NHS
West Cheshire
Clinical Commissioning Group

# NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

## AGENDA

**Formal Governing Body Meeting to be held in Public on Thursday 18th May 2017, at 9.00a.m. in Rooms A&B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ**

| Item | Time | Agenda Item | Action | Presenter |
|---|---|---|---|---|
| | 9.00 | Welcome and **Open Forum** | - | Dr Chris Ritchieson<br>*GP Chair* |
| | 9.15 | Chairs Opening Remarks | I | Dr Chris Ritchieson<br>*GP Chair* |
| A | 9.20 | Apologies for absence | - | Dr Chris Ritchieson<br>*GP Chair* |
| B | 9.20 | Declarations of interests in agenda items | - | Dr Chris Ritchieson<br>*GP Chair* |
| C | 9.20 | Minutes of last meeting held on 16h March 2017 | DR | Dr Chris Ritchieson<br>*GP Chair* |
| D | 9.25 | Matters arising/actions from previous Governing Body meetings | D | Dr Chris Ritchieson<br>*GP Chair* |
| WCCCGGB/17/05/01 | 9.30 | Chief Executive Officer's Business Report | DR | Alison Lee<br>*Chief Executive Officer* |
| WCCCGGB/17/05/02 | 9.45 | Unified Health Commissioning in Cheshire | DR | Alison Lee<br>*Chief Executive Officer* |
| WCCCGGB/17/05/03 | 9.55 | GP Network Chair Update | Verbal | Dr Steve Pomfret<br>*GP Representative – Rural*<br><br>Dr Jeremy Perkins<br>*GP representative – Ellesmere Port and Neston*<br><br>Dr Annabel Jones<br>*GP Representative – Chester City* |
| WCCCGGB/17/05/04 | 10.10 | Senate Report | D | Peter Williams<br>*Hospital Physician Representative* |
| WCCCGGB/17/05/05 | 10.20 | Primary Care Committee Report | D | Laura Marsh<br>*Director of Commissioning* |
| **10.45 BREAK** | | | | |

| Item | Time | Agenda Item | Action | Presenter |
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| WCCCGGB/17/05/06 | 10.55 | Quality Improvement Committee Report | D | Paula Wedd<br>*Director of Quality and Safeguarding* |
| WCCCGGB/17/05/07 | 11.10 | Finance, Performance and Commissioning Committee Report | D | Chris Hannah<br>*Vice Chair*<br><br>Gareth James<br>*Chief Finance Officer*<br><br>Laura Marsh<br>*Director of Commissioning* |
| WCCCGGB/17/05/08 | 11.35 | Audit Committee Report | D | Kieran Timmins<br>*Lay Member*<br><br>Gareth James<br>*Chief Finance Officer* |
| **CONSENT ITEMS** | | | | |
| WCCCGGB/17/05/09 | 11.45 | Clinical Commissioning Group Policies and Governance Documents | DR | Alison Lee<br>*Chief Executive Officer* |
| WCCCGGB/17/05/10 | 11.50 | Governing Body Assurance Framework | I | Gareth James<br>*Chief Finance Officer* |
| WCCCGGB/17/05/11 | 11.55 | Clinical Commissioning Group Sub-Committee Minutes | I | Alison Lee<br>*Chief Executive Officer* |
| WCCCGGB/17/05/12 | 12.00 | Any Other Business<br>**(to be notified to the Chair in advance)** | D | All |
| **Date and time of next formal Governing Body meeting – Thursday 20th July 2017, 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 16th March 2017, 9.00 a.m.
## Rooms A&B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ

**PRESENT**

**Voting Members:**

| | |
|---|---|
| Dr Chris Ritchieson | 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 |
| Ms Pam Smith | Lay Member |
| Mr Peter Williams | Hospital Physician Representative |
| Ms Sarah Faulkner | Nurse Representative |
| Dr Annabel Jones | GP representative – Chester City |
| Dr Jeremy Perkins | GP representative – Ellesmere Port and Neston Locality |
| Dr Steve Pomfret | GP representative – Rural Locality |
| Ms Laura Marsh | Director of Commissioning |
| Mrs Paula Wedd | Director of Quality and Safeguarding |
| Ms Clare Dooley | Head of Governance |

**In attendance:**

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| Ms Christine France | Governing Body and Committees Coordinator |

| 17/03 | AGENDA ITEM | Action |
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| | **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.<br><br>No questions were raised prior to, or during the meeting. | |
| | **CHAIR'S OPENING REMARKS** | |
| | Thank you all for attending the last formal Governing Body of 2016-17 financial year. We have a packed agenda, even more so than usual and as such I wanted to keep my introduction brief to allow us to concentrate on our first priority, scrutinising the reports before us. | |

| 17/03 | AGENDA ITEM | Action |
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| | There are a few points which I wanted to highlight, especially as this is a meeting in public. At January's Governing Body Meeting we trialled filming the meeting and posted that film on the clinical commissioning group website for public consideration. I feel that the process was successful and from May 2017 we would hope to start doing so for each of our in public Governing Body meetings.<br><br>For today's meeting, in line with the considerable efforts all parts of the organisation and wider health economy are making to meet our financial obligations by year end, I have made the decision to stand down our audio visual support but again expect this to resume in the new financial year.<br><br>It is also important to note that this month's Primary Care Commissioning Committee has been postponed due to member availability and is due to take place on 30th March, this will therefore be reported to the May Governing Body.<br><br>As we reach the end of this financial year and look towards 2017-18, I felt it is worth reflecting on the progress that has been made in a relatively short space of time. Despite the focus on our financial recovery plan, or perhaps because of it, we have with our partner organisations made considerable steps forwards in terms of integrating health care and developing a model which is aimed at providing care in the most appropriate place and by the most appropriate person. As we will touch on in our later agenda items, the coming year has the potential to be transformative in terms of how we deliver health and social care to our population. Though there will be large challenges to overcome I believe the hard work within our organisation will stand us in good stead to meet those challenges. | |
| **A** | **APOLOGIES FOR ABSENCE** | |
| | Apologies were received on behalf of Delyth Curtis and Lee Hawksworth. | |
| **B** | **DECLARATIONS OF MEMBER'S INTERESTS** | |
| | Dr Annabel Jones declared an interest in agenda item WCCCGGB/17/03/111 – Quality Improvement Committee Report, in relation to Crawfords Walk Nursing Home, as Dr Jones' practice provides medical cover to that nursing home.<br><br>Dr Andy McAlavey declared an interest in agenda item WCCCGGB/17/03/106 – Chief Executive Officer's Business Report in relation to the development of the Ellesmere Port shared services hub as Dr McAlavey is a GP at Great Sutton Medical Centre and Old Hall Surgery.<br><br>Kieran Timmins declared an interest in agenda item WCCCCGB/17/03/106 – Chief Executive Officer's Business Report, in relation to the development of the Ellesmere Port shared services hub as Mr Timmins is the interim finance director for ForViva who have won the contract for managing the housing stock in Ellesmere Port. | |

| 17/03 | AGENDA ITEM | Action |
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| **C** | **MINUTES OF FORMAL GOVERNING BODY MEETING HELD ON 19TH JANUARY 2017** | |
| | The minutes of the formal governing body meeting held on 19th January 2017 were accepted as an accurate record of the meeting. | |
| **D** | **MATTERS ARISING/ACTIONS FROM PREVIOUS GOVERNING BODY MEETINGS** | |
| | **Matters Arising from the minutes of 17th November 2017**<br><br>**Action Log**<br><br>16/11/83 GP Network Chair Update – Urgent Care – *provide an update on the work in progress regarding the use of the urgent care data collected*.<br><br>Laura reported that the urgent care data is moving in to a new system which provides data on a daily basis which will assist with planning and staffing. One of the clusters had been having some difficulties gaining access to the hospital discharges information but all the teams now receive weekly information on their patients and discharges. The rural team have a weekly conference call, we need to review the usefulness of this call and if it is successful it can be rolled out for use by the other teams.<br><br>16/11/84 Senate Report - *Care Coordinator roles to be considered further at a future Senate.*<br><br>Peter informed the governing body that the care coordinator roles could be usefully considered when the accountable care organisation is discussed at senate.<br><br>**Matters Arising from the minutes of 19th January 2017**<br><br>**Action Log**<br><br>17/01/95 GP Network Chair Update<br>*An update to be provided to the networks and governing body regarding the attendance of network representatives for Primary Care Cheshire at the Systems Leaders Group.*<br><br>All three localities have representatives who attend the system leaders group on behalf of Primary Care Cheshire and are giving feedback to their respective networks. Steve queried how we engender those people with the right information prior to the meetings to enable them to act on behalf of primary care so they are not just reporting back. These representatives are being funded by Primary Care Cheshire to attend the meetings. | |

| 17/03 | AGENDA ITEM | Action |
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| | *Update on the timeframe for conclusion of discussions regarding city cluster working.*<br><br>Annabel informed the governing body that recent network discussions have focused on the accountable care organisation attendance. Alison commented that within the clinical commissioning group we have nine integrated clusters and there is a feeling that city may not be configured in the right way and if the GPs wish to review this they can. The clinical commissioning group is open minded to the footprint which should be suitable for the population in that area. Laura responded that this is part of the integrated team review and that the decision making around this process will be taken through the Cheshire and Wirral Partnership contract meetings.<br><br>17/01/97 – Quality Improvement Committee - *consider which forum to progress discussions on market robustness or fragility of our nursing home provision in the wider economy.*<br><br>Paula reported that this issue was discussed at the last quality improvement committee meeting and there was consensus that the committee spend a proportionate amount of time discussing care homes and the clinical commissioning group have a monthly mechanism with the local authority and the Care Quality Commission to review current issues and share intelligence in relation to risks. Paula along with representatives from Cheshire West and Chester and Vale Royal clinical commissioning groups also meet with the Care Quality Commission every 2 months to look at wider market issues in relation to stability and risk, this includes domiciliary care.<br><br>The Chair and Alison attended the Health and Wellbeing Board yesterday and it was very briefly touched on that one of the high level conditions from the monies received from the recent budget may be to stabilise the care home market.<br><br>Chris asked that as the Care Quality Commission has a very specific role around care home regulation, are they sharing their intelligence with us? Paula responded that we have an operational group locally which has Care Quality Commission representation on it, which is where the intelligence is shared and the Care Quality Commission do contribute to this.<br><br>Sarah commented that the local system, that Paula has been key in building, gives the clinical commissioning group a grip on this that many other clinical commissioning groups do not have. It allows issues to be picked up much earlier which then allows us the chance to do improvement work in partnership with work with the homes. | |
| **106** | **CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT** | |
| | Alison informed the governing body that today's report contains no decisions to be made and highlighted the following points:<br><br>• Recovery checkpoint and improvement and assessment framework meetings continue to be held with NHS England, formal notes have yet to be provided for the meetings held in January and February 2017. | |

| 17/03 | AGENDA ITEM | Action |
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| | • A positive first meeting has been held with Graham Urwin who has replaced Clare Duggan as the NHS England Cheshire and Merseyside Director of Commissioning.<br><br>• The local authority is leading the West Cheshire Poverty Truth Commission which aims to tackle and eradicate the root causes of poverty and ensure that people with first-hand experience are at the heart of how we think and act in tackling poverty and inequality.<br><br>• Alison and Andy McAlavey had attended a positive workshop hosted by Cheshire West and Chester Council along with partners from housing, fire, police and NHS colleagues to discuss the one public estate proposals for Ellesmere Port. Several million pounds are to be invested across the public sector and discussions are ongoing on the NHS capital elements. Alison and Andy showcased the Bromley by Bow model that they would like to echo for the NHS services.<br><br>• The report contained a section on clinical commissioning group allocations. This is of growing importance in West Cheshire clinical commissioning group as we are funded approximately £9 million less than our fair share, or target, allocation as notified by NHS England. There is increasing pressure for clinical commissioning groups to operate within their allocations which means that governing bodies will be asked to make difficult funding decisions that might impact on the health of local populations. Other neighbouring clinical commissioning groups in Cheshire are also funded at lower levels than their target allocation with a total distance from target across Cheshire of approximately £40 million. In comparison, clinical commissioning groups in Merseyside are funded at greater than £50 million in excess of their fair share, or target, allocations.<br><br>Peter commented that he had attended the local medical committee forum in Liverpool where allocations were discussed and he had pointed out that West Cheshire were worse off than Liverpool. On reflection he does not think other health economies understand our position.<br><br>Steve remarked that primary care appears to be overprovided for and he would like to know the background to that. The local medical committee were quite keen to point out that Cheshire wide practices were underprovided for which seems at odd with that statement. He queried how do we balance that when we move forward as an accountable care organisation? Alison responded that she could not comment on the primary care allocation as it stands as we would need to do due diligence in the next financial year to understand this. The Chair commented that the main issue is that we are underfunded. The common theme for the accountable care organisation work is delivering care closer to patients, partners recognise that will mean a move to more community based care. Gareth will undertake due diligence on the delegated budgets for primary care in 18/19. | **GJ** |

| 17/03 | AGENDA ITEM | Action |
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| | Kieran commented that whilst it is important that we lobby for fair resources it is essential the clinical commissioning group balance its books.<br><br>Jeremy queried why there is such a slow pace of change to get the allocation correct, and it becomes slower over future years. Gareth responded that in times of high growth it was easier to move very quickly in pace of change policy, but in times of slow growth it is much more difficult to do without taking money from other areas. The Chair suggested that perhaps in our lobbying we can push for this to be quicker.<br><br>The gaps in the public health allocation were highlighted and the negative impact for the population of West Cheshire. Public health will need to recommission services in line with the allocation.<br><br>It is important the clinical commissioning group are involved as a stakeholder when the local authority recommissions its public health services and we will need to lobby the health and wellbeing board that we are included as a stakeholder and not just through engagement.<br><br>The briefing provided to elected members is too complex and will be rewritten in a simpler form to be used as a lobbying tool. The Chair is having introductory meetings with all the local MPs and will raise the simplified briefing as part of them.<br><br>Andy requested governing body support in relation to the Ellesmere Port shared services hub as it has been very slow to get answers back on the NHS capital issue from NHS England and NHS Property Services. The Chair will raise this issue with other local clinical commissioning group officers to see if there is any additional input they can offer.<br><br>The governing body noted the contents of the report. | **AL**<br>**CR**<br><br>**CR** |
| **107** | **DEVELOPING AN ACCOUNTABLE CARE ORGANISATION IN WEST CHESHIRE** | |
| | Alison thanked the directors and staff of the clinical commissioning group for their focus on financial recovery in 2016/17. The future focus for the West Cheshire NHS system is the development of the accountable care organisation with the current four organisations reforming into one organisation for the care of West Cheshire population. The paper provided to the governing body today summarise the work to date.<br><br>PricewaterhouseCoopers were appointed for the first phase of work and they facilitated three workshops to help inform a detailed roadmap for the next phase of work, which includes the integrated teams. The roadmap has been shared by all members of the leadership group and also contains an overall assessment of our position to setting up an accountable care organisation.<br><br>The next steps are to use collective finances to move forward whilst maintaining financial stability. Four workstreams have been developed to work on this: | |

| 17/03 | AGENDA ITEM | Action |
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| | • Developing a high level operating model<br>• Redesigning the key care pathways<br>• Building a finance and activity model<br>• Developing a system wide business case<br><br>The development of the new organisation will require the support and impact of clinicians, leaders and staff during a challenging period for all the organisations involved. It will be necessary to find a parallel way to manage the day to day running of the organisations whilst completing the transitional work.<br><br>Pam queried how patients and the public will be involved. Alison responded that a simple, understandable narrative will need to be developed. Today's finance, performance and commissioning committee paper talks of a co-production process which is to be undertaken involving representatives of the clinical commissioning group and identified stakeholders, in order to develop a new engagement and participation framework for the organisation. Once developed this will be used to design services with the public. Communications will be needed for all NHS and local authority staff involved, it is essential to share an understandable form and a functions model with a series of structure and governance illustrations to identify future job roles for them.<br><br>All organisations will need to free up capacity to focus on developing the new organisation, with the ambition of the clinical commissioning group being 25% of our capacity. Additional external support will need to be identified, a bid is being made to the transformation funding held by the five year forward view.<br><br>Jeremy queried if there was a structure available to view. Alison responded that there will not be a single diagram but more likely a series of illustrations showing the different parts of the operating model.<br><br>The Chair commented that the next ten weeks are critical to produce the outline business case for organisations to consider and sign up to.<br><br>Andy asked if the funding model will be different in the accountable care organisation, as if the models are to work the resources need to be right. The Chair responded that this is why we need to be clear about the function of the new organisation before we could begin looking at the form. Consideration will need to be given to those wider determinants of health looking outside the normal health services boundary.<br><br>The governing body:<br><br>a. received the West Cheshire Accountable Care Organisation Programme Update Report<br><br>b. noted the positive progress made so far in developing an Accountable Care Organisation<br><br>c. noted the next steps and the implications of pursuing the Roadmap | |

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| **108** | **SENATE REPORT** | |
| | The Chair introduced the report on behalf of Peter Williams, who had not been in attendance at the last senate meeting, on 26th January, and it was noted that the main focus of the meeting were health optimisation and demand management in primary and urgent care.<br><br>Iestyn Harrod, Consultant Anaesthetist from the Countess of Chester Hospital, spoke compellingly on the importance of health optimisation and using the opportunity to address longer term changes not just for the recovery from surgery. A paper written by the Academy of Medical Royal Colleges entitled 'Exercise: The miracle cure and the role of the doctor in promoting it' was cited as a useful source of information. The senate considered how these messages are communicated and these discussions will now feed into the work being undertaken to draw up the health optimisations paper. Discussions were also held at the recent Health and Wellbeing meeting, as part of the public health agenda, on fitness, weight management and smoking.<br><br>Not all partner organisations were able to attend the meeting which was unfortunate as demand management is a piece of work which stretches across all organisations. The Chair has communicated to Chief Executive Officers of partner organisations regarding attendance and positive responses were received to ensure future representation will be improved at the appropriate level.<br><br>Alison informed the governing body that consideration has been given to how the senate will connect to the development of the accountable care organisation moving forwards along with how the clinical voice is obtained as part of this development. It was agreed that the senate should focus on the accountable care organisation and that it will be the place for the clinical drive for this. Peter agreed that the March senate meeting will be the last in the old style and it will then focus on the development of the accountable care organisation.<br><br>The governing body noted the issues discussed by the senate. | |
| **109** | **2017/18 FINANCIAL BUDGET** | |
| | The Chief Finance Officer, Gareth James, provided the background to this report. The budget is developed following the principles agreed in the 2017/18 financial plan. The following points were noted:<br><br>• For 2017/18 the clinical commissioning group have a budget of £341,446million including a £5,182million running cost allowance.<br><br>• We are planning to return to financial balance by the 31st March 2018. This is a huge challenge although not in accordance with NHS England business rules as there is a requirement for all clinical commissioning groups to deliver a minimum of 1% surplus. However, financial balance will comply with our legal directions and gives some confidence that we can be out of directions by the end of the 2017 / 18 financial year. | |

| 17/03 | AGENDA ITEM | Action |
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| | • The 2017/18 financial plan requires £10.5million of efficiency savings. The development of plans to deliver this was discussed.<br><br>• There is a significant level of risk to the delivery of the 2017/18 and this has been reported to NHS England as a risk adjusted deficit.<br><br>• The 2017/18 financial plan allows for additional investment in mental health. This will ensure that we will meet our 'parity of esteem' expectations.<br><br>• Our minimum contribution will be provided to the Better Care Fund.<br><br>• During 2017/18 we will receive £400,000 additional Vanguard funding to aid new models of care transformation.<br><br>Budget holders will be required to sign-off their budgets. The next steps are for the budget to be signed off by the key budget holders. The financial detail provided to the governing body (Appendix A) is a traditional way of presenting data, consideration is being given to how this can be presented differently more in line with the plan and the monthly returns that are made to NHS England.<br><br>Steve queried if there was confidence for manoeuvre within the primary care prescribing budget. Gareth responded that it will be hugely challenging and there are risks to delivering this budget. The medicines management team are now working on deliverability and further updates will provided to the committee in June 2017.<br><br>Peter questioned if the block contract with the Countess of Chester Hospital is over generous Gareth responded to report that the contract with the trust is based on outturn from the last financial year and does not include any growth.<br><br>Jeremy commented that it is important to maintain the momentum with primary care ensuring best use is made of Accenda, referral support, system.<br><br>Kieran asked what forum will be used to discuss the other budgets in the system. Chris responded that this if one of the critical workstreams programmed in the development of the accountable care organisation.<br><br>It was noted that continuing health care and NHS funded nursing care continue to grow and cause pressure and the allocated budget may be underestimated and will need close monitoring throughout the year.<br><br>The governing body agreed the 2017/18 financial budget. | |

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| 110 | **FINANCE, PERFORMANCE AND COMMISSIONING COMMITTEE REPORT** | |
| | Chris, as chair of the committee, introduced this item saying the report sets out the financial position of the clinical commissioning group comprehensively which has been subject to a high level of scrutiny at the committee. Progress had been made against some of our performance targets and at the last committee meeting a deep dive was undertaken into cancer and diagnostic targets, including a presentation from the Director of Operations from the countess of Chester NHS Foundation Trust. The committee agreed the required actions and the revised trajectory for delivery of the target.<br><br>The committee considered the financial position to the end of month 10, with a £7.8million forecast deficit. There is a risk of £2.2million and at April's informal governing body meeting further mitigations towards year-end were considered, including an opportunity to adjust our year-end accounting treatment for repeat prescribing. Locally NHS England approved this but nationally NHS England have confirmed this is not supported. Therefore, in Month 11 the year-end forecast deficit has increased £1.2million, Gareth plans a discussion with our external auditor on this issue. The governing body continue to support the measure agreed for repeat prescribing and to apply this subject to advice from the external auditor and confirm to NHS England that this is our decision as a clinical commissioning group.<br><br>Laura highlighted the following points from the performance section of the report:<br><br>• the clinical commissioning group is failing on five of its constitutional targets – referral to treatment, diagnostics, cancer waiting times (62 days), accident and emergency and ambulance calls. The referral to treatment target has been achieved for January and diagnostics is likely to be achieved by the end of March. Good progress has been made through this financial year despite being in financial recovery which shows good partnership working across the health system;<br><br>• Pressure will be maintained for the recovery plans to deliver in quarter 4 and continuing into 2017 / 18. Time has been freed up for the project managers to refresh the 2017 / 18 plans from their 2016 / 2017 learning;<br><br>• There was discussion on work taking place across the local delivery service footprint and we are leading on mental health for this group of clinical commissioning groups. There are 9 workstreams across Cheshire and Wirral and it is hoped others will take on the lead for other areas such as learning disability and continuing healthcare so we can relinquish some of our responsibility in these areas;<br><br>• The difficult decision has been take to reduce some of our third sector grants; | **GJ** |

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| | • There was discussion at the committee regarding those 2017 / 18 projects that require investment. The table in paragraph 37 of the report summarises the current position, there may be further savings as project initiation documents are still being worked up for some of the projects and the final position will be reported to the next committee meeting.<br><br>Alison informed the governing body that NHS England are undertaking a review of 108 clinical groups nationally on their quality, innovation, productivity and prevention commissioning plans. We are part of this and have Deloittes working with us who will be presenting their findings to the senior management team tomorrow.<br><br>The governing body:<br><br>a. noted the business discussed and decisions made at the finance performance and commissioning committee meeting held on 9th March 2017;<br><br>b. reviewed and challenged the progress of the priority Financial Recovery Programmes of work;<br><br>c. agreed that the decision around repeat prescribing stands depending on discussion with auditors and direction from NHS England. | |
| **111** | **QUALITY IMPROVEMENT COMMITTEE REPORT** | |
| | The Director for Quality and Safeguarding, Paula Wedd, provided the background to this report and the following points were noted:<br><br>• The report contains a link to the neonatal review carried out at the Countess of Chester Hospital. The clinical commissioning group are not the lead commissioners for neonatal services, so our role in the monitoring of the action plan is to support the Trust and Specialised Commissioning. Paula is working with our designated doctor for safeguarding children to identify what actions we need to take in respect of the references in the report to the Cheshire Child Death Overview Panel.<br><br>• The Care Quality Commission re-inspected Cheshire and Wirral Partnership Trust's mental health and substance misuse services in October 2016. The report from this visit was published in February 2017.<br><br>• Cheshire and Wirral Partnership Trust have received two regulation 28s which are sent when the coroner is not assured that future deaths might not occur if changes are not made.<br><br>• Further to the information provided to the governing body at their last formal meeting in January regarding Never Events in ophthalmology services at Wirral University Teaching Hospital another Never Event has occurred in the same specialty. Wirral Clinical Commissioning Group are leading the process to review these events and will invite Paula to their meetings with the Trust. | |

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| | Paula was asked what assurances she has that issues in neonatal at the Countess of Chester Hospital will not occur again. Paula responded that the unit has currently changed its admission criteria to change the level of dependency of the babies cared for as a means of mitigating the risk. In terms of recovery the report contains a number of recommendations, an action plan is being drawn up and specialised commissioning will hold the Trust to account over this plan. The clinical commissioning group will receive updates through the monthly contract meeting we hold with the hospital.<br><br>Alison asked Paula if she felt the pace of the enhanced surveillance process led by NHS England is sufficient enough for the Countess of Chester Hospital regarding Never Events. Paula responded that the draft quality risk profile has been completed and the meeting of the commissioners and regulators has taken place. NHS England believe it is more effective to present to the Trust with as many partners who have contributed to the risk profile in attendance to enable a meaningful discussion to take place.<br><br>Alison queried if Paula felt there is reason to request the director of nursing from the Countess of Chester Hospital to attend the quality improvement committee monthly contract meeting due to the number of falls with harm at the Trust. Paula responded that every fall with harm has been recorded as a serious incident and a detailed root cause analysis is received for each occurrence. The director of nursing has been asked to attend the next serious incident review group to discuss these reports and pace of improvement actions.<br><br>• Of the four nursing homes under review three have an improved position. Some of the information we report is more real time than that of the Care Quality Commission due to their processes prior to publication;<br><br>• It is important to note that the quality team are focused on improvement processes as well as responding to and managing incidents in nursing homes;<br><br>• We have an improving position on health assessments for children in care, but this is still lower by 10% than the North West position;<br><br>• GPs are submitting case conference reports consistently, providing over 75% of reports for initial child protection case conferences. The governing body recognised the improvements but still have some concerns regarding improving performance further and asked that the quality improvement committee look at additional support / sanctions that can be put in place to improve performance and shared with the governing body at a future meeting;<br><br>• The quality premium target for continuing health care sets targets for the number of assessments completed in a non-acute hospital environment and the timeliness within which they are completed. The intermediate care programme needs to sustain momentum to help deliver this through discharge to assess processes. Assurance was provided to the governing body that this is part of our programme for 2017/18; | |

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| | • As part of the national learning disabilities mortality review of deaths of people with learning disabilities aged 4 to 74 across England a local review has been completed and feedback will be provided to the committee.<br><br>The governing body:<br><br>a. reviewed the issues and concerns highlighted and identify any further actions for the quality improvement committee;<br><br>b. discussed the impact of the future quality premium targets in relation NHS continuing healthcare on the discharge to assess and intermediate care programme;<br><br>c. noted the positive assurance provided about the quality premium targets for antibiotic prescribing;<br><br>d. noted the update provided in relation to our equality and inclusion duties;<br><br>e. reviewed the current position reported by the Designated Nurses for Safeguarding Children and Children in Care and identified any further assurances required against the actions taken to mitigate exceptions;<br><br>f. noted assurance on the delivery of the requirements to support the national Learning Disabilities Mortality Review programme. | |
| **112** | **RESULTS OF SERVICE REVIEW POLICY CONSULTATION** | |
| | Laura informed the governing body that the results of the service review policy consultation had been discussed at the recent finance, performance and commissioning committee meeting. The report for today's meeting outlines the results of the public consultation carried out across Cheshire and Wirral. Each clinical commissioning group reviewed both their own consultation and the wider results. The decisions for the recommendations, at the end of the paper, were based on the results from the consultation, clinical findings and a review of evidence. The quality and equality impact assessment was formally considered against these recommendations.<br><br>For in vitro fertilisation the recommendation is to reduce from three cycles to two, depending on the clinical basis for decision this may include two cycles of in vitro fertilisation or one of in vitro fertilisation and one of intrauterine insemination. One session of intrauterine insemination can include up to a maximum of 6 cycles.<br><br>The Chair commented that we must contextualise our provision of in vitro fertilisation, whilst we currently provide three cycles in line with NICE guidance we are in the minority as the vast majority of clinical commissioning groups provide less. | |

| 17/03 | AGENDA ITEM | Action |
|---|---|---|
| | The Chair informed the governing body that as with all agreed policy decisions they must been underpinned by clinical judgement and there is the option to take forward through Individual funding requests or asking for further advice.<br><br>The report that is published will contain a link to the quality and equality impact assessment along with robust clinical statements for the decisions that have gone against public opinion.<br><br>Alison requested that we look at learning from the other Cheshire and Wirral clinical commissioning groups as they had a higher response rate than us. Laura will take this back to our communications and engagement team as a learning point.<br><br>The governing body:<br><br>a. noted the response to the public consultation across participating clinical commissioning groups;<br><br>b. discussed and supported the recommendations agreed by the Finance Performance and Commissioning Committee in line with the Clinical Commissioning Groups in Cheshire following review of public and clinical feedback. | **LM** |
| **113** | **LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16** | |
| | Paula Wedd highlighted the following areas from the 2015/16 report:<br><br>• Due to the introduction of the new care act safeguarding policies and procedures have been updated, and there is a new website.<br><br>• Two new strategies have been developed.<br><br>• There is a stronger focus on supporting victims of financial abuse.<br><br>• A sub-group has been set up to look at people with capacity who self-neglect.<br><br>• An ongoing priority focus is around making safeguarding personal, driven by the circumstances and wishes of the adult at risk.<br><br>• The board are actively aware of the broader safeguarding issues of modern slavery and radicalisation.<br><br>The governing body noted the contents of the report. | |

| 17/03 | AGENDA ITEM | Action |
|---|---|---|
| **114** | **LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16** | |
| | Paula Wedd highlighted the following areas from the 2015/16 report:<br><br>• The focus in 2015/16 was the Ofsted inspection for which the board received a good rating. Ofsted made four recommendations which have been incorporated into the 2016/17 business plan.<br><br>• Two serious case reviews were completed in 2015, these were the first case reviews the board had undertaken for a number of years.<br><br>• Practice learning reviews are undertaken for learning from cases that do not meet the threshold for a serious case review. Four were undertaken and a key issue was hidden males, ie somebody not known to the school or a GP or health visitor along with fabricated or induced illness.<br><br>• The Local Authority Designated Officer had received 220 contacts regarding concerns for adults working with children. This number has risen from 102 received in the previous year. Of the 220 only 8 of the concerns were substantiated.<br><br>• There are concerns around adults working with children staying in contact with the children through social media. There is a constant issue regarding what will be the next thing to cause an issue through social media and technology, last year this was around smart phones and bank accounts.<br><br>• The information in the report regarding homeless 16/17 year olds will be useful to GPs and Paula appealed to the GP members of the governing body to consider how they could share this information with their network colleagues.<br><br>The governing body noted the contents of the report. | |
| **115** | **CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS** | |
| | The Chief Finance Officer advised that nine policies are provided for ratification by the governing body, as proposed by the committee outlined in the covering paper.<br><br>The governing body approved/ratified the policies. | |
| **116** | **GOVERNING BODY ASSURANCE FRAMEWORK** | |
| | The governing body noted the information provided on the governing body assurance framework. | |

| 17/03 | AGENDA ITEM | Action |
|---|---|---|
| 117 | **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. | |
| 118 | **ANY OTHER BUSINESS** | |
| | There were no other items of business discussed. | |
| | **DATE AND TIME OF NEXT FORMAL MEETING** | |
| | The next meeting will take place on Thursday,18th May 2017, at 9.00 am, Rooms A&B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ | |

**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 16th March 2017 | | | | |
| 17/03/106 | **Chief Executive Officer's Business Report**<br>a. Undertake due diligence on the delegated budgets for primary care in 18/19.<br>b. The briefing for elected members on financial allocations to be simplified.<br>c. Use the simplified briefing as part of introduction meetings with local MPs.<br>d. Raise with other local clinical commissioning group officers the issue of NHS capital information from NHS England and NHS Property Services to see if there is any additional input they can offer. | Gareth James<br>Alison Lee<br>Chris Ritchieson<br>Chris Ritchieson | May 2017<br>May 2017<br>May 2017<br>May 2017 | Verbal update to be provided to May 2017 meeting<br>Verbal update to be provided to May 2017 meeting<br>Verbal update to be provided to May 2017 meeting<br>Verbal update to be provided to May 2017 meeting |
| 17/03/110 | **Finance, Performance and Commissioning Committee Report**<br>Discuss the year-end accounting treatment for prescribing with the external auditor. | Gareth James | May 2017 | Verbal update to be provided to May 2017 meeting |
| 17/03/112 | **Results of Service Review Policy Consultation**<br>Raise with the communications and engagement team if any learning can be gathered from the other Cheshire and Wirral clinical commissioning groups on gaining a higher response rate to consultations. | Laura Marsh | May 2017 | Verbal update to be provided to May 2017 meeting |

| | |
|---|---|
| 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:** | 18th May 2017 |
| **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:<br>• An overview of the quarter 3 improvement and assessment framework meeting and a summary of the business discussed at the financial recovery reset meeting with NHS England.<br>• An overview of a Quality, Innovation, Productivity and Prevention (QIPP) review undertaken by Deloitte UK, on behalf of NHS England.<br>• An update from the Cheshire West and Chester Health and Wellbeing Board meetings held on 15th March 2017.<br>• An update on the development of an accountable care organisation for West Cheshire.<br>• An update on the next steps for NHS England's Five Year Forward View |
| **4.** | **Recommendations** | The governing body is asked to note the contents of this report |
| **5.** | **Report Prepared By:** | Clare Dooley<br>Head of Governance<br>May 2017 |

## 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 our progress towards financial recovery and development of enhanced wider system financial planning via the development of strategic commissioning with other clinical commissioning groups. |
| 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 | |

## 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 & 2 | Financial duties | Evidence of financial recovery monitoring via meetings with NHS England. | - |
| 12 | Delivery of integrated health system. | Implementing five year forward view commissioning on wider footprints. | - |

# 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.

## RECOVERY CHECKPOINT AND IMPROVEMENT AND ASSESSMENT FRAMEWORK MEETINGS WITH NHS ENGLAND

2. A formal record of the discussion with NHS England for the clinical commissioning group's quarter 3 improvement and assessment framework meeting held on 23rd March 2017 is provided here.

3. In addition, a financial recovery reset meeting took place with the newly appointed Director of Commissioning Operations, Graham Urwin, and senior members of the NHS England area team on 24th April 2017. At this meeting, the clinical commissioning group executive team were asked to provide a presentation to cover:

    - A clear analysis of the financial context (both for the clinical commissioning group and the West Cheshire health and social care wide system).
    - Financial performance timeline (2013/14 plan through to 2016/17 outturn and 2017/18 plan).
    - Track record on QIPP (i.e. for each year QIPP plans vs. QIPP delivery).
    - Financial recovery plan status and plans to align this with 2017/18 plans.
    - Actions taken and in progress to deliver the 2017/18 plan, in particular progress made since the 27th March submission on of reducing unidentified QIPP or reducing unmitigated risks
    - The role of the governing body and membership in driving recovery
    - Demonstration of full competence in financial and contract management, outlining how the governing body takes assurances on these issues
    - Outline of the plan to move to business rules and sustainability
    - How all the above makes clear links with the local delivery system and sustainability and transformation plan

4. A formal summary of the financial recovery reset meeting is awaited and will be provided to the governing body at the July meeting.

## QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) REVIEW UNDERTAKEN BY DELOITTE UK FOR NHS ENGLAND

5. The clinical commissioning group took part in a further review of improvement activities, commissioned by NHS England (QIPP review) undertaken by Deloitte UK and Mersey Internal Audit Agency in March 2017.

6. The review was undertaken by 106 clinical commissioning groups nationally. For NHS West Cheshire Clinical Commissioning Group the format of the review consisted of a detailed desktop review of a wide range/suite of planning and governance documents, followed by a series of interviews/meetings by the exectuive team and programme managers with senior representatives from Deloitte UK. A copy of the findings from the review is provided.

7. Overall, the summary/findings report provided the clinical commissioning group with significant assurance that financial recovery and implementation of QIPP programmes is progressing well.

8. The executive team are in the process of identifying any further QIPP activities to be considered/implemented (as proposed by Deloitte UK following the review). Any decisions and monitoring of further QIPP programmes/schemes will be agreed by the finance, performance and commissioning committee and reported to the governing body as part of the committee report to each governing body meetinhg.

## HEALTH AND WELLBEING BOARD UPDATE

9. The Health and Wellbeing Board met formally on the 15th of March 2017. The agenda included:

- A presentation of the Public Health Annual Report.
- An update on the Eat Well Be Active framework and an agreement that this goes out to formal consultation. This includes services to promote healthy weight, breastfeeding, healthy eating and being active.
- A health and wellbeing board dashboard.

## DEVELOPMENT OF WEST CHESHIRE ACCOUNTABLE CARE ORGANISATION

10. The West Cheshire Way- our plans for improving health and social care is being delivered through our Accoutable Care programme.

11. We launched phase two of our pgramme on the 25th of April. There was a high level of attendance and engagement from all partner organisations including primary care Cheshire. Primary Care Cheshire are considering what support they need to help with the future vision and outcomes for primary care.

12. Phase two workstreams include agreeing a target operating model, care pathway development and financial and activity modelling.

13. Overall there are now more than 40 people involved in phase two work from primary care, the Countess of Chester Hospital, Cheshire and Wirral Partnership and Cheshire West and Chester Council.

14. The accountable care organisations leadership Group is currently tendering for phase two consultancy support.

## NEXT STEPS ON THE NHS ENGLAND FIVE YEAR FORWARD VIEW

15. In March 2017, NHS England published Next steps on the Five Year Forward View.

16. This plan takes stock of progress at the half way point of the Five Year Forward View and sets out priorities for the next two years. The most important aspects of the plan can be summarised as:

- Four national service improvement priorities identified as urgent and emergency care; primary care; cancer and mental health.
- Acknowledgement that the need to deliver financial balance will require sometrade-offs, including more pressure on waiting times for elective care.
- Sustainability and Transformation Plans are now referred to as 'Sustainability and Transformation Partnerships',with the best given the opportunity to evolve into accountable care systems (ACSs).
- A ten-point efficiency plan lays out the steps trusts and clinical commissioning groups must take to cut waste and improve efficiency.
- NHS England and NHS Improvement commit to joint working at both a national and regional level, while still retaining their distinct statutory responsibilities.

17. Perhaps the single most important message is that given the current funding constraint (which is assumed will not change) the NHS will need to make hard choices to reduce expenditure, choice and access in some services to enable the priorities in A&E, Improving GP access, Mental health and Cancer to be delivered.

18. The document sets out what these start to look like ranging from potential changes to elective care targets (Referral To Treatment (RTT)) to the focus on stopping the prescribing of low clinical value drugs.

## RECOMMENDATIONS

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

**Alison Lee**
**Chief Executive Officer**
**May 2017**

# Memorandum of Understanding for West Cheshire ACO governance

## This memorandum of understanding is made on [ ] 2017

### 1. Parties

1.1 The Parties to this Memorandum of Understanding (MoU) are the following NHS commissioners and providers and local authorities in the West Cheshire footprint:

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

### 2. Background

2.1 The Five Year Forward View published in October 2014 (the "Forward View") sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."

2.1.1 Our local vision is that the people of West Cheshire will live longer, healthier lives at home, or in a homely setting. People will be at the centre of all decisions, and receive support to the highest standards of quality and safety. We will achieve this by joining up delivery of our health and social care and focussing on prevention, early identification and supported self-management, where hospital based care is minimised.

2.2 In entering into and performing their obligations under this MoU, the Parties are working towards the implementation of an integrated care model. In particular, this MoU is intended to support the Parties' ongoing work towards the establishment of an accountable care organisation ("ACO") for West Cheshire.

2.3 This MoU sets out the West Cheshire ACO Parties' shared commitment to the ACO, what it means for organisations that want to be part of the ACO construct and what it means for those that do not want to be part of it.

2.4 The Parties will set out a timetable for the ACO development that incorporates the due diligence process as set out in this MoU and details the anticipated journey to full ACO over time.

2.5 All Parties acknowledge that there is further work to be completed to fully describe the concepts within the ACO (e.g. how will the capitated budget be calculated, how will the clinical pathways be developed and how will risk and reward be calculated) and to meet the timetable.

2.6 The Parties are committed to ensuring that all communications relating to the ACO are easily understood and are transparent.

### 3. Leadership

3.1 The Parties have formed the West Cheshire ACO Leadership Group (ALG) to lead the stabilisation of, and the options for the future integration of, the West Cheshire health and care economy, and for which:

3.1.1 Chris Hannah has been designated Independent Chair;

3.1.2 Alison Lee has been designated Senior Responsible Officer (SRO).

3.2 The role and remit of the ALG is set out in the ACO Leadership Group Terms of Reference.

### 4. Term and Termination

4.1 This MoU shall commence on the date of signature by all the Parties, and shall expire on the earlier of the execution of a formal legally binding agreement between the Parties in connection with the delivery of the ACO or 01 April 2018.

4.2 Any Party may withdraw from this MoU by giving at least 30 calendar days' notice in writing to the other Parties.

### 5. Objective

5.1 The Objective of this MoU is to provide a mechanism for securing the Parties' agreement and commitment to sustained engagement with and delivery of the ACO to realise an integrated model of care across health and social care in West Cheshire.

### 6. Agreed principles

6.1 To deliver Better Health the ACO will;

- Strive for excellence;

• Be informed by need and quality of care; and
• Put the provision of safe and effective care first.

6.2 To deliver Better Care the ACO will;

• Provide great care to people regardless of who they are, or where they live;
• Empower people, families and the community to be at the heart of great care; and
• Develop population facing and focussed services.

6.3 To deliver Better Value the ACO will;

• Enable and support self-care; and
• Use what we have got effectively.

## 7. Effect of the MoU

7.1 This MoU does not and is not intended to give rise to legally binding commitments between the Parties.

7.2 The MoU does not and is not intended to affect each Parties' individual accountability as an independent organisation.

7.3 Despite the lack of legal obligation imposed by this MoU, the Parties:

7.3.1 have given proper consideration to the terms set out in this MoU; and

7.3.2 agree to act in good faith to meet the requirements of the MoU.

## 8. ACO Membership

8.1 The Parties intend that any organisation who is to be a member of the ACO structure shall:

8.1.1 commit to the ACO Principles and the outcomes and ownership of the system success/failure. The Parties acknowledge that the delivery of health outcomes is the biggest determining factor for success of the ACO (in other words, the organisational success of each Party is not a determining factor in judging the success of the ACO);

8.1.2 agree to move towards the adoption of a capitated budget and acknowledge that the Parties have a shared responsibility for the system-wide finances under an appropriate risk and reward structure;

8.1.3 commit to being part of the ACO at this stage and shall engage with further work to define the capitation arrangements;

8.1.4 acknowledge that the consequence of a move to a capitation based budget is that each Party will have a share in the financial risk and reward; and

8.1.5 agree to work towards developing how the principle of proportionality of impact and risk share will operate within the ACO governance and decision making.

## 9. Other ACO providers

9.1 The Parties accept that a number of organisations may not be appropriate to be or wish to be ACO members and consider that organisations that deliver services to the population of West Cheshire who are not ACO members shall:

9.1.1 contribute to the health and wellbeing of the population through the delivery of their contracted services;

9.1.2 acknowledge that the ACO shall determine the clinical strategy and direction and contracts are set to deliver the clinical strategy;

9.1.3 have a voice in developing the clinical pathways as the ACO will need to harness the clinical expertise of all providers of services to the population of West Cheshire; and

9.1.4 acknowledge that in relation to commissioning arrangements, contracts with organisations outside the ACO membership could be separate from the capitated arrangements that operate for organisations within the ACO membership as set out in Paragraph 8 above.

## 10. Involvement of Primary Care, Patients and Public

10.1 Whilst this MoU does not include providers of primary care services at this stage the Parties all acknowledge that primary care is a vital aspect in the creation of an effective ACO construct for West Cheshire. The involvement of primary care representatives will be a key consideration and the Parties agree that representatives of primary care will be invited to consider their position under this MoU at such point as the providers of primary care services have agreed their operating structure to engage with the Parties in the ACO process.

10.2 This invitation allows provision for primary care to become a member of the ACO at a later stage not limited to the annual review cycle and subject to satisfying the conditions of the due diligence process.

10.3 All Parties acknowledge their various requirements to engage with patients, service users, carers, patient groups and members of the public at relevant points and will cooperate to do so in a co-ordinated way.

## 11. Due Diligence

11.1 The Parties each commit in principle to operating as a member of the ACO and shall work through a due diligence process together during 2017 to assess the viability and detail of the ACO construct.

11.2 Any Parties who have not decided as to whether they intend to be an ACO member or to be a provider working outside of the ACO at the date of this MoU shall confirm their position to the other Parties as soon as practicable

and thereafter undertake due diligence in an agreed process if they decide that they are committed to being a ACO member. The admission process for new members to the ACO will form part of an annual review cycle allowing for the entry of additional Parties at later stages.

11.3 Parties that have decided not to be part of the ACO do not need to engage in the due diligence process.

## 12. Governance

12.1 The overall aim of the governance arrangements is to make it as clear as possible where accountability, assurance and responsibility sit for the delivery of the ACO.

12.2 The Parties have agreed to establish the ALG to co-ordinate achievement of the Objective.

12.3 The Parties have agreed Terms of Reference of the ALG.

12.4 In particular the Terms of Reference describe arrangements for aligned decision-making of the Parties which they agree is necessary to achieve the Objective.

12.5 The Parties agree that the ALG will be responsible for co-ordinating the arrangements set out in this MoU and providing overview and drive for the ACO.

12.6 The ALG will normally meet monthly or as otherwise may be required to meet the requirements of the ACO, including agreeing its developing governance.

12.7 The ALG does not have any authority to make binding decisions on behalf of the Parties.

## 13. Subsidiarity

13.1 The Parties acknowledge and respect the importance of subsidiarity.

13.2 This principle of subsidiarity will underpin this approach, with decisions being made at the lowest appropriate level to allow flexibility and adaptation to local conditions.

## 14. Resources

14.1 The Parties have agreed to commit their own resources to achieve the Objective in accordance with the arrangements set out in the ALG Terms of Reference.

14.2 The Parties have further agreed arrangements to engage external resource and advice.

## 15. Openness and transparency

15.1 The Parties agree that they will work openly and transparently with each other and with other stakeholders including non-executive directors, MPs, governors, members and councillors of the Parties and other local health and care organisations.

15.2 The ALG will oversee and co-ordinate the Parties' compliance with their duties of public involvement.

## 16. Duty of Confidentiality

16.1 The Parties hold and use sensitive information about organisations and individuals in order to perform their core functions. It is important that such information is on occasion shared between the Parties. The Parties recognise that this exchange of information needs to be carried out responsibly and within the guidelines set out in this MOU.

16.2 The Parties are subject to the duty of confidentiality owed to those who provide them with confidential information and the confidentiality and security of this information will be respected.

16.3 It is understood by the Parties that statutory and other constraints on the exchange of information will be fully respected, including the requirements, where appropriate, of the Data Protection Act 1998, the Freedom of Information Act 2000 and the Human Rights Act 1998.

## 17. Dispute Resolution

17.1 The Parties will attempt to resolve any dispute between them in respect of this MoU by negotiation in good faith. The effectiveness of the working relationship between the Parties will be ensured through regular contact, both formally and informally, at all levels up to and including chief executives and chairs of the respective organisations. This will be kept under review by the key role of Independent Chair.

17.2 Any dispute between the Parties will normally be resolved at a programme or workstream level. If this is not possible, the Steering Group may refer the matter to the executive directors of the respective organisations who will try to resolve the issues within 14 calendar days of the matter being referred to them.

17.3 Unresolved disputes may be referred upwards to the ALG, who will be jointly responsible for ensuring a mutually satisfactory resolution with the facilitation of the Independent Chair.

17.4 Throughout this process it is agreed that one or more Parties shall not have the right to veto or block a decision by another Party and that no Party can make a decision which binds another Party to making a decision that the Party does not agree with.

17.5 Where a dispute arises in the delivery of collaborative work the clinical and managerial leads will work to resolve this locally before escalating it to the Steering Group. A subsequent escalation to the ALG will be used where agreement cannot be reached.

## 18. General provisions

18.1 This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

18.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18.3 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18.4 Where expected to be legally binding this MoU shall be governed by and constituted in accordance with English law and each Party agrees to submit to the exclusive jurisdiction of the courts of England.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

| | | |
|---|---|---|
| **SIGNED** by | **)** | ..... |
| Duly authorised to sign for and on | **)** | Authorised Signatory |
| behalf of | **)** | Title: |
| **NHS WEST CHESHIRE CLINICAL** | **)** | |
| **COMMISSIONING GROUP** | **)** | DATE: |

| | | |
|---|---|---|
| **SIGNED** by | **)** | ..... |
| Duly authorised to sign for and on | **)** | Authorised Signatory |
| behalf of | **)** | Title: |
| **THE COUNTESS OF CHESTER** | **)** | |
| **HOSPITAL NHS FOUNDATION TRUST** | **)** | DATE: |

| | | |
|---|---|---|
| **SIGNED** by | **)** | ..... |
| Duly authorised to sign for and on | **)** | Authorised Signatory |
| behalf of | **)** | Title: |
| **CHESHIRE WEST AND CHESTER** | **)** | |
| **COUNCIL** | **)** | DATE: |

| | | |
|---|---|---|
| **SIGNED** by | **)** | ..... |
| Duly authorised to sign for and on | **)** | Authorised Signatory |
| behalf of | **)** | Title: |
| **CHESHIRE AND WIRRAL** | **)** | |
| **PARTNERSHIP NHS FOUNDATION** | **)** | DATE: |
| **TRUST** | | |

**ACO LEADERSHIP GROUP (ALG)**

**TERMS OF REFERENCE**

## 1 Membership

1.1 The membership of the ALG shall be as follows:

1.1.1 Chris Hannah – Independent Chair

1.1.2 West Cheshire Clinical Commissioning Group (CCG):

Chris Richieson – Clinical Chair

Alison Lee – Chief Executive Officer and ACO Senior Responsible Officer (SRO)

Andy McAlavey – Medical Director

1.1.3 The Countess of Chester NHS Foundation Trust (COCH):

Duncan Nichol – Vice Chair (ALG) / Chair

Tony Chambers – Chief Executive

Ian Harvey – Medical Director

1.1.4 Primary Care Cheshire (PCC):

Kevin Guinan – Chester City Locality

Emily Morton – Ellesmere Port and Neston Locality

Alistair Adey – Rural Locality

1.1.5 Cheshire & Wirral Partnership NHS Foundation Trust (CWP):

Mike Maier – Chair

Sheena Cumiskey – Chief Executive

Anushta Sivananthan – Medical Director

1.1.6 Cheshire West and Chester Council (CWaC):

Cllr Louise Gittens – Deputy Leader, Cabinet Member - Communities and Wellbeing

Cllr Paul Dolan – Cabinet Member – Adult Social Care

Gerald Meehan – Chief Executive

1.1.7 ACO Programme Director – Ben Wright

1.2 If a Party's representative is unable to attend a meeting, the Party may be represented by a previously named deputy at the meeting. The Party shall:

1.2.1 ensure that the deputy has been duly authorised to take decisions on the Party's behalf at the meeting; and

1.2.2 shall give prior written notice of the deputy's attendance at the meeting to the chair of the meeting.

## 2 Non-Voting Members

2.1 The Parties may invite other representatives to attend meetings of the ALG as necessary as non-voting attendees with prior approval of the Independent Chair.

## 3 Meetings

3.1 The ALG shall meet monthly or at such other frequency as may be agreed by the Parties from time to time.

3.2 The ALG shall be chaired by Chris Hannah (**Chair**). One of the elected Councillors shall chair the ALG in the Chair's absence or where they are prevented from chairing a meeting (**Vice Chair**)

3.3 If the Chair or Vice Chair is not present at any meeting, the other members present shall by majority agreement nominate one of them to be the chair of the meeting.

3.4 The quorum for meetings of the ALG shall be one representative from each of the Parties.

3.5 Decisions of the ALG shall be made by unanimity. If unanimity cannot be reached in the meeting, the Chair will take this up offline with the relevant members of the ALG to agree the next steps.

## 4 Delegated Authority

4.1 The ALG is authorised to make decisions within the limits of the delegated authority of its members.

## 5 Voting rights

5.1 Voting rights are allocated to the **Chair** and one to each partner organisation (CWP, CoCH, CCG, CWaC), together referred to as the '**Executive'**.

5.2 As per paragraph 3.5, decisions of the Executive shall be made by unanimity.

5.3 Primary Care representatives will remain non-voting members until they have a nominated Chief Executive or equivalent with the authority to take decisions on behalf of Practices.

## 6 Administrative support

6.1 The ALG shall be supported by staff from the Parties.

6.2 Minutes shall be taken of each meeting and shall be circulated to the Parties within seven (7) days of the meeting.

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

**1. Date of Governing Body Meeting:** 18th May 2017

**2. Title of Report:** Unified Health Commissioning in Cheshire

**3. Key Messages:** This paper provides an update to the governing body on progress towards strengthening health commissioning arrangements for the Cheshire clinical commissioning groups. It outlines an initial case for change and seeks approval to explore and progress a programme of work looking at a unified health and care commissioning approach for the population of Cheshire. This paper was initially considered by the governing body during a private meeting on 20th April 2017 and the paper is now presented in public for ratification. The paper has also be discussed, at public meetings by other Cheshire CCGs.

**4. Recommendations** The governing body is asked to ratify that during the private meeting held on 20th April 2017 the members:

- noted the detail within the paper;
- noted the recommendation of the Cheshire Clinical Commissioning Group Accountable Officers in supporting a move to a unified health and care commissioning approach for the population of Cheshire and the need for a pragmatic phased approach which engages with all member practices, staff and partners;
- approved the recommendation of the Cheshire Clinical Commissioning Group Accountable Officers to endorse the establishment of a Joint Committee of the Cheshire Clinical Commissioning Groups as a first step in the direction of travel towards a unified approach to commissioning health and care for the population of Cheshire;

- subject to approval to proceed, noted that the Accountable Officer will bring a further paper to a subsequent Governing Body seeking approval of the required Constitutional changes and supporting documentation to enable the establishment of a Joint Committee of the Cheshire Clinical Commissioning Groups;

- subject to approval to proceed, noted that the Accountable Officer will provide further detail to Governing Body members regarding arrangements for all four Cheshire Clinical Commissioning Group Governing Body members (or identified representatives) to meet in a facilitated workshop to discuss progressing a unified health and care commissioning approach for Cheshire.

**5. Report Prepared By:**

Alison Lee
Accountable Officer
NHS West Cheshire Clinical Commissioning Group

Simon Whitehouse
Accountable Officer
NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups

Jerry Hawker
Accountable Officer
NHS Eastern Cheshire Clinical Commissioning Group

Matthew Cunningham
Head of Corporate Services
NHS Eastern Cheshire Clinical Commissioning Group

May 2017

# NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

# GOVERNING BODY

# UNIFIED HEALTH COMMISSIONING IN CHESHIRE

## INTRODUCTION

1. This paper provides an update to the governing body on progress towards strengthening health commissioning arrangements for the Cheshire clinical commissioning groups. It outlines an initial case for change and seeks approval to explore and progress a programme of work looking at a unified health and care commissioning approach for the population of Cheshire. This paper was initially considered by the governing body during a private meeting on 20th April 2017 and the paper is now presented in public for ratification.

## BACKGROUND

2. Clinical commissioning groups were established from April 2013 as the local statutory bodies to commission the majority of health services for their populations. A key difference between clinical commissioning groups and predecessor organisations (such as primary care trusts) was the emphasis on clinical leadership and the nature of the relationship with General Practice, whereby practices were 'members' of clinical commissioning groups, thereby responsible for their work. This resulted in the creation of governing bodies which had a significant number of GPs and other clinicians as members, and thus in leadership roles in commissioning. This has enabled commissioning strategies to be more clinically driven, with a greater understanding of patient needs.

3. Local areas spent considerable time developing the right footprint for the shape of clinical commissioning groups which would best optimise commissioning for their populations, taking account of Local Authority boundaries. However, the demand for health and social care continues to grow and to outstrip the expected growth in resources available, and service quality and access are being increasingly affected by cuts in Local Authority spending as well as the deteriorating financial position of NHS organisations across Cheshire. In response to this, organisations across Cheshire have been working as part of the Cheshire and Wirral Local Delivery System and signing up to a programme of work to make best use of resources across primary, social care, community and hospital settings. As part of this, commissioning organisations need to have clarity of vision on a footprint which makes sense for taking strategic decisions which will enable change to happen and which also maximises resources and improves patient outcomes, as such the Cheshire clinical commissioning group Accountable Officers and Executive Teams have been discussing in detail what work would be required to be undertaken to enable a unified approach to health and care commissioning for Cheshire.

4. A fundamental principle of commencing this work is that it is essential that we look to build on the strong clinical engagement that the four clinical commissioning groups that cover Cheshire have developed over the past five years. Moving, initially, to a health commissioning approach at a larger geographical scale can realise benefits but this cannot be at the expense of local clinical leadership. Whilst recognising this aspect any health commissioning evolution should not be seen in isolation. All areas are looking to develop systems that are more integrated and place based. Accountable care systems working across Cheshire all have General Practice as playing a central role to any move towards a place-based system of health care.

5. The development of a 'unified health and care commissioning approach for Cheshire must be aligned to the core principles that clinical commissioning groups have already established around collaborative commissioning, namely:

   - Any changes must create value for the public through:

     – implementing integrated health commissioning as an initial approach and then work to progress unified health and care commissioning for the population of Cheshire.
     – improving capacity and capability to commission better care.
     – ensuring the future commissioning system operates within its "Place based" Allocation.
     – transparency and good governance.

   - Any change must support improving the provision of care by:

     – reducing inappropriate demand for health and social care
     – driving forward system enablers (digital technology, One Public estate)
     – supporting and incentivising the transformation of care
     – supporting the development of integrated community health and social care
     – supporting and developing clinical leadership
     – empowering and involving local people to improve their health (self-care) and shaping future health and care services
     – creating a commissioning and outcomes framework to support the successful development of accountable care that will improve the health outcomes of the local population.

6. It is recognised that any work undertaken to develop new unified commissioning structures will need to be done in parallel with the emergence of new accountable care organisations/approaches. This will require significant provider development to occur at the same time. The current rate of change in this area is slower than anticipated and the progress being made to deliver the Five Year Forward View Plan for Cheshire and Merseyside requires significant focus from all involved. It is no longer acceptable that any plan for a place based approach to care delivery looks to miss out or indeed fails to include General Practice. However General Practice also needs to have a very clear focus on how it will change to me these increasing demands and respond to the changing nature of health and care delivery.

7. It is also recognised that, in undertaking the work described, this will prove challenging but it is believed to be achievable if the four clinical commissioning groups work more closely together and resources are aligned. It is also our belief that this approach would be expected and supported by NHS England, showing that the Cheshire clinical commissioning groups are working collaboratively to address the shared challenges faced by the Cheshire economy.

8. The intention is to focus our combined efforts in three main areas:

    - to explore and develop a unified health commissioner for Cheshire that will have a focus on outcomes and will lead on the consultation required for service reconfiguration. This could be through formal collaborative arrangements, including the development of joint commissioning committees and may lead to a merger of the four clinical commissioning groups. Any decision to merge the clinical commissioning groups must be taken and led by the GP membership of each clinical commissioning group.

    - to commission and support the development and implementation of three accountable care systems/organisations across Cheshire that will work toward a common operating model, build on the current transformation programmes that already exist (Connecting Care, Caring Together and West Cheshire Way), be place based and have strong GP and wider care professional involvement / leadership

    - to work closely with Cheshire West and Chester Council and East Cheshire Council, as well as NHS England, to progress the development of a unified health and care commissioning approach for the population of Cheshire building on the mandate given to health and wellbeing boards, and maximising future opportunities that may arise through devolution. Whether a single integrated health and care commissioning approach can be delivered through a single statutory organisation or through a Committee of an NHS organisation(s) and Local Authorities will need to be further explored as part of this programme of work.

## DRIVERS FOR CHANGE

9. The following are key drivers for change:

    - **Capacity of Clinical Commissioning Groups to lead the changes needed** – Local delivery system plans are describing hugely ambitious programmes of change, which will require strong clinical leadership from commissioners as well as providers. Arguably, we are not making the most of our existing skills and resources, both clinically and managerially. However, given the gap in funding for health and social care locally, without these changes happening or additional resources being put in, we will no longer have an NHS free at the point of delivery with the current service offer.

- **Developing the provider landscape through commissioning** – there are discussions amongst local providers to explore providers working more closely. However the current provider system is unsustainable locally both in terms of the clinical care model and the financial position. Strong commissioning will be needed to ensure that we continue the drive to enhanced community and primary care services, optimising our spend in hospitals in order to free up resources and skills to treat people in their own homes whilst also improving mental health outcomes.

- **The advent of accountable care systems** – the Five Year Forward View describes a number of organisational models in which financial and clinical risks are shared across providers, with some elements of more traditional commissioning functions built in to enable this to happen – for example pathway redesign. Given our fragmented starting point, if we are to move to this model of health care delivery, there are a number of steps which could help on the way including integration across providers, and integration across commissioner.

- **An agenda for change** – NHS England recognises the appetite amongst some clinical commissioning groups to come together to more effectively address the growing challenges being faced across the health system. The introduction of a Legislative Reform Order ("LRO") in October 2014 allowed clinical commissioning groups to form decision making joint committees and gave clinical commissioning groups an additional option for undertaking collective strategic decision making. Whilst primarily this was aimed at the commissioning of primary care (GP services) it allows clinical commissioning groups to consider other commissioning areas as well. Furthermore, NHS England for the first time issued guidance in November 2016 around clinical commissioning group mergers, paving the way for this to happen, and is seen as supportive towards strengthening the commissioning role across the health system on a bigger geographical footprint and in response to the Five Year Forward View. Over recent months, there has been an increase in the number of clinical commissioning groups regionally and nationally forming joint committees or being approved to progress towards formal mergers as a response to the clinical service and financial pressures that they face and which mirror those across Cheshire.

**10.** It is probably fair to say that the level of change needed across the health and care system across the next five years is greater than anything that has gone before. No one organisation has the capacity and capability to lead these changes.

## PROGRESS TO DATE

11. At the end of December 2016 and beginning of January 2017 the five Cheshire and Wirral clinical commissioning group governing bodies received and/or considered an exploratory paper regarding further strengthening and formalising collaborative commissioning arrangements across the Cheshire and Wirral Local Delivery System.

12. Within this paper, governing body members were provided with the detail of how clinical commissioning groups could progress, and the benefits and risks of pursuing / progressing the following options:

    - establishment of a joint committee across Cheshire and Wirral;
    - formal merger of four or five clinical commissioning groups into one;
    - establishment of formal arrangements for sharing expertise in relevant areas, development of a single leadership team and lead commissioning arrangements.

13. The paper also provided detail on the following:

    - case for and process towards the establishment of a joint leadership team across Cheshire and Wirral, and formal arrangements for the sharing of expertise in relevant areas possible commissioning areas to be done at scale / jointly across Cheshire and Wirral.

14. Whilst each clinical commissioning group governing body provided their own individual views on the proposals outlined within the exploratory paper, there was consistency across the main areas detailed in the responses to these discussions, namely:

    - recognition of the need to and support towards clinical commissioning groups to work more closely together in a collaborative way on commissioning responsibilities where scale and capacity made sense to do, and also where the benefits of such arrangements could be articulated
    - further clarity required as to how the development of joint/integrated commissioning arrangements supported and/or worked alongside the development of accountable care systems, with concern noted that progressing towards joint commissioning should not divert or distract from business critical functions and the development of accountable care systems
    - that the clinical leadership and engagement built through clinical commissioning groups should be used as the building block to any future changes and should be viewed as being fundamental to the success of any organisational change
    - that any organisational change did not become a distraction or risk the failure of any single part of the system delivering the very challenging financial targets in each area
    - that the risk of 'doing nothing' was as significant in terms of failing in our collective ability to maximise the benefits for our local population.

15. Throughout January and February 2017 the Cheshire clinical commissioning group's Accountable Officers have continued to meet and have discussed further the need to enhance the governance arrangements around decisions made collaboratively at these meetings. Discussions have also continued on how to further progress joint / integrated commissioning at scale to help address the challenges faced by each clinical commissioning group, as well as develop and strengthen collaborative commissioning on a 'place' basis, in line with national policy and the objectives of the Sustainability and Transformation Plan.

16. In February 2017 the Accountable Officers and Chairs of the Cheshire and Wirral clinical commissioning groups met to discuss further the case for formally progressing joint commissioning arrangements and a consensus was met by those in attendance to proceed to bringing back to each clinical commissioning group governing body at a meeting held in public a further paper outlining a direction of travel towards a strengthened and more resilient health commissioning arrangements for Cheshire and Wirral. Subsequent to this meeting, there has been a consensus to focus initially on the Cheshire clinical commissioning groups whilst NHS Wirral Clinical Commissioning Group progresses with regards integration with Wirral Council.

17. Since January 2017, the Executive Teams of each clinical commissioning group have started to meet collectively on a monthly basis to further collaborative working arrangements, to identify which areas to prioritise over the coming year and to identify and articulate options/models on how lead directors and clinical commissioning groups could be best placed to progress collaborative commissioning of key service areas, such as continuing healthcare, primary care contracting, mental health, and learning disability.

18. The Accountable Officers and executive teams of each clinical commissioning group are supportive towards the development of a unified approach to health and care commissioning on the basis that all the factors detailed earlier are covered and included. It is the belief that the focus over the next 12 months – and resources - should be centred on this

19. There is recognition that even talking about this can be very unsettling for staff. That is not the intention but we are cognisant of this impact. Regular team briefs and drop in sessions will continue to be held across all the clinical commissioning groups as this progresses but we are also clear that we do not yet have all the answers.

20. The Cheshire clinical commissioning group Accountable Officers recommend that the Cheshire clinical commissioning groups should now undertake the following key steps:

    - Clinical commissioning group governing body endorse the undertaking of the required work to move to a unified health and care commissioning approach for the population of Cheshire
    - Clinical commissioning group governing body members, or identified representatives of, to meet with other clinical commissioning group governing body members within a facilitated workshop to discuss progressing a unified health commissioning approach for Cheshire
    - Clinical commissioning group governing body to endorse the establishment of a joint committee of the Cheshire clinical commissioning groups as a first step in the direction of travel towards a unified approach to commissioning health and care for the population of Cheshire.

## WHY ESTABLISH A JOINT COMMITTEE?

21. Clinical commissioning group Accountable Officers, Chief Finance Officers and Directors across Cheshire have been meeting together for the last four years in meetings or committees under various terms of reference, memorandum of understandings and with varying remits so as to take forward a number of issues of common interest and 'collaboratively commission' services where it makes sense to do so over a larger scale/geography. These meetings have proved useful in sharing good practice and discussing areas which are common to all clinical commissioning groups, however these arrangements have not been set up with any formally delegated powers / authority from clinical commissioning group governing bodies and have largely operated on the basis of collective and collaborative decision making that is within the responsibilities / standing Financial Instructions of those in attendance.

22. This arrangement has often resulted in delays in decision making as approval/authorisation on issues outside of individuals delegated making authority / standing financial instructions and on areas common to all four clinical commissioning groups have had to defer back to individual clinical commissioning groups hierarchy for formal approval of decisions. This arrangement has also contributed to variation in decisions and approach taken when and where a singular collective approach/way forward would have been the desirable approach, contributing in avoidable variation in service commissioning and provision for the population of Cheshire.

23. The development of a joint committee allows the opportunity for greater consistency and facilitates effective and timely decision making on a wider geography. In turn, it also provides a single focal point in the event of legal challenge as opposed to all constituent members. Whilst a committee of this nature provides opportunity for variation in views and a forum for discussion, it binds all organisations to a singular decision – so no risk of one organisation acting alone, however equally an occasion may occur where one clinical commissioning group may be bound by a decision they disagree with. Establishment of a joint committee may therefore also expose a clinical commissioning group to greater financial risk from shared decision making.

24. In summary, there are some obvious benefits to adopting a more formalised joint arrangement - through a joint committee - for commissioning some of our services at scale across Cheshire:

    - it reflects the overall national direction of travel and STP objectives for effective system leadership;
    - more efficient decision-making in terms of time and resources;
    - potential reduction in variability of provider performance and ensuring consistent standards of delivery in key transformation areas that are collectively identified in in individual clinical commissioning group commissioning intentions, operational plans and local delivery system priorities;

- maximising the benefits and ensuring that we can oversee and incentivise at scale the collaboration that we require from our providers – particularly in acute care;
- sharing our collective skills and capabilities to realise the maximum possible benefits.

## ESTABLISHING A JOINT COMMITTEE

25. The NHS Act 2006 (as amended) ('the NHS Act'), was amended through the introduction of a Legislative Reform Order ("LRO") to allow Clinical Commissioning Groups to form joint committees. This means that two or more Clinical Commissioning Groups exercising commissioning functions jointly may form a joint committee as a result of the Legislative Reform Order amendment to s.14Z3 (clinical commissioning groups working together) of the NHS Act. Joint committees are a statutory mechanism which gives clinical commissioning groups an additional option for undertaking collective strategic decision making.

26. Across Cheshire each clinical commissioning group has previously operated or is currently operating a joint commissioning committee (agreement) with regards the commissioning of primary care. As such each clinical commissioning group constitution currently contains the necessary legal 'wording' to allow the formation of joint committees. Therefore each governing body can delegate decision making responsibility to another joint committee for other commissioning areas currently the individual responsibility of each clinical commissioning group.

27. Subject to the governing body of each clinical commissioning group supporting progressing work to achieve a unified approach to health and care commissioning and the establishment of a joint committee, there would be need to be undertaken an urgent piece of work to:

    - agree the functions to be delegated to the new Cheshire joint committee
    - agree the scope of the decision making
    - develop and propose an annual work plan for the committee
    - development of a partnership agreement/memorandum of understanding (MOU)
    - development of a terms of reference to include:
        - the formal functions of the committee
        - the scope of service areas/clinical commissioning group commissioning responsibilities to be considered under the remit of the committee
        - linkages to other system wide programmes of work
        - conflict of interest management
        - membership – incorporating how many people from each clinical commissioning group sit on this committee and who as well as status of chair of committee (i.e. independent, rotating chair)
        - quoracy – the absolute number, and mix (clinical, lay, managerial) of members needed to be in attendance in order for formal decisions to be made

  - other practical arrangements such as voting (right/weight), notice period for meetings, operation of committee (in public/in camera), resourcing and minimum distribution period for circulation of papers.

- understand and agree changes to the clinical commissioning groups scheme of reservation and delegation - to reflect any amendment to the standing financial instructions of the relevant clinical commissioning group committee member(s).
- seek legal advice and support in the process towards establishing a joint committee.

## TIMELINE TO ESTABLISHING A JOINT COMMITTEE

28. It is important to recognise that even if there is not final agreement from the governing bodies of each clinical commissioning group to a full merger of the clinical commissioning groups that the joint committee is still an important development that needs to happen anyway.

29. It is proposed that the first meeting happens in either June or July 2017 with task and finish meetings taking place in April and May to support its development and establishment.

30. A Cheshire joint commissioning committee would be a committee of each of the Cheshire clinical commissioning groups. As such each governing body will be required to receive and approve the terms of reference for this committee and the resulting clinical commissioning group constitutional changes. Each clinical commissioning group will also be individually required to submit to NHS England its constitutional amendments for authorisation.

**31.** Subject to approval to proceed, the Accountable Officer will bring a further paper to a subsequent governing body seeking approval of the required constitutional changes and supporting documentation to enable the establishment of a joint committee of the Cheshire clinical commissioning groups.

## JOINT WORKING WITH LOCAL AUTHORITIES

32. A key relationship in all of this is that with the two Local Authorities of Cheshire, the role of the two Health and Wellbeing Boards and the continued development of and response to the respective Joint Strategic Needs Assessments of each Local Authority area.

33. The development of the Better Care Fund has demonstrated opportunities for how local authorities and clinical commissioning groups can commission better together, but equally has demonstrated inefficiencies and challenges that a unified integrated commissioning approach could deliver far greater value to our communities.

34. Inevitably it may prove that integrating health and care commissioning may need to progress at different paces to comply with the governance and legislation effecting each partner. The opportunities to bring the clinical commissioning groups together may progress at a faster pace but must be done in such a way that joint working with the Local Authorities is both maintained and further strengthened. This is being considered with Local Authority Chief Executives and other colleagues.

## CHALLENGES AND RISKS

35. As well as the opportunities described within this paper, there are undoubtedly some challenges and risks in moving forward in this way. These include:

- bringing together the different cultures across multi organisations
- ensuring a bigger structure connects with the local communities
- managing the differences across governing bodies and its constituent practices, including the makeup and remuneration of the governing bodies
- ensuring that the skills of all governing body members and clinical commissioning group staff are used to optimum effect in the new arrangements
- maximising local clinical leadership
- maintaining delivery of cost savings, financial duties and clinical commissioning group statutory duties
- managing the differences in financial position across the clinical commissioning groups in an equitable way
- ensuring existing strategies are built upon
- ensuring that local relationships are not lost, recognising differences in key community influencers and decision makers
- ensuring a smooth transition for staff
- ensuring that the development of accountable care is coterminous with the new commissioning approach.

## ENGAGEMENT

36. In line with the direction of travel set out within the paper, if the Governing Body of each Clinical Commissioning Group supports progressing the work to be undertaken then engagement with Governing Body members, Clinical Commissioning Group membership, staff and key stakeholders to inform and shape the development of a new unified commissioning approach for Cheshire will need to commence.

37. Whilst existing clinical commissioning group constitutions allow for the establishment of a joint committee and delegation of commissioning responsibilities to that committee and as such formal approval is not required – as such, it will still be important that each clinical commissioning groups member practices to understand and support the changes and how they can continue to shape commissioning locally. If this direction of travel is endorsed by the governing bodies, there will need to be a formal mechanism to assess this support.

38. If through the work undertaken there emerges a consensus to consider a formal proposal to merge clinical commissioning groups then there would be a need to seek and receive practice member support.

39. Whilst there is no requirement for formal public consultation on these changes, it is recommended that these changes are explained to the public, so they are assured of their continued ability to inform the shape their local NHS. As such, a programme of public engagement will need to be scheduled during this period of change to include working with the Healthwatch organisations in both areas, as well as local patient and carer groups operated/supported by the respective clinical commissioning groups.

## NEXT STEPS

40. Subject to approval to proceed by the governing bodies, the following key steps will be undertaken over the next two to three months:

- facilitated workshop date agreed and details circulated to governing body members (April – May 2017)
- staff and GP members briefing developed and circulated (April - May 2017), and engagement plan put in place (May 2017)
- Task and finish groups to meet to work through the development to a joint committee and approaches to unified health and care commissioning (April –May 2017)
- Joint committee and constitutional changes governing body paper developed and presented to the governing body (May 2017)
- Joint committee meeting (June – July 2017)

41. Further key steps to be undertaken will be detailed in a future update to the Governing Bodies.

42. This paper was presented to the governing bodies of NHS South Cheshire Clinical Commissioning Group[1] and NHS Vale Royal Clinical Commissioning Group[2] on 6th April 2017 and Eastern Cheshire Clinical Commissioning Group on 26th April 2017.

## RECOMMENDATION

43. The governing body is asked to ratify that during the private meeting held on 20th April 2017 the members:

a) noted the detail within the paper;

[1] http://www.southcheshireccg.nhs.uk/events/11244-governing-body-meeting
[2] http://www.valeroyalccg.nhs.uk/events/11241-governing-body-meeting

b) noted the recommendation of the Cheshire Clinical Commissioning Group Accountable Officers in supporting a move to a unified health and care commissioning approach for the population of Cheshire and the need for a pragmatic phased approach which engages with all member practices, staff and partners;

c) approved the recommendation of the Cheshire Clinical Commissioning Group Accountable Officers to endorse the establishment of a Joint Committee of the Cheshire Clinical Commissioning Groups as a first step in the direction of travel towards a unified approach to commissioning health and care for the population of Cheshire;

d) subject to approval to proceed, noted that the Accountable Officer will bring a further paper to a subsequent Governing Body seeking approval of the required Constitutional changes and supporting documentation to enable the establishment of a Joint Committee of the Cheshire Clinical Commissioning Groups;

e) subject to approval to proceed, noted that the Accountable Officer will provide further detail to Governing Body members regarding arrangements for all four Cheshire Clinical Commissioning Group Governing Body members (or identified representatives) to meet in a facilitated workshop to discuss progressing a unified health and care commissioning approach for Cheshire.

**Alison Lee**
**Chief Executive Officer**
**May 2017**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

| | | |
|---|---|---|
| **1.** | **Date of Governing Body Meeting:** | 18th May 2017 |
| **2.** | **Title of Report:** | Senate Report |
| **3.** | **Key Messages:** | This report provides an overview of the business discussed at the senate meeting held on 23rd March 2017. The meeting focussed on:<br>• A review of the senate terms of reference;<br>• Presentations from North West Ambulance Service NHS Foundation Trust and the Countess of Chester Hospital NHS Foundation Trust followed by a discussion/workshop on urgent care services/pressures for West Cheshire. |
| **4.** | **Recommendations** | The governing body is asked to note the issues discussed by the Senate. |
| **5.** | **Report Prepared By:** | Clare Dooley<br>Head of Governance<br>May 2017 |

| **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 important and ongoing review and improvement of urgent care services for the population of West Cheshire. |
| 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 | This report highlights discussions on improved integrated and primary care services to reduce the impact on urgent care services. |
| We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets | This report highlights improvements and service development to meet constitutional targets for urgent care services. |
| We will develop our staff, systems and processes to more effectively commission health services | |

# 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. This paper provides an overview of the March senate meeting.

## CONTENT

2. The Senate met on 23rd March 2017 with Peter Williams, Hospital Doctor Member on NHS West Cheshire Clinical Commissioning Group Governing Body, as chair. The first point of action was to review and agree the revised terms of reference for the senate, followed by a presentation by Paul Maddock from North West Ambulance Service NHS Trust on the support for the service's frequent callers, followed by a presentation from Sarah Faulkner on the service's current pressures. David Wilson and Ian Harvey provided a presentation on the pressures at the front door of the Countess of Chester Hospital NHS Foundation Trust and the group discussed how the health economy can support change. Peter Williams ended the session with a summary of discussions and the group confirmed their reflections of the meeting.

### Review of Terms of Reference

3. The group agreed the changes made to the terms of reference and Peter noted the purpose of the senate is to review and recommend changes. It was agreed the meetings will continue to be held bi-monthly and will focus on the delivery of the strategic plans of the West Cheshire Way and the Five Year Forward View.

### North West Ambulance Service - Frequent Callers

4. Paul Maddock from North West Ambulance Service NHS Trust presented to the group on the Trust's frequent callers programme. Paul has been a Paramedic for over 20 years and started working for the frequent caller service three years ago. The service operates with a team of nine staff and is funded by clinical commissioning groups.

5. A frequent caller is someone who calls five times in one month or twelve times in three months.

6. The average number of new frequent callers in Cheshire is nine per month. Paul advised the group that IT systems have been developed to identify if callers have been involved with other services. A new pilot system has been set up in Yorkshire, which will be operational from 1st April 2017 which will highlight the most frequent callers and work with safeguarding teams to pick up on any safeguarding issues that may have been missed.

7. Paul confirmed there are four stages of intervention for frequent callers and a triage tool is in place to prioritise who is seen first. Any callers under 18 years old are automatically referred to the appropriate safeguarding team for review.

8. Stage 1 callers receive a telephone call to discuss why they are frequently calling then a follow up letter will be provided and their GP will be contacted to confirm what has been discussed. A stage 2 intervention involves a face to face meeting with the caller, although these are rare and only make up 10 – 15% of callers with many cases resulting from social isolation issues. Stage 3 escalations are reviewed at a multi-disciplinary team meeting to discuss how these callers will be dealt with.

9. Ninety percent of the frequent callers service time is spend on stage 4 interventions. While these interventions only make up 10% of calls they are very complex cases. These cases are reviewed by a complex case board where a change to response may be proposed, although not all of plans for change are successful in reducing call numbers.

10. Paul provided figures on frequent calls for the past 12 months and noted some of callers will start calling more often after an intervention has taken place. However, the results show an overall reduction of 69% in calls following an intervention. Paul confirmed there have been issues in Merseyside with patients regularly attending the different local hospitals and advised that the hospitals now meet on a quarterly basis and adhere to the individual care plans developed for these patients. Paul suggested the same approach should be implemented in Cheshire, and is important from a safeguarding perspective.

11. Paul provided the following case studies regarding frequent callers:

    a) A 71 year old lady was making nine calls per month. When Paul spoke to her he found out that as well as caring for her husband who was in the early stages of dementia she was also caring for her son who was terminally ill. Although Social Care were involved they were unaware this lady was looking after her terminally ill son. Once these issues were identified, extra support was put in place to support the family and the call numbers reduced.

    b) An 81 year old lady has been on the frequent calls list since the service began in Cheshire and Wirral. She presents with pain, is frail but has fluctuating capacity according to her situation. She has completed mental health assessments which she has passed, is very demanding of services and her family as a consequence has had services withdrawn from Age UK and has been removed from a nursing home as she refuses to self-fund.

This patient's case has now been referred to the complex case review board and she currently fluctuates between two calls within 28 days to as many as 98. A significant contributory factor in this case is social isolation as her family have now disconnected from her. She has been referred to the Brightlife service but refuses to get involved with their services. Paul confirmed he feels little more can be done to reduce the numbers of calls from this lady.

12. Paul noted the outcomes achieved from the service are:

- Capacity to support more frequent callers;
- Freeing up more resources;
- Early interventions;
- Safeguarding issues are being picked up;
- Improved patient care;
- Decrease in 999 and transport to emergency departments;
- Individual case management;
- Improved partnership working;
- Positive cost implications.

13. The group discussed the success of the frequent caller service that is provided in Blackpool which is funded by GP surgeries. This has resulted in an 89% reduction in calls to 999 services and an 82% reduction in self harm incidents. The number of calls to the police has also reduced which shows it has impacted on many different services this has created a £2.7million saving for services.

14. Paul confirmed estimated savings of £0.5million could be made within 12 months in Cheshire and Merseyside. However, to achieve these savings and meet patient's needs a Specialist Paramedic would need to be employed for each clinical commissioning group.

15. The group agreed a big issue for frequent callers is social isolation and agreed these patients need to be supported before they become socially isolated. The group discussed the issues around frequent callers in primary care and noted a lot of frequent callers have an open door policy with their GPs. It was agreed the demand on services is across the population and there needs to be a whole health community initiative around this.

16. Peter thanked Paul for his presentation and noted the whole health economy approach is something the senate would like to recommend. Andy McAlavey, Medical Director from NHS West Cheshire Clinical Commissioning Group, agreed the discussions had been useful to support the clinical commissioning group's work with the RightCare data to identify specific areas for further work to support prevention and self-care initiatives which are a priority for the delivery of the West Cheshire Way.

## North West Ambulance Service - Current Pressures

17. Sarah Faulkner, Director of Quality at North West Ambulance Service NHS Trust and Nurse Representative on NHS West Cheshire Clinical Commissioning Group Governing Body, provided an update on current pressures for the North West Ambulance Service NHS Trust. Sarah confirmed system pressures are impacting on the service and there are different elements to the service which include a 'hear and treat' service where patients can be referred to other clinical services and an urgent care desk to help avoid sending vehicles out when not necessary.

18. Sarah reported that recent data shows current targets are not being met and advised there are breaches in response and handover times at the hospital which means paramedics are waiting in accident and emergency for patients to be handed over before they are able to respond to their next call. Some calls are waiting for over 60 minutes for a response including some red 1 category calls.

19. Sarah advised the service is stretched beyond capacity which is creating risks to patients and patient stories are hitting the headlines as families are being affected. Managing demand has become unsustainable and the service cannot continue as it is. The group agreed there need to be fewer acute calls as currently only 10% of calls are life threatening.

20. Sarah confirmed there were some issues in relation to GPs sending patients to accident and emergency departments although work is taking place to resolve these. It was agreed that although the numbers for each GP practice are small when amalgamated across the area they are significant. The group discussed the issues around triaging of calls and Sarah advised a tool has been created to help staff triage calls better.

## Countess of Chester Hospital - Pressures at the Front Door

21. David Wilson, Consultant at the Countess of Chester Hospital NHS Foundation Trust provided a presentation to the group on the pressures at the Trust's accident and emergency department. David confirmed attendance and admissions have increased nationally, with pressures on the system increasing, although he felt there were other factors involved and suggested this is a whole system problem.

22. David noted that he feels although the Countess of Chester Hospital NHS Foundation Trust is better than most acute trusts there are still improvements to be made. One of the main issues is overcrowding which does impact/compromise care.

23. It was agreed people are now using emergency services differently than they have previously and they are calling ambulances more frequently. It was suggested this is due to social issues and changed expectations. The group agreed that the demands of generations of the population have changed.

24. David advised the Government have suggested all emergency departments have a GP led triage service, although some professionals feel this should be nurse led as more appropriate than using GP capacity. David commented that the use of emergency departments as a place of safety is an issue, as is the fragmentation of services.

25. David confirmed a number of initiatives are taking place to help prevent people being admitted to accident and emergency. The group agreed a whole system approach is the only way to resolve these issues.

## CONCLUSIONS

26. The group reflected on how these changes could be supported to include the following points:

- Just make changes!
- Attitudes need to change, what is the best investment to make for the future?
- Work across boundaries.
- Encourage people to support change.
- Share good practice.
- Accountable care organisation, better use of money to support front line services and avoid duplication.
- Listen to the public - “accept it, don’t fight it”.
- Wider system change around prevention.
- We’re still working in silos.
- Understand the way people want to use health and social care has changed.
- Stop saying we are failing as this is demoralising for staff.
- Focus on health care and be more realistic.
- Focus on where we are today, make people aware of the work we are doing.
- Think outside of the box to implement changes
- Find a balance between developing the system, balancing the books and continuing to deliver fantastic patient care

### Summary and Reflections of the Meeting

27. Peter thanked everyone for their thoughts and reflections at the meeting.

## RECOMMENDATION

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

**Dr Peter Williams**
**Senate Chair / Hospital Doctor Governing Body Member**
**May 2017**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

**1. Date of Governing Body Meeting:** 18th May 2017

**2. Title of Report:** Primary Care Comissioning Committee Report.

**3. Key Messages:**

The Primary Care Committee reviewed and revised the options available for those practices with Personal Medical Services contracts in relation to the funding premium and associated Key Performance Indicators.

The Support and Escalation process has been further refined to define those practices in formal escalation and those who are being supported informally.

The Committee considered revised specifications for Local Enhanced Services for Anticoagulation, Vasectomy and Medicines Managers.

The outline costs for the provision of the Extended Hours services in 2017/18 were reviewed.

All Practices have achieved the Primary Care Commissioning for Quality and Innovation Scheme (CQUIN) for 2016/17. As a result those patients have been identified as moderately/severly frail have been assessed and care plans developed.

There are ongoing concerns with the service provided by Primary Care Support (Capita) in relation to outstanding patient notes with all practices undertaking an audit to understand the scale of the problem.

## 4. Recommendations

The governing body is asked to note the decisions and recommendations made by the Primary Care Commissioning Committee including;

a. The recommendation of the Committee to offer the Personal Medical services practices the options of stretch Key Performance Indictors or alternatively to reduce the amount of discretionary funding they receive equivalent to the Personal Medical Services premium

b. To suspend the withdrawal of Western Avenue Medical Centre's Personal Medical Services premium while further work is undertaken

c. To accept the reviewed Local enhanced service specifications for

- Medicines Manager Service
- Vasectomy Service
- Anti-coagulation Service

d. To accept the Committee's approval of the outlined costs and the process for commissioning the extended hours service for 2017/18.

e. Note the level of concern regarding the service provision by Primary Care Support (Capita) and the Committee's recommendation to write to NHS England collectively as Cheshire and Wirral Clinical Commissioning Groups voicing those concerns.

## 5. Report Prepared By:

Laura Marsh
Director of Commissioning
May 2017

| **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 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 | **The report provides an update on the Personal Medical Services contracts** |
| We will commission integrated health and social services to ensure improvements in primary and community care | **The report provides an update on Personal Medical Services, local enhanced services and extended hours** |
| 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 in primary care | No change |
| 9 | Engagement of stakeholder in new models of care | The report provides an update on GP forward plan | No change |
| 10 | Delivery of financial recovery plan | The report provides an update on outlier practices project | 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 COMMISSIONING COMMITTEE REPORT

## INTRODUCTION

1. This report provides an overview of the business discussed and decisions made at the Primary Care Commissioning Committee meeting on 27th April 2017.

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

## PRIMARY CARE CONTRACTING

### Personal Medical Services

3. There are five practices in West Cheshire Clinical Commissioning Group with Personal Medical Services contracts. As part of the contractual process, a set of Key Performance Indicators are negotiated annually for delivery of services over and above the core General Medical Services contract. As part of the national Personal Medical Services review, these practices will have the additional funding (also known as the Personal Medical Services premium) withdraw gradually over a four year period and therefore the Key Performance Indiactors are expected to be re-negotiated each year to remain proportionate to the funding received. However the Committee were concerned that the Key Performance Indicators were not robust enough for 2017/18.

4. Therefore following considerable further discussion it was agreed that the Clinical Commissioning Group would inform the practices that they would have two options for 2017/18; either to accept stretch Key Performance Indicators that would ensure delivery over and above core General Medical Services or alternatively to choose not to have Key Performance Indicators but then the Clinical Commissioning Group would reduce the discretionary funding element of the Primary Care Quality and Innovation scheme to equate to the amount of the Personal Medical Services premium for that practice. The GP Network leads will support the Clinical Commissioning Group in the discussions with each of the Personal Medical Services practices.

5. At the March committee meeting, members considered evidence submitted by Western Avenue Medical Centre as to why they should be considered exceptional in retaining their Personal Medical Services premium. However members felt that the evidence was insufficient to justify the retention of the additional funding to address the needs of this specific population.

6. This issue was further considered by the primary care operational group meeting who felt that any change in funding could destabilise the practice to the extent where they would look to hand their contract back to NHS England.

7. The committee therefore agreed that there should be a pause of three months in the reduction of funding for Western Avenue whilst work is undertaken with the practice, to determine how best to utilise the available funding in the short and medium term to address the health inequalities faced by this practice population.

## Formal Support and Escalation Process

8. The Support and Escalation process is now further refined whereby practices will be 'formally' in escalation based on whether they are two standard deviations from the clinical commissioning group average on two or more indicators. Those practices that are one standard deviation from the mean will be 'informally' in escalation and therefore supported to address opportunities for learning but are not at risk of financial penalties. The committee discussed the need to continuallty review and refine the process as it is embedded, including moving to national/peer average over time. The full Primary Care Dashboard for April is available here.

## PRIMARY CARE COMMISSIONING REPORT

9. The Committee supported the Primary Care Operational Group's recommendation to approve the Local Enhanced Services for;

- Medicines Manager Service
- Vasectomy Service
- Anti-coagulation Service

10. NHS England wanted to build on the work around Enhanced Extended Hours that had been developed with the Prime Minister Challenge Fund pilot sites. In 2016-17, NHS England introduced the General Practice Access Fund (GPAF) to enable Clinical Commissioning Groups to commission and fund extra capacity to ensure that everyone has access to GP services. The remit of Extended Hours service is to provide routine primary care to patients outside core hours of GP practices.

11. The prorata funding from NHS England for 2016/17 (£1.17m) was paid to Primary Care Cheshire. In 2017/18 the full year allocation of approx. £1.5m will be paid directly to the Clinical Commissioning Group. It is worth noting that those Clinical Commissioning Groups that did not access the Prime Minister's Challenge Fund will only receive prorata funding for Extended Hours in 2018-19 and the full funding allocation from 2019-2020.

12. An overview of the estimated costs for delivering the Extended Hours service for 2017/18 was considered. NHS West Cheshire Clinical Commissioning Group is keen to maintain continuity of delivery of these services and continue to use the current providers. However, there is a need to demonstrate that the proposed costs also offer value for money.

13. The Committee approved the outlined costs and the process for commissioning the extended hours service for 2017/18.

## PRIMARY CARE QUALITY

14. The Clinical Lead for Quality and Safety continues to keep an overview of incidents and themes reported by Primary Care. A thematic feedback report is being drafted to share with GP Practices as recommended at the last committee.

15. All Practices have achieved the Primary Care Commissioning for Quality and Innovation Scheme (CQUIN) for 2016/17. A significant proportion of vulnerable patients within West Cheshire have now received a frailty review enabling practices to be prepared for the changes to the General Medical Services contact for 2017/18. Further work will now be undertaken to look at patient outcomes within the target patient group.

## PRIMARY CARE SUPPORT/CAPITA

16. There are ongoing concerns being reported by practices regarding patient notes. As a result the clinical commissioning group has asked all West Cheshire practices to carry out a reconciliation and inform NHS England of how many records they are missing to support escalation discussions.

17. The Director of Quality and Safeguarding noted that the clinical commissioning group are not getting any assurance that improvements are being made for practices to receive their patient notes in a reasonable timescale and that this is no longer acceptable. The committee agreed that they should take action to progress this issue and it was agreed to contact neighbouring clinical commissioning groups, within the next week, to discuss the search for missing patient records. Following this the clinical commissioning group will co-ordinate a letter to be sent to the Board of NHS England from Cheshire and Wirral clinical commissioning groups voicing the collective concerns.

## RECOMMENDATIONS

18. The Governing Body is asked to note the decisions and recommendations made by the Primary Care Commissioning Committee including;

    a. The recommendation of the Committee to offer the Personal Medical services practices the options of stretch Key Performance Indictors or alternatively to reduce the amount of discretionary funding they receive equivalent to the Personal Medical Services premium;

    b. To suspend the withdrawal of Western Avenue Medical Centre's Personal Medical Services premium while further work is undertaken;

c. To accept the reviewed Local enhanced service specifications for:

- Medicines Manager Service
- Vasectomy Service
- Anti-coagulation Service

d. To accept the Committee's approval of the outlined costs and the process for commissioning the extended hours service for 2017/18;

e. Note the level of concern regarding the service provision by Primary Care Support (Capita) and the Committee's recommendation to write to NHS England collectively as Cheshire and Wirral Clinical Commissioning Groups voicing those concerns.

**Laura Marsh**
**Director of Commissioning**

**May 2017**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

**1. Date of Governing Body Meeting** 18th May 2017

**2. Title of Report:** Quality Improvement Report

**3. Key Messages:**

- The Countess of Chester Hospital NHS Foundation Trust is supporting a national campaign to keep people as active as possible when they are in hospital. The campaign "End PJ Paralysis" encourages patients to get dressed and stay mobile. There is strong evidence that this can help people return home more quickly.

- Wirral University Teaching Hospital NHS Foundation Trust has reported five Never Events over twelve months in ophthalmology services. They have commissioned an external review of the ophthalmology service and following site visits in April the Trust is now waiting for the report. Wirral Clinical Commissioning Group is part of this process and will keep us informed of recommendations and actions from the review.

- We are working closely with St Cyril's Rehabilitation Hospital in Chester to assure ourselves that the hospital provides good quality care to people who need specialist rehabilitation for complex neurological conditions.

- We have published our annual patient insight and intelligence report which highlights patient experience intelligence gathered from a diverse range of patient and public engagement activities undertaken in the previous 12 months.

  The top 5 themes are :
  - **Access:** Patients want to be able to access reliable health services when they need it.
  - **Information:** Patients want clear information that is easy to understand and access about local health services and their clinical conditions.
  - **Continuity of care:** Patients want continuity of care, particularly in relation to care pathways and longer term treatments.
  - **Clean environment:** Attention to cleanliness in relation to both personal and environmental needs is very important to patients,
  - **Building better relationships:** Patients want to be involved in their individual care, and want professionals to respect their decisions and particularly to work in partnership with them.

**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. Note the update provided in relation to our equality and inclusion duties

c. Note the update provided by the Designated Nurse for Safeguarding Adults

d. Approve the delegation of the duty to the Director of Quality and Safeguarding to provide the commissioner commentary response to the Foundation Trusts Quality Accounts.

e. Review the update provided by the governing body nurse member in relation to primary care nursing and identify any further actions to mitigate the risk identified

f. Note assurance on the delivery of the requirements to support the national Transforming Care Partnership work

g. Review the Patient Insight and Intelligence Report and identify any escalations to programme managers and clinical leads

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

May 2017

| **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 to commission safe, effective and harm free care from Providers | This identifies how:<br>*risk to the delivery of neonatal services is being mitigated through changes in the delivery of critical care services to high risk babies<br>*risk to the consistent performance against the national safer surgery practice guidelines is being managed by the Countess of Chester Hospital | No change |
| 6 | Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children | This report identifies that we are contributing to the Prevent Multiagency Channel Panel to reduce the risk of radicalisation and links to terrorism | No change |
| 7 | Failure to ensure robust arrangements are in place for the safeguarding of adults at risk | This report identifies how:<br>*risk in care homes/independent hospitals is being mitigated through closure to admissions and close surveillance<br>*we are delivering our commitments against the national Transforming Care Programme | 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 3rd May 2017.

## INFECTION CONTROL

4. The committee noted the positive performance in West Cheshire in the delivery of the objective of no more than 78 cases of clostridium difficile in 2016/17. The year to date performance to the end of February was 46 cases.

## COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

### Neonatal Services

5. The Trust has published the report from the independent review undertaken in September 2016 of their neonatal service from the Royal College of Paediatrics & Child Health and The Royal College of Nursing. The Trust has developed a draft action plan that has been shared with the commissioners of the service and the Care Quality Commission for comments. It is not a complete plan as the Trust are not able to address all the findings as a number of them are attributable to other partners, such as the Cheshire and Merseyside Neonatal Network. NHS England's North West Specialised Commissioning Hub is responsible for commissioning our neonatal services and they will share the final version of the action plan with us through our committee.

### Never Events

6. The committee were advised that there have been no further Never Events since January 2017. The Trust Medical Director has appointed an experienced surgeon to his senior team to focus on safety and the Trust have reported sustained improvements in surgical and anaesthetic block site marking processes.

## Falls

7. The Trust Director of Nursing has attended the Serious Incident Review Group for a detailed discussion about the number of inpatients who fall and sustain injuries. The Director of Nursing has advised that they are adopting the same approach of focussed accountability and learning at ward level that was used to successfully reduce the number of pressure ulcers.

8. The Trust has identified the reduction of falls with harm as a priority in their Quality Accounts for the forthcoming year and is adopting best practice guidance referred to as the "end PJ paralysis" campaign. This campaign is aimed at encouraging people to be dressed and as mobile as possible during hospital stays as this aids recovery and maintains mobility.

9. The Director of Quality and Safeguarding is asking the Trust for updates on delivering these actions at each Quality and Performance meeting and will keep the committee briefed.

## CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

### Serious Incident Reporting

10. NHS England has recently identified the Trust as being a high reporter of apparent / actual suspected self-inflicted harm incidents when compared to the other two mental health providers in the region. The committee were advised that we had completed a local analysis which has confirmed, that of the incidents reported on the national serious incident reporting system under the category apparent/actual/suspected self-inflicted harm, that 33% were not found to be actual self-harm. The system has a limited number of categories to select from.

11. In collaboration with other local commissioners and NHS England we have demonstrated that the Trust is not an outlier for self-harm incidents. The Trust reports all unexpected deaths on the national system which reflects their positive culture of learning from serious incidents and all the investigations we review at our Serious Incident Review Group, regardless of whether self-harm is proven, do identify opportunities for learning.

## WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

12. West Cheshire Clinical Commissioning Group is an associate to Wirral Clinical Commissioning Group's contract with Wirral University Teaching Hospital NHS Foundation Trust. The governing body have previously been informed that Wirral Clinical Commissioning Group had notified us that there have been five Never Events over twelve months in ophthalmology services at the Trust.

13. The Trust have commissioned an external review of the ophthalmology service and following site visits in April the Trust is now waiting for the report. Wirral Clinical Commissioning Group is part of this process and will keep us informed of recommendations and actions from the review.

## TARVIN COURT

14. Tarvin Court is a care home owned by Tarvin Estates LLP. They are registered to provide residential and nursing care for up to 28 residents. In October 2016 Cheshire West and Chester Council imposed a contractual suspension on the provider for environmental breaches of their contract, which resulted in them being closed to admissions. The provider did undertake environmental improvements to the care home.

15. The Care Quality Commission undertook an unannounced inspection during February 2017. The report was published 27th April 2017 and the provider is rated Requires Improvement.

16. Cheshire West and Chester Council and NHS West Cheshire Clinical Commissioning Group continue to visit the home to support staff to improve care delivery. NHS West Cheshire Clinical Commissioning Group has reviewed the patients who are in receipt of funded nursing care. The clinical commissioning group and Cheshire West and Chester are working proactively with the provider to improve and sustain the changes required. There is engagement from the newly appointed manager and owners and our quality monitoring visits are in place weekly. When assurance is provided the standards are met the suspension of placements will be reviewed.

## ST CYRILS – INDEPENDENT HOSPITAL

17. St Cyril's Rehabilitation Hospital provides 24 inpatient beds and two transitional bungalows for adults who require specialist rehabilitation with significant neurological conditions. The hospital is registered with the Care Quality Commission as an Independent Hospital - Mental health/capacity, Rehabilitation (illness/injury) for adults over 18. The hospital is also registered to provide treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act 1983.

18. The committee has previously escalated concerns to the governing body of following a safeguarding referral in August 2015 relating to the care of a patient. In December 2016 the coroner and jury made a ruling on the cause of death and did note aspects of poor care delivery. The coroner was assured by the changes made at the independent hospital. The police closed the criminal case and Cheshire West and Chester concluded the section 42 safeguarding enquiry as substantiated.

19. In October 2016 NHS West Cheshire Clinical Commissioning Group agreed a contract with St Cyril’s part of the St George Healthcare Group. This was to ensure the clinical commissioning group had oversight of the quality of care delivered by the provider as multiple out of area health commissioners place their patients at this provider.

20. Our quality assurance visits over 3 separate days in February 2017 resulted in the clinical commissioning group issuing a contract performance query seeking assurance in relation to expected standards of medical cover and the transfer of patients to the acute hospital. This contract performance query remains open.

21. The Care Quality Commission has conducted an unannounced inspection and is in the final stages of agreeing their findings with the provider before publishing their report.

22. We have agreed with NHS England that we will develop a quality risk profile for this provider to highlight areas of good practice and those that need improvement. We have contacted other commissioners to advise them of this process and asked them to review the patients they have placed there. The Director of Quality and Safeguarding has written to the provider explaining the quality risk profile process and advising them this process will involve commissioners and regulators.

23. Our Quality Improvement Manager and Designated Nurse Safeguarding Adults are working closely with the provider to address areas of concern.

## EQUALITY AND INCLUSION

24. The committee received and agreed the NHS England equality delivery system outcomes for 2017/18. This was also supported by a local delivery plan for 2017/18.

25. For 2017/18 there is a focus on ensuring our processes for equality impact assessments are developed and factored into our commissioning decisions and programmes.

## SAFEGUARDING ADULTS

26. The committee received an update on :

    a. The publication of a consultation paper by the Law Commission, which sets out recommendations to parliament, together with a draft Bill for a replacement scheme for the current Deprivation of Liberty Safeguards. In addition the draft Bill makes wider reforms to the Mental Capacity Act which ensure greater safeguards for persons before they are deprived of their liberty. There are challenges across our health and social care system to respond to the increased need for Deprivation of Liberty Safeguard requests following the 2014 Supreme Court judgment known as “Cheshire West”. This judgment gave a significantly wider definition of Deprivation of Liberty Safeguards than had been previously understood (both by public authorities and the lower courts) to apply in the health and social care context.

    b. The work by partners in Cheshire West and Chester to support the work the Prevent Multiagency Channel Panel. Prevent forms part of the government’s Counter Terrorism strategy called Contest. The aim of Prevent is to stop people becoming or supporting terrorists, by challenging the spread of terrorist ideology, supporting vulnerable individuals, and working in key sectors and institutions. Channel Panel works with our local communities to help support vulnerable people and build resilience to groups or individuals who seek to create divisions and cause harm.

## QUALITY ACCOUNTS 2016/17

35. NHS Improvement requires all NHS Foundation Trusts to produce reports on the quality of the care they provide (as part of their annual reports). Publication of reports on quality aim to help Trusts improve public accountability for the quality of care they provide.

36. Foundation Trusts must publish quality accounts each year, as required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010.

37. Trusts are required to obtain external assurance on their quality reports. NHS Improvement states that subjecting Quality Accounts to independent scrutiny improves the quality of data on which performance reporting depends.

38. Both Cheshire and Wirral Partnership NHS Trust and the Countess of Chester Hospital NHS Foundation Trust are required to submit their draft quality accounts to West Cheshire Clinical Commissioning Group to seek a commissioner commentary.

39. The corroborative opinion that the commissioners offer will be published in the Quality Account and will cover issues that West Cheshire Clinical Commissioning Group is in a position to comment on. It is not therefore a signing-off of the Quality Account - that remains the responsibility of the provider. The Quality Accounts inclusive of commissioner's statements must be made public by 30th June 2017.

40. The regulations state that the commissioning organisation must take reasonable steps to check the accuracy of the information contained in the draft relevant document in relation to NHS services provided under contracts with that commissioner.

41. The commissioner must provide a written statement, which is no longer than 500 words in length confirming whether or not they consider the draft relevant document contains:
    a. accurate information in relation to NHS services provided under contracts with that commissioner
    b. any other information they consider relevant to the quality of NHS services provided during the reporting period

42. The response must be made within 30 days beginning with the date the draft relevant document is received by the commissioning organisation. The regulations also require providers to send the draft Quality Account to Healthwatch and Overview and Scrutiny Committees.

43. The Director of Quality and Safeguarding will lead this process in submitting the 500 word responses in line with the regulations for both of our local Foundation Trusts.

## PRIMARY CARE NURSING

44. The committee received a report from the Clinical Lead Primary Care Nurse and the Governing Body Lead Nurse on current primary care nursing issues.

45. The update identified that the Clinical Lead Primary Care Nurse has :

    a. Maintained a quarterly Nurse Forum - topics discussed include Year of Care, appraisal and revalidation, referral for self-care, modern slavery, change to services, commissioning and future educational needs.

    b. Arranged quarterly training opportunities - nurse training sessions have included a dementia update, respiratory Inhaler technique, immunisation, cervical cytology and cancer care.

    c. Supported the introduction of Revalidation – through collaboration with the Avarto Management team developed an appraisal and revalidation tool to help nurses in Primary Care meet the requirements of revalidation.

    d. Overseen the relationship with Public Health England to ensure West Cheshire staff maintain 3 yearly cervical cytology updates and annual immunisation training for new and existing immunisers both registered and non-registered.

    e. Overseen the governance of non-medical prescribing – includes policies, audits, training and monitoring of prescribing by 61 non-medical prescribers.

    f. Health Care Assistants - successfully bid for funding from Health Education England to provide training for local Health Care Assistants to undertake the Care Certificate. The Care Certificate is a set of standards that social care and health workers undertake in their daily working life. It is the new minimum standard that must be included in induction training for new care staff.

46. The paper identified that there are risks to the clinical commissioning group meeting the nursing workforce requirements of new care models in terms of the absence of a nursing strategy, and the lack of a clear line of professional leadership from national and regional networks to the executive team and on to the primary care nursing workforce.

47. The Director of Quality and Safeguarding attends all national and regional nursing networks and suggested the committee reflect on the need to promote a nursing strategy across the health economy, not solely for primary care nursing. The committee agreed to bring this to the attention of the governing body.

## TRANSFORMING CARE UPDATE

48. The committee received a detailed update on how we are delivering our commitments against the Transforming Care Partnership work. This national programme requires commissioners to transform the way we manage patients that are currently in a hospital placement who have a learning disability or autism.

49. The programme's aim is that people with a learning disability and/or autism can lead fulfilling lives in the community supported by main stream services and staff who have the skills to support them and their needs in their local community, whenever possible. This requires commissioners to develop community services that mean people can live independent lives and reduce how many people need to go into hospital. Work is taking place on a Cheshire and Merseyside footprint to develop a service specification for Learning Disability Community Intensive Support Services.

50. The committee reviewed information about where our current patients are placed and the processes we follow to ensure minimal delays are experienced by our patients who are ready to move out of hospital care.

## PATIENT INSIGHT AND INTELLIGENCE REPORT

51. Now in its fifth year of development, the Patient Insight and Intelligence Report highlights the patient experience intelligence gathered from a diverse range of patient and public engagement activities undertaken in the twelve months from November 2015 to December 2016. The full report is available here.

52. The clinical commissioning group has continued to develop a single data repository for patient information so that themes and trends can be collated and analysed. This insight and intelligence is critical to us as commissioners to inform commissioning and contracting decisions. This information has been shared with the programme managers and clinical leads. As in previous years the programme managers will be invited to present to members of the Quality Improvement Committee on how they used the intelligence from last year's report to improve patient experience and how they will use this year's insight to influence forward plans.

53. Patient experience information has been analysed from our database, which includes the following sources:
    - Local NHS providers
    - Local GP practices and GP patient participation groups
    - Patient Advice and Liaison Service (PALS) and Complaints
    - Public events and clinical commissioning group road shows
    - Patient stories
    - Focus groups held with local patient groups
    - Healthwatch Cheshire West feedback
    - Friends and Family Test results
    - Patient websites such as NHS Patient Choices

54. The top five themes to emerge from the information in the database were similar to previous years :

    a. **Access:** This year once again the overriding theme from the insight data was access to health and social care. Patients want to be able to access reliable health services when they need it. There are still some issues concerning access to primary care services, although improvements in patient satisfaction were evident. There were also delays in accessing other services such as mental health and services for people with dementia.

    b. **Information:** Patients feedback that they wanted clear information about local health services and their clinical conditions. There was an encouraging sign that patients are being given more information, particularly in digital formats, and it will be interesting to see the impact of this in the coming year. In particular, there is evidence that shows people with long term conditions, have begun to participate in self-care programmes and are learning to self-manage their conditions. However, patients and their carers still want more information (in written and verbal form) in ways that are easy to understand and access.

    c. **Continuity of care:** Continuity of care is very important to patients, particularly in relation to care pathways and treatments. Some patients told us that they wanted a seamless integrated service that was co-ordinated across systems and boundaries. They did not always experience this. This ranged from seeing the same GP to better working between health and social care services.

    d. **Clean environment:** Attention to cleanliness in relation to both personal and environmental needs is very important to patients, particularly pertinent to those were fed back via inpatient wards and clinics. Patients also informed us that they wanted safe good quality treatment delivered to them by health professionals that they could trust.

    e. **Building better relationships:** Dignity and respect was a particularly strong theme raised by children and older people in particular. People told us that they needed emotional support, empathy and respect from health professionals. Patients want to be involved in their individual care, and want professionals to respect their decisions and particularly to work in partnership with them

## COMMITTEE CHAIR

55. The committee wanted to record their thanks to Sarah Faulkner for her commitment as chair of the committee and wish her success for the future.

## RECOMMENDATIONS

56. The governing body is asked to:

a. Review the issues and concerns highlighted and identify any further actions for the quality improvement committee

b. Note the update provided in relation to our equality and inclusion duties

c. Note the update provided by the Designated Nurse for Safeguarding Adults

d. Approve the delegation of the duty to the Director of Quality and Safeguarding to provide the commissioner commentary response to the Foundation Trusts Quality Accounts.

e. Review the update provided by the governing body nurse member in relation to primary care nursing and identify any further actions to mitigate the risk identified

f. Note assurance on the delivery of the requirements to support the national Transforming Care Partnership work

g. Review the Patient Insight and Intelligence Report and identify any escalations to programme managers and clinical leads

**Paula Wedd**
**Director of Quality and Safeguarding**
**May 2017**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

| | | |
|---|---|---|
| **1.** | **Date of Governing Body Meeting:** | 18th May 2017 |
| **2.** | **Title of Report:** | Finance, Performance and Commissioning Committee Report |
| **3.** | **Key Messages:** | |

- At the end of March 2017 the clinical commissioning group achieved a year-end deficit of **£5.719 million**. This follows the release of the1% non-recurrent headroom (£3.278m).

- Draft year-end accounts have been submitted to NHS England. This year-end position is, therefore, subject to external audit although no financial adjustments are expected.

- The year-end deficit position was achieved following the delay in investment of several in-year revenue allocations totalling approximately £1 million. An additional disclosure has been included in our year-end accounts reporting that if these actions had not been taken then the deficit would have been approximately £6.7 million

- Actual savings to the end of the financial year are reported to be £8.4 million against planning target of £12.8.

    - We have operated within our 2017/18 running cost allowance.

    - We have now published an agreed revised Cheshire-wide Commissioning Policy

    - A SEND Strategy and Action Plan were recommended for approval by the Governing Body.

    - At the end of February 2017 we were failing to deliver 5 constitutional performance measures (Referral to treatment target, Diagnostics, Cancer waiting times (62 days), Accident and Emergency, Ambulance calls).

**4. Recommendations**

The governing body is asked to:

- Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 4th May 2017.
- Note the latest position against the Financial Recovery Plan 2017/18
- Approve the Special Educational Needs and Disabilities Strategy and Action Plan
- Note the performance against national standards / locally agreed performance measures

**5. Report Prepared By:**

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

May 2017

| **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 as at 31/03/17 | The report provides an update on financial performance for the year-ended 31st March 2017. | No change |
| 2 | Delivery of 2017/18 financial plan (and comply with legal directions) | The report provides an update on the underlying financial position carried forward into 2017/18. | No change |
| 9 | Engagement of stakeholder in new models of care | The report provides an update on continuing involvement of stakeholders in development of the new model of care. | No change |
| 10 | Delivery of financial recovery plan | The report provides an update on each of the financial recovery plan programmes. | No change |
| 11 | Delivery of NHS constitutional targets | The report provides an update on the performance against constitutional targets. | 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 4th May 2017.

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

## FINANCE AND CONTRACTING PERFORMANCE FOR THE YEAR ENDED 31ST MARCH 2017

3. The Chief Finance Officer provided an update on financial performance at the end of March 2017 and delivery of the 2016/17 financial recovery plan savings target. The following table reports performance against our financial duties at the end financial year 2016/17:

West Cheshire Clinical Commissioning Group Financial Performance Summary - 31st March 2017

| Performance measure | Description | Year-end Performance |
|---|---|---|
| Delivery of financial duty | Operate within allocation | RED |
| Delivery of NHS 'business rules' | CCGs expected to deliver minimum 1% surplus | RED |
| Delivery of planned deficit | Target of £3.186 million deficit | RED |
| Delivery of revised Forecast deficit | Target of £9.086 million deficit | GREEN |
| Delivery of financial recovery plan | Delivery of FRP and 'pipeline' | AMBER |
| Running cost allowance (RCA) | Financial duty to operate within RCA | GREEN |
| Capital allowance | Operate with capital allocation | GREEN |
| Better payment practice code | Payment of 95% of invoices within 30 days | GREEN |

4. At the end of March 2017 the clinical commissioning group achieved a year-end deficit of **£5.719 million**. This follows the release of the1% non-recurrent headroom (£3.278m). Draft year-end accounts have been submitted to NHS England. This year-end position is, therefore, subject to external audit although no financial adjustments are expected at this stage.

5. The year-end deficit position was achieved following the delay in investment of several in-year revenue allocations totalling approximately £1 million. An additional disclosure has been included in our year-end accounts reporting that if these actions had not been taken than the deficit would have been approximately £6.7 million.

6. The committee discussed the year-end financial position and agreed that there was a consistency with the original planned deficit. The in-year movements in the reported position can be analysed as follows:

| **Description** | **£M** |
|---|---|
| Planned deficit | 3.186 |
| Funded nursing care price increase | 1.400 |
| 1% headroom (not affordable in 2016/17 plan) | 3.278 |
| Repeat prescribing adjustment (not supported nationally) | 1.200 |
| Year-end movements | (-)0.067 |
| **Year-end deficit before headroom** | **8.997** |
| Release of headroom | (-)3.278 |
| **Reported year-end position** | **5.719** |

7. The committee considered the key risk areas that have been discussed throughout the financial year; summarised as follows:

- ***Prescribing;*** the year-end prescribing position reflects a significant achievement and reflects over delivery of the financial recovery savings target. The forecast has improved by £200,000 since the previous month. This success, however, was mitigated by the decision of NHS England not to fund the cost of flu vaccinations; £295,000 had previously been included in the year-end forecast.

- ***Secondary care contracts;*** at the end March 2017 secondary care contracts are reporting a year to date financial pressure of £6.1 million.

  The Countess of Chester 2016/17 contract is managed on a block basis with an annual value of £144 million. At the end of the year there was an over performance against this contract of £1.380 million (mainly in respect of urgent care activity). This means that the clinical commissioning group would have paid this additional amount if the contract was on a 'payment by results' basis.

  The committee had previously asked for further updates on performance against the following 2 contracts:

  Wirral NHS Foundation Trusts;
  Grosvenor Nuffield Chester;

- ***Continuing healthcare and complex care;*** at the end of the year there was a financial pressure against this budget of £1.2 million made up of the combined impact of the nationally negotiated funded nursing care (FNC) price increases (now estimated to be C£1.5 million full-year effect) and a small underspend against the CHC/complex care budget. This means that (excluding the FNC increase) growth in expenditure has been limited to less than 1% and reflects over delivery of the financial recovery savings target for this programme. This is compared to previous years when expenditure growth has been in excess of 30% since 2013/14.

In addition, a year-end financial provision has been included in respect of the potential cost of the backlog of CHC case reviews. The backlog is now being tackled and, therefore, the provision is lower than previous years.

- ***Running costs;*** during the year we have been reporting a potential significant over spend against our running cost allowance. During quarter 4 we undertook a review of all pay and non-pay expenditure to reduce spend before the end of March 2017. These actions, coupled with the reclassification of several areas into programme (or healthcare) enabled delivery of the running cost duty.

## FINANCIAL RECOVERY

8. The Chief Finance Officer reported that actual savings to the end of the financial year are reported to be £8.4 million against planning target of £12.8 million and provided further details across the following categories:

    - £3m financial recovery plan; in the main, from medicines management and CHC reviews.
    - £1.4m pipeline; repeat prescribing and escalation of 'outlier practices'.
    - £4m; demand management delivered in the block contract with Countess of Chester NHS Foundation Trust.

9. The committee recognised that there was a significant increase in reported savings during quarter 4. The Chief Finance Officer reported that the majority of quarter 4 savings are recurrent and we should, therefore, continue to see delivery into quarter 1 2017/18.

## UNDERLYING FINANCIAL POSITION

10. We will end 2016/17 with a recurrent deficit of £6.2 million. This means that we are spending £6.2 million more than our recurrent allocation before any allocation or activity growth in 2017/18.

11. In addition, we will begin 2017/18 with a cumulative deficit of £5.719 million (equal to 2016/17 deficit) which will need to be re-paid at some stage in the future. Subject to delivery of the 2017/18 financial plan, we will reduce (repay) approximately £1.7 million of the cumulative deficit at the end of 2017/18. We plan to return to cumulative surplus during 2019/20.

12. The Chief Finance Officer reported that there is pressure from NHS England to increase the pace of repayment; in particular with delivery of a surplus during 2018/19.

## FINANCIAL RECOVERY PLAN DELIVERY

13. The Committee noted the infrastructure that has been developed to assure optimal delivery of the financial recovery plan in 2016/17 and into 2017/18 which includes the following;

    i. Programme Management Office capacity to track and report delivery within all financial recovery plan projects
    ii. Weekly Programme Delivery group meetings
    iii. Programme Gateway review infrastructure
    iv. Live Financial Recovery Plan tracker
    v. Online Project management tool (Verto) and document store (Glasscubes) to enable collaborative working with partner organisations
    vi. Realigned programme management capacity to focus on programmes which deliver greatest efficiencies
    vii. Monthly internal scrutiny via Finance, Performance and Commissioning committee as well as monthly reporting to NHS England via checkpoint meetings

14. As well as receiving significant assurance from the internal audit process in 2016/17, the external QIPP programme review by Deloittes undertaken in Q4 16/17 noted the following:

    *"As a result of this turnaround programme the CCG has introduced a more robust governance structure and invested heavily in a newly defined PMO function"*

    **Monitoring and reporting**; "*strong systems in place – robust gateway review process."*
    **Stakeholder and provider engagement; "***joint plan in place with providers – strong joined up leadership."*
    **Programme management capacity**; "*clear evidence of a stepped change in QIPP governance."*
    **Planning cycle; "***problem of timing of contract agreement and availability of detailed plans."*
    **QIPP documentation; "***PID documentation is fairly comprehensive – including milestones, detailed gateway review process"*

15. As we move into 2017/18, it was noted that the focus has been on refreshing the Project Initiation Documents for those projects that are continuing, which includes refreshing the risk logs and associated documentation such as Quality Impact Assessments and Equality Impact Assessments. In addition a number of new Project Initiation Documents have been developed, particularly within planned care, where there will be a transition from focusing on the overarching mechanisms of referral management, to individual clinical pathway redesign, as part of the national Rightcare programme, for which we are a member of phase two. The Committee noted that the pathways that represent the most significant opportunity to increase value will be prioritised first.

16. The total target savings for 2017/18 is £11.6m. To date the Financial Recovery Plan projects are projected to deliver circa £7m with a further £1.2m non-recurrent income. The Committee were therefore concerned that as a priority plans be developed to address the remaining £3.4m of the target. Further opportunities to address the gap include;

    b. Implementation of further revised clinical pathways identified through Rightcare data
    c. Joint efficiencies across the Local Delivery System (confirmed by Deloittes) in 2017/19 e.g. MSK and implementation of the public health prevention PIDs.
    d. The development of the Accountable Care Organisation (additional demand management approaches to be worked up at clinical pathway level)
    e. Cheshire system wide efficiencies via a Cheshire unified CCG.

17. An updated version of the programme outcome dashboard is available here.

18. As outlined we are looking to work increasingly in collaboration, on the commissioning of some services, with our Clinical Commissioning Group peers across Cheshire, as well as with Wirral where that makes sense. As a result we have now published an agreed revised Cheshire-wide Commissioning Policy and are continuing to work together on the implementation of health optimisation prior to surgery.

**Starting Well Programme Thematic Report**

19. The Committee received a thematic report on the progress within the Starting Well programme in 2016/17. The Committee thanked the Starting Well team and clinical leads for a comprehensive update including the progress against outcomes measures.

20. The Committee noted the Cheshire and Merseyside Women's and Children's Services Partnership has been awarded a Maternity Pioneer to develop models for choice and personalisation in maternity services. Personal Maternity Budgets have been piloted at Liverpool Women's Hospital, with rollout across Cheshire and Merseyside by the end of 2018/19.

21. The Committee also discussed that the North West Neonatal Operational Delivery Network Board endorsed the preferred options for the Cheshire and Merseyside Neonatal Surgery Service Delivery Model and Neonatal Intensive Care Services for Cheshire and Merseyside Neonatal Network on 9th March. The recommendations are progressing through the NHS England assurance processes and will have implications for organisations providing maternity and neonatal services within Cheshire and Merseyside. The Committee noted that it is understood there will be no public consultation on this issue.

## Special Educational Needs and Disabilities (SEND)

### SEND Joint Commissioning Strategy and Action Plan

22. The SEND Code of Practice introduced in 2014 states that Local Authorities and Clinical Commissioning Groups must make joint commissioning arrangements for education, health and care provision for children and young people with Special Educational Needs or disabilities. The Joint Commissioning Strategy has been developed by Commissioners from Cheshire West and Chester Local Authority, Vale Royal and West Cheshire Clinical Commissioning Groups and sets out the vision for the commissioning of service provision for children and young people with SEND. Feedback from the most recent Joint Local Area Inspections by the Care Quality Commission and OFSTED is that Inspectors are requesting to view the SEND specific Joint Commissioning Strategy and a strong emphasis is being placed on whether it was based on local need and had been co-produced with parents/carers. This has been taken into account in the development of this strategy; it has been shared with the SEND Strategy Group, Parent Carer Forum and internally within the Clinical Commissioning Group.

23. An Action Plan has been developed and sets out the work that the Joint Commissioning Group will take forward. It is planned that the group will look at the Joint Strategic Needs Assessment, service user feedback and other data sources to identify future commissioning intentions, including service reviews like the current Child Development Service Review. Any implications for the Clinical Commissioning Group will be brought to the appropriate committee for approval.

### SEND Strategy Action Plan

24. The SEND Strategy 2016-20 was ratified in 2016 with the overarching aim to improve educational, health and emotional wellbeing outcomes of children with SEND in Cheshire West and Chester. The Action Plan sets out how the outcomes will be delivered and what steps are required to achieve them. The ongoing monitoring of the action plan will be via the SEND Strategy Group. The development of the plan was led by a Senior Special Educational Needs Manager at the local authority with input from relevant staff within the Clinical Commissioning Group. Any actions that have an implication for the Clinical Commissioning Group will be brought to the appropriate committee for approval.

25. Committee members reviewed the SEND Strategy and Action Plan and recommend approval to the Governing Body.

## PERFORMANCE

26. At the end of February 2017 we were failing to deliver 5 constitutional performance measures (Referral to treatment target, Diagnostics, Cancer waiting times (62 days), Accident and Emergency, Ambulance calls). The Countess of Chester achieved the Referral to treatment target for the first time in several months, however the performance at Wirral University Teaching Hospital is substantially below Referral to treatment target in all areas. A summary of performance to the end of February is provided here.

27. For Diagnostics 96.7% of patients are waiting less than 6 weeks for tests (target is 99%), an improvement on the performance seen last month. 85.6% of these breaches are attributable to echocardiography, although the actual number has fallen substantially from last month. This continues to be a focus at the monthly contract meetings.

28. For cancer, performance for the cancer 2 week waits are continuing to exceed target, and all 31 day waits except surgery have met target for this month. However, breaches have been seen in the 62 day measure this month, primarily as a result of delays in referrals between providers. The Clinical Commissioning Group is working with the provider to address these issues and it is anticipated that the implementation of improved pathways across certain specialties in quarter 4 16/17 will improve performance.

## RECOMMENDATIONS

29. The governing body is asked to:

    a. Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 4th May 2017.
    b. Note the latest position against the Financial Recovery Plan 2017/18
    c. Approve the Special Educational Needs and Disabilities Strategy and Action Plan
    d. Note the performance against national standards / locally agreed performance measures

**Gareth James**
**Chief Finance Officer**

**Laura Marsh**
**Director of Commissioning**

**May 2017**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

| | | |
|---|---|---|
| **1.** | **Date of Governing Body Meeting:** | 18th May 2017 |
| **2.** | **Title of Report:** | Audit Committee Report |
| **3.** | **Key Messages:** | This report provides an overview of the key items of business discussed and decisions taken at the audit committee meeting held on 6th April 2017. The key items for the governing body to note are:<br>• As at 31st March 2017 the clinical commissioning group is 91% compliant with the national information governance toolkit.<br>• The Director of Internal Auditor's annual opinion provides significant assurance that we have sound systems of internal control.<br>• The audit committee approved the external audit annual plan for the audit our 2016/17 accounts. |
| **4.** | **Recommendations** | The governing body is asked to note the key items of business discussed and decisions taken at the audit committee on 6th April 2017. |
| **5.** | **Report Prepared By:** | Gareth James<br>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 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. | No change. |
| 4 | Failure to embed sound systems of information governance. | The audit committee report demonstrates progress on compliance with information governance requirements. | No change. |

# 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 taken at the audit committee meeting held on 6th April 2017.

## 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 April 2017 audit committee are summarised in paragraphs 4 to 13.

## INFORMATION GOVERNANCE

4. The Head of Governance reported that version 14 of the information governance toolkit had been submitted. The clinical commissioning group is 91% compliant with the toolkit. In addition, there was a 98% completion rate on statutory and mandatory training requirements.

5. The representative from Mersey Internal Audit Agency reported that there had been some problems in obtaining information to inform their internal audit review of our arrangements to manage information governance. These problems were as a result of staffing issues at Midlands and Lancashire Commissioning Support Unit, as the Head of Governance had submitted all information/evidence in a timely manner. The issues were resolved by the submission deadline, a performance note provided to the Commissioning Support Unit and internal audit had been able to provide significant assurance to the Committee.

## INTERNAL AUDIT

6. The committee received a progress report from Mersey Internal Audit Agency providing an update on progress to deliver the 2016/17 Annual Audit Plan. Assurance was provided that the plan has been delivered.

7. Since the last committee meeting the following 8 internal audit reviews have been completed; all of which received significant assurance:

- Programme and performance management.
- Contract management.
- Financial recovery plan.
- Stakeholder engagement and impact of change.
- Better care fund.
- Quality of commissioned services.
- Commissioning investment and disinvestment.
- Information governance.

8. The committee further discussed the review of our financial recovery plan governance and delivery. Although significant assurance was provided Mersey Internal Audit also provided the following context:

*"The Significant Assurance opinion needs to be seen in the context of the scale of the challenge facing the CCG. The design and operation of the CCG's systems are reasonable but are, and will continue to be, severely tested to a level that has previously not been encountered. There is a high risk that overall delivery of the FRP will not be achieved and this is reflected in Governing Body deliberations and is evident in the Governing Body Assurance Framework. The opinion also needs to be seen in the context of the dependency upon whole system transformation and the CCG's participation and influence in the STP setting. The recommendations in the report are relatively narrow in their focus but they do signal wider concerns over the challenge, risk mitigation and volume of programmes".*

9. A review of arrangements for managing conflicts of interest was also undertaken. 7 medium recommendations have been made with overall assurance that the clinical commissioning group is compliant with NHS England's statutory guidance on managing conflicts of interest.

10. The committee also received the 2016/17 Director of Internal Audit opinion which provided significant assurance that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. The opinion was also provided with additional context; similar to the context given to support the financial recovery review.

## EXTERNAL AUDIT

11. The representative from Grant Thornton UK LLP provided the Annual Audit Plan for the audit of the 2016/17 accounts. As our appointed external auditors, Grant Thornton are required to perform the audit in line with the Audit and Accountability Act 2014 and in accordance with the code of practice issued by the National Audit Office (NAO) on behalf of the Comptroller and Auditor General in April 2015. Their responsibilities under the Code are to:

    - Give an opinion on the CCG's financial statements.
    - Give an opinion on the regularity of expenditure and income recorded in the CCG's financial statements.
    - Satisfy their selves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

12. The audit committee approved the external audit annual audit plan.

## COUNTER FRAUD UPDATE

13. Counter fraud services are provided by Mersey Internal Audit Agency. The audit committee approved the Anti-Fraud Services Work plan 2017-18

## RECOMMENDATIONS

14. The governing body is asked to note the key items of business discussed and decisions taken at the audit committee on 6th April 2017.

**Gareth James**
**Chief Finance Officer**
**May 2017**

**AGENDA ITEM NO: WCCCGGB/17/05/09**

NHS
West Cheshire
Clinical Commissioning Group

# GOVERNING BODY REPORT

| | |
|---|---|
| **DATE OF GOVERNING BODY MEETING:** | 18th May 2017 |
| **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:** | Christine France<br>Governing Body and Committees Coordinator |

# NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

# GOVERNING BODY

# CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS

## INTRODUCTION

1. Nine clinical commissioning group policy / 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. | Policy for Safeguarding Adults | Quality Improvement Committee | May 2016 | Paula Wedd<br>Director of Quality and Safeguarding<br>01244 385272<br>paula.wedd@nhs.net |
| 2. | Policy for Managing Safeguarding Allegations Against Staff | Quality Improvement Committee | New Policy | Paula Wedd<br>Director of Quality and Safeguarding<br>01244 385272<br>paula.wedd@nhs.net |

## RECOMMENDATION

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

**Gareth James**
**Chief Finance Officer**
**May 2017**

**WEST CHESHIRE CLINICAL COMMISSIONING GROUP**

## GOVERNING BODY ASSURANCE FRAMEWORK 2016/17

| Risk No | Sponsor | NHS England Improvement and assessment category | Objective Description & Risk Type | Risk Description | Impact Rating | Positive Assurance on Key Controls to the Governing Body | Likelihood Rating | Risk Score | Changes/ comparison to September 2016 Framework reporting | Gaps in Control and Assurance | Residual Impact | Residual likelihood | Residual Risk Score | Partnership Issues |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Corporate Objective | What are the principle risks that could prevent the Clinical Commissioning Group from achieving this objective *(Types of Risk include clinical, financial, reputation, statutory, target)* | 1 to 5 | Evidence to the Governing Body that the organisation is reasonably managing its risks and that objectives / projects are being delivered by describing what controls / systems the Clinical Commissioning Group has in place to assist in securing delivery | 1 to 5 | sum | | Where the controls / systems / assurances have either not yet been put in place or are yet to be fully effective. What needs to be done | | | | Where the management of risk and delivery of objectives is dependent upon other organisations |
| 5 | 2 | 2 | 4 | 6 | 7 | 8 | 10 | 11 | | 15 | | | | 16 |
| **FINANCE AND GOVERNANCE** | | | | | | | | | | | | | | |
| 1 | Chief Finance Officer | Sustainability | We will deliver financial sustainability for the health economy providing value for money for the West Cheshire pound | Failure of the Clinical Commissioning Group to deliver financial duties; risk that the revised 2016/17 financial forecast will not be delivered. **(Statutory and Financial)** | 4 | Following delivery of a small surplus as at 31st March 2016, we planned for a 1% deficit for 2016/17. This position deteriorated in-year with a revised forecast of £7.886 million (including national NHS funded nursing care pressure and 1% non-recurrent headroom). In order to deliver this revised deficit pipeline savings of C£3m is required. A non-payments by results contract is in place with the Countess of Chester Hospital NHS Foundation Trust which reduces risk. Programme pipeline schemes have been agreed to reduce costs against key risk areas; including repeat prescribing, activity at non-Countess providers and increasing complex care costs. Performance against our recovery plan is closely managed by our programme management office (PMO) and is monitored weekly at programme delivery group with further monthly scrutiny at finance, performance and commissioning committee. | 4 | HIGH 16 | New Risk | There is a significant level of risk to delivery of the 'pipeline' schemes. Significant progress has been, and is being made, but there is a risk that pace of delivery will not ensure delivery before the end of March 2017. There is also a risk that other pressures will not be mitigated in full and, despite delivery of recovery plans, the required deficit will not be delivered. The Chief Finance Officer is pursuing other non-recurrent year-end mitigations to secure delivery. | 4 | 4 | HIGH 16 | Collaborative approach is vital to delivery. Efficiency plans are being combined with Countess of Chester Hospital NHS Foundation Trust. |
| 2 | Chief Finance Officer | Sustainability and Delivery of the 5 year forward view | | Failure to deliver the 2017/18 financial plan (break-even) and, therefore, not comply with our legal directions. **(Statutory and Financial)** | 4 | A revised financial plan has been submitted to NHS England. We plan to operate within our allocation (break-even). This will be reliant on delivery of further efficiencies of C£10.5 million. However, this Quality Innovation Productivity Prevention/Financial Recovery Programme requirement assumes new investments of £3 million with a further contingency of £1.7 million. Monitoring of delivery of recovery plans will be as above. A block contract has been agreed with the Countess of Chester NHS Foundation Trust and there will be a full-year impact of activity at non-Countess providers and other key risk areas. In addition, a joint recovery plan will be agreed with local partners **(**Service Development and Improvement Plan in Countess contract**)** which will be based on our commissioning intentions and will support the removal of costs of provision in the West Cheshire Health economy. Performance of delivery of this joint plan will be the focus of monthly quality and performance meetings. | 4 | HIGH 16 | New Risk | We continue not to receive our 'fair share' of NHS funding. 3.1% financial recovery target is very challenging. We are yet to agree the recurrent impact of 2016/17 recovery schemes (an assumption of £1.4 million has been made and netted off budgets). There is a further risk that the governing body will prioritise investment and that not all 5-year forward view requirements will be met. | 4 | 4 | HIGH 16 | Development of a joint Cost Improvement Plan/Financial Recovery Plan is essential to delivery. Relationships across providers is managed by the system leaders group. |
| 3 | Chief Finance Officer | Leadership and Sustainability | We will develop our people, systems and processes to effectively commission health care for the people of West Cheshire | Failure to embed systems and processes of good governance. ***(Statutory, Reputational & Clinical)*** | 5 | Internal and external audit opinions. Risk management is embedded throughout the organisation. Membership agreement to constitution and conflicts of interest policy. Robust mechanism for declaring and publishing declarations of interest. Governance arrangements have also been reviewed following the PricewaterhouseCoopers capacity and capability review commissioned by NHS England. | 2 | HIGH 10 | Unchanged | Aligning the Clinical Commissioning Group governance to wider strategic leadership with partners. It is likely that governance structures will change with the development of integrated care and strategic commissioning organisations. | 5 | 2 | MED 10 | Strategic leadership and primary care. |
| 4 | Chief Finance Officer | Leadership and Sustainability | We will develop our people, systems and processes to effectively commission health care for the people of West Cheshire | Failure to embed sound systems of information governance; including the compliance with the national Information Governance toolkit and management of patient confidential data. ***(Statutory, Reputational & Clinical)*** | 5 | The Clinical Commissioning Group is fully compliant with Information Governance Toolkit and systems and processes have been agreed to manage and process patient confidential data. Working closely with Midlands and Lancashire Commissioning Support Unit to ensure all actions to comply with Information Governance toolkit are being implemented across the Clinical Commissioning Group. Data sharing agreements signed by all local partners. Commissioning Support Unit has embedded staff within Clinical Commissioning Group Head Quarters. | 3 | HIGH 15 | Unchanged | Implementing revised training arrangements and briefings for staff with the commissioning support unit. | 5 | 3 | MED 15 | Midlands and Lancashire Commissioning Support Unit. |
| **QUALITY AND SAFEGUARDING** | | | | | | | | | | | | | | |
| 5 | Director of Quality and Safeguarding | Better care | We will improve quality and cut variation in standards of care | Failure of commission safe, effective and harm free care from Providers. ***(Statutory, Clinical and Targets)*** | 5 | Quality requirements in contract.<br>Commissioning for Quality and Innovation Schemes.<br>Quality and performance meetings.<br>Serious incident performance monitoring.<br>Clinical engagement meetings.<br>Insights and intelligence from user surveys.<br>Insights and intelligence from Patient Advice and Liaison Service (PALS), incidents, claims and complaints.<br>Insights and intelligence from patients and public engagement.<br>Quality Improvement Committee.<br>Clinical Commissioning Group Governing Body quality improvement/ performance report.<br>National Institute for Clinical Excellence (NICE) quality standards.<br>Quality Surveillance Group. | 3 | HIGH 15 | Unchanged | Sharing of incident information across commissioners.<br>Fragmented commissioner roles.<br>Limited capacity to monitor quality of care in smaller provider contracts such as nursing homes and hospices. | 5 | 2 | MED 10 | Countess of Chester Hospital NHS Foundation Trust.<br>Cheshire and Wirral Partnership NHS Foundation Trust.<br>Partners4Health.<br>Nuffield Health.<br>Cheshire West and Chester Council<br>One to One midwifery |
| 6 | Director of Quality and Safeguarding | Better care and Leadership | We will improve quality and cut variation in standards of care | Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children ***(Statutory, Clinical and Targets)*** | 5 | Local Children Safeguarding Board and Business Plan, Safeguarding Children Policy, Quality and performance meetings with Providers.<br>Safeguarding Assurance Framework received from Providers identifying levels of compliance with these standards.<br>Exceptions in assurance against these standards are escalated to Quality and Performance meetings<br>Routine reporting to Quality Improvement Committee and Governing Body.<br>Annual report to Quality Improvement Committee.<br>Designated nurse and doctor in post including looked after children function.<br>Early intervention services developed to progress outcome from previous Ofsted inspection.<br>Monitoring GP attendance and reporting to case conferences.<br>Staff training levels.<br>Unannounced Care Quality Commission inspection into children safeguarding and looked after children January 2014 identified areas of good practice.<br>Good report from Ofsted 2015 - NHS a key partner in the inspection process<br>NHS England assurance framework shows high levels of compliance with statutory requirements to safeguard children, young people and adults at risk.<br>Completion of action plans from 2 serious case reviews | 3 | HIGH 15 | Unchanged | Fragmented commissioner roles in children's services.<br>Developed an action plan to mitigate a small number development objectives against NHS England assurance framework.<br>Reduction in the number of GPs attending case conferences and number submitting case conference reports | 5 | 2 | MED 10 | Working with new commissioners of children's services to adopt shared safeguarding assurance framework methodology |

# WEST CHESHIRE CLINICAL COMMISSIONING GROUP

| Risk No | Sponsor | NHS England Improvement and assessment category | Objective Description & Risk Type | Risk Description | Impact Rating | Positive Assurance on Key Controls to the Governing Body | Likelihood Rating | Risk Score | Changes/ comparison to September 2016 Framework reporting | Gaps in Control and Assurance | Residual Impact | Residual likelihood | Residual Risk Score | Partnership Issues |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7 | Director of Quality and Safeguarding | Better care and Leadership | We will improve quality and cut variation in standards of care | Failure to ensure robust arrangements are in place for the safeguarding of adults at risk<br>***(Statutory, Clinical and Targets)*** | 5 | Executive representation at Local Adult's Safeguarding Board.<br>Clinical Commissioning Group led contracts contain commissioning standards for Safeguarding.<br>Safeguarding Assurance Framework received from Providers identifying levels of compliance with these standards.<br>Exceptions in assurance against these standards are escalated to Quality and Performance meetings.<br>Routine reporting to Quality Improvement Committee and Governing Body.<br>Collaborative working e.g. Care Quality Commission inspections.<br>Annual report to Quality Improvement Committee.<br>Designated nurse in post working in partnership with providers and local authority.<br>Investigation and monitoring of safeguarding concerns in care homes in collaboration with local authority safeguarding adults team.<br>System in place to report concerns about care homes to GPs.<br>Adult safeguarding training in primary care.<br>NHS England assurance framework shows high levels of compliance with statutory requirements to safeguard children, young people and adults at risk. | 3 | HIGH 15 | Unchanged | Developed an action plan to mitigate a small number development objectives against NHS England assurance framework. | 5 | 2 | MED 10 | Cheshire West and Chester Council |
| 8 | Director of Quality and Safeguarding | Better care | We will improve quality and cut variation in standards of care | Failure to maintain safe quality services when delivering financial recovery plan<br>***(Reputation, statutory and Clinical)*** | 5 | Quality Impact Assessment policy in place. Reviewed and updated in November 2016.<br>Requirement in contracts for providers to share Quality Impact Assessment risks with commissioners.<br>Mechanisms in place at Clinical Commissioning Group programme gateway meetings to review Quality Impact Assessments | 3 | HIGH 15 | New Risk | Lack of mechanism to share quality risks arising from Cost Improvement Plans across the system. | 2 | 5 | MED 10 | Countess of Chester Hospital NHS Foundation Trust.<br>Cheshire and Wirral Partnership NHS Foundation Trust. |
| **COMMISSIONING AND OPERATIONS** | | | | | | | | | | | | | | |
| 9 | Director of Commissioning/Director of Operations | Better care and Leadership | We will commission improvements in primary care and community care and ensure the integration of health and social care | Inability to maintain engagement of all key stakeholders towards development of new care model considering size of changes required including contracts, financial flows, employment status, new roles, changing use of technology and impact on estates<br>***(Clinical and Financial)*** | 3 | Greater system-wide working including systems Leaders group, Directors-level forum. Joined up Commissioning for Quality and Innovation schemes across providers, joining up of key work streams across Clinical Commissioning Group and Countess of Chester Hospital NHS Foundation Trust | 4 | High 12 | Reduced Risk | Development of single system-wide plan | 3 | 4 | MED 12 | Countess of Chester Hospital NHS Foundation Trust.<br>Cheshire and Wirral Partnership NHS Foundation Trust. |
| 10 | Director of Commissioning/Director of Operations | Delivery of the 5 year forward view, Leadership and Sustainability | We will commission improvements in primary care and community care and ensure the integration of health and social care | Failure to deliver the work streams within the financial recovery plan and business as usual programmes through; Insufficient capacity assigned to delivery, inability to track progress, inability to address issues identified as impeding progress and inability to develop sufficient pipeline projects<br>***(Reputation, statutory and Clinical)*** | 4 | Regular programme delivery group weekly meetings, use of project/programme management system (Verto) Financial Recovery Plan tracker, programme management office function, joint control total and block contract with Countess of Chester Hospital NHS Foundation Trust, joining up of key work streams with Countess of Chester Hospital NHS Foundation Trust and focus at contract meetings with both main providers, continual realignment of capacity to projects that deliver financial recovery plan | 5 | HIGH 20 | Unchanged | Development of single system-wide plan | 3 | 5 | 15 | Countess of Chester Hospital NHS Foundation Trust.<br>Cheshire and Wirral Partnership NHS Foundation Trust. |
| **CONTRACTING & PERFORMANCE** | | | | | | | | | | | | | | |
| 11 | Chief Finance Officer / Director of Operations / Director of Quality and Safeguarding | Better Health and Better Care | We will improve hospital care, by working with local hospitals to deliver effective care and achieve NHS constitutional targets | Failure to deliver NHS Constitution standards and other locally agreed performance measures.<br>***(Reputational, Clinical, Financial and constitutional targets)*** | 4 | Monthly reporting to finance, performance and commissioning committee. Regular "deep dives" into poorly performing measures (constitutional targets). Increased scrutiny from governing body and system leadership. Agreement of improvement trajectories with both NHS England and NHS Improvement. Link between improved performance and sustainability and transformation funding for trusts. | 4 | 16 HIGH | Unchanged | There has been significant improvement during Quarter 1 and Quarter 3 2016/17. However, at the end of November 2016 the following measures are not being delivered; Diagnostic waiting times, cancer 62-day target, A&E 4-hour wait, ambulance turnaround, friends and family test and mixed sex accommodation. Areas that are not on course to deliver the agreed trajectory are monitored each month at the quality and performance meetings. | 4 | 4 | HIGH 16 | System wide ownership to improved performance |
| **CORPORATE** | | | | | | | | | | | | | | |
| 12 | Chief Executive Officer | Leadership and Sustainability | We will develop our people, systems and processes to effectively commission health care for the people of West Cheshire | Failure of Clinical Commissioning Group (along with health economy stakeholders/providers) to embed/deliver the West Cheshire Way and deliver an integrated health system for the people of West Cheshire<br>***(Financial and Clinical)*** | 4 | Collaborative work with Countess of Chester Hospital NHS Foundation Trust , Cheshire and Wirral Partnership NHS Foundation Trust, and Cheshire West and Chester Council on developing integrated care through an Accountable Care Organisation or similar approach. | 4 | HIGH 16 | Unchanged | Road map for developing the integrated care/Accountable care Organisation is in development between December 2016 -March 2017. | 3 | 4 | 12 MED | Countess of Chester Hospital NHS Foundation Trust.<br>Cheshire and Wirral Partnership NHS Foundation Trust.<br>Cheshire West and Chester Council |
| 13 | Chief Executive Officer | Improvement | We will develop our people, systems and processes to effectively commission health care for the people of West Cheshire | Failure to deliver the actions from the turnaround plan (now organisational improvement plan)<br>***(Financial)*** | 5 | PricewaterhouseCoopers capacity and capability work is completed. This has resulted in an organisational improvement plan which has been signed off by NHS England. Monthly improvement assurance framework and recovery checkpoint meetings take place with NHS England. These are continuing into 2017 and the Clinical Commissioning Group remains in formal directions. | 2 | HIGH 10 | Reduced Risk | Clarity is required from NHS England on the downgrading process in relation to formal directions | 2 | 5 | MED 10 | NHS England |

NHS
West Cheshire
Clinical Commissioning Group

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|---|---|---|
| **1.** | **Date of Governing Body Meeting:** | 18th May 2017 |
| **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:** | Christine France<br>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 February and March 2017 Chester City Locality GP Network meetings are available here.

### Rural Locality GP Network

4. The approved minutes from the February and March 2017 December 2016 and January 2017 Rural Locality GP Network meetings are available here.

### Ellesmere Port and Neston Locality GP Network

5. The approved minutes from the February and March 2017 Ellesmere Port and Neston GP Locality Network meeting are available here.

## PRIMARY CARE COMMISSIONING COMMITTEE

6. The approved minutes from the March 2017 primary care commissioning committee meeting are available here.

## QUALITY IMPROVEMENT COMMITTEE

7. The approved minutes from the February 2017 meeting are available here.

## FINANCE PERFORMANCE AND COMMISSIONING COMMITTEE – minutes

8. An update of the March 2017 committee meeting is contained within the finance, performance and commissioning committee report.

## AUDIT COMMITTEE

9. An update of the April 2017 committee meeting is contained within the audit committee report.

## RECOMMENDATION

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