The committee received an update on our statutory duties in relation to our children in care and wants to highlight the following information to the governing body.

44. The child in care population for Cheshire West and Chester steadily decreased during 2015-16 and was 8.3% less by December 2015 (463) compared to December 2014. This number has risen during Quarter 1 and 2 of 2016-17 to 484 as of 30th September 2016.

45. It is a statutory requirement for all children who become Looked After to have a holistic health assessment on entering care. This initial health assessment should result in a health plan by the time of the first review of the child's care plan, 20 working days after becoming looked after. During their time in care children who are under 5 years of age have a review health assessment every six months and children and young people over 5 years have annual review health assessments (Promoting the health and well-being of looked after children statutory guidance for local authorities, clinical commissioning groups and NHS England DoE / DoH 2015). The Clinical Commissioning Group has a duty to cooperate with requests from the local authority to undertake health assessments.

46. Timescales and quality of all Health Assessments for Children in Care are monitored regularly and reported on the Countess of Chester Hospital NHS Foundation Trust and the Cheshire and Wirral Partnership NHS Foundation Trust Safeguarding Assurance Frameworks.

47. Table below shows the Health Assessment data recorded on the local authority monthly performance report for Quarter 2 2016-17 for all children in care for 12 consecutive months or more. In summary the percentage of children with an up to date Health Assessment for Quarter 2 was 80.0% in comparison to 78.0% for Quarter 1.

Source: Cheshire West and Chester local authority

Performance Indicator	England (latest)	Statistical Neighbour (Latest)	North West (Latest)	CWAC 2015/16	CWAC Q2 2016/17	Direction of Travel (against previous Quarter)
Percentage of children looked after for at least 12 months with a recent health assessment	89.7%	85.5%	90.9%	77.3%	80.0%	↑

48. The committee receives regular updates on this position and whilst it is acknowledged that focussed partnership working to improve this performance has been delivered by the Designated Nurse and Doctor for Children in Care, Cheshire and Wirral Partnership NHS Foundation Trust and the local authority, this is still an inadequate performance against a statutory duty.

49. Further partnership working has taken place to establish on a month by month basis the number of older young people who have declined a health assessment. This data started to be reported monthly during August 2016. Currently there are 20 health assessment declines recorded. Work is underway by the Children in Care Health Team to develop a more proactive and flexible approach to reach these young people and provide them with the health information that they need as they move to independence.

50. The process of ensuring that a child in care has a health assessment relies on children's social care initiating a timely request to health partners. The committee have previously been alerted to recurrent challenges in social care meeting that requirement and the impact this had on the timeliness of the completion of health assessments for West Cheshire children in care, placed both in and out of area. Consequently the escalation process for late health assessment requests from children's social care was strengthened. This has resulted in a significant improvement in the timeliness of requests and the ability of Cheshire and Wirral Partnership NHS Foundation Trust to undertake the assessments.

51. The percentage of Review Health Assessments completed by Cheshire and Wirral Partnership NHS Foundation Trust on West Cheshire Children in Care within statutory timescales for Quarter 1 2016 – 17 was 82.6%. The percentage of Review Health Assessments completed for West Cheshire Children in Care by other clinical commissioning groups (our children placed out of area) for Quarter 1 was 30.4%.

52. The committee were advised that further assurance has been requested from the Trust by the Designated Nurse regarding the escalation of Review Health Assessments, which have been commissioned for completion by other clinical commissioning groups and completed out of statutory timescales. The committee will receive an update on progress against this important duty.

Dental checks

53. This data has been obtained from the local authority children information system. Dental check data for Quarter 2 2016-17 was 64% which remains unacceptably low in comparison to statistical neighbours and national data as demonstrated in table below although slightly better than Quarter 1 at 63.4%.

Source: Cheshire West and Chester local authority

Performance Indicator	England (latest)	Statistical Neighbour (Latest)	North West (Latest)	CWAC 2015/16	CWAC Q2 2016/17	Direction of Travel (against previous quarter)
% of children looked after for at least 12 months with recent dental check (snapshot)	85.8	79.8	85.7	71.2	64.4%	↑

54. Dental checks for every child in care should be accurately reported by their carer's to the child's social worker during every statutory visit and recorded on the local authority system. Dental check dates should also be discussed and recorded during every statutory health assessment and an action identified on the health plan if the child/young person is not up to date or there are any other problems accessing appropriate dental care.

55. Dental checks and health plans should also be scrutinised by the child/young person's Independent Reviewing Officer and challenged if a date is not recorded or the health plan does not accurately reflect the health needs of the child with timely health actions identified.

56. The committee were advised that further assurance on dental checks has been requested by the Designated Nurse for Children in Care.

Unaccompanied Asylum Seeking Children

57. The Interim National Transfer Protocol has been created to enable the safe transfer of Unaccompanied Asylum Seeking Children from 1 local authority (the entry local authority from which the unaccompanied child transfers) to another UK local authority (the receiving local authority) from 1st July 2016. The Interim National Transfer protocol provides guidance on the operation of the National transfer scheme and the way in which local authorities can transfer Unaccompanied Asylum Seeking Children into the care of another local authority under the Immigration Act 2016.

58. The key principle of the transfer scheme is to achieve a fairer distribution of unaccompanied children through a scheme which is equitable and transparent across all local authorities and regions. The new Interim National Transfer Protocol requires each local authority in England to be responsible as the Corporate Parent for a number of Unaccompanied Asylum Seeking Children which equates to 0.07% of the general local 0-18 years population. This equates in Cheshire West and Chester to approximately 50 children and young people.

59. The local authority has not been advised of timescales for the movement of these children yet but is in the process of planning to receive and care for the children and young people as Children in Care. Many of these young people will have experienced significant trauma and physical health difficulties because of their lived experiences and asylum seeking journeys.

60. The movement of the Unaccompanied Asylum Seeking Children may impact on local health services for children such as Child and Adolescent Mental Health Services, Primary Care, Secondary Care and the Specialist Children in Care Health Services. Timely accurate notification by the local authority to the clinical commissioning group of any Unaccompanied Asylum Seeking Children will be key to effective planning of resources for this most vulnerable group. Access to Unaccompanied Asylum Seeking Children health website will make available expert guidance and advice i.e. Child and Adolescent Mental Health Services competency framework for Child and Adolescent Mental Health Services Practitioners working with Unaccompanied Asylum Seeking Children.

61. The Multi-agency Children in Care Strategy Group has agreed to consider Unaccompanied Asylum Seeking Children as a standard agenda item so that any identified gaps in services, challenges and risks can be discussed at a multi-agency strategic level.

TRANSFORMING CARE FOR PEOPLE WITH LEARNING DISABILITIES

62. The committee received a report updating The Transforming Care for People with Learning Disabilities programme of work. The five areas in the Transforming Care programme are:

    a) Empowering individuals – giving people with learning disabilities and/or autism, and their families, more choice and say in their care
    b) Right care in the right place – ensuring that we deliver the best care now, including a new approach to care and treatment reviews, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning
    c) Regulation and inspection – tightening regulation and the inspection of providers to drive up the quality of care
    d) Workforce – developing the skills and capability of the workforce to ensure we provide high quality care
    e) Data and information – making sure the right information is available at the right time for the people that need it, and continuing to track and report progress

63. West Cheshire Clinical Commissioning Group is part of the Wirral and Cheshire Delivery Hub of the overarching Cheshire and Merseyside Transforming Care Partnership and has worked with the other clinical commissioning groups across Cheshire and Wirral to develop a new service model.

64. The committee were assured that there are plans in place for the 13 people who are currently being cared for in an in-patient setting. NHS England requires each clinical commissioning group to hold a register of the start date of an admission, predicted discharge date, actual discharge date and Care Treatment Reviews. The clinical commissioning group has this information and it is updated regularly on the NHS Data Assuring Information Site.

65. The clinical commissioning group also works with providers and community teams to ensure people are not admitted unnecessarily using the 'blue light' protocol. This ensures that any admission into a Learning Disability Assessment and Treatment Unit or Mental Health inpatient facility is supported by a clear rational of planned admission and treatment with measurable outcomes. It ensures all parties work together with the person and their family to support discharge into the community. It ensures each person has a person centred plan and any barriers to discharge are overcome.

66. The clinical commissioning group is developing a robust 'risk of admission' register with the Local Authority and Cheshire and Wirral Partnership NHS Foundation Trust to monitor all residents with a learning disability who may be 'at risk of admission' to hospital.

RECOMMENDATIONS

67. The governing body is asked to:

a) review the issues and concerns highlighted and identify any further actions for the quality improvement committee
b) improve the position that to date 6 out of 16 governing body members have completed the training and at 37.5% this is below the expected 80% compliance rate
c) note the actions to improve the timeliness of the health assessments completed for children in care
d) note the local programme of work with regard to transforming care for people with learning disabilities

Paula Wedd
Director of Quality and Safeguarding
November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

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

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

3. Key Messages:

- At the end of September 2016 the year-end financial forecast has been changed to £7.886 million deficit.
- In addition to our key duty of financial balance, we will also not operate within our running cost allowance.
- The most significant financial risk this year is the financial pressure relating to contracts with other (non-Countess) hospitals.
- Delivery of the revised deficit is dependent on delivery of the original £12.8 million financial recovery plan and £3 million of additional, or 'pipeline', savings. At the end of September 2016 we have delivered £975,000 savings against a profiled savings plan of £1.135 million.
- As of August 2016 we are failing to deliver 6 performance measures (Diagnostics, Cancer waiting times (31 and 62 days), Accident and Emergency, Ambulance calls, Methicillin-resistant Staphylococcus aureus and Improving Access to Psychological Therapies recovery. Plans have been agreed to recover performance and deliver the measures by 31st March 2017.

- Concern regarding engagement by Consultants in the implementation of the virtual basket and Consultant Connect is being escalated to Systems Leaders Group.

- The emergency preparedness, resilience and response policy has been updated in line with changes required by NHS England. The clinical commissioning group has also updated the business continuity plan.

- The Committee reviewed the Commissioning Intentions for 2017/18.

4. Recommendations

The governing body is asked to:

a. Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 3rd November 2016.

b. Review and challenge the progress of the priority Financial Recovery Programmes of work.

c. Note the changes to the emergency preparedness, resilience and response policy and the updated business continuity plans

d. Review the work to date on Commissioning Intentions.

5. Report Prepared By:

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

November 2016

Alignment of this report to the clinical commissioning group's corporate objectives	
Corporate objectives	**Alignment of this report to objectives**
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	**The report provides an update on performance against financial duties and on our priority programmes which support the delivery of financial sustainability.**
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	**The report provides an update on our priority programmes which will deliver reduced variation in standards of care.**
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	**The report provides an update on our priority programmes which will support patients taking control of their health and wellbeing.**
We will commission integrated health and social services to ensure improvements in primary and community care	**The report provides an update on our priority programmes that focus on integration.**
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	**The report provides an update on our performance against constitutional standards and locally agreed performance measures and our priority programmes which will deliver improved hospital services and achievement of constitutional targets.**
We will develop our staff, systems and processes to more effectively commission health services	**The report provides oversight of how we use our staff, systems and processes that enable effective commissioning.**

Alignment of this report to the governing body assurance framework			
Risk No	**Risk Description**	**Assurance / mitigation provided by this report**	**Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)**
1	**Delivery of financial duties**	**The report provides an update on financial performance to the end of September 2016**	**No change**
2	**Delivery of planned deficit.**	**The report provides an update on financial performance to the end of September 2016.**	**No change**
11	**Delivery of NHS constitutional targets**	**The report provides an update on performance to the end of August 2016.**	**No change**

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

FINANCE, PERFORMANCE AND COMMISSIONING COMMITTEE REPORT

INTRODUCTION

1. This report provides an overview of the business discussed and decisions made at the finance performance and commissioning committee meeting held on 3rd November.

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

FINANCE AND CONTRACTING PERFORMANCE FOR THE PERIOD ENDED 31ST SEPTEMBER 2016

3. The Chief Finance Officer provided an update on financial performance at the end of September 2016 and delivery of the 2016/17 financial recovery plan savings target
.

4. At the end of September 2016 the year-end forecast has been changed to £7.886 million deficit. This represents a deterioration of £3.3 million and follows a financial 'deep dive' undertaken by NHS England at the end of month 5 (August 2016). The revised financial forecast can be analysed as follows:

	£M
Original financial plan	**3.278**
Return of 2015/16 surplus	(-)0.092
NHS funded nursing care pressure	1.400
Forecast reported for month 4 and 5	**4.586**
Additional financial pressure	3.300
Forecast reported at month 6	**7.886**

5. The following table reports performance against our financial duties at the end of September 2016:

West Cheshire Clinical Commissioning Group Financial Performance Summary - 30th September 2016

Performance measure	Description	In-Year Performance	Forecast Performance
Delivery of financial duty	Operate within allocation	RED	RED
Delivery of NHS 'business rules'	CCGs expected to deliver minimum 1% surplus	RED	RED
Delivery of planned deficit	Target of £3.186 million deficit	RED	RED
Delivery of revised deficit (incl. FNC)	Target of £4.586 million deficit	RED	RED
Delivery of revised deficit (M06)	Target of £7.886 million deficit	AMBER	GREEN
Delivery of financial recovery plan	Total savings target of £16.1 million	RED	RED
Running cost allowance (RCA)	Financial duty to operate within RCA	RED	RED
Capital allowance	Operate with capital allocation	GREEN	GREEN
Better payment practice code	Payment of 95% of invoices within 30 days	RED	GREEN

6. In addition to our key duty of financial balance, we will also not operate within our running cost allowance.

7. A detailed financial forecast is repeated each month. The forecast at the end of September 2016 can be summarised as follows:

Budget	FOT (£M)	Description/underlying assumptions
Prescribing	0.2	Based on prescribing information to the end of August 2016.
Secondary care contracts – other contracts	2.7	The forecast is based on M5 data and remains unchanged.
Secondary care contracts – negative reserve	4.0	Majority relating to 1% headroom inclusion in Countess block contract.
Complex care – in-year pressure	0.4	Potential additional FRP opportunities to mitigate. FNC pressure (now factored in).
Complex care – FNC	1.4	
Joint commissioning	0.6	BCF Care Act saving. Position reflects a negotiated settlement of C£300,000.
Running Cost Allowance	0.2	Currently forecasting £0.4 million pressure. Recent executive scrutiny is expected to mitigate this pressure by £200,000.
Contingencies – 0.5%	(-)1.7	0.5% contingency.
Planned deficit	3.2	
Other budgets	(-)0.1	Assume other budgets and non-recurrent measures will deliver £0.1 million mitigation.
FRP pipeline	(-)3.0	
Sub-total	**7.9**	Revised year-end forecast at month 6

8. The committee considered the assumptions that currently underpin the financial forecast and the actions required in order to deliver the revised forecast. The key issues discussed are as follows:

- The current forecast overspend against the prescribing budget will need to be mitigated by the nationally negotiated reduction in the price of generic medicines.

- The in-year secondary care financial risk will be mitigated down to £2.7 million by the actions being taken with neighbouring (non-Countess of Chester) acute hospitals.

- Financial pressure of complex care packages will not exceed current forecast of £0.4 million.

- A reduction of £300,000 in the Care Act contributions to Cheshire West and Chester Local Authority.

- Delivery of £3 million savings with the implementation of the recovery pipeline of projects.

9. The most significant financial risk this year is the pressure relating to contracts with other (non-Countess) trusts. Based on activity during the first 5 months of the financial year, the potential pressure is in excess of £4 million. It is currently forecast that this pressure will be mitigated down to £2.7 million following the full implementation of financial recovery schemes during the second half of the year and the actions being taken with individual hospitals.

10. Delivery of the revised deficit is dependent on delivery of the original £12.8 million financial recovery plan and £3 million of additional, or 'pipeline' savings. At the end of September 2016 we have delivered £975,000 savings against a profiled plan of £1.135 million.

11. The committee considered the various pipeline savings proposals which are planned to deliver additional in-year efficiencies with a total value of £3 million. The success of these additional savings is vital to the delivery of the revised financial forecast.

12. We began 2016/17 with an underlying deficit (or negative run-rate) of £5.9 million. The full delivery of the 2016/17 financial plan, including delivery of £9.3 million recurrent savings, would have meant that we would have ended the financial year with an underlying deficit of £342,000 (and, therefore, virtually financial balance). However, following the deterioration in the financial forecast the closing underlying deficit has increased to £5.042.

PERFORMANCE FOR THE PERIOD ENDED 31ST AUGUST 2016

13. The Committee noted that, at the end of August 2016, the clinical commissioning group is failing to deliver the following 6 performance measures:

- Diagnostics waiting times.
- Cancer waiting times (31 and 62 days).
- Accident and Emergency.
- Ambulance response and handover times.
- Methicillin-resistant Staphylococcus aureus (MRSA).
- Improving Access to Psychological Therapies recovery.

A summary of performance to the end of August is provided here.

14. Concern regarding deterioration in the cancer waiting time performance was discussed. Although performance for the 2 week waits for suspected cancers continues to exceed the target and the clinical commissioning group is performing better than the England average, performance in 62 day waits has been an issue with 8 breaches resulting in an overall non-achievement of the 85% standard. This was primarily due to performance at the Clatterbridge Centre for Oncology and the clinical commissioning group is working with the provider to address these issues.

15. The Committee queried whether, as failure of the target involved Clatterbridge, whether other clinical commissioning groups are also failing the target but it appears not and therefore the pathway/handover between the Countess and Clatterbridge needs further review in light of the revised breach allocation policy that comes into force with effect from October 2016.

16. The 31 day wait performance has worsened this month with the overall target and drug regime treatments both breaching. The clinical commissioning group has submitted an action plan to NHS England in relation to those patients not transferred to other Trusts as part of their cancer pathway, such as Clatterbridge Centre for Oncology, in a timely manner. This action plan is based on the existing Cancer Action Plan at the Countess of Chester Hospital NHS Foundation Trust and focusses on capacity and process within specialty areas, which in turn will assist in the delivery of the targets moving forwards.

17. The Committee noted that there is disparity between the local and national data for IAPT recovery and it is expected that we will achieve the target at the end of quarter 2.

18. It was agreed that the continuing failure to achieve the diagnostics target would be escalated to the Systems Leaders Group in November.

FINANCIAL RECOVERY DELIVERY

19. The committee were assured by the outcomes of the gateway review process, for Starting Well: Maternity and Mental Health/Learning Disabilities, both of which have a resulting increased focus on delivery of efficiencies in this financial year.

20. A summary of the highlights within each programme were reviewed by the Committee:

Starting Well

21. Paediatrics was the first specialty to go live with Consultant Connect. This has been well received by primary care and has had a positive impact on reducing referrals (by 61%). Unfortunately, the Countess of Chester Hospital NHS Foundation Trust has reduced the hours of operation / access to Monday to Friday afternoons only due to internal capacity pressures, paediatrics has temporarily reduced the hours of operation. This is being escalated through discussions between GPs and the Consultants.

Being Well

22. The team have presented to all three GP Network meetings and have invited all practices to submit an expression of interest in rolling out Year of Care and the Acute to Community model. This is following the successful pilot in Ellesmere Port which has demonstrated; a reduction in GP appointments for long term conditions patients under the Year of Care and a reduction in outpatient appointments for Acute to community integration for diabetes. The Acute to Community integration will now focus on respiratory and rheumatology.

23. A successful assurance meeting has been undertaken with NHS England on the roll out of the Diabetes Prevention Programme as they feel we are in a good position to achieve the targeted number of patients successfully completing the programme due to the strong self-care infrastructure we have developed.

Elective Care

24. The pathway portal is now live, with a soft launch. Pathways will continue be added as part of the programme plan. There has been concern regarding availability of consultants to review referrals via the virtual basket. Escalation conversations are taking place with the Trust particularly the potential impact on the Referral to Treatment targets. The Countess of Chester Hospital NHS Foundation Trust Chief Executive has committed to identifying consultant time, by speciality, to support go live in November. The Committee requested that both organisations work to a single project plan going forward. This issue will be escalated again at the Systems Leaders Group as implementation of the virtual basket is critical to the success of the elective care programme.

Urgent / Intermediate Care

25. There has been four week slippage on delivery of the primary care streaming and intermediate care projects. Both projects are due to now go live in November and will be enabled by the Countess of Chester Hospital NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust integrated working plans and work streams. Implementation is critical for west Cheshire in order to have the required resilience to manage the imminent winter period. The Committee asked that the Director of Commissioning reviews the detailed progress of the intermediate care project particularly in terms of the balance between step up and step down beds.

26. The Committee supported the proposal for the Acute Visiting Service to be delivered within the core GP Out of Hours Contract.

Medicines Management

27. As well as continuing with the existing practice-level Quality, Innovation, Productivity and Prevention work, the focus has been on developing a model for repeat prescribing that can be implemented at pace whilst a longer term model is developed. To this end 17 practices have been recruited to implement a 'check and challenge' system that will go live in November 2016 with discussions continuing with the remaining practices.

Complex Care

28. Work is continuing on the delivery of continuing healthcare reviews with additional resources allocated to enable a stretch on the original target to be achieved.

29. The committee were provided with an overarching programme delivery tracker report, available here, that provides the latest position against each of the programmes and their constituent targets. Although this provides sufficient overview, it was agreed that where there was any significant concern with progress or issues that required escalation, these would continue be highlighted separately to the committee. Following refinement of the detail of individual projects within the pipeline, the total expected savings for this financial year equate to £3million.

30. The committee were provided with an overarching dashboard to utilise, in conjunction with the above tracker report, to provide oversight of the impact of delivery of the programmes on performance targets/metrics, available here

31. NHS England Monthly Financial Recovery Checkpoint assurance meeting was held on 27th October 2016. There was positive assurance regarding progress being made on the delivery of performance targets as the Referral to Treatment target is now being achieved. The risk associated with the number of recovery plan projects delivering in the second half of the financial year was discussed however there was assurance that the programme management infrastructure within the clinical commissioning group would support tracking of delivery.

32. The Committee reviewed and supported the emergency preparedness, resilience and response policy which has been updated to meet the changing requirements of the clinical commissioning group from NHS England. The policy and the changes can be found at agenda item WCCCGGB/16/11/91 for governing body ratification. To ensure congruency, our business continuity plan has also been updated and can be found agenda item WCCCGGB/16/11/91 for governing body ratification.

IMPROVEMENT PLAN DELIVERY

33. The Committee reviewed progress since the capacity and capability review. An initial draft Improvement Plan has been submitted to NHS England and the Clinical Commissioning Group are working on a further iteration following feedback.

34. GP Federation development and achievement of constitutional targets are the only outstanding areas of action from the original capability and capacity action plan. In relation to the GP Federation, the Committee agreed that this will be a priority for Dr Chris Ritchieson, as the incoming Chair. It was agreed that additional focus on the implementation of a 'mini-Multispecialty community provider' is required as part of the development of the primary care incentive scheme for 2017/18.

COMMISSIONING INTENTIONS

35. It has been agreed that the Cheshire and Wirral Local Delivery System will take a consistent approach in relation to the development of the operational plan. The Clinical Commissioning Group commissioning intentions and plan therefore fully reflect these key strategic deliverables in 2017/19.

36. Our approach, as we move into a two-year planning and contracting round, is to work collectively to deliver our aspiration of an Accountable Care Organisation. Our delivery programmes are focussed to support changes to improve the effectiveness, efficiency and outcomes over the next 2 years. These have also been fully aligned to our financial recovery as set out in our Savings Plan. The key programme areas going forward will therefore be:

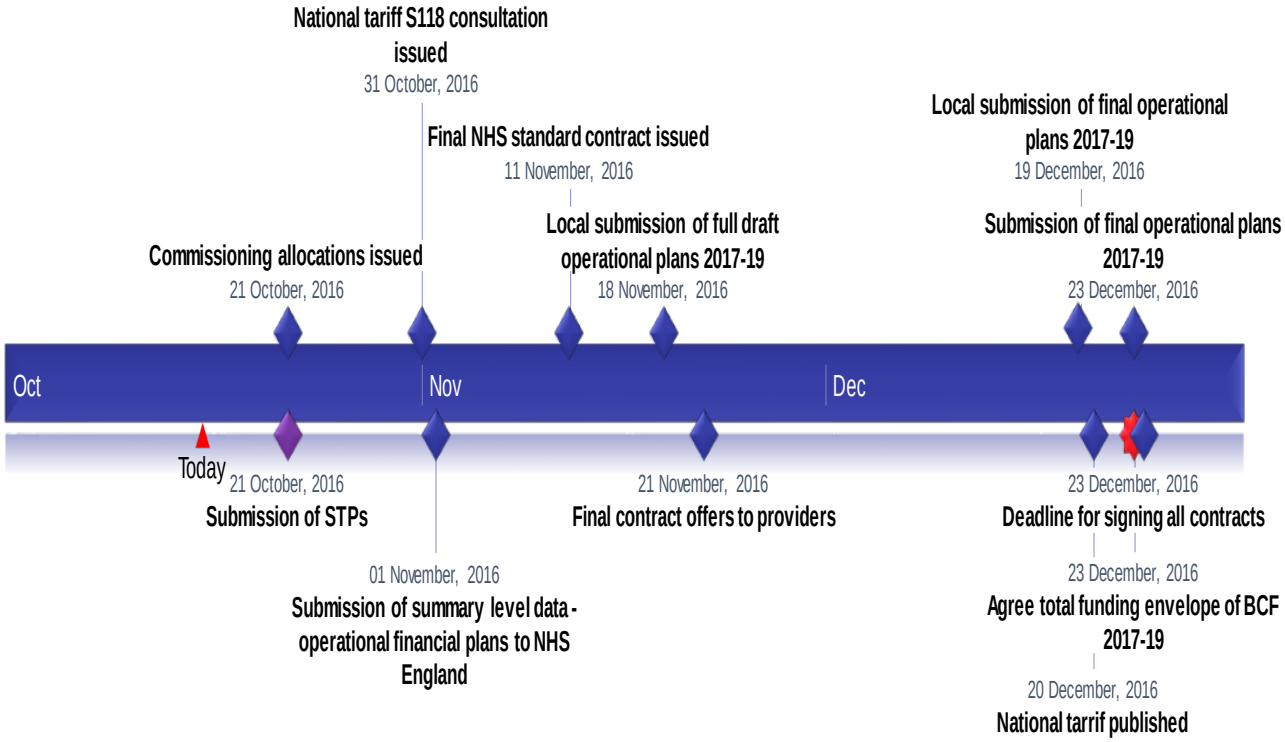
- Urgent Care
- Intermediate Care
- Elective Care

- Primary Care
- Medicines Management
- Complex care and Continuing Health care
- Being Well
- Starting Well
- Mental health
- Learning Disabilities

37. The Committee noted that the clinical commissioning group will work to the key intention that our primary providers will remain on a 'block contract' arrangement over the next two years based on the principle of using the 2015/16 financial envelope currently in place. In addition, with other commissioners, we will move away from activity based currencies to alternative arrangements that incentivise improved outcomes and service integration.

38. As the Sustainability and Transformation Plan priorities become clearer, we will also work across Cheshire and Wirral (and beyond) to ensure that the developments of Accountable Care Organisations in neighbouring health economies work closely in the commissioning and provision of pathways of care with the most suitable providers (both NHS and independent). Our focus will be on the utilisation of outcomes to assess commissioning effectiveness of the total pathway of care, ensuring a value based approach.

39. The key contracting milestones are set out below:



40. The full Commissioning Intentions document is available here

RECOMMENDATIONS

41. The governing body is asked to:

    a. Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 1st September 2016.

    b. Review and challenge the progress of the priority Financial Recovery Programmes of work.

    c. Note the changes to the Emergency preparedness, resilience and response policy and the updated Business Continuity Plans

    d. Review the work to date on Commissioning Intentions.

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY

1. Date of Meeting: 17th November 2016

2. Title of Report: Pre-operative Medical Optimisation

3. Executive Sponsor: Laura Marsh, Director of Commissioning

4. Key Messages:

- This paper seeks Governing Body approval for the introduction of a period of health optimisation before referral and commencement of non-urgent elective surgery as part of the strategic approach to improving the health and wellbeing of the population of West Cheshire.

- The life style choices we make will affect our long term health. If the choices we make impact on the ability of the NHS to provide services to all, the clinical commissioning group should consider action to preserve the ability to get the best value from NHS resources.

- One way of achieving this is for the clinical commissioning group to prioritise the promotion of a healthy lifestyle and to prevent as much ill-health as possible. We can do that in a wide range of ways – tackling smoking and obesity, detecting pre-diabetes and high blood pressure, reducing inactivity and alcohol consumption, increasing immunisation and uptake of cancer screening and helping people to understand their options and manage their own health through self-care and shared decision making.

- Given that we can identify reversible risk factors, it is considered that we have a duty of care to not perform planned surgery until these have been addressed and managed to the optimum possible level. This would provide an opportunity for the NHS to support an individual in improving their health while they wait for a referral and then a date for surgery.

- Public Health England report that the prevalence of obesity among adults has increased sharply during the 1990s and early 2000s. The proportion who were categorised as obese (Body Mass Index 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014 (Health and Safety Executive). By 2050 obesity is predicted to affect 60% of adult men and 50% of adult women.

- Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. It is also the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups.

4. Recommendations

The Governing Body is asked to review the contents of this paper and approve the following commissioning policies as part of a wider holistic approach to ensure patients have optimised their health prior to surgery:

a. All non-urgent referrals to surgical specialties with a Body Mass Index of ≥ 30 to be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery

b. All non-urgent referrals to surgical specialties where the patient is a smoker to be offered a referral to smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If the smoking cessation provider confirms a positive quit to the patient's GP within this period then the referral could be expedited

c. Patients with a Body Mass Index of ≥ 30 who also smoke will be offered referral to both Tier 2 weight management and smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If Tier 2 weight management attendance and a positive quit are confirmed to the patient's GP then a referral could be expedited.

d. The Governing Body is asked to also consider whether alcohol should be considered within the pre-operative optimization period.

5. Report Prepared By:

Amanda Lonsdale
Head of Elective Care

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

PRE-OPERATIVE MEDICAL OPTIMISATION

PURPOSE

1. One of the many expectations on clinical commissioning groups in the NHS Five Year Forward View is to prioritise action on preventable ill health including smoking, obesity and diabetes.

2. The Governing Body is asked to review the contents of this paper and approve the commissioning policies as part of a wider holistic approach to ensure patients have optimised their health prior to surgery.

3. These recommendations will be in addition to advice on self-care and wider lifestyle behaviours e.g. alcohol reduction and optimisation of long term condition management

INTRODUCTION

4. The vision for West Cheshire is clear:

5. "We want to ensure that every person is able to live longer, healthier lives, at home or in a homely setting. We will have an integrated health and social care system, with a focus on prevention, early identification and supported self-management. Whatever the care setting, support will be provided to the highest standards of quality and safety with the person at the centre of all decisions and planning. This supports our focus on ensuring that people get back into their home or community as soon as possible, with minimal risk of acute readmission".

6. To achieve this, the clinical commissioning group must enable, encourage and support the people it serves to live the healthiest lives possible and it must do so within the resources available. Only by doing so will we ensure we get the very best value from the NHS. Exceeding the clinical commissioning group's resources risks the ability of the NHS to be there when people really need it.

7. The life style choices we make will affect our long term health. If the choices we make impact on the ability of the NHS to provide services to all, the clinical commissioning group should consider action to preserve the ability to get the best value from NHS resources. One way of achieving this is for the clinical commissioning group to prioritise the promotion of a healthy lifestyle and to prevent as much ill-health as possible. We can do that in a wide range of ways – tackling smoking and obesity, detecting pre-diabetes and high blood pressure, reducing inactivity and alcohol consumption, increasing immunisation and uptake of cancer screening and helping people to understand their options and manage their own health through self-care and shared decision making.

8. We know that anaesthesia and surgery is very safe. Less than 1% of patients undergoing surgery die during the same hospital admission. However starting at a 'fitter' level prior to surgery improves the recovery from surgery and also improves quality of life should any complications occur.

9. Given that we can identify reversible risk factors, it is considered that we have a duty of care to not perform planned surgery until these have been addressed and managed to the optimum possible level. This would provide an opportunity for the NHS to support an individual in improving their health while they wait for a referral and then a date for surgery.

10. The aim is to ensure clinicians and patients together understand the reduction in risk (6 fold) of losing weight or stopping smoking or reducing drinking.

IMPACT OF OBESITY ON HEALTH

11. Public Health England report that the prevalence of obesity among adults has increased sharply during the 1990s and early 2000s. The proportion who were categorised as obese (Body Mass Index 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014 (Health and Safety Executive). By 2050 obesity is predicted to affect 60% of adult men and 50% of adult women.

12. As the prevalence of obesity in England increases, it has become a major public health concern due to its association with serious chronic diseases and related morbidity and mortality. We know that obese patients are much more likely to have diabetes, hypertension, cardiovascular disease and pulmonary disease than their normal weight equivalents. These conditions are associated with increased perioperative complications and increased mortality

13. NHS West Cheshire Clinical Commissioning Group is part of the national Diabetes Prevention Programme which is tackling the progression from Pre-Diabetes to Diabetes.

14. Compared with a healthy weight man, an obese man is:

- five times more likely to develop type 2 diabetes
- three times more likely to develop cancer of the colon
- more than two and a half times more likely to develop high blood pressure – a major risk factor for stroke and heart disease[1]

15. Compared with a healthy weight woman, an obese woman is:

- almost thirteen times more likely to develop type 2 diabetes
- more than four times more likely to develop high blood pressure
- more than three times more likely to have a heart attack[1]

16. Obesity increases the risk of the development of other disease including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke.

17. The impact of obesity stretches to cancer survival rates with both survival and recurrence being linked to obesity. For example, it is understood that substantial weight gain after diagnosis and treatment is adversely associated with breast cancer prognosis. Obesity has been shown to increase the risk of recurrence and death among breast cancer survivors by around 30%[1].

OBESITY AND IMPACT ON JOINT REPLACEMENT AND OTHER SURGERY

18. Obesity is an increasing problem for the NHS and is a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischaemic heart disease, hypertension and sleep apnoea.

19. A report[2] produced by the Arthritis Research Campaign stated that joint surgery is less successful in obese patients because:

- obese patients have a significantly higher risk of short-term complications during and immediately after surgery e.g. longer operations, excess blood loss requiring transfusions, Deep Vein Thrombosis, wound complications (including infection)

- the heavier the patient, the less likely that the surgery will bring about an improvement in their symptoms for joint replacement surgery in that they are less likely to regain normal functioning or reduction in pain and stiffness

- within joint replacement surgery the implant is likely to fail more quickly, requiring further surgery e.g. within 7 years; obese patients are more than 10 times as likely to have an implant failure

- people who have joint replacement surgery because of obesity-related osteoarthritis are more likely to gain weight post operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels)

20. The report also concluded that “Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery”. A study of obese patients with knee osteoarthritis found that those who dropped their weight by 10% after a combination of diet and exercise reported less pain, better knee function, improved mobility and enhanced quality of life[3].

21. A recent extensive literature review advises assessment of ’timely weight loss as a part of conservative care’[4]. It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.

22. Across other surgical specialties, there is good evidence that shows that obese patients are more likely to experience:

- a nearly 12-fold increased risk of a post-operative complication after elective breast procedures[5]
- a 5-fold increased risk of surgical site infection[6]
- an increased risk of surgical site infection as much as 60% when undergoing major abdominal surgery and up to 45% when undergoing elective colon and rectal surgery[7]
- an increased risk of bleeding and infections after abdominal hysterectomy[8]
- a higher incidence of peri-operative deep venous thrombosis and pulmonary embolism[9]
- increased risk of complication after elective lumbar spine surgery[10]

LOCAL CONTEXT - OBESITY

23. In conjunction with our Public Health colleagues, NHS West Cheshire Clinical Commissioning Group is committed to improving the health of our population. It is understood that obesity is a national concern and itself is a burden on the health economics of the population.

24. Treatments directly relating to diabetes currently cost the NHS approximately £14 billion per annum[11]. With the incidence of Type 2 diabetes increasing in line with obesity levels, this is adding to pressures on services.

	West Cheshire Clinical Commissioning Group	National Average
Percentage of adults classified as overweight or obese[12]	64.3%*	64.6%
Percentage of children aged 4-5 classified as overweight or obese[12]	23.1%*	21.9%
Percentage of population diagnosed with hypertension (high blood pressure) [13]	14.22%	13.8%

Note – Cheshire West and Chester level data

25. The links between obesity and Type 2 diabetes are clear. The prevalence of diabetes recorded by GPs in West Cheshire, for people aged 16 years and over is 6.4%, although, it is estimated that the true prevalence is around 8.4% due to a large number of people remaining undiagnosed[14]. In addition, the prevalence of type 2 diabetes is predicted to increase to 9.7% by 2035[14].

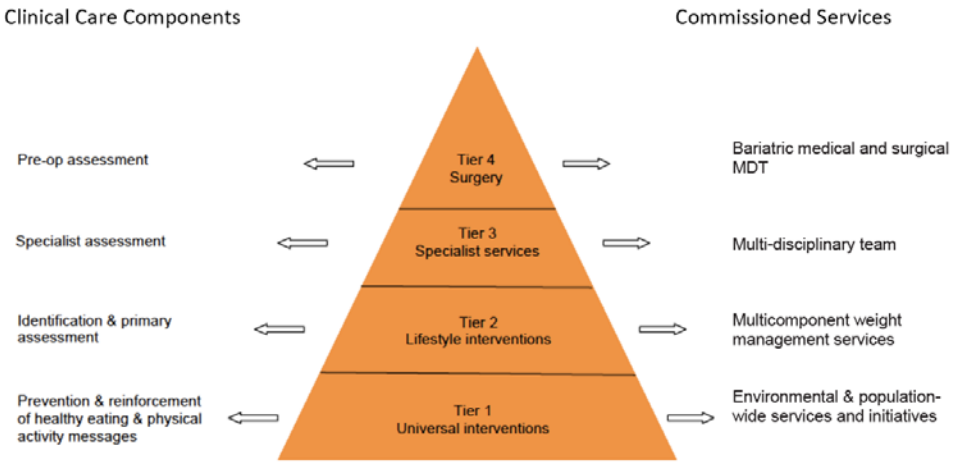
OVERVIEW OF CHESHIRE WEST AND CHESTER WEIGHT MANAGEMENT SERVICES

26. In West Cheshire the commissioning arrangements for weight management services are shared between Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group.

27. The provision of Tier 1 and 2 services are available to people aged 16 years and above who meet the Body Mass Index thresholds of 25 and over. The service will allow people to access the service at different points creating flexibility across these levels with a "step up/step down" approach. Those entering at levels 1 and 2 (see diagrammed) will have a holistic assessment to identify not only their health needs, but also any underlying social or emotional issues (relationships, debt, housing, environment, employment, skills) which may be contributing to poor health and may be barriers to achieving health and wellbeing goals. In addition, individuals can be signposted to non-NHS services that can support their goal to lose weight.

.

The national model for managing obesity is outlined below:



BODY MASS INDEX NON-URGENT ELECTIVE SURGERY OPTION FOR CONSIDERATION

28. The Governing Body is asked to consider the adoption of the following Commissioning Policy in relation to Body Mass Index before elective surgery:

29. NHS West Cheshire Clinical Commissioning Group does not routinely commission referral to secondary care for routine, non-elective surgery for patients whose Body Mass Index is 30 or more (≥). Patients with a Body Mass Index of 30 ≥ are to be offered a referral to Tier 2 weight management to enable completion of a period of health optimization for 6 months before commencement of surgery, offering an opportunity for weight loss to improve health and surgical outcomes.

30. If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request (IFR) Panel for consideration.

31. It is suggested that patients with the following will be excluded from this policy:

- patients undergoing surgery for cancer
- 2 week wait referral for suspicion of cancer
- patients with a Body Mass Index of 30 (≥) but who have waist measurement less than 94cm in males or 80cm in females
- patients with severe mental health illness, Learning Disability or significant cognitive impairment
- referrals for interventions of a diagnostic nature e.g. endoscopy
- children under 18 years
- frail elderly
- any urgent procedures (based on clinical judgement)

IMPACT OF SMOKING ON HEALTH

32. Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. It is also the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups.

33. Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. It can also cause complications in pregnancy and can be associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery[15.]

34. The recent 'Joint Briefing: Smoking and Surgery' (April 16) document produced by ASH and 5 Royal Colleges as well as the Faculty of Public Health, provides a powerful summary of the significant risks associated with smoking and surgery and the benefits of achieving smoking cessation pre-operatively[15] .

35. In England in 2011, an estimated 79,100 adults aged 35 years and over died as a result of smoking (18% of all deaths) and nearly half a million hospital admissions of adults aged 35 years and over (5% of all admissions) were attributable to smoking. Treating smoking-related illnesses cost the NHS an estimated £2.7 billion in 2006. The overall financial burden of all smoking to society has been estimated at £13.74 billion a year[16].

SMOKING AND IMPACT ON SURGICAL OUTCOMES

36. There is strong evidence that smokers who undergo surgery[15]:

- have a higher risk of lung and heart complications
- have higher risk of post-operative infection
- have impaired wound healing
- are more likely to be admitted to an intensive care unit
- have an increased risk of dying in hospital
- are at higher risk of readmission
- remain in hospital longer

37. Also, there is evidence to suggest that stopping smoking before having surgery:

- reduces the risk of post-operative complications
- reduces lung, heart and wound-related complications
- decreases wound healing time
- reduces bone fusion time after fracture repair
- reduces length of stay in hospital
- Even 6 weeks of smoking cessation can reduce postoperative pulmonary and wound complications.

LOCAL CONTEXT – SMOKING

38. Smoking is the primary cause of preventable ill health and early death, accounting for approximately 1594 deaths a year in Cheshire West and Chester[17.]

39. 35,100 individuals in Cheshire West and Chester smoke. People in our most deprived areas are more than twice as likely to smoke as people in our least deprived areas[17.]

40. Reducing smoking rates in these groups and areas is one of the fastest ways to increase life expectancy and reduce smoking related ill health.

41. Deaths from smoking are more numerous than the next six most common causes of preventable death combined i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse.

42. Treating smoking related illness cost the local NHS £12.9 million in 2015. The costs of tobacco use are much greater than just costs to the NHS, with the overall economic burden of tobacco use to Cheshire West and Chester estimated at £89.3million a year. These costs comprise not only treatment of smoking related illness but also the loss in productivity from smoking breaks and increased absenteeism, the cost of cleaning up cigarette butts, the cost of smoking related house fires and the loss in economic output for people who die from a disease relating to smoking or exposure to second-hand smoke[18].

OVERVIEW OF CHESHIRE WEST AND CHESTER SMOKING CESSATION SERVICES

43. Smoking cessation services are commissioned by Cheshire West and Chester Council. Patients can also be advised of the wider options to support their goal to stop smoking.

44. The smoking cessation service offers support to residents aged 13 years and above. Requests for children younger than 13 years of age will be assessed for acceptability on a case by case basis.

45. The service offers:

- support to stop smoking
- support to quit chewing tobacco
- support to quit shisha and e-cigarettes
- provision of multiple sessions of behavioural support
- approved stop smoking medicines

SMOKING OPTION FOR CONSIDERATION

46. The Governing Body is asked to consider the adoption of the following Commissioning Policy in relation to stopping smoking before elective surgery:

NHS West Cheshire Clinical Commissioning Group does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients who are active smokers. Patients who are active smokers are to be offered a referral to smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery, unless a quit status is confirmed by smoking cessation provider, whichever is sooner. A confirmed quit means that a person has been smoke free for 4 weeks after their individual quit date; this will allow a period of health optimisation.

47. If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request (IFR) Panel for consideration.

48. It is suggested that patients with the following are excluded from this policy:

- patients undergoing surgery for cancer
- 2 week wait referral for suspicion of cancer
- patients with severe mental health illness, Learning Disability or significant cognitive impairment
- referrals for interventions of a diagnostic nature e.g. endoscopy
- children under 18 years
- frail elderly
- any urgent procedures based on clinical judgement

49. Patients who only use electronic cigarettes will be classified as a non-smoker for the purposes of the policy.

THE BURDEN OF EXCESSIVE ALCOHOL CONSUMPTION

50. In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK Chief Medical Officer's lower-risk guideline and increase their risk of alcohol-related ill health. Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries. There are nearly 22,500 alcohol-attributable deaths per year.

51. Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health – this is the group for which identification and brief advice is effective. Identification and brief advice (IBA) results in recipients reducing their weekly drinking by approximately12%. Because alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health.

LOCAL CONTEXT – ALCOHOL

52. Estimates from the Local Alcohol Profiles for England (LAPE) 2014 suggest that around 87% of Cheshire West and Chester residents aged 16 and over drink alcohol (NHS West Cheshire = 166,600). This is a higher percentage of people than the England average.

53. Of those that drink alcohol, 72.5% (NHS West Cheshire = 120,900) engage in lower risk drinking (fewer than 22 units per week for men and 15 units per week for women). 20.7% (NHS West Cheshire = 34,500) of people engage in increasing risk drinking, and the remaining 6.8% (NHS West Cheshire =11,200) of people are classed as higher risk drinkers. A higher risk drinker is a man who drinks more than 50 units of alcohol per week, or a woman who drinks more than 35 units of alcohol per week.

54. There are an estimated 45,700 people who are increasing or higher risk drinkers in NHS West Cheshire. The percentage of increasing risk drinkers is higher than the England average and the percentage of higher risk drinkers is lower. Neither are statistically significant. People who are higher risk drinkers are at greater risk of developing alcohol related ill-health.

55. Locally (Cheshire West and Chester), 24% of people aged 16 and over were estimated to be binge drinkers. This is significantly higher than the England average of 20%. This equates to around 45,100 binge drinkers in NHS West Cheshire. Binge drinking is defined as a man who drinks eight or more units of alcohol, or a woman that drinks six or more units of alcohol, on their heaviest drinking day in the last week.

56. Often heavy alcohol intake, smoking and malnutrition go hand in hand. However, drinking more than the recommended amount of alcohol per week increases your chances of complications from surgery. The increase in risk of complications is directly proportional to the amount of alcohol consumed. For example, if you drink 3-4 alcoholic drinks a day, your risk of complications is 50% higher, if you drink 5 drinks a day that rises to between 200-400%. The main ways that alcohol increases risk are:

- Reduced immune capacity
- Cardiac failure, arrhythmias and cardiomyopathy
- Altered haemostasis
- Increased endocrine stress response to surgery

57. Many of those with hazardous drinking may not realise that what they are doing is detrimental to their health. Many of these effects are reversible with a period of abstinence. In those who have a more serious problem of alcohol dependence, help will be required to enable them to give up. But the long term benefits are clear to see, regardless of the short term benefits from safer surgery.

58. Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers.

59. Like smoking, abstinence for a period of time is associated with a reduction in risk and should be sought before elective surgery is offered.

60. The Governing Body is asked to consider whether to include alcohol within the pre-surgery pre-operative optimization period.

IMPLEMENTATION

61. As part of the implementation, a clear and comprehensive communications and engagement process will take place with primary care colleagues and information will be produced to inform the public regarding these policies.

62. Clinicians across the system will be provided with clear guidance regarding the process of implementation and the effectiveness of this will be monitored through clinical commissioning group committees (see Appendix 2 for a GP Frequently Asked Questions sheet). GPs in West Cheshire will be supported with materials to support patients and inform them of the benefits of their health optimisation period.

63. It is anticipated that any potential short term impacts on people with lifestyle risk factors will be balanced by a longer term reduction in health inequalities. Although people excluded within the policy will not be expected to complete a 6 month health optimisation period if they smoke or are obese, they will also be supported to address lifestyle factors.

RISKS

64. The following risks in relation to the impact on our stakeholders have been identified:

- increase in the number of referrals to Tier 2 weight management services
- increase in referral to smoking cessation
- increase in number of GP appointments required during pre and post health optimisation period
- increase in the number of referrals for exceptional circumstances through the Individual Funding Request Panel

65. The following reputational risk has been identified:

- The public and other key stakeholders may have concerns about these proposals.

CONCLUSION

66. It should be noted that this paper has been based around documentation received from NHS Harrogate Clinical Commissioning Group who have already undertaken a similar exercise as to the proposal within this paper.

67. The clinical commissioning group is consulting with the General Medical Council regarding any conflict with this proposal and the GP code of conduct.

68. This paper seeks Governing Body approval for the introduction of a period of health optimisation before referral and commencement of non-urgent elective surgery as part of the strategic approach to improving the health and wellbeing of the population of West Cheshire.

RECOMMENDATIONS

69. The Governing Body is asked to review the contents of this paper and approve the following commissioning policies as part of a wider holistic approach to ensure patients have optimised their health prior to surgery:

a. All non-urgent referrals to surgical specialties with a Body Mass Index of ≥ 30 to be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery.

b. All non-urgent referrals to surgical specialties where the patient is a smoker to be offered a referral to smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If the smoking cessation provider confirms a positive quit to the patient's GP within this period then the referral could be expedited.

c. Patients with a Body Mass Index of ≥ 30 who also smoke will be offered referral to both Tier 2 weight management and smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If Tier 2 weight management attendance and a positive quit are confirmed to the patient's GP then a referral could be expedited.

d. The Governing Body is asked to also consider whether alcohol should be included within the pre-surgery pre-operative optimization period.

Amanda Lonsdale
Head of Elective Care
November 2016

APPENDICES

Appendix 1

1. Healthier Lives, Healthier People – A Call to Action on Obesity in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf

2. Arthritis Research Campaign: "Osteoarthritis and Obesity" (2009) http://www.arthritisresearchuk.org/external-resources/2012/09/17/15/29/osteoarthritis-and-obesity-a-report-by-the-arthritis-research-campaign.aspx#

3. Effects of intensive diet and exercise on knee joint loads, inflammation, and clinical outcomes among overweight and obese adults with knee osteoarthritis: the IDEA randomised controlled trial Messier et al JAMA 310(12) 1263-73 (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450354/

4. Obesity and total joint arthroplasty: a literature based review. Journal of Arthroplasty May (2013) http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

5. Chen CL et al. (2011). The impact of obesity on breast surgery complications. Plast Reconstr Surg 2011; 128 (5): 395e-402e https://www.ncbi.nlm.nih.gov/pubmed/21666541

6. Waisbren E et al (2010). Percent body fat and predication of surgical site infection. J am Coll Surg 2010: 210(4):381-9 https://www.ncbi.nlm.nih.gov/pubmed/20347729

7. Hourigan JS (2011). Impact of obesity on surgical site infection in colon and rectal surgery. Clin Colon Rectal Surg 2011;24(283-290 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3311496/

8. Osler M et al. (2011) Body mass and risk of complications after hysterectomy on benign indications. Human Reproduction 2011; 26: 1512-1518. http://humrep.oxfordjournals.org/content/26/6/1512.full 14

9. DeMaria EJ, Carmody BJ. (2005) Preoperative management of special population: obesity. [Review] [31 refs]. Surgical clinics of north America 2005;85 (6): 1283-1289 https://www.ncbi.nlm.nih.gov/pubmed/16326208

10. Elgafy H et al. (2012) Challenges of spine surgery in obese patients. [Review]. American Journal of Orthopaedics 2012;41 (3): E46-E50 https://www.ncbi.nlm.nih.gov/pubmed/22530204

11. Diabetes UK – The Cost of Diabetes http://www.diabetes.co.uk/cost-of-diabetes.html

12. Public Health England Outcomes Framework – Obesity
http://www.phoutcomes.info/search/obesity#pat/6/ati/102/par/E12000002
And
Active Peoples Survey
www.sportengland.org/research/who-plays-sport

13. Public Health England – Hypertension Profile
http://info.wirral.nhs.uk/document_uploads/Downloads/E08000015_hypertension.pdf

14. Public Health England; Diabetes prevalence model for local authorities and clinical commissioning groups
http://www.yhpho.org.uk/resource/view.aspx?RID=154049

15. Joint briefing: Smoking and surgery - Action on Smoking and Health
http://ash.org.uk/files/documents/ASH_1023.pdf

16. NICE - Smoking: acute, maternity and mental health services
https://www.nice.org.uk/guidance/ph48/chapter/2-public-health-need-and-practice

17. Local Tobacco Control Profiles for England (2015)
http://www.tobaccoprofiles.info/tobacco-control#page/0/gid/1938132885/pat/6/par/E12000002/ati/102/are/E08000015

18. Collins, B (2014). Cost Effectiveness of Smoking Services in Wirral report. Wirral JSNA. 2014
http://info.wirral.nhs.uk/document_uploads/Health-Economics/Cost%20Effectiveness%20of%20Stop%20Smoking%20Services%20in%20Wirral%202015%20v12.pdf

Appendix 2

FREQUENTLY ASKED QUESTIONS for clinicians about the health optimisation period to ensure patients are fit for surgery

What is the 'health optimisation' pathway?

The pathway applies when making any referral to a surgical speciality. If the patient has a BMI of 30 or above AND/OR they are an active smoker, they should be offered a health optimisation period of 6 months and referral to weight management and/or smoking cessation service before the referral is made, unless exclusions apply. Even if exclusions do apply, it is good practice to still offer lifestyle advice.

What are the exclusions?

- Any urgent or non-routine procedures
- Patients undergoing surgery for cancer
- Referral for suspicion of cancer
- Patients with a BMI of 30 or greater but who have waist measurement less than 94cm in males or 80cm in females
- Patients with severe mental health illness, Learning Disability or significant cognitive impairment
- Referrals for interventions of a diagnostic nature e.g. endoscopy
- Children under 18 years
- Frail Elderly (as a guide – 3 or more of the following: unintentional weight loss; self-reported exhaustion; weakness (grip strength); slow walking speed; low physical activity)
- Ophthalmology referrals as an ophthalmology referral is usually initiated by an optometrist, until a health optimisation pathway is developed with optometrists, referrals for eye surgery is excluded.

Dentistry and oral surgery is not commissioned by the CCG and therefore the policy does not apply to this speciality.

What if the referral is for an opinion or diagnostic uncertainty?

If this is the case then patients are excluded and referral can proceed. However, patients should be counselled that if planned routine surgery is the outcome from their outpatient appointment, then the 6 month health optimisation period will still apply if other exclusions are not met. The hospital will provide the patient with the patient information leaflet, and refer them back to their GP with a letter to the GP and to the patient clearly stating that they are on the health optimisation pathway. GPs will need to decide whether to see the patient at that stage. At the end of the 6 month health optimisation pathway, the patient will need to be reassessed by the GP to see whether clinical condition has changed any of the indications for surgery.

What if a patients doesn't meet the exclusion criteria but there is an exceptional case?

Clinicians can apply through the CCG's IFR (Individual Funding Request) panel through the normal route.

What is meant by ' urgent or non-routine'?

Clinical discretion should be used at any time by the GP or secondary care clinician during the health optimisation pathway as to what is meant by urgent or non-routine. This could include, for example:

- If the patient has worsening severe persistent pain not adequately relieved by an extended course of non-surgical management
- If there are any safety concerns about delaying referral (eg symptomatic gallstones)

How should a referral be made to a surgical specialty?

The process will need to be developed. A possible process is that for all referrals to secondary care there is a question that would need to be completed to be accepted into the virtual basket. The question would be asking if the patient is a non-smoker with a BMI less than 30, or is an active smoker or BMI above 30 but there are exclusions, or a patients six month health optimization period has been completed.

Consultant to consultant referrals

If the patient needs to be referred to another consultant for the original clinical issue, then BMI and smoking status should not preclude this. However, if and when a decision is made to proceed to surgery, it should only proceed if the exclusions apply, otherwise the patient should be discharged back to their GP (with patient leaflet and letter to GP and patient copied in).

Why has the CCG developed this pathway?

The CCG has a duty to achieve the best health outcomes for the whole local population and to achieve this within the limited resources available. One of the ways to improve health and wellbeing is to increase the number of people accessing smoking cessation and weight management services. The point of referral to a surgical specialty is an opportune moment for people to take responsibility for their own health and wellbeing. We want people to recover from surgery, to live healthier lives and to ensure that the money being spent is on the most clinically effective treatments; a 6 month health optimisation period will be beneficial to those who may not have otherwise accessed services. It is expected that the pathway will save some referrals and procedures in the short term whilst promoting better health in the long term.

Is this a blanket ban on surgery for people who smoke or are obese?

No. Being an active smoker or having a BMI of 30 + will not exclude any patient from surgery. Whether a successful quit or a healthy weight is achieved, people will have access to surgery after the 6 month health optimisation period – although patients should be encouraged to set and achieve realistic goals during the 6 month health optimisation period.

What support is available to help people who smoke?

Free support to help patients quit smoking is available through Cheshire West and Chester Council's 'Quit 51' programme. There is a range of support, including drop-in clinics, group sessions, online support, telephone support or weekly one-to-one appointments with a free supply of medication, such as Nicotine Replacement Therapy (NRT). Home visits are available for patients with long term conditions, learning disability and pregnancy.

For more details call 0800 622 6968, or text 'smokefree' to 66777 and an advisor will call you back. Or contact the service via email on contact.quit51@nhs.net. The service can be accessed via www.quit51.co.uk

What support is available to help people who are obese?

Free support to help lose weight is available through Cheshire West and Chester Council's 'More-Life' programme.

Slimming World deliver the Tier 2 adult weight management service, and will work alongside More-Life to provide a comprehensive overview of Slimming World within the education and awareness programme plus be on hand to challenge any misconceptions that referrers may have. There are 52 slimming world sites across Cheshire West and Chester.

Twelve weekly group sessions and additional support (including free online support via website and mobile devices) in between groups. Approach is NICE compliant and involves: healthy eating (food optimising); A psychological approach enables people to identify their triggers and behaviours that they need to change to make permanent improvements to weight and health (IMAGE Therapy: Individual Motivation & Group Experience); An activity approach (body magic) which aims to get people moving more, ultimately meeting the government aim of 30 mins of exercise 5 times/ week.

The Tier 3 programme is also delivered by More-Life. Patients are offered a 24 session multi-component programme which is NICE compliant. A tailored approach is offered for males only, with an emphasis on fitness and health not weight loss, with a focus on technology and an on-line offer. All interventions will include clear maintenance, follow-up and support planning as well as sign-posting and discharge to support services in the community. A community asset approach is used to ensure a long term sustainability of lifestyle change.

For more information on More-Life call 0800 043 1650 or look at www.more-life.co.uk

What happens at the end of the 6 month health optimisation period?

The patient will need to be assessed by the GP in order to progress the referral. The health status may have changed so that surgery is now not needed.

What if people achieve their weight loss goals or quit smoking before 6 months?

If a patient achieves a BMI of <30 and/or quits smoking (for a 4 week period) before the end of the 6 month health optimisation period, they should make a follow up appointment to see their GP to assess whether referral can proceed.

What surgical specialities are included?

This policy relates to all GP and consultant referrals to any surgical speciality, except ophthalmology.

For the time being, ophthalmology is not included as the pathway for referral is usually through optometrists. The health optimisation pathway before referral is not yet in place for ophthalmology.

Dentistry and oral surgery is not commissioned by the CCG and therefore the policy does not apply to this specialty.

What if patients with a BMI >30 and/or are smokers are referred for assessment and as a result are offered surgery?

Patients being referred for diagnostic assessment should be advised that if non-urgent, planned surgery is the outcome they will still need to complete the 6 month health optimisation period unless exclusions apply. Secondary care will give the patient information leaflet, write to their GP and patient outlining that health optimisation period is needed, and refer the patient back to primary care. Patients will need referring back at the end of the health optimisation period.

What if the health status changes during the 6 month health optimisation period?

Patients should be counselled to contact their GP should their health decline during the health optimisation period. Please use clinical discretion at all times.

If a patient has concerns about the policy, who should they contact?

Concerns should be discussed with their GP or secondary care clinician in the first instance and any ongoing concerns from patients can be fed back through the CCG's clinical leads.

Should patients wish to feedback to the CCG on any part of the policy this can be done through the CCG's website:
https://www.westcheshireccg.nhs.uk/contactus/patient-advice-and-liaison.htm

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

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

2. Title of Report: Audit Committee Report

3. Key Messages: This report provides an overview of the key items of business discussed and decisions made at the audit committee meeting held on 16th September 2016. The key items for the governing body to note are:

- The clinical commissioning group is on course to remain compliant with the national information governance toolkit.
- The audit committee approved the 2015/16 Annual Audit Letter. A partially qualified value for money conclusion was received due to the financial outlook of the clinical commissioning group.
- There were no fraud investigations during 2015/16.
- Following a joint procurement process, external auditors have been appointed with effect from 2017/18.

4. Recommendations The governing body is asked to:

a) Note the key items of business discussed and decisions taken by the audit committee at its meeting on 16th September 2016.

b) Endorse the decision of the joint external audit procurement panel to award the external audit contract to Grant Thornton UK LLP.

5. Report Prepared By: Gareth James
Chief Finance Officer

Alignment of this report to the clinical commissioning group's corporate objectives

Corporate objectives	Alignment of this report to objectives
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	The audit committee ensures that there are sound systems of governance in place to support delivery of financial duties.
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	
We will commission integrated health and social services to ensure improvements in primary and community care	
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	
We will develop our staff, systems and processes to more effectively commission health services	The audit committee ensures that there are sound systems of governance in place to support delivery of financial duties.

Alignment of this report to the governing body assurance framework

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
3	Failure to embed sound systems of information governance.	The audit committee report demonstrates progress on compliance with information governance requirements.	N/A

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
2	Failure to embed systems and processes of good governance.	The audit committee ensures that the clinical commissioning group has adequate systems of governance and internal control. The report to the governing body provides assurance form both internal and external auditors.	N/A

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 and decisions made at the audit committee meeting held on 16th September 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 key issues discussed at the September 2016 audit committee are summarised in paragraphs 5 to 14.

INFORMATION GOVERNANCE

4. The Head of Governance provided a verbal update to the committee and confirmed that the clinical commissioning group is on course to remain compliant with the National Information Governance Toolkit. A more detailed update will be provided to the committee in December 2016.

UPDATED SCHEME OF RESERVATION AND DELEGATION

5. The committee approved several minor changes to the scheme of reservation and delegation. In the main, the changes involved increases to individual approval limits to support the flow of invoice approval. Other general housekeeping changes to amend job titles and additions of new members of staff were also approved.

MERSEY INTERNAL AUDIT AGENCY UPDATE AND ASSURANCE FRAMEWORK REVIEW

6. The committee received a report from Mersey Internal Audit Agency covering the following key issues:

- An updated 2016/17 Annual Internal Audit Plan; previously approved by the clinical commissioning group's executive team.

- An update on work undertaken up to the month of September 2016. The key item to note was that limited assurance has been provided following the review of arrangements in place for personal health budgets. A joint action plan is being developed with neighbouring clinical commissioning groups to address the issues raised in the review,

ANTI-FRAUD ANNUAL REPORT 2015-16

7. During 2015/16 the anti-fraud service completed a wide range of work across the areas of activity outlined by NHS Protect and previously agreed in the work-plan by the audit committee. The plan has been delivered in full without changes. There were no fraud investigations in the period.

2015/16 ANNUAL AUDIT LETTER

8. The committee approved the 2015/16 Annual Audit Letter which summarised the key findings arising from the work undertaken by Grant Thornton UK LLP for the year ended 31st March 2016. As previously reported, unqualified audit opinions were received with the exception of the value for money opinion which was partially qualified (described as an 'except for' value for money conclusion) due to the financial outlook of the clinical commissioning group.

9. Detailed findings from the audit work were reported to the audit committee on 25th May 2016.

APPOINTMENT OF EXTERNAL AUDITOR

10. Following the passing of the Local Audit and Accountability Act 2014, the current arrangements for external audit will cease in 2016/17 and clinical commissioning groups will need to make arrangements to procure their own external audit service from 2017/18.

11. Further guidance issued on the 18th March 2016 indicated that clinical commissioning groups may work together provided that they agree the governance arrangements. The audit committee had previously agreed to undertake a joint procurement with 4 neighbouring clinical commissioning groups.

12. Following the joint procurement process, a successful bidder was chosen. A paper detailing the procurement process that was undertaken and details of the successful bidder is provided here.

13. Both the West Cheshire Clinical Commissioning Group Chief Finance Officer and the Audit Committee Chair took part in the procurement process.

RECOMMENDATIONS

14. The governing body is asked to:

a) Note the key items of business discussed and decisions taken at the audit committee on 16th September 2016.

b) Endorse the decision of the joint external audit procurement panel to award the external audit contract to Grant Thornton UK LLP.

Gareth James
Chief Finance Officer
November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

1.	**Date of Governing Body Meeting:**	17th November 2016
2.	**Title of Report:**	Chief Executive Officer's Business Report
3.	**Key Messages:**	This report provides an overview of important clinical commissioning group business which has not been provided in other papers to the governing body. Key issues raised are as follows: • An overview of the proposed 2017 – 2019 financial plan. • An update on the recovery checkpoint and meetings with NHS England and the submission of the organisation improvement plan. • An update on progress of the Cheshire and Wirral sustainability and transformation plan. • An overview of the business discussed at the West Cheshire strategic leadership group.
4.	**Recommendations**	The governing body is asked to note the contents of this report.
5.	**Report Prepared By:**	Clare Dooley Head of Governance November 2016

Alignment of this report to the clinical commissioning group's corporate objectives

Corporate objectives	Alignment of this report to objectives
We will deliver financial sustainability for the health economy providing value for money for the people of West Cheshire	The report outlines the financial planning process for 2017-19 and also covers the development of the Sustainability and Transformation Plan
We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people	The paragraghs on STP includes a section on reducing variation in standards of care
We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission	
We will commission integrated health and social services to ensure improvements in primary and community care	The update on systems leadership provides assurance on this objective
We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets	
We will develop our staff, systems and processes to more effectively commission health services	

Alignment of this report to the governing body assurance framework

Risk No	Risk Description	Assurance / mitigation provided by this report	Proposal for amendment to risk as a result of this report (revised risk description, revised mitigation or scoring)
1	Delivery of financial duties.	The report provides an update on the financial recovery/checkpoint process that the CCg is undertaking with NHS England.	No Change
8	To lead the development of a shared vision for the health and social care economy	The report provdes an update on the development of the ACO	No change

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.

2017/18 – 2018/19 FINANCIAL PLANNING

2. A draft two year financial plan has been submitted to NHS England. The timetable for agreeing plans is much earlier than previous financial years. The plans currently assume the following trajectory:

   - Delivery of financial balance and, therefore, achievement of financial duty, as at 31st March 2018.
   - Delivery of 1% surplus as at 31st March 2019.

3. There is, however, a significant level of risk within the draft plan with a 'risk-adjusted' planned deficit of approximately £9.5 million. Key risk areas can be summarised as follows:

   - Greater than planned increase in cost of hospital activity.
   - Continued growth in high cost complex care packages.
   - Non-delivery of planned recurrent financial savings (financial recovery plan and pipeline).

4. Further iterations of the financial plan will be submitted to NHS England before the end of the calendar year. During that time our planning assumptions and scenarios will be further tested, both internally, and with local partners.

NHS ENGLAND RECOVERY CHECKPOINT MEETINGS AND ORGANISATION IMPROVEMENT PLAN

5. Members of the governing body met with NHS England for monthly recovery checkpoint meetings on 29th September 2016 and 27th October 2016. At our recovery checkpoint meetings we have discussions with NHS England about our progress with financial and non-financial improvement, in-line with formal directions issued to the clinical commissioning group in September 2016.

6. At the recovery checkpoint meeting on 27th October NHS England advised that we were required to submit a revised format of our improvement plan. Members of the executive team attended a workshop with NHS England to discuss the preferred format and content of clinical commissioning groups organisation improvement plans on 2nd November 2016.

7. The notes from NHS England of the September recovery checkpoint meeting is provided here. I have also attached a letter received from NHS England on the 11th November detailing the next steps following the Baseline and Improvement meeting held on the 14th September 2016, which is available here.

8. We submitted the organisation improvement plan to NHS England on Friday 11th November 2016. Progress on feedback of this plan from NHS England and our improvement delivery will be provided to future governing body meetings.

SUSTAINABILITY AND TRANSFORMATION PLAN

9. The following is a summary of the sustainability and transformation plan that is being developed in Cheshire and Merseyside.

10. **Cheshire and Merseyside Sustainability and Transformation Plan:** Whilst on a day-to-day basis most areas of the NHS are running well, we are seeing signs of the strain the system is under in areas such as hospital care, Accident and Emergency and GP services.

11. It is estimated that without radical changes to the way the NHS works as demand rises and costs rise, the NHS will become unsustainable. If we do nothing we face a £30 billion funding gap for the NHS nationally by 2020.

12. The *NHS Five Year Forward View*, published by NHS England in October 2014, set out strategic intentions, opportunities and the challenges facing the NHS in the years to 2021. It signalled the need for the NHS and its partners to take a longer term approach to planning to ensure the NHS remains clinically and financially sustainable. The NHS Forward View highlighted three key priorities:

    - The health and wellbeing of the population;
    - The quality of care that is provided; and
    - NHS finance and efficiency of services.

13. This guidance was backed up by the establishment of a new Sustainability and Transformation Fund to support the achievement of financial balance and to provide investment for transformational plans.

14. NHS England has established 44 Sustainability and Transformation (STP) 'footprints' (including Cheshire and Merseyside), which bring together NHS organisations, local authorities and other partners to collaborate and propose

plans to improve health, improve quality of services and to ensure that the NHS remains financially sustainable.

15. Sustainability and transformation plans represent a change in the way that the NHS in England plans its services; with a stronger emphasis on collaboration and integrated ways of working. In practice, this means different parts of the NHS and social care system working together to provide more coordinated services – for example, GPs working more closely with hospital specialists, district nurses and social workers to improve care for people with long-term conditions.

16. If we are to deliver a step change in health, supporting people to live well for more of their lives and to have excellent, safe NHS and care services, we need to have strong community services that can support people to stay well and reduce avoidable use of hospital services. If we can achieve this, we can improve and re-design hospital services to meet the needs of patients in the 21st century.

17. The Cheshire and Merseyside sustainability and transformation plan covers a population of 2.5 million people and brings together over 30 NHS organisations and nine local authorities. The financial challenge facing the Cheshire and Merseyside health system is significant. The 'do nothing' financial gap for this area is forecast at £908million by 2020/21.

18. This is a diverse footprint, bringing together areas of deprivation where people have higher levels of poor health, alongside more affluent areas that have a different set of challenges, including an increasing proportion of frail older people.

19. Due to the size and diversity of Cheshire and Merseyside it has been divided further into 3 Local Delivery Systems (LDS) – North Mersey; the Alliance (Mid Mersey) and unified Cheshire and Wirral. Each of the three local delivery systems has established its own ideas and proposals, guided by a common set of strategic priorities, which are:

    - Improving the health of the Cheshire and Merseyside population;
    - Improving the quality of care and addressing the sustainability of services in community settings and in the region's hospitals
    - Maximising the efficiency of clinical and administrative support services

The Cheshire and Wirral Local Delivery System

20. We have used our knowledge of local challenges to identify four priorities to make our health and care system sustainable in the near, medium and long term.

Managing care in the most appropriate setting

21. There will be a significant focus on prevention to help people live healthier lives and thereby reduce demand on health and care services. This involves building on work already progressed to develop strategies to improve the management of care in areas including alcohol related harm, hypertension, respiratory and diabetes. By doing this we will be working more closely than ever with other health and social care partners as we develop Accountable Care Systems which allows us to make better use of resources.

Reducing variation across our system

22. This priority recognises that there is variation in how our different health providers apply some policies and clinical pathways. This will mean that hospitals and other care providers develop standardised care pathways and common approaches to areas such as Infection Prevention and Control and Referral Management. In order to do this we will develop Information Technology platforms to support these improvements and to improve the management of patient pathways in a more consistent way.

Back/Middle Office Collaboration

23. Back office functions are vital to support organisations in achieving their goals and historically many of these functions have existed in isolation although some work has been progressed to share functions such as payroll.

24. There is an opportunity for us to further improve efficiency and productivity by developing collaborative working across our major support functions and in some cases developing joint teams to support a wider group of health providers. This will enable us to use expertise that has to date not been shared outside individual organisations and for us to utilise the shared purchasing power that collaboration presents in getting a better deal from some of our suppliers.

Changing how we work together

25. A major part of this priority will be to enable healthcare providers to access shared care records in a local setting to improve patient care and experience. This work is already well progressed and will be furthered to better utilise the use of data to support people who are at risk of developing long term conditions.

26. We will also be working together more as a system and we will be looking at ways in which our leaders, both clinical and non-clinical can work effectively to progress our priorities and to achieve a sustainable health and care system for Cheshire and Wirral.

Engaging with our communities and staff

27. Whilst many of our local health systems have already begun to engage with their communities about the challenges faced by the NHS, the development of the local delivery system plan enables us to widen this enagement in an open and transparent manner. We are committed to engaging and communicating with our communities and staff.

WEST CHESHIRE SYSTEMS LEADERS GROUP

28. The business items at the West Cheshire Strategic Leaders group meeting held on Wednesday 9th November 2016 included an update on the sustainability and transformation plan, a discussion on the development of an accountable care organisation, a draft memorandum of understanding for future working of the strategic leaders group and system performance (financial and non-financial).

29. The majority of the meeting focused on discussing the Sustainability and Transformation Plan and the development of an Accountable Care Organisation. Regarding the accountable care organisation, the group agreed to progress the appointment of an interim programme director for the accountable care organisation working across the health and care system and to specify a short term piece of work to identify the greatest potential to manage demand in West Cheshire and identify obstacles to current delivery.

30. A number of actions were taken at the meeting to ensure thorough engagement with stakeholders, staff and the public. All parties were asked to get behind projects being put in place to aid financial pressures and to provide assurance on these to ensure that they work.

RECOMMENDATIONS

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

Alison Lee
Chief Executive Officer
November 2016

NHS
West Cheshire
Clinical Commissioning Group

GOVERNING BODY REPORT

DATE OF GOVERNING BODY MEETING:	17th November 2016
TITLE OF REPORT:	Clinical Commissioning Group Policies and Governance Documents
KEY MESSAGES:	This report provides two clinical commissioning group policies / governance documents for governing body ratification.
RECOMMENDATIONS:	The governing body is asked to approve / ratify the policies / governance documents.
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. Two clinical commissioning group policies / governance documents are 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, and any amendments from previous versions are highlighted in yellow. 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.	Emergency Preparedness, Resilience and Response	Finance, Performance and Commissioning Committee	N/A	Lee Hawksworth Director of Operations 01244 650365 l.hawksworth@nhs.net
2.	Business Continuity Plan	Finance, Performance and Commissioning Committee	May 2015	Clare Dooley Head of Governance 01244 650318 claredooley@nhs.net

RECOMMENDATION

3. The governing body is asked to approve/ratify the policies / governance documents provided.

Gareth James
Chief Finance Officer
November 2016

NHS
West Cheshire
Clinical Commissioning Group

1.	**Date of Governing Body Meeting:**	17th November 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 or reports are available via hyperlink.

GP LOCALITY NETWORKS

Chester City Locality GP Network

3. The approved minutes from the July and September 2016 Chester City Locality GP Network meetings are available here.

Rural Locality GP Network

4. The approved minutes from the July and September 2016 Rural Locality GP Network meetings are available here.

Ellesmere Port and Neston Locality GP Network

5. The approved minutes from the September 2016 Ellesmere Port and Neston GP Locality Network meeting are available here.

QUALITY IMPROVEMENT COMMITTEE – minutes

6. An update of the October 2016 meeting is contained within the quality improvement report.

FINANCE PERFORMANCE AND COMMISSIONING COMMITTEE – minutes

7. An update of the November 2016 committee meeting is contained within the finance, performance and commissioning committee report.

AUDIT COMMITTEE – minutes

8. An update of the September 2016 meeting is contained within the audit committee report.

REMUNERATION COMMITTEE

9. There is no update scheduled to be provided to the governing body.

RECOMMENDATION

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