

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

AGENDA

Formal Governing Body Meeting to be held in Public on Thursday 18th January 2018, 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 <u>Open Forum</u> | - | Dr Chris Ritchieson <i>GP Chair</i> |
| | 9.15 | Chairs Opening Remarks | I | Dr Chris Ritchieson <i>GP Chair</i> |
| A | 9.20 | Apologies for absence | - | Dr Chris Ritchieson <i>GP Chair</i> |
| B | 9.20 | Declarations of interests in agenda items | - | Dr Chris Ritchieson <i>GP Chair</i> |
| C | 9.20 | Minutes of last meeting held on 16 th November 2017 | DR  !C DRAFT - Govern Body Minutes Nov | Dr Chris Ritchieson <i>GP Chair</i> |
| D | 9.25 | Matters arising/actions from previous Governing Body meetings | D  !D WCCCGGB GE Actions Log Januar | Dr Chris Ritchieson <i>GP Chair</i> |
| WCCCGGB/18/01/01 | 9.30 | GP Network Chairs Update | D Verbal | Dr Steve Pomfret <i>Chair - Rural Network</i> Dr Annabel Jones <i>Chair – City Network</i> Dr Jeremy Perkins <i>Chair – Ellesmere Port & Neston Network</i> |
| WCCCGGB/18/01/02 | 9.45 | Chief Executive Officer's Business Report | D  WCCCGGB-18-01- Chief Officer's Bus | Alison Lee <i>Chief Executive Officer</i> |
| WCCCGGB/18/01/03 | 9.55 | Integrated Care Partnership Update | D  WCCCGGB-18-01- Integrated Care P | Alison Lee <i>Chief Executive Officer</i> |
| WCCCGGB/18/01/04 | 10.00 | Full Delegation of Primary Care Commissioning | DR  WCCCGGB-18-01- Full Delegation of F | Laura Marsh <i>Director of Commissioning</i> |

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| WCCCGGB/18/01/05 | 10.15 | Quality Improvement Committee Report | D  WCCCGGB-18-01- Quality Improvem | Paula Wedd <i>Director of Quality and Safeguarding</i> |
| WCCCGGB/18/01/06 | 10.30 | Audit Committee Report | D  WCCCGGB-18-01- Audit Committee R | Kieran Timmins <i>Lay Member</i> Gareth James <i>Chief Finance Officer</i> |
| BREAK | 10.40 | | | |
| WCCCGGB/18/01/07 | 10.50 | Finance, Performance and Commissioning Committee Report | D  WCCCGGB-18-01- Finance Performar | Gareth James <i>Chief Finance Officer</i> Laura Marsh <i>Director of Commissioning</i> |
| WCCCGGB/18/01/08 | 11.05 | Local Safeguarding Adults Board Annual Report 2014/15 • For information – Annual Report | I/D | Paula Wedd <i>Director of Quality and Safeguarding</i> Geoffrey Appleton <i>Independent Chair LSAB</i> |
| WCCCGGB/18/01/09 | 11.20 | Local Safeguarding Children Board Annual Report 2014/15 • For Information – Annual Report | I/D | Paula Wedd <i>Director of Quality and Safeguarding</i> Gill Frame <i>Independent Chair LSCB</i> |
| WCCCGGB/18/01/010 | 11.35 | Governing Body Assurance Framework | DR  WCCCGGB-18-01- Governing Body As | Gareth James <i>Chief Finance Officer</i> |
| WCCCGGB/18/01/11 | 11.45 | Clinical Commissioning Group Policies and Governance Documents | DR  WCCCGGB-18-01- Policies and Gover | Gareth James <i>Chief Finance Officer</i> |
| CONSENT ITEMS | | | | |
| WCCCGGB/18/01/12 | 11.50 | Clinical Commissioning Group Sub-Committee Minutes | I  WCCCGGB-18-01- Minutes of Govern | Gareth James <i>Chief Finance Officer</i> |
| WCCCGGB/18/01/13 | 11.55 | Any Other Business (to be notified to the Chair in advance) | D | All |

| Item | Time | Agenda Item | Action | Presenter |
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| Date and time of next formal Governing Body meeting – Thursday 15th March 2018, 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
Formal Governing Body Meeting**

**Thursday 16th November 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 |
| Mr Kieran Timmins | Lay Member |
| Ms Pam Smith | Lay Member |
| 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 |

In attendance:

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| Mr Ian Ashworth | Director of Public Health, Cheshire West and Chester Council |
| Debbie Bryce | Head of Governance |
| Lorraine Maughan | Executive Assistant |

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| | WELCOME AND OPEN FORUM | |
| | <p>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.</p> <p>No questions were received from the public.</p> <p>It has been brought to our attention that Mrs Tessa Parkin who usually joins us has been unwell. We would like to send her our best regards and hope she is fit and well soon.</p> | |

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| | CHAIR'S OPENING REMARKS | |
| | <p>In preparing for this Governing Body I was struck by the pace and volume of work in the office. The amount of commitment and hard work from all levels has been striking. As we will hear through the various reports today there is more and more pressure on the CCG to meet its financial obligations whilst commissioning high quality care. As such my introduction is likewise focused on practical and business issues.</p> <p>I would like to welcome Debbie our new Head of Governance to her first formal Governing Body meeting. I am also pleased to advise the Governing Body that we have been successful in appointing a new Nurse Representative to the vacant post; Sheila Hillhouse has also been appointed in West and East Cheshire through a joint appointment process and will be starting with both organisations at the end of the month.</p> <p>We have unfortunately had no expressions of interest for the vacant secondary care doctor post despite going out to advert twice. We are currently exploring options with NHS England and will update at future meetings when we have heard more.</p> <p>I would like to thank Dr Andy McAlavey who has put himself forward as GP representative in relation to the newly formed Joint Committee. I am delighted he has agreed to take up the role and I am confident Andy will bring a wealth of experience and expertise to the role. We have taken the draft work plan for the joint committee to the three networks and this has been well received. We are however still awaiting formal confirmation of the constitutional changes from NHS England.</p> <p>Finally I would like to make the Governing Body aware that the University of Chester is in the very early stages of developing a medical school to complement its existing nursing and life science programmes. I have signed a memorandum of understanding between the University and the clinical commissioning group which indicates continued joint working if the development continues. Given the well-publicised workforce pressures nationally, this is hopefully an excellent opportunity to address some of those challenges locally over the coming years.</p> | |
| A | APOLOGIES FOR ABSENCE | |
| | Apologies were received from Chris Hannah | |
| B | DECLARATIONS OF MEMBER'S INTERESTS | |
| | Dr Annabel Jones declared an interest in agenda item WCCCGGB/17/11/38 Quality Improvement Committee Report, in relation to Crawfords Walk Nursing Home, as Dr Jones' practice provides medical cover to that nursing home. | |
| C | MINUTES OF FORMAL GOVERNING BODY MEETING HELD ON | |
| | The minutes of the formal governing body meeting held on 21st September 2017 were accepted as an accurate record of the meeting with one minor amendment. | |

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| | Page 4 – paragraph 4 of Chief Executive Officers report: To be amended to read PS raised a challenge that the clinical commissioning group may be being harsh on all our amber core assurance criteria. | |
| D | MATTERS ARISING/ACTIONS FROM PREVIOUS GOVERNING BODY MEETINGS | |
| | <p>D - Matters Arising</p> <p>17-09-26 Senate Report – Page 6 Paragraph 3 The senate report has been amended to reflect a more accurate discussion.</p> <p>17/07/14 – Chief Executive Officer’s Business Report <i>CR will have a conversation with NHS England about the resources that come to clinical commissioning groups for this function/additional work.</i></p> <p>Further discussions have taken place and we have been informed they will offer resource support should we chose to take on full delegation of primary care for 12-18 months during transition. Discussions are to continue as we haven’t got the formal approval of the membership to go ahead with primary care delegation and make changes to constitution. This item is to remain on the tracker.</p> <p>17/09/028 - Finance, Performance and Commissioning Committee Report <i>The group discussed the appetite for suspension of some work to aid financial recovery and agreed this should be discussed at the November governing body as part of the FPCC item.</i></p> <p>We do not have any plans at present to suspend referrals to secondary care. We are keeping a watchful eye on the areas that fall under the Capital Expenditure Programme and we will be using the contract we have set up in place.</p> <p>17/09/30 – Audit Committee Report <i>CR requested that an update on audits taken across organisations be provided at the governing body and these are progressed through the audit committee.</i></p> <p>There are various reviews taking place by MIAA. We haven’t had a meeting since the last Governing Body meeting and the update will feature in the next report for Governing Body in January 2018.</p> | |
| 35 | GP NETWORK CHAIRS UPDATE | |
| | <p>JP informed the group that there continues to be a good attendance and a high level of challenge at Ellesmere Port and Neston network. Updates were provided on the financial situation and our financial recovery plan and it was noted that the joint committee work plan was well received following a little further explanation. Some of the members were still unclear on some aspects of the health optimisation flowcharts and that further reassurance may be needed when patients exceed the threshold. Ellesmere Port & Neston are changing the structure of the local community care teams to help cover vacancies. Discussions have begun on the Primary Care CQUIN and these will continue next month. Lorna Hall delivered an update on behalf of Primary Care Cheshire on the work they are doing relating to Integrated Care Partnerships.</p> | |

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| | <p>AJ reported discussions at City Network followed similar themes as Ellesmere Port & Neston with discussions on primary care commissioning and the implications of full delegation. There was concern from the network on the capacity of the Primary Care Team to be able to give this due diligence in the interim. They welcomed the work plan and its recommendations and showed their appreciation of how much is going on in primary care commissioning. Cluster-level data around urgent care and unplanned admissions was also discussed and practices were asked to take this back individually. Winter resilience planning was also discussed – particularly in relation to cover over Christmas.</p> <p>SP echoed the point about fully delegated responsibility for primary care and queried whether the Clinical Commissioning Group should take it on if additional resource doesn't follow. No challenge was received in respect of the work plan and he reported the rural network's desire to do something soon for winter. He reported to the group there had been some issues with Turning Point and communication with the practices and it had been felt that the local authority commissioner of this service should have been present at a recent meeting as it was hard to have meaningful discussions without the commissioner present.</p> <p>IA responded that he will follow up the issue raised by SP and provide a response outside of the meeting.</p> <p>CR thanked the network chairs for their updates and continued work. In relation to health optimisation he wanted to be absolutely clear that the process of trying to optimise the health of a patient doesn't prevent a patient from having surgery or obtaining the clinical treatment required.</p> <p>AL responded that there is still a lack of clarity about how the health optimisation pathway is going to operate and there is a need for assurance that the networks are clear on the pathway. It was agreed that Amanda Ridge would be asked to attend the December network meetings and the item would stay on the agenda for the foreseeable future.</p> <p>AL updated that in relation to urgent care and winter we are struggling as a system to deliver a robust service and improve the performance. At a recent event with NHS England and NHS Improvement it was clear that many other systems operate whereby GP admissions do not go via A & E they are signposted to the correct area. Clinical escalation plans in general practice was also raised and the network chairs were asked if they have assurance that clinical escalation plans are in place in the practices?</p> <p>The network chairs responded that plans would be in place but not necessarily all written down. It would just happen. GP practices always have to flex and adapt to meet the demands in primary care and cover appointments and in particular over the winter period to meet demand.</p> <p>LM responded that there will be a discussion regarding developing agreed standardised escalation triggers for GP practices at the Network meetings in December.</p> <p>The contents of the reports of the GP network chairs were noted.</p> | <p>IA</p> <p>SP/JP/ AJ</p> |

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| 36 | CHIEF EXECUTIVE OFFICER'S BUSINESS REPORT | |
| | <p>AL reminded the Governing Body that an update on the annual NHS Emergency Planning, Resilience and Response (EPRR) assurance process was included in her paper following the challenge made by the Governing Body about being overly critical on the self –assessment scoring. The scores have been reviewed by the new Head of Governance and we have now upgraded 6 of the 38 standards from amber to green which will now lead us to partial compliance. AL reported that in relation to criteria 31, “on call must meet identified competencies” there is now a greater expectation to provide 7 day cover over the winter and Christmas and New year period. Clinical Commissioning Groups and the local authority that would not normally run a 7 day service are being expected to do so during a crisis period.</p> <p>AL then referred to the section on Integrated Care and assured Governing Body that the system leadership group is meeting regularly and permission has been received from all partners to proceed with phase 3 of the work with Alison Lee acting as Senior Response Officer. A Memorandum of Understanding has been produced that sets out the governance arrangements of how the providers including Primary Care Cheshire will work together. Priority pathways have been agreed by all partners.</p> <p>It was noted that a team from NHS Improvement, Emergency Care Improvement Programme were working with the Countess of Chester Hospital looking at urgent care and once completed will provide recommendations.</p> <p>The first meeting of the joint committee will take place on 30th November. Paragraph 25 and 26 provides clarity about the decision making of the committee and paragraph 27 provides clarity on the role of Health and Wellbeing Board. The members have been given assurance that they will be given the opportunity to approve the work plan.</p> <p>Finally AL raised the issue of the current sickness levels at the Clinical Commissioning Group. The level is significantly above target which is of concern. She outlined a combined approach of improved absence management and supporting staff during times of considerable uncertainty. Pam Smith asked for assurance that the policy is being looked at more robustly and that staff are being reminded of the support available to them? Debbie Bryce responded that the policy needs to be clarified and that discussions are ongoing with HR around the long term absence management policy. Jeremy Perkins asked if there was any way to address the impact of potential changes with staff and to provide assurance and acknowledgement of the continued anxiety and to hopefully given some assurance about future roles. AL responded that staff are communicated to regularly via weekly team brief, monthly extended team brief and team events.</p> <p>The governing body is asked to:</p> <ol style="list-style-type: none"> a. Note the contents of this report. b. Approve the updated emergency planning, resilience and response core assurance self-assessment and overall compliance statement submission to NHS England. | |

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| 37 | SENATE REPORT | |
| | <p>This report provides an overview of the business discussed at the Senate meeting held on 28th September 2017, which focused on dementia care and the future of senate meetings. CR reported that dementia is an area that is subject to scrutiny around the local targets and diagnosis. It was noted that we are still below target following adjustments and that we face challenges in reaching them.</p> <p>The Primary Care team in conjunction with the mental health team provided information on the work being done to improve their dementia diagnosis rates. It was confirmed that NHS England changed the denominator for the calculation of the diagnosis rate last year which meant that the pool of potentially undiagnosed patients increased by 3%. An action plan has been implemented to address this. There has also been an issue around coding.</p> <p>Dr Annabel Jones talked the group through a specific case study of a patient at her practice and the difficulties in diagnosing the condition. She advised it can sometimes be difficult to diagnose someone with early stage dementia and noted when someone is diagnosed with dementia they do not always have to go through mental health services for this. The case also demonstrated how patient's families are often key in flagging up problems to clinicians.</p> <p>Discussions on whether we should look to achieve a target for the sake of it or whether it is for the benefits of the patients and families involved took place. It was acknowledged that early identification and putting place medical and practical steps can be immensely valuable.</p> <p>The future of the senate meetings and what form these should take as progress is made towards the integrated care partnership was discussed.</p> <p>PS supported the value of senate as it is a forum where the patient voice could be heard but suggested that we need to be mindful of meeting targets for the sake of it.</p> <p>IA commented due to the nature of the work we do with partners especially the third sector it is valuable to have the network available to challenge the system.</p> <p>AL responded that we need to ensure that dementia goes back to the Health & Wellbeing Board and we pledge allegiance to the dementia strategy and to ensure a connection between all the organisations.</p> <p>In relation to the future of the meetings AL felt that there is a need for senate to provide an opportunity to focus on the issues coming out of Cheshire and Merseyside and that a clear set of priorities and the role of senate moving forward be put in place.</p> <p>CR summarised that there is a hope to bring a number of pieces of work together around falls prevention and dementia. A joint paper being presented at Health & Wellbeing Board on dementia will be a positive step forward.</p> <p>The governing body is asked to note the issues discussed by the senate.</p> | |

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| 38 | QUALITY IMPROVEMENT COMMITTEE REPORT | |
| | <p>PW provided an overview in relation to the provider issues and highlighted the following from the report.</p> <ul style="list-style-type: none"> • Neonatal Services - The position in terms of admission criteria remains unchanged from earlier updates from the committee. • Quality Risk Profile – We have seen sustained improvements in the majority of areas at the hospital with the exception of the number of inpatient falls that cause injuries. The Trust has now joined the falls programme of work lead by the local authority and has begun implementation of the national falls improvement programme. In respect of how we monitor the impact of these programmes we will report this information to the Governing Body. • St Cyril's – The Care Quality Commission visited in March and reported an overall rating of inadequate. We continue to offer support to St Cyril's on a number of aspects of quality improvement. The three senior clinical roles are now appointed to and the people are in post. • Crawfords Walk – On 20th October BUPA ceased to be the registered provider and the home has transferred to a new owner, Barker Care Limited. The home has been renamed Grosvenor Gardens, the owner and registered manager are working with local commissioners to improve the care provided here. The Care Quality Commission has yet to inspect the home. The owner has a number of other homes in England which are rated as good by the Care Quality Commission. A session has been set up with all parties to reflect and learn from the process of BUPA withdrawing from Crawfords Walk and to identify what interventions are needed to support the care sector from closing businesses. • Medicines management - The Clinical Commissioning Group is working with partners including Cheshire and Wirral Partnership NHS Foundation Trust to reduce the inappropriate prescribing of psychotropic drugs to people with learning disabilities. It is acknowledged that some challenge will be faced as patients will have been on the medications for a long time and that the right support in and out of the home environment will be required. • Infection Control – There is a national target to reduce gram negative blood stream infections by 50%. The current E.coli blood stream infections Quality Premium target locally is no more than 203 cases of infection in 2017/18 and a local process is being developed for how we report this performance in conjunction with the hospital. • Safeguarding – There is a lot of detail in the report and regular updates are provided to the Governing Body. The Chairs of the Local Safeguarding Adult and Children Boards will be invited to a future governing body to present their annual reports. • Patient Experience – The Governing Body received the Listening - Responding – Learning- Improving” report. PW confirmed that this is a statutory requirement that feeds into the insight and intelligence report. PW highlighted that the contacts we receive are showing themes in relation to how to access care, how to navigate the NHS and individual experiences of direct care delivery. There is a theme specific to continuing health care in term of timeliness of assessments and associated process, plus a level of dissatisfaction with the outcome of decisions made in awarding funding. | |

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| | <ul style="list-style-type: none"> • Continuing Health Care/ Complex Care – we have received assurance that our service is compliant with the protected use of the title “nurse”. The letter has also been circulated to Primary Care nurses so they are sighted on what the Chief Nurse is seeking assurance on. We have been successful in our bid to improve workflow through the Continuing Health Care/ Complex Care service by using electronic workflow methodology. <p>JP commented that he was delighted that some practices were using the TARGET toolkit and having taken part in the webinars this one stands out as being incredibly beneficial in terms of prescribing. JP asked what actions could be taken to encourage all the practices to use it.</p> <p>AMcA responded that the TARGET toolkits could be promoted through prescribing leads. JP suggested that the leads should reinforce the message at the network meetings.</p> <p>AL sought assurance that whilst the 3 intensive care cots remain closed at the Trust that our babies are going to another hospital for care.</p> <p>PW provided assurance that care is undertaken at an alternative hospital and that if there is a known problem during pregnancy that the hospital arrange for a delivery at a location where there is a neo-natal cot available. Feedback from the network is that this process is working well.</p> <p>AL requested that information about inpatient falls with harm is brought back to Governing Body in order for the committee to ensure focussed assurance.</p> <p>AL asked “Have we got any sense when Grosvenor Gardens Care Home will open to new admissions?”</p> <p>PW responded that any decision to take new admissions will be made by the new provider once they feel able to do so. The Care Home Programme Board will seek assurance the provider is able to do this. There is currently no rating from the CQC and this will need to be taken into account when making that decision. We are not aware that this will be imminent.</p> <p>AMcA responded that the child in care data is much improved and it is really rewarding to see that for our children in care. What reassurance do we have that when children leave care there is still the support in place?</p> <p>PW responded that it would be helpful to have that discussion at the next governing body when the independent chair of the Local Safeguarding Children Board is in attendance. CR proposed that this item be put on the action tracker to be picked up when they attend.</p> <p>PW highlighted that we have made direct contact with neighbouring clinical commissioning groups who are responsible for the timeliness of the health checks of our children who are living in their area. This has had an impact on improving the performance in delivering these assessments.</p> | |

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| | <p>The governing body is asked to:</p> <ol style="list-style-type: none"> a. Review the issues and concerns highlighted and identify any further actions for the quality improvement committee b. Note the West Cheshire Clinical Commissioning Group Safeguarding Children, Children in Care and Adults at Risk Annual Report 2016/17 c. Note the West Cheshire Clinical Commissioning Group Patient Experience and Complaints Annual Report 2016/17 – “Listening - Responding – Learning - Improving” | |
| 39 | FINANCE, PERFORMANCE AND COMMISSIONING COMMITTEE REPORT | |
| | <p>GJ reported that month 6 was seen by NHS England as the opportunity for clinical commissioning groups to lock down their financial forecasts and to deliver agreed 2017/18 control totals. The governing body has considered our financial forecast position on a number of occasions and following our internal deep dive we have been able to report a reduced risk with a risk adjusted forecast of £2 million deficit. At the end of September 2017 we have reported an in-year deficit of £1.674 million although we continue to report that this position will be recovered and that we will, therefore, deliver financial balance as at 31st March 2018. This position was agreed by the governing body in October 2017.</p> <p>Paragraph 11 of the report identifies the key actions that are needed to deliver the latest financial forecast of £2 million. Although we are pleased with the financial recovery progress that we are making there remains a significant level of risk. The expectation from NHS England that we will deliver our plan.</p> <p>GJ also reported that since the November 2017 committee meeting, we have reported on the month 7 position to NHS England and the trajectory of reducing risk has continued. GJ noted that the reported position to the end of October 2017 continues to exclude the local financial impact of the national prescribing issue; described as ‘no cheaper stock obtainable’ issue</p> <p>The committee considered the following 3 areas that had been scrutinised in detail at month 6: prescribing, complex care/continuing healthcare and secondary care contracts. There is a lot of caution as there is still risk and at the moment £1.8 million is our likely finishing point. In the next 5 months we will, in all likelihood, need some non-recurrent support to achieve financial balance.</p> <p>GJ also reported that we are forecasting we will meet our other financial duties around running costs and prompt payment code.</p> <p>KT commented that this is really good progress and it is good news to hear we are going in the right direction. These are inevitably big figures but it is important to keep in mind that the likely year-end deficit is less than 1% of the whole budget.</p> | |

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| | <p>In response to paragraph 11 JP commented that in order for us to delivery there is a need to encourage patients to utilise our block contract. How is this initiative progressing? GJ responded that early indications are that the uptake is fairly positive. Most of the problems we encounter are being bale to have the necessary conversations with patients. Additional resource maybe added to this project in the second half of the year. CR added that it would be helpful if members of the public had the context behind this initiative with the emphasis that we haven't made a decision to remove patient choice but by having a conversation about where they choose to be treated they can help us in terms of our financial position and also help us to support patients to make an informed decision on the facts. When this was discussed with Healthwatch they were positive about the concept of having the mature conversation about supporting the local hospital.</p> <p>PW commented that in terms of trying to ensure that we have the greatest impact in contacting people who are on waiting lists to consider alternative providers we must work extended hours to reach people who may be out in office hours. LM responded that the member of staff has now aligned their hours to deliver this most effectively.</p> <p>In response to a question about confidence levels regarding our 'must do' actions GJ responded that significant progress is being made in relation to complex care reviews. He also reported that we continue to report a prudent view of the likely savings in respect of both prescribing and secondary care contracts.</p> <p>GJ reported that there is a national problem relating to a reduction in supply and a corresponding increase in the cost of some drugs described as the no cheaper stock obtainable concession whereby pharmacists are permitted to dispense more expensive alternative products. Our estimate of the local impact of this pressure is approximately £2.3 million and, in line with NHS England guidance, this is excluded from our reported financial position.</p> <p>Laura Marsh updated on commissioning intentions for 2017-19 and reported that due to the pace of change these had been refreshed to include an update on the integrated care work, the development of the Joint Committee with neighbouring Clinical Commissioning Groups across Cheshire and the development of joint commissioning arrangements with the Local Authority e.g. Learning Disabilities and Children's Services.</p> <p>GJ asked What we plan to do with these next.</p> <p>LM responded that they will be signed off virtually by Finance Performance and Commissioning Committee and then taken to the contract meeting with the Countess of Chester Hospital and we will write formally to Cheshire and Wirral Partnership Foundation Trust. There are limited requirements to submit to NHS England as the requirement was for two year plans. We will look to share widely with our partners.</p> | |

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| | <p>AL responded that discussions at Finance Performance Commissioning Committee were helpful but it is going to be quite a difficult job to deliver financial recovery and the transformation that we need to do. How do we balance that work? We can't put pressure on our providers if we won't change. We need to think about the impact for the Clinical Commissioning Group and the impact on our partners.</p> <p>GJ responded that we have had thoughts about how we contract with our local partners from April 2018 but we haven't got a clear path how we put that into a contract at the moment.</p> <p>LM agreed that there is likely to need to be a system-wide document that sets out what we are planning to deliver through integrated care, linked to the NHS standard contracts</p> <p>CR responded that mental health and learning disabilities is a great early example of where we might jointly strategically commission services with the Local Authority to see what efficiencies and opportunities could be achieved.</p> <p>LM highlighted to the committee a thematic report from starting well that provided an update on the Cheshire & Merseyside work on Women's and Children's services. The Cheshire and Merseyside Women's and Children's Partnership Vanguard has been leading the facilitation of discussions across Sustainability and Transformation footprint for maternity, paediatrics and neonates. A multi-agency Partnership Summit meeting was held on 10th October 2017, which included detailed updates on the progress made to date within the programme. Colleagues from the Countess of Chester and Wirral University Hospital Trusts delivered a 'Local Solutions' presentation at the event, where they reported that their Trust Executive Boards were happy to support increasing collaborative work. Clinicians are exploring the strengths and weaknesses and it is early days but really positive discussions are taking place. LM confirmed that both Wirral and West Cheshire clinical commissioning groups are involved in the discussions.</p> <p>LM reported that the preferred options for the Cheshire and Merseyside Neonatal Surgery Service Delivery Model for Cheshire and Merseyside Neonatal Network had been approved and implemented but that no decision regarding Neonatal Intensive Care Services had been made to date and confirmed that the decision would not be made in isolation, particularly within the context of the wider work underway.</p> <p>The committee were updated on the approach to the joint framework for Learning Disabilities and Mental Health and Autism Spectrum Disorder. the current framework will be extended until 30th September 2018 to allow time for the development of a joint framework</p> <p>PS talked about patient and public involvement and sought assurance that Equality Impact Assessments are completed to ensure equity.</p> | |

| 16/11 | AGENDA ITEM | Action |
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| | <p>LM responded that we have support from the commissioning support unit and the communications and engagement team to ensure that assessments are completed for all changes to services. LM assured the committee that we have a robust process in place.</p> <p>AL noted the positivity around integration of mental health services and asked whether this would give us the potential to increase the support for people with autism.</p> <p>LM responded that from a health perspective we have started on a journey and are starting to understand the gaps in care</p> <p>LM reported on performance and informed the committee that we continue to fail several constitutional targets including referral to treatment (RTT) 18-week, Cancer 62-day, A&E 4-hour, Ambulance and dementia targets. The committee has sought improvement on RTT as this has only just tipped into failing and discussions are ongoing as to how we could look to help and understand which specialities struggle to achieve the target Conversations will continue with NHS England and NHS Improvement in relation to A & E and Cancer targets. LM informed the committee that the Emergency Care Improvement Programme were currently in Countess of Chester Hospital with a focus on looking at both how we can look to improve performance against the A&E target but also at reasons for delayed transfers of care</p> <p>It was noted that there is realism from NHS England that the 95% A&E target may not be achievable across the system but should a trust fail to achieve this target they will potentially not be eligible for additional sustainability and transformation funding. The North region is currently achieving a target of 90%</p> <p>CR responded that we are seeing improvements in response to some of the changes being made and for some of our constitutional targets the percentage by which we are failing is small and therefore we need to continue to strive to improve.</p> <p>AMcA talked about the balance between our priorities and the financial position we are in. Do other localities have the same issue?</p> <p>GJ responded that NHS England are very clear of the priority performance targets as well as financial balance</p> <p>AJ noted the diagnostics performance and in particular improvement in echo waits. LM agreed that in terms of diagnostics this continues to be a focus at the Countess contract meeting.</p> <p>AJ asked In relation to mental health/IAPT waiting times is there anything more we can do?</p> <p>LM responded that there is an expectation from the provider that there is investment in line with national guidance. As set out in our commissioning intentions, it is important that if we are making additional investment it is focused on key priority areas that ideally benefit the wider system rather than smaller amounts of funding across a large number of services.</p> | |

| 16/11 | AGENDA ITEM | Action |
|-------|---|--------|
| | <p>CR responded that this illustrates the issues we face in trying to achieve all of our priorities</p> <p>The governing body is asked to:</p> <ol style="list-style-type: none"> a. Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 2nd November 2017. b. Note the financial position to the end of September 2017 and progress against the 2017/18 Financial Recovery Plan. c. Note the update from the Starting Well programme particularly the developing acute alliance between Wirral Hospital and the Countess of Chester d. Note the approved approach in relation to the Adult Learning Disabilities, mental health and autism spectrum disorder framework e. Note the position against national/local performance targets | |
| | PRIMARY CARE COMMISSIONING COMMITTEE | |
| | <p>CR apologised to PS and LM that due to an oversight a paper reporting from Primary Care Commissioning Committee had not been included on the agenda. It was noted that the agenda and papers would be uploaded to the website and if members of the Governing Body had any queries these could be raised virtually following the meeting.</p> <p>LM highlighted the following key points from the paper.</p> <p>Full Delegation – the committee were clear that due diligence would need to take place particularly in relation to any financial risk and that full engagement with the membership would be needed during Nov-Jan.</p> <p>Ongoing concerns in relation to Primary Care Services and the issue of patient notes going missing was discussed and it was agreed by the committee to escalate the concerns to NHS England and to attend a meeting at East Cheshire with Primary Care Services.</p> <p>The committee approved revised LES recommendations to improve the Primary Care offer to care home residents. The Clinical Commissioning Group recognises there is a need to look to increase the funding further in 2018/19 to ensure an equitable primary care offer to all care home residents to avoid admissions, gold standard dementia care and support around falls.</p> <p>The committee were informed that a planning application will be submitted in relation to the Blacon Development and that the NHS England alternative medical services contract for Willaston had been awarded to Cheshire and Wirral Partnership.</p> <p>CR noted that he had written as Chair of the Clinical Commissioning Group to the Head of Primary Care Services to provide challenge to the report and highlight a number of issues in relation to the collection and delivery of patient records and tracking of notes. The numbers of records involved is lower than originally thought. We haven't received an adequate response as yet so we are keeping this on our radar and continue to escalate. Members of Capita have</p> | |

| 16/11 | AGENDA ITEM | Action |
|-----------|---|-----------|
| | <p>been called to attend the Primary Care Commissioning Committee meeting in East Cheshire to answer questions as this situation is not unique to our area and is starting to attract national attention. Issues have also been raised by Local Medical Committee and the British Medical Association around some of the other functions that Capita perform.</p> <p>If there are any further points of clarity we will ensure those questions are responded to in full and summarised for the next GB meeting.</p> | |
| 40 | GOVERNING BODY ASSURANCE FRAMEWORK | |
| | <p>DB reported that 2 new risks have been added to the framework and that these have both been discussed on a number of occasions through the individual committees in detail and that all risk owners were present at today's meeting.</p> <p>KT requested that due to the scale and national issues 'no cheaper stock available' financial risks should be added to the register.</p> <p>GJ agreed to the suggestion and confirmed that these would be added.</p> <p>RECOMMENDATIONS</p> <p>The governing body is asked to consider and approve the 2017/18 governing body assurance framework proposed by the Executive risk sponsors, noting the summary of changes from the previous assurance framework (to the governing body in September 2017).</p> | GJ |
| 41 | CLINICAL COMMISSIONING GROUP POLICIES AND GOVERNANCE DOCUMENTS | |
| | <p>The Chief Finance Officer advised that the Translation and Interpretation policy was provided for ratification by the governing body as proposed by the committee outlined in the covering paper.</p> <p>RECOMMENDATIONS</p> <p>The governing body were asked to approve / ratify the policies / governance documents provided.</p> <p>PS queried whether the policy has had a full equality impact assessment.</p> <p>DB confirmed that the policy had had an Equality Impact Assessment completed.</p> <p>The Chief Executive Officer reported that the Clinical Commissioning Group is undertaking a review of all of the policies and that a small number of policies will be coming through the committees for ratification. These are documents by which we assess our own performance and there is a need to ensure that we give them due scrutiny. He recommended to the board that we add these to the work of the Governing Body.</p> | |

| 16/11 | AGENDA ITEM | Action |
|-----------|--|--------|
| | The policy was approved by the Governing Body. | |
| 42 | 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. | |
| 43 | ANY OTHER BUSINESS | |
| | There was no other business to be discussed. | |
| | DATE AND TIME OF NEXT FORMAL MEETING | |
| | The next meeting will take place on Thursday, Thursday 18 th January 2018, at 9.00 am, Rooms A&B, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ. | |

Minutes received by: _____ (Chair)

Date _____

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 20th July 2017 | | | | |
| 17/07/014 | Chief Executive Officer's Business Report CR will have conversations with NHS England about the resources that come to clinical commissioning groups for this function/additional work. | Chris Ritchieson | Nov 2017 | An update was provided to the November 2017 meeting – discussions are ongoing |
| Meeting Held on 21st September 2017 | | | | |
| 17/09/028 | Finance, Performance and Commissioning Committee Report The group discussed the appetite for suspension of some work to aid financial recovery and agreed this should be discussed at the November governing body as part of the FPCC item. | Gareth James | Nov 2017 | Complete |
| 17/09/030 | Audit Committee Report CR requested that an update on audits taken across organisations be provided at the governing body and these are progressed through the audit committee. | Gareth James | Jan 2018 | An update is provided under agenda item 18/01/06 |
| Meeting Held on 16th November 2017 | | | | |
| 17/11/35 | GP Network Chairs Update IA to follow up the issue raised by SP regarding Turning Point and provide a response outside of the meeting. | Ian Ashworth | Jan 2018 | Update to January 2018 Meeting |
| 17/11/35 | GP Network Chairs Update The health optimisation pathway to be discussed at all network meetings in December. | Steve Pomfret Jeremy Perkins Annabel Jones | Jan 2018 | Complete |
| 17/11/40 | Governing Body Assurance Framework 'No cheaper stock available' financial risks to be added to the register. | Gareth James | Jan 2018 | Complete |

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

GOVERNING BODY REPORT

- 1. Date of Governing Body Meeting:** 18th January 2018
- 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 provided include:

 - The emergency planning, resilience and response workplan
 - An update on winter
 - The acute sustainability programme
 - The CCG expected to come out of formal directions from April 2018
 - System transformation fund establishment
 - 360° stakeholder survey update
 - Deviation from Standing Orders
 - An update on the development of unified commissioning across Cheshire
 - An update on the Joint Committee for clinical commissioning groups.
 - An update on general CCG business
 - High level meetings/events attended by the Chief Executive Officer
- 4. Recommendations**

The governing body is asked to:

 - a. Note the contents of this report.
 - b. Ratify the deviation from Standing Orders
- 5. Report Prepared By:** Debbie Bryce
Head of Governance
January 2018

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 Acute Sustainability Programme |
| 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 | The Joint Commissioning Committee. Third Sector Grants. |
| 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 | 360° stakeholder survey |

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) |
|---------|---|--|---|
| 2 | Failure to embed systems and processes of good governance | The emergency planning workplan provides assurance | |

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.

EMERGENCY PLANNING RESILIENCE AND RESPONSE CORE ASSURANCE

2. An update was provided in November 2017 to the Governing Body on the updated annual NHS Emergency Planning, Resilience and Response (EPRR) core assurance self-assessment standards.
3. The update stated that a work plan would be developed by the Head of Governance to focus on addressing the six amber criteria within the core assurance framework and the Clinical Commissioning Group's overall 'partial' compliance rating.
4. The workplan has now been drafted and can be found in the following [link](#).
5. The Head of Governance will oversee the work plan and will continue to attend meetings of the Local Health Resilience Partnership.
6. The Governing Body are asked to note the workplan and also note that on-call managers have attended EPRR training on 5th December, 2017, provided by Midlands & Lancashire Commissioning Support Unit.

WINTER EMERGENCY PRESSURES

7. The local health care system is under considerable pressure again this winter. The Clinical Commissioning Group has had a winter communications plan in place since September. There is a national focus and a system wide communications strategy in place and we have effective signposting in place and a priority on self care. The Clinical Commissioning Group is working more cohesively with our local partners and across the Cheshire patch and we have set up a winter wellbeing page on the website that includes information on self-care, pharmacy, primary care access and dental.
8. The cold weather spells have exacerbated the underlying health conditions of some of our patients, along with peaks in demand, causing a stretch on the Countess of Chester Hospital. We are working with our operational colleagues across the system to ensure services are safe and effective.

9. The NHS National Emergency Pressure Panel has issued recent guidance aimed at supporting the demands being faced by providers during the winter period. The guidance (Publications Gateway Reference: 07578) lists the following actions to be undertaken by NHS providers in order to reprioritise clinical time, namely:
- Extending the operational recommendations of 21 December 2017 to 31 January 2018 to include deferral of all non-urgent inpatient elective care to free up capacity (excluding cancer operations and time critical procedures that prevent rapid deterioration in a patient's condition).
 - Deferral of daycases and routine outpatient appointments or a change in setting (for example telephone consultation).
 - Immediate prioritisation of the vaccination of all front line staff over the next two weeks.

THE ACUTE SUSTAINABILITY PROGRAMME

10. An Acute Sustainability Programme is in place within NHS Cheshire and Merseyside (the STP). The Programme Board met on 19th December and a number of key milestones were agreed to the end of January 2018. By the end of January there will be a case for change and emerging clinical scenarios for urgent & emergency care and elective care (Women's and Children's already completed), an assessment of the public and health care organisations' readiness for change and an understanding of the decision making and governance framework for reconfiguration proposals. Progress with the case for change and clinical scenarios has been slower than anticipated.
11. A communications lead is now a member of the Acute Sustainability Programme Board and will actively support the programme in developing its narrative for stakeholders (including the public and clinicians), advise on engagement activities and, downstream, on formal consultation. Engagement activities will encourage patient/public involvement, clinicians being closely involved in driving discussions about clinical reconfiguration and engaging commissioners about the commissioning implications of changes in reconfiguration to achieve a sustainable NHS for Cheshire & Merseyside.

CLINICAL COMMISSIONING GROUP DIRECTIONS

12. The Clinical Commissioning Group met with NHS England on 22nd November 2017 for a planned review meeting. NHS England was encouraged by the scope of the Clinical Commissioning Group initiatives in place and expressed confidence that we will meet our financial control total. There was recognition that the 'no cheaper stock obtainable' drugs expenditure issue was outside of the Clinical Commissioning Group's control.
13. NHS England confirmed at the meeting that due to the confidence in the Clinical Commissioning Group meeting its control total it will put in train the process now for releasing the Clinical Commissioning Group from directions at the first

available point. The Clinical Commissioning Group is expected, therefore, to come out of formal directions in April 2018 when the accounts are delivered.

SYSTEM TRANSFORMATION FUND ESTABLISHMENT

14. To address the need for ring-fenced funding for the purpose of supporting place-based care systems, NHS Cheshire & Merseyside (STP) is proposing to set a target contribution of 0.25% of allocation for all CCGs (with the exception of one) in 2018/19. This will create a Transformation Fund of circa £7m which would be held by NHS Cheshire & Merseyside (STP) for this purpose. This is linked to the individual control totals to be set for each Clinical Commissioning Group to ensure that the overall plan for Cheshire & Merseyside Clinical Commissioning Group is consistent with the overall Cheshire & Merseyside control total.
15. For NHS West Cheshire Clinical Commissioning Group this 0.25% target contribution would be in addition to the 0.5% surplus we will plan to achieve in 2018-19. The Clinical Commissioning Group are seeking assurance on the process regarding the establishment of the transformation fund and the process for sign-off of the control total for 2018-19.

360° STAKEHOLDER SURVEY

16. The 360° Stakeholder Survey assesses how stakeholders perceive the Clinical Commissioning Group and how the CCG works with them to improve quality and outcomes for patients within the West Cheshire health and care system. The results of the survey contribute to NHS England's statutory annual assessment of CCGs, and provide a valuable tool for all CCGs to evaluate their progress and inform future development.
17. The CCG was required to provide a list of its stakeholders and any localised question statements to Ipsos MORI by 08 December 2017. This has been completed and work is now expected to be undertaken by Ipsos MORI between 15 January and 23 February 2018. The CCG should then receive the final stakeholder survey report by the end of March 2018.

THIRD SECTOR GRANTS

18. A third sector grants event, with a number of presentations, was held by the Clinical Commissioning Group on 11th December 2017. The attendees appreciated the opportunity to come together and have discussions with the Clinical Commissioning Group. A step for any questions/queries to be answered and sent out was completed and the closing date for application for grants from the Clinical Commissioning Group was 15th January 2018. These applications will now be reviewed and will then be awarded on 29th January 2018

STAFF SURVEY RESULTS

19. The Clinical Commissioning Group staff survey was undertaken in October 2017 and the Organisational Development group are formulating a plan based on the staff survey results.
20. Key positive results from the survey were:
 - *Are you aware of the CCG's Corporate Values and Team Charter?* 98% of staff responding agreed.
 - *Does the CCG take positive action on health and wellbeing?* 93% of staff responding agreed
 - *Is your manager supportive in a personal crisis?* 90% agreed.
21. Less positive points for consideration by the Clinical Commissioning Group are:
 - *There are opportunities for me to develop my career in the CCG?* 41% of staff responding agreed.
 - *I am able to meet all the conflicting demands on my time at work?* 45% of staff responding agreed.
 - Concerns have been raised by a small number of staff around bullying, harassment and discrimination and the number of ways available for staff that need support with this has been discussed with staff at team brief, along with the fact that any issues of this nature are taken very seriously.
 - In relation to career options, it can be difficult within a small organisation for promotion and progression.
 - Suggestions for how to meet conflicting demands on time and prioritisation were made and discussed at the December extended team brief with staff.

THE CONSTITUTION AND STANDING ORDERS DEVIATION

22. The governing body met in private on 21st December 2017 and received a presentation on the Clinical Commissioning Group's constitution. There was much useful discussion and a number of areas were highlighted for review. It is agreed that the Head of Governance will work with the Chair and suggest a number of changes to the constitution in February 2018 to help clarify some issues and to make some minor changes to keep it 'in order'. These changes will be recommended to the Governing Body and then to the Membership Council.
23. At the 21st December 2017 Governing Body it was declared that the practice within the constitution Standing Orders for recording minutes of the meeting of the Membership Council had not been followed. This practice has now been rectified.
24. There has been a deviation from Standing Orders for the appointment of the Clinical Commissioning Group's Nurse Member. The term of office of the Nurse Member is detailed within the Standing Orders as four years and the

appointment has been made in November 2017 for 12 months. This is due to the local development of strategic commissioning.

INTEGRATED CARE DEVELOPMENT

25. The Governing Body are asked to note that developments in integrated care are now provided within a separate dedicated report.

UNIFIED COMMISSIONING DEVELOPMENT ACROSS CHESHIRE

26. In May 2017, the Governing Body considered a paper supporting a move to a unified health and care commissioning approach for the population of Cheshire.
27. Since then, there has been a series of workshops and meetings culminating with the first Joint Committee meeting (see below). Each CCG in Cheshire has then discussed its preferred option for the future of CCGs and commissioning in Cheshire. There were five options presented including no change, a combined management team working across existing CCGs, fewer CCGs but not coterminous with local authority boundaries, fewer CCGs and coterminous with local authority boundaries.
28. The preference agreed by the governing body was to be part of a CCG coterminous with the local authority. We were, however, cognisant those things might change in terms of national policy and indeed in the future a single CCG across Cheshire might be preferable.
29. The governing body is mindful that we have not yet discussed this with our member practices or wider partners.

UPDATE ON THE JOINT COMMITTEE FOR CLINICAL COMMISSIONING

30. A first meeting of the Joint Commissioning Committee for clinical commissioning of the four Cheshire Clinical Commissioning Groups (CCG) - West Cheshire, Eastern Cheshire, South Cheshire and Vale Royal – was held on 30th November, 2017.
31. The agenda and papers for the meeting were made available to the public on a dedicated section of the Clinical Commissioning Group's website, which was also replicated on the websites of the other three CCGs.
32. Items discussed included the remit and operation of the committee, the terms of reference, the annual workplan, and the Eastern and Central Cheshire Adult and Older Persons Specialist Mental Health Services Redesign Pre-Consultation Business Case (for Central and East Cheshire) and items for consideration at the following meeting.

33. The Clinical Commissioning Group's Constitution was amended to include the Joint Committee and was submitted to NHS England on 6th October, 2017. Feedback was received on 22nd November and 20th December 2017 and the feedback regarding re-inclusion of the Scheme of Reservation and Delegation was considered at the private meeting of the Governing Body on 21st December 2017. Further changes to the constitution have now been drafted following the feedback and agreement by the Governing Body to maintain the Scheme of Reservation and Delegation as a standalone document, but reference it within the Clinical Commissioning Group's Constitution and have been re-submitted to NHS England. These changes will also be recommended at the next meeting of the Membership Council in February 2018, for approval.

GENERAL CCG BUSINESS ITEMS

34. NHS West Cheshire Clinical Commissioning Group will complete a **full review of the declarations of interest register in February 2018**.
35. NHS West Cheshire Clinical Commissioning Group has heard from NHS England that the **planned on-line conflicts of interest training roll out has been delayed** (due mid-November 2017). It is expected that all CCG employees, Governing Body members and practice representatives involved in the business of the CCG will be expected to complete this training, once available.
36. **Midlands & Lancashire Commissioning Support Unit (CSU) has rolled out a new system for the management of recruitment services**, on 4th January 2018. This should, in the near future, improve the performance of the recruitment service provided to the Clinical Commissioning Group and, in turn, improve the rating score by the CCG of the performance of the CSU for recruitment services (recently reduced from 3 (satisfied) to 2 (dissatisfied)).
37. The **Medicine's Management team** from Midlands & Lancashire Commissioning Support Unit (CSU) who provide services to the Clinical Commissioning Group won the Midlands & Lancashire Commissioning Support Unit **Outstanding Achiever award** in December 2017.
38. An advisory **audit is currently underway of Clinical Commissioning Group remuneration arrangements for clinical leads** by the advisory arm of Mersey Internal Audit Agency (MIAA). Once available, the recommendations will be considered by the Clinical Commissioning Group.

MEETINGS/EVENTS ATTENDED BY THE CHIEF EXECUTIVE OFFICER

39. Provided below is a summary of some of the high level meetings and events attended by the Chief Executive Officer since the previous formal governing body meeting in November 2017:
- West Cheshire A & E Delivery Board

- Meeting with NHS England and CCG Accountable officers across Cheshire and Merseyside
- Meeting with NHS England and NHS Improvement on A & E
- Meeting with GP Practice managers

RECOMMENDATIONS

40. The governing body is asked to:

- a. Note the contents of this report.
- b. Ratify the deviation from Standing Orders

Alison Lee
Chief Executive Officer
January 2018

GOVERNING BODY REPORT

1. **Date of Governing Body Meeting:** 18th January 2018

2. **Title of Report:** Integrated Care Partnership Update

3. **Key Messages:** This report provides an overview of the progress to deliver Integrated Care across West Cheshire.

4. **Recommendations** The governing body is asked to:
 - Note the progress to date
 - Note the commencement of the next phase of service redesign to support the delivery of integrated care.

5. **Report Prepared By:** Jonathan Lloyd
Programme Consultant
18th January 2018

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 | Yes |
| We will improve patient safety and the quality of care we commission by reducing variation in standards of care and safeguarding vulnerable people | Yes |
| We will support people to take control of their health and wellbeing and to have greater involvement in the services we commission | Yes |
| We will commission integrated health and social services to ensure improvements in primary and community care | Yes |
| We will commission improved hospital services to deliver effective care and achieve NHS constitutional targets | Yes |
| We will develop our staff, systems and processes to more effectively commission health services | Yes |

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) |
|----------------|-------------------------|---|--|
| | | | |
| | | | |

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

INTEGRATED CARE IN WEST CHESHIRE

PURPOSE

1. This paper is to update the Governing Body regarding activity relating to the Integrated Care Partnership (ICP).
2. Our 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.
3. 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

BACKGROUND

4. The Governing Body will recall that previous updates on integrated care have formed part of the Chief Executive's report. It was agreed that because of the increasing focus on integration that a separate report would be produced from now on.
5. Health and social care partners have entered the third phase of our integration work. Phase two ended with a detailed document outlining the proposed model of care informed by extensive work with over 130 individuals across West Cheshire.

PHASE THREE WORK

6. The third phase will deliver the new model of care in a number of different areas including respiratory, frailty and older people, risk stratification, enhanced community service and increasing access to health and advice via digital and community solutions.
7. The content of the work will be shaped over the next few weeks. A summary of the draft delivery intentions from each area are as follows:
 - **Respiratory** -will improve health outcomes for those experiencing respiratory conditions, focusing initially on Chronic Obstructive Pulmonary Disease (COPD) and pneumonia.

The programme of work will redesign the end to end care pathway in line with the principles set out in the *West Cheshire Integrated Care Partnership*

Compendium, led by respiratory physicians, GPs, nurses, consultants, primary care, local authority, allied health, community care professionals, patients and the third sector. The focus of the new care pathway will be to proactively target individuals and either enable them to self-care, or direct them receive care in the community where appropriate.

- **Frail and/or elderly** : A number of areas have been identified to focus on as initial priorities, including falls prevention, dementia support and care homes. Specific areas and interventions associated with these will be selected to be focused on first using data and information, with an emphasis on focusing on which will release the most benefit in the shortest time frame. The programme of work will be led by consultants, GPs, nurses, primary care, local authority, allied health, community care professionals, patients and the third sector.
- **Enhanced care through Integrated Working** will support all health and social care providers to work seamlessly together. The work will expand beyond Community Care Teams (CCT) to support the increased utilisation of self and community care over acute and bed based options. Health and social care professionals will be supported to work together across organisational boundaries to provide the most appropriate care in a timely manner.
- **Digital Front Door** will design an implementation plan for a single Digital Front Door, supported by a contact centre. This will be used as the primary gateway to accessing health and social care services. The design will focus on features and services for both professionals and the public. The Digital Front Door will allow individuals to complete self-assessments of their health status, providing information on health and non-health care support services, or gain personalised self-care advice as necessary. The Digital Front Door will include a full service directory which will support the triage of people into the system, helping them to navigate to the appropriate services first time around.
- **Community Front Door** will provide consistent access to services across all community entry points. The work stream will signpost people to appropriate services, providing access to booking appointments for all services and consistent use of the risk stratification tool to support signposting individuals to the right services.
- **Risk Stratification** – The Risk Stratification tool will support the health and social care professionals to proactively target high risk individuals to provide appropriate care in a timely manner. The Risk Stratification work stream will work with a range of health and social professionals care to determine requirements, and then select and embed a consistent risk stratification tool across the partnership. Work completed in phase two will be used as a basis for the tool, with an effective process so that professionals utilise the outputs of the tool to target, create and adapt care plans to meet the individual's needs.

8. We held a phase three introduction session for clinical sponsors, programme leads on Thursday 11th January 2018. The overall aim was to reinvigorate the programme and ensure key players are briefed to help improve implementation. Specific objectives were to:
 - To reinstate the overall aim of the Integrated Care Partnership
 - Clarify overview of the role of clinical sponsor, programme lead and programme support
 - Outline programme structure, timescales and governance arrangements
 - High level run through of scope and nature of work in each work stream
 - Highlight key dependencies
 - Agree on next steps
9. We are also working on the governance and decision making for phase three including the delivery group (formed from the Integrated Services Steering Group) and the (Clinical) Advisory Group.
10. There is a commitment from all services across West Cheshire recognising that we need to change; part of this communication process we have developed a supporting document called '[Joining up care in West Cheshire](#)'
11. In summary, we have commenced the next phase of work, and we are actively engaging services to come up with solutions to the challenges we face set out in the attached document; some of these may be simple cross system solutions we can implement and others that may take longer. As part of any process, there is and will continue to be the engagement of all partners and when we have some early options the population of West Cheshire.

RECOMMENDATION

12. The governing body is asked to:
 - a) note the progress to date;
 - b) note the commencement of the next phase of service redesign to support the delivery of integrated care.

Alison Lee
Chief Executive Officer
January 2018

- 1. Date of Meeting:** 18th January 2018
- 2. Title of Report:** Full Delegation of Primary Care Commissioning
- 3. Key Messages:**
 - Primary care co-commissioning was one of a series of changes set out in the NHS GP Five Year Forward View.
 - A number of Clinical Commissioning Groups took on responsibility for commissioning general practice services in April 2015.
 - Within NHS Cheshire & Merseyside, West Cheshire Clinical Commissioning Group is one of five Clinical Commissioning Groups which are currently Joint Commissioning general practice with NHS England.
 - The other three Clinical Commissioning Groups in Cheshire are fully delegated.
 - The primary care allocation for 2017/18 is £34m
 - There are a number of opportunities and challenges for the Clinical Commissioning Group associated with becoming fully delegated and these are detailed in the report.
 - The consultation and due diligence processes have commenced.
- 4. Recommendations**
 - The Governing Body is asked to consider the content of the report and the recommendation of the Primary Care Commissioning Committee to approve the proposal to continue to primary care full delegation from 1st April 2018 including approval of the proposed revised terms of reference for the Primary Care Committee.
 - The Governing Body is asked to recommend the resulting changes to the Clinical Commissioning Group's constitution for approval by the membership council in February 2018.
- 5. Report Prepared By:** Sarah Murray, Head of Primary Care
Debbie Bryce, Head of Governance
- 6. Executive Sponsor:** Laura Marsh, Director of Commissioning

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

FULL DELEGATION OF PRIMARY CARE COMMISSIONING

PURPOSE

1. The purpose of this report is to seek approval from the Primary Care Commissioning Committee for the Clinical Commissioning Group to take full delegated responsibility for commissioning general practice.
2. The report details the risks and opportunities of becoming fully delegated and provides an option paper setting out the consequences for both becoming fully delegated and remaining co-commissioners with NHS England, to help inform members' decision making.

BACKGROUND

3. In May 2014, NHS England invited Clinical Commissioning Groups to come forward with expressions of interest to take on greater responsibility for commissioning general practice.
4. In addition, in April 2016, NHS England published the GP Forward View which further described the pressures and challenges facing General Practice. In summary this document sets out how the NHS will address these pressures through practical and funded steps across 5 key areas: investment, workforce, workload, infrastructure and care redesign.
5. In 2015, the Clinical Commissioning Group put forward an expression of interest to work together with NHS England (Cheshire and Merseyside) under 'joint' co-commissioning arrangements. This was supported by NHS England and arrangements have been in place since 1st April 2015 and managed through a joint committee; the Primary Care Commissioning Committee.
6. Across the Sustainability and Transformation Partnership area; NHS Cheshire & Merseyside, seven Clinical Commissioning Groups are fully delegated and West Cheshire Clinical Commissioning Group is one of five which are currently Joint Commissioning general practice with NHS England. Wirral, Warrington, South Sefton and Southport and Formby Clinical Commissioning Groups are yet to take on full delegation.
7. It is likely that Wirral and Warrington Clinical Commissioning Groups will become fully delegated in April 2018.

Summary of Commissioning Functions

8. The table below sets out what is covered by the different levels of commissioning responsibility.

| Primary care function | Joint commissioning | Delegated commissioning |
|--|--|--|
| General practice commissioning | Jointly with area teams | Yes |
| Pharmacy, eye health and dental commissioning | Potential for involvement in discussions but no decision making role | Potential for involvement in discussions but no decision making role |
| Design and implementation of incentives schemes i.e. QOF | Subject to joint agreement with the area team | Yes |
| General practice budget management | Jointly with area teams | Yes |
| Complaints management | Jointly with area teams | Yes |
| Practice investigations/Quality issues | Jointly with area teams | Yes |
| Contractual GP practice performance management | Jointly with area teams | Yes |
| Medical performers' list, appraisal, revalidation | No | No |

OPPORTUNITIES AND RISKS OF FULL DELEGATION

9. Delegated commissioning offers an opportunity for Clinical Commissioning Groups to assume full responsibility for commissioning general practice services. This will include contractual GP performance management, budget management and national Directed Enhanced Services (DES). Legally, NHS England retains the liability for the performance of primary care, as with the other models. NHS England will therefore require robust assurance that its statutory functions are being discharged effectively. The Clinical Commissioning Group retains its liability to improve the quality of general practice (which is part of its statutory obligations at all levels of commissioning).
10. This model also allows the option to invest in primary care in ways that align to local priorities. For example; some Clinical Commissioning Groups have designed a local scheme as an alternative to and building on the Quality and Outcomes Framework (QOF), which is recognised to have been successful but continues to place emphasis on process rather than outcomes. Alternatively Clinical Commissioning Groups have redesigned Directed Enhanced Services (DES) with the voluntary support of local practices.

11. Delegated commissioning allows Clinical Commissioning Groups to establish new GP practices, approve practice mergers, and make decisions regarding discretionary payments such as returner / retainer schemes and PMS reinvestment, in the context of local strategy and intelligence.
12. A further significant benefit of full delegation will be the ability of the Clinical Commissioning Group to tailor service specifications when procuring APMS contracts, based on our local knowledge of primary care and a strategic overview of the wider system.
13. To date West Cheshire Clinical Commissioning Group has worked closely with NHS England colleagues as part of joint commissioning and has enjoyed a high level of cooperation and agreement, which has meant that there have been few barriers experienced by the Clinical Commissioning Group when agreeing approaches to procurement, undertaking investigations etc. However there have been specific issues where the Clinical Commissioning Group has been overruled e.g. in relation to Out of Hours service provision. It would also give greater control over whether procurement was the best option or whether to explore alternatives.
14. The table below sets out the potential risks to the Clinical Commissioning Group of taking on responsibility for commissioning general practice and the mitigation to those risks:

| Issues to consider | Risks | Mitigation | Risk score |
|-------------------------------|--|--|------------|
| Support to undertake the work | <p>1 The Clinical Commissioning Group will not receive any funding for running costs to support the delegated function; therefore this is a financial cost pressure to the Clinical Commissioning Group if additional staff are recruited.</p> <p>2 Resources not in place to manage core contracts and all tasks associated with the day to day operational functions of being fully delegated.</p> <p>3 The Clinical Commissioning Group may find that the</p> | <p>1 NHS England have assured the Clinical Commissioning Group that they will provide support for any of the individual tasks for the first year and/or until staff are recruited and the Clinical Commissioning Group are able to accept full responsibility, recognising additional primary care and finance resources will be required to support the process. The Clinical Commissioning Group will also continue to negotiate access to additional primary care resources from NHS England.</p> <p>2 There may be an opportunity to undertake some of the transactional tasks collaboratively across neighbouring Clinical Commissioning Groups to reduce the need for additional capacity.</p> <p>3 NHS England have assured the Clinical Commissioning Group that they will fully support the</p> | Medium |

| | | | |
|--|--|--|--------|
| | <p>support that comes from NHS England is not enough to fulfil the demand of commissioning activity and day to day management.</p> <p>4 The Clinical Commissioning Group may find themselves with competing priorities and over use of the NHS England team to support them with fully delegated commissioning.</p> <p>5 Crisis Management (as and when they occur).</p> | <p>Clinical Commissioning Group with the move to fully delegated arrangements for a minimum of 12 months or longer if required until the Clinical Commissioning Group is in a position to continue without their support. The Clinical Commissioning Group are negotiating with NHS England on the level of support required.</p> <p>4 The Clinical Commissioning Group has excellent relations with NHS England.</p> <p>5 Regular project team meetings will be held between the Clinical Commissioning Group and NHS England during the “handover” process and beyond.</p> | |
| Managing potential conflicts of interest | <p>6 There may be an increase in perceived conflict of interest in relation to the commissioning of services from member practices.</p> <p>Potential risks to the Clinical Commissioning Group in the probity of their decisions if governance arrangements are not robust.</p> | <p>6 The Clinical Commissioning Group has reviewed its conflict of interest policy in line with NHS England’s <i>revised statutory guidance on managing conflicts of interest for Clinical Commissioning Groups</i> and is compliant with this.</p> | Low |
| Governance | <p>7 Potential risk that the governance processes and procedures are exposed to challenge / appeal.</p> | <p>7 Members will need to agree to the delegated model and the Clinical Commissioning Group’s constitution will need to be amended in line with the guidance.</p> <p>This is an opportunity for the Clinical Commissioning Group to review and revise their governance arrangements which should strengthen approaches to Clinical Commissioning Group governance.</p> | Low |
| Practice Quality Issues | <p>8 Potential capacity issues for the quality</p> | <p>8 The clinical lead for primary care nursing may be able to provide</p> | Medium |

| | | | |
|------------------------------|---|---|--------|
| and Assurance | team associated with reactive and ad hoc clinical issues in member practices. | support on an ad hoc basis. | |
| Practice Contract Management | 9 Potential that the Clinical Commissioning Group could be accused of policing practices (with its contract levers/removal powers) and this could lead to damaged relationship with practices if this is not executed well. | 9 NHS England ultimately remains the contract holder, and will need to be assured that the Clinical Commissioning Group is taking appropriate decisions. NHS England sit on the Primary Care Commissioning Committee where decisions are taken. In addition, the Clinical commissioning Group already has joint responsibility for contract management and has always focused on providing support wherever possible to individual practices. | Low |
| Financial | <p>10 Capita have assumed responsibility for managing PMS/ GMS / APMS contract payments. To date there have been many issues with this process.</p> <p>11 Potential pressure for additional resources to be given to Primary Care.</p> <p>12 There are a number of estates capital projects in the pipeline, funded via the Estates and Technology Transformation Fund. Whilst the capital cost will be covered by NHS England centrally, the ongoing revenue implications will need to be picked up by the Clinical Commissioning Group.</p> <p>13 There are currently 4 practices that hold an APMS contract. As each APMS contract</p> | <p>10 Capita are slowly improving their services and are being contract managed by NHS England and weekly conference calls are in situ.</p> <p>11 The Clinical Commissioning Group would have a scrutiny process and would be managed through the Primary Care Commissioning Committee.</p> <p>12 Work is currently underway to quantify the revenue implications of each of the developments. Assurances have been provided by the Head of Digital Technology/Capital Programmes Lead at NHS England Cheshire and Mersey that any additional revenue costs incurred will be reimbursed by NHS England to the Clinical Commissioning Group in the financial year they are required. This assurance would need to be confirmed in writing by NHS England. This risk is not necessarily increased by being delegated.</p> <p>13 The Clinical Commissioning Group will ensure that there is an allocation within the transitioned budget for re-</p> | Medium |

| | | | |
|--|--|--|-----|
| | <p>comes up for re-procurement, there will be an associated cost (of approximately £15k.)</p> <p>14 Key financial risk in terms of expenditure versus allocation</p> | <p>procurement.</p> <p>14 This will be discussed between the Clinical Commissioning Group and NHS England to ensure any financial risk is minimised. There is also a risk of the finances remaining centralised as the financial pressures on the whole NHS continue.</p> | |
| Relationships with member practices | <p>15 There is the potential for relationships between member practices and the Clinical Commissioning Group in general, and the primary care team in particular, to be detrimentally effected by the change from one of supportive and facilitative working together to one of contract performance monitoring.</p> | <p>15 Other Clinical Commissioning Groups have adopted a model of separating the performance monitoring and the transformation function. The Clinical Commissioning Group has already had a performance monitoring role for some aspects of primary care e.g. PMS, CQUIN and has managed to perform this while being mindful of pressures primary care face.</p> | Low |
| Development of Integrated Care Partnership | <p>16 If the resources of the primary care team are required to focus on primary care commissioning this will inhibit the team's ability to work with general practices on the primary care development opportunities presented by the development of the Integrated Care Partnership.</p> | <p>16 If additional resources were available to focus on the primary care commissioning tasks this would allow the existing team to continue to focus on the transformation agenda and support the development of the Integrated Care Partnership.</p> | Low |

FINANCIAL AND RESOURCE IMPLICATIONS

- 15. Should the Clinical Commissioning Group continue to progress to full delegation, the primary care, quality and finance functions would need to be strengthened and resources committed to support both the primary care development agenda and the contract management/payment to practices.

16. The Clinical Commissioning Group currently has 6.5 WTE primary care committed resource that supports:
- General practice transformation including the development of clusters, the Integrated Care Partnership, new models of care and the workforce.
 - Writing of bids on behalf of member practices for additional funding for service developments.
 - Engagement with and support to practices including facilitation and development of practice staff including the Releasing Time For Care Programme, Practice Manager training and development programme and administrative staff training to support the transformation agenda
 - Servicing of a number of forums including Locality Network meetings, Practice managers' meeting, Secretaries' Forum, Nurses' Forum.
 - Responsible for delivering a forecast £2.2 million savings for the Financial Recovery Plan in 2017/18.
 - The Clinical Commissioning Group's statutory duty to monitor and improve Primary Care quality.
 - Joint co-commissioning arrangements (including practice procurements, practice investigations and dealing with practice quality issues).
17. It is likely that there will be a need for additional resource to undertake the responsibilities associated with fully delegated budgets. We have undertaken benchmarking with neighbouring clinical commissioning groups who are already fully delegated and we are in discussion with NHS England about potential additional primary care expertise that may be available to support full delegation, during the first year as a minimum.
18. Significant further work will be required regarding the additional support needed by the finance and contracting team and due diligence against potential financial risk.
19. Advice from neighbouring Clinical Commissioning Groups which are fully delegated is that it is important to spend sufficient time focussing in detail on the transitioned budget. They advised that it would be sensible to work through every budget line to ensure that there is a clear understanding and agreement about what funding will be coming to the Clinical Commissioning Group in baseline and what is included within this.
20. The Clinical Commissioning Group is reviewing the proposed impact of additional primary care quality responsibilities under full delegation, with additional capacity likely to be required.
21. There may be an opportunity to share any additional resources with neighbouring Clinical Commissioning Groups as well as to learn from their experience of taking on delegation.

OPPORTUNITIES AND RISKS ASSOCIATED WITH CONTINUING IN JOINT DELEGATED CO-COMMISSIONING

22. Joint co-commissioning arrangements will continue as currently.

Benefits

23. The benefits of continuing with Joint Co-Commissioning arrangements are described below:

- Provides more time for thought and further consultation on moving to a fully delegated model in relation to responsibilities and governance
- Enables the Clinical Commissioning Group to align the timing of the development of the Integrated Care Partnership and the move to full delegation.
- Enables the Primary Care Team to focus on primary care development associated with moving to an Integrated Care Partnership
- Arrangements will be developed gradually e.g. staff recruitment, committee structures and reporting mechanisms
- Operationally the day to day management will remain with NHS England and therefore no additional resources will be required from the CCG.
- NHS England will remain responsible for core contracts and performance and therefore will continue to manage the difficult decisions and conversations that may be required with individual GPs and or Practices; therefore this would not negatively impact on relations between the Clinical Commissioning Group and member practices.

Risks

24. The table below sets out the risks associated with remaining as co-commissioning:

| Issues to Consider | Risk | Mitigation | Risk Score |
|--|--|---|------------|
| Support to undertake the work | There is a risk that we miss the opportunity to negotiate some of the primary care team resources over to the Clinical Commissioning Group (as the NHS England area team are likely to be reconfigured at some point). | To continue to maintain relationships with NHS England as the remaining Clinical Commissioning Groups move to delegation to ensure parity of resources/support. | Low |
| Managing potential conflicts of interest | Decision making is through a joint committee; therefore the Clinical Commissioning Group is not taking decisions alone. | None required. | Low |

| | | | |
|--|--|---|--------|
| Operational issues and Practice Contract Management | The fragmentation of current management could cause confusion to practices on a day to day basis. | CCGs and NHS England to work collaboratively together to resolve issues jointly. | Low |
| Ability to re-design service delivery models including integrated care | Lack of ability/control to transform primary care services in line with local strategy. | West Cheshire Clinical Commissioning Group has worked closely with NHS England colleagues as part of joint commissioning and has enjoyed a high level of cooperation and agreement which we would like to continue however it is recognised that this is dependent on key individuals continuing to be in post. | Medium |
| Financial | Risk of central financial pressures resulting in the area team making financial decisions that are not in line with local priorities | To continue to work closely with NHS England to understand the primary care budget and associated expenditure particularly in relation to estates and IT. | Low |

Governance Arrangements and Proposed Timescales

25. At the last meeting in October 2017, the Primary Care Commissioning Committee considered the above risks and mitigations and agreed that the committee was open to the principle of taking on full delegation. The committee felt that substantially more work was needed to complete the due diligence around taking on delegation, however it was felt that this could be undertaken after an expression of interest application had been made, on the understanding the Clinical Commissioning Group could withdraw if the committee was not favourable, following the due diligence.
26. The shortened timescales from NHS England for the delegation process prevented the Clinical Commissioning Group from adequately engaging with our membership before the 1st November 2017 deadline, both about the decision to become fully delegated and the constitutional amendments required. The Clinical Commissioning Group therefore agreed to express an interest in taking on full delegation but with the caveat that there was sufficient opportunity to discuss with our Membership moving to full delegation, during November. This was agreed and actioned.
27. The proposal to move to full delegation was first discussed with member practices in 2016 and more recently member practices were informed of the intention to move to full delegation at the Membership Council in May 2017. There was further discussion at each Locality Network in November 2017

regarding the initial thoughts on the implications of moving to fully delegated commissioning of primary care with effect from April 2018.

28. A further discussion took place at the Membership Council on 29 November 2017 and at the Locality Network meetings in January 2018.
29. The decision making process is for consideration by the Primary Care Committee to then make a recommendation to the Governing Body. The Governing Body then make the decision whether to move to full delegation with effect from April 2018. GP members on the Governing Body who have conflicts of interest in the decision may contribute to the discussion but will absent themselves from any vote on the issue. Governing Body will also need to recommend to the Membership Council on 28 February 2018 the amended constitution for their approval. Following approval of the changes, the constitution variation request will be submitted to NHS England. Proposed changes to the NHS West Cheshire CCG constitution are outlined in Appendix 3, for approval by the Governing Body.
30. A project plan has been developed (Appendix 2) to ensure that all key milestones are met within the timescales required.

Due Diligence

31. Since our GP membership supported the need for due diligence to help determine whether the Clinical Commissioning Group should become fully delegated from April 2018, the Chief Finance Officer and other Clinical Commissioning Group staff have met with NHS England Finance colleagues to understand the financial risks associated with the delegation of primary care (medical) budgets.
32. The purpose of this section of the report is to provide the primary care committee with an early indication of the financial risks associated with the decision about becoming fully delegated, or not.

Allocation

33. All Clinical Commissioning Groups, fully delegated or not, have been notified of primary care (medical) budgets as part of 'place based' allocations. For NHS West Cheshire Clinical Commissioning Group primary care (medical) budgets can be summarised as follows:

| Description | £M | % |
|---------------------------|---------------|------|
| Opening DFT | | 4.47 |
| 2017/18 allocation | 34.786 | |
| 2018/19 uplift | 0.671 | 1.93 |
| 2018/19 allocation | 35.457 | |
| Closing DFT | | 2.89 |

34. At the end of 2017/18 West Cheshire's allocation is 4.47% above target which means that the Clinical Commissioning Group we will only receive 1.93% allocation growth (Clinical Commissioning Groups below target have received up to 3.96% uplift). At the end of 2018/19, potentially our 1st year of delegation, we will have move to 2.89% above target allocation.

Financial Forecast

35. Colleagues from NHS England produce a monthly financial forecast. At the end of October 2017 (month 7) there is a forecast underspend against allocation of approximately £75,000; analysed as follows:

| <u>Description</u> | <u>£M</u> |
|-----------------------------|---------------|
| Published allocation | 34.786 |
| Less 1% reserve | (-)0.348 |
| Less other budget transfers | (-)0.471 |
| Net budget | 33.967 |
| Forecast annual expenditure | (-)33.892 |
| Forecast underspend | 0.075 |

36. The deduction described as 1% risk reserve relates to the primary care (medical) contribution to the national NHS England risk reserve. Currently Clinical Commissioning Groups have to provide 0.5% to this risk reserve.
37. Other budget transfers relate to other budget areas that have already been transferred to the Clinical Commissioning Group; including personal medical services (PMS) premium and extended hours directly enhanced services (DES) funding.

Financial Risk

38. Conversations with NHS England would indicate that this forecast should be an accurate indication of the underlying position and that the level of potential financial risk has reduced during recent years, as elements of the quality and outcomes framework (QOF) have been moved into the 'global sum'.
39. There remains an element of uncertainty about future financial risk. However, as part of the budget handover process we will seek assurance from NHS England that any unforeseen (material) pressures will be funded over and above the notified allocation. We understand that this has been the case with previous waves of delegation, covering both legacy and new financial pressures.
40. NHS England medical budget guidance, including contract uplifts, is expected during January 2018. This is another important piece of information to inform our due diligence.

Staffing Capability and Capacity (Finance, Contracting and Business Intelligence Functions)

41. The impact on staffing capacity has been cited as another potential risk of accepting fully delegated primary care (medical) budgets. We are working with other local Clinical Commissioning Groups, who have already become fully delegated, to understand the impact on their staffing capacity. Although further detail is required, it is certain that additional financial and contracting support will be needed.

42. We are aware that our running cost allowance is reducing during 2018/19 and that this might be extended to support the transition to a different commissioning footprint. Any additional staffing requirements will need to be factored into our running cost projections.
43. The financial management of these budgets is a specialised area; an area where there is a lack of corporate knowledge and history in the Clinical Commissioning Group. With this in mind, we have secured the temporary support from an individual with significant experience in this field. This will give us the following support:
- Several days input during January and February 2018 to support our due diligence and preparation.
 - Development of a detailed action plan to ensure compliance with our delegated responsibilities from 1st April 2018.
 - 2 days per week to develop internal systems and process from April 2018 and provide training to new/existing staff (period of support yet to be agreed).
44. We already produce a detailed primary care dashboard and, therefore, the impact on our Business Intelligence offer is expected to be minimal, although this will be closely monitored.

Primary Care Commissioning Committee consideration of the proposal on 11th January, 2018

45. The Primary Care Commissioning Committee met on 11th January, 2018 to consider the proposal on primary care full delegation. Conflicts of interest were declared and discussed at length prior to the decision as there was agreement that GP members and the NHS England member of the Primary Care Committee could not vote on the proposal (should that be required), although input into the discussions was accepted.
46. A few concerns were discussed by the Committee with mitigations agreed, as follows:
- The CCG would look to mitigate any additional costs to resource primary care commissioning with neighbouring CCGs who are moving to full delegation. Holding the primary care budget also provides the CCG with opportunities as there is currently a small underspend
 - Transfer of staff resource is needed (with written assurance via a delegation agreement) from NHS England to support the establishment of processes for primary care commissioning particularly for finance, contracting and quality, during the first year as a minimum
 - Capability around commissioning – there were reassurances that nothing further is asked of our network GPs, but support explored for professional development for non-GP members of the Governing Body on understanding the business model of primary care.
47. The Committee agreed to recommend to the Governing Body that we continue to full delegation of primary care with effect from 1st April 2018.

RECOMMENDATIONS

48. The Governing Body is asked to consider the content of the report and the recommendation of the Primary Care Commissioning Committee to approve the proposal to continue to primary care full delegation from 1st April 2018 including approval of the proposed revised terms of reference for the Primary Care Committee.

49. The Governing Body is asked to recommend the resulting changes to the Clinical Commissioning Group's constitution for approval by the membership council in February 2018.

Sarah Murray
Head of Primary Care
January 2018

Appendix 1 - Full Delegation Project Plan

| ID | Task Name | Description | Progress update | Start | Finish | Resource Names | Timeline | | | | | | | | | | | |
|----|---|--|-----------------|---------------|---------------|----------------|-------------|-------------|-----|-----|-------------|-----|-----|-----|-----|-----|--|--|
| | | | | | | | 4th Quarter | 1st Quarter | | | 2nd Quarter | | | | | | | |
| | | | | | | | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | | |
| 1 | Tasks sponsored by Primary Care Exec | Brief Description | | 02 Oct | 02 Apr | PW | | | | | | | | | | | | |
| 2 | Engagement with Member Practices - November Network | Discussed at each Network meeting | | 01 Nov | 15 Nov | CR, SM | | | | | | | | | | | | |
| 3 | Engagement with Member Practices - Membership Council | Took delegation risks and benefits paper to Membership Council | | 01 Nov | 29 Nov | CR, SM | | | | | | | | | | | | |
| 4 | Engagement with Member Practices - January Network | Present results of due diligence to Member Practices for further discussion in January 2018 Networks | | 02 Jan | 11 Jan | CR, SM | | | | | | | | | | | | |
| 5 | Engagement with LMC | To be discussed at next quarterly meeting | | 02 Jan | 30 Mar | CR, SM, TJM | | | | | | | | | | | | |
| 6 | Continue to develop a case for change | Research benefits to Practices from other CCGs who are delegated | | 14 Dec | 29 Dec | TJM, SM | | | | | | | | | | | | |
| 7 | Attend training sessions - 1 | Attend Policy Book update sessions by NHS England Regional Team | | 01 Nov | 29 Dec | SM, TJM | | | | | | | | | | | | |
| 8 | Attend training sessions - 2 | Attended two shadowing for delegation sessions from NHS England | | 02 Oct | 30 Mar | SM, TJM, DT | | | | | | | | | | | | |
| 9 | Consider team structure and agree new roles; speak to NHSE around support | Ongoing | | 01 Jan | 29 Jan | SM, LM | | | | | | | | | | | | |
| 10 | Discussions with LDS to share learning | Meeting arranged with SC & VR Contracting, Governance and Finance | | 01 Dec | 31 Jan | SM, TJM | | | | | | | | | | | | |
| 11 | Discussions with LDS colleagues re. transactional tasks e.g. CQRS | LDS meeting arranged | | 01 Dec | 31 Jan | SM | | | | | | | | | | | | |
| 12 | Attend task and finish group meetings with NHS England | completed | | 07 Dec | 07 Dec | SM, TJM | | | | | | | | | | | | |
| 13 | Apply to CQRS for commissioning body status | Details to be clarified | | 01 Mar | 29 Mar | SM, TJM | | | | | | | | | | | | |
| 14 | Set-up CQRS accounts for relevant team members | Details to be clarified | | 01 Mar | 29 Mar | SM, TJM, DT | | | | | | | | | | | | |
| 15 | Confirm all contract variations are complete and paperwork transferred to CCG | Details to be clarified | | 01 Mar | 29 Mar | SM, TJM | | | | | | | | | | | | |
| 16 | Recruitment of new team members if required & NHSE unable to support | Ongoing | | 12 Jan | 02 Apr | SM, LM | | | | | | | | | | | | |
| 17 | Obtain Job Descriptions | | | 12 Jan | 12 Jan | TJM, SM | | | | | | | | | | | | |
| 18 | Agree CCG JD's | | | 19 Jan | 19 Jan | TJM, SM | | | | | | | | | | | | |
| 19 | Advertise role | | | 31 Jan | 31 Jan | TJM, SM | | | | | | | | | | | | |
| 20 | New employee start | | | 02 Apr | 02 Apr | TJM, SM | | | | | | | | | | | | |
| 21 | Be clear what functions are retained by NHS England | To be discussed in Task & Finish Group Meetings | | 01 Jan | 29 Jan | SM, TJM | | | | | | | | | | | | |
| 22 | Obtain log-ins and change permissions for Primary Care Webtool | Details to be clarified | | 01 Mar | 16 Mar | SM, TJM, DT | | | | | | | | | | | | |
| 23 | Tasks Sponsored by Governance Exec | | | 02 Oct | 28 Feb | GJ | | | | | | | | | | | | |
| 24 | Obtain agreement from Primary Care Commissioning Committee to commence | Complete | | 02 Oct | 27 Oct | SM, DB | | | | | | | | | | | | |
| 25 | Review conflict of interest policy | Ongoing | | 02 Jan | 29 Jan | DB | | | | | | | | | | | | |
| 26 | Propose update to constitution at the 18th Jan meeting | propose changes to constitution for agreement at 18th January Governing Body | | 02 Jan | 18 Jan | DB | | | | | | | | | | | | |
| 27 | Propose new PCC committee ToR | New Terms of Reference for the Primary Care Commissioning Committee | | 18 Dec | 22 Dec | SM | | | | | | | | | | | | |

APPENDIX 2 – DRAFT TERMS OF REFERENCE

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

Primary Care Commissioning Committee

NHS West Cheshire Clinical Commissioning Group and NHS England

Terms of Reference

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups to expand their role in primary care commissioning and to submit expressions of interest setting out the Clinical Commissioning Group's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a Clinical Commissioning Group.
2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to West Cheshire Clinical Commissioning Group. The delegation agreement is available in [Schedule 1](#).
3. The Clinical Commissioning Group has established the West Cheshire Clinical Commissioning Group Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.
4. It is a committee comprising representatives of the following organisations:
 - West Cheshire Clinical Commissioning Group
 - NHS England
 - And other relevant organisations as appropriate.

Statutory Framework

5. NHS England has delegated to the Clinical Commissioning Group authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the Clinical Commissioning Group.
7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the Clinical Commissioning Group acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
 - a) Management of conflicts of interest (section 14O);
 - b) Duty to promote the NHS Constitution (section 14P);
 - c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - d) Duty as to improvement in quality of services (section 14R);
 - e) Duty in relation to quality of primary medical services (section 14S);
 - f) Duties as to reducing inequalities (section 14T);
 - g) Duty to promote the involvement of each patient (section 14U);
 - h) Duty as to patient choice (section 14V);
 - i) Duty as to promoting integration (section 14Z1);
 - j) Public involvement and consultation (section 14Z2).
8. The Clinical Commissioning Group will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act.
9. The Committee is established as a committee of the West Cheshire Clinical Commissioning Group Governing Body in accordance with Schedule 1A of the “NHS Act”.
10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the West Cheshire area, under delegated authority from NHS England.
12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and West Cheshire Clinical Commissioning Group, which will sit alongside the delegation and terms of reference.
13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.
14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.
15. This includes the following:
 - General Medical Services (“GMS”), Personal Medical Services (“PMS”) and Alternative Provider Medical Services (“APMS”) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
 - Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
 - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
 - Decision making on whether to establish new GP practices in an area;
 - Approving practice mergers; and
 - Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).
16. The Clinical Commissioning Group, via the Committee, will also carry out the following activities:
17. To plan, including by carrying out relevant needs assessment, primary medical care services in the West Cheshire area;

18. To undertake reviews of primary medical care services in the West Cheshire area;
19. To co-ordinate a common approach to the commissioning of primary care services generally;
20. To manage the budget for commissioning of primary medical care services in the West Cheshire area;
21. To drive the continuous improvement of primary care; including quality improvement, workforce training and development and changes to the model of care in order to deliver the ambitions of the West Cheshire Way and ensure continuous improvement of clinical outcomes;
22. Securing continuous improvements in the quality of services for patients with particular regard to clinical effectiveness, safety and patient experience;
23. Providing assurance to the NHS West Cheshire Clinical Commissioning Group governing body that patient safety and quality outcomes and benefits are realised;
24. Escalation of concerns and issues/risks that impact on the delivery of the high quality of services, and recommending appropriate courses of action;
25. Monitoring incidents, claims, concerns and complaints trends from commissioned services to ensure corrective and preventative action is being taken;
26. Identifying themes of concerns to patients through complaints, patient surveys and engagement activities and recommend action to address those themes;
27. Ensuring lessons are learnt from patient experience intelligence and serious untoward incident;
28. Having oversight of exceptions and assurance received from reporting groups;
29. Ensuring that the Clinical Commissioning Group's safeguarding duties are discharged.

Accountability

30. The committee is accountable to NHS West Cheshire Clinical Commissioning Group's governing body and any changes to these terms of reference must be approved by the governing body and supported by the membership council.

Geographical Coverage

31. The Committee will comprise the West Cheshire Clinical Commissioning Group.

Membership

32. The Voting Committee Members shall consist of:

- Committee Chair – Clinical Commissioning Group Lay Member for Patient and Public Involvement
 - Committee Vice Chair – Clinical Commissioning Group Vice Chair will not routinely attend but will Chair the committee in the Committee Chair's absence
 - Clinical Commissioning Group Chief Executive Officer
 - Clinical Commissioning Group Chief Finance Officer
 - Clinical Commissioning Group Director of Commissioning
 - Clinical Commissioning Group Director of Quality & Safeguarding
- a) Co-opted non-voting members will consist of:
- Clinical Commissioning Group GP Chair
 - Clinical Commissioning Group Medical Director
 - Clinical Commissioning Group GP Locality Network Chairs
 - Clinical Commissioning Group Head of Primary Care
- b) Co-opted non-voting attendees will consist of:
- NHS England Representative
 - Local Medical Committee representative
 - Healthwatch / Local Authority representative.

Meetings and Voting

33. The committee shall adopt the Standing Orders of NHS West Cheshire Clinical Commissioning Group insofar as they relate to the:

- Notice of meetings;
- Handling of meetings;
- Agendas;
- Circulation of papers; and
- Conflicts of interest - in particular in relation to primary care decision making by the GP members of the committee

34. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.
35. Meetings of the Committee will be held in public subject to the application of 23(b); (publicised on the clinical commissioning website) and a report from the Committee will be provided to the Clinical Commissioning Group governing body meeting, also held in public.
36. The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
37. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
38. Members of the Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the committee in which event these shall be observed.
39. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

40. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
41. It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Quorum

42. A meeting will be quorate if at least four voting members are in attendance. These members will comprise of:
 - Chair or vice chair of the Committee;
 - At least three of the clinical commissioning group executive voting members.
43. Where a meeting is not quorate, owing to the absence of certain members, the meeting will be deferred until such time as a quorum can be convened.
44. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the Chair of the meeting shall consult with the Clinical Commissioning Group's Chief Finance Officer on the action to be taken.

Decisions of the Committee

45. The Committee will make decisions within the bounds of its remit.
46. The decisions of the Committee shall be binding on NHS West Cheshire Clinical Commissioning Group and NHS England.
47. Decisions will be published by NHS West Cheshire Clinical Commissioning Group via the governing body.

Authority of the Committee

48. The Committee is authorised by the NHS West Cheshire Clinical Commissioning Group governing body to:

- investigate any activity within its terms of reference and produce an annual work programme;
- be responsible for ensuring compliance with financial and governance arrangements when undertaking its terms of reference;
- establish and approve the terms of reference of such sub-committees, groups or task and finish groups (e.g. programme assurance boards and system resilience group) as it believes are necessary to fulfil its terms of reference.

Frequency of meetings

49. It is proposed the Committee will meet on a bi-monthly basis throughout the year.

Procurement of Agreed Services

50. The detailed arrangements regarding procurement will be set out in the delegation agreement.

Signatures:

APPENDIX 3

Proposed Changes to NHS West Cheshire CCG Constitution

1.0 That the updated Primary Care Commissioning Committee Terms of Reference in Appendix 2 above be adopted within the constitution (which is based on the NHS England model terms of reference and also includes new voting rights to reflect NHS England conflicts of interest guidance and new quoracy arrangements for the meeting).

2.0 That section 6.7.6 within the NHS West Cheshire CCG constitution be **deleted**, as follows:

Joint Primary Care Commissioning Committee

It is proposed that the joint primary care commissioning committee will oversee, together with NHS England (from October 2016 to 1st April 2017), all commissioning and quality of General Medical Services in West Cheshire. The role and draft terms of reference are provided at Appendix F.

That section 6.7.6 within the NHS West Cheshire CCG constitution be **replaced with**:

Primary Care Commissioning Committee

The Committee undertakes the function of commissioning a common approach to primary medical care services for the population of West Cheshire.

The Committee shall make recommendation and decisions towards the commissioning of primary medical services that:

- *Are within the bounds of its remit and terms of reference*
- *Reflect the local requirements and population health needs for NHS West Cheshire*
- *Support the strategic ambitions of the Clinical Commissioning Group*
- *Support an approach of co commissioning in line with the strategic vision of the Clinical Commissioning Group.*

The Primary Care Commissioning Committee is accountable to the Governing Body and terms of reference are approved and kept under review by that body. The decisions of the Committee shall be binding on NHS West Cheshire Clinical Commissioning Group and NHS England.

3.0 That the Clinical Commissioning Group's Scheme of Reservation and Delegation be updated with an addition to include the authority of the Primary Care Commissioning Committee (to be approved by the Audit Committee and recommended to the Governing Body).

GOVERNING BODY REPORT

1. **Date of Governing Body Meeting** 18th January 2018

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

3. **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. Review the concerns and positive assurance highlighted in the update provided by the Designated Nurse for Safeguarding Children and identify any further actions for the quality improvement committee
 - c. Note the update from the patient experience service that identifies the concerns and queries raised with our organisation

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

January 2018

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: *risk to the number of falls of inpatients causing harm is being managed by the Countess of Chester Hospital *Cheshire and Wirral Partnership Trust are taking action to understand gaps in their transfer of care processes | No change |
| 6 | Failure to ensure robust arrangements are in place for the safeguarding of vulnerable children | This report identifies that: *we have taken action to improve the timeliness of health assessments for looked after children *we have had positive practice identified in our arrangements by the Joint Targeted Area Inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester | Board assurance framework scoring reduced to an improved position |
| 7 | Failure to ensure robust arrangements are in place for the safeguarding of adults at risk | This report identifies how: *risk in care homes/independent hospitals is being mitigated through closure to admissions and close surveillance | No change |

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

QUALITY IMPROVEMENT REPORT

PURPOSE

1. To provide information to the governing body on the quality of services commissioned by NHS West Cheshire Clinical Commissioning Group by identifying areas where performance falls below expected standards.
2. To seek scrutiny of the assurance provided by the quality improvement committee in relation to the risks and concerns managed by the committee that may impact on patient safety, experience and outcomes in this health economy.
3. The quality improvement committee identified a number of issues to be brought to the attention of the governing body from its meeting on 14th December 2017.

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

Inpatient falls

4. Focussed surveillance will remain on the number of inpatients who fall and sustain significant harm. The Serious Incident Review Group has been advised that the newly appointed Falls Prevention Co-ordinator will have a role in reviewing all of the Root Cause Analysis reports completed following a fall. When gaps in best practice are identified the Falls Prevention Coordinator will offer ward managers additional support in educating staff. This targeted approach will supplement a broader falls awareness training programme and all new starters to the Trust will receive falls awareness training. Falls Champions for each area have been identified and a one day training programme has been developed for those staff to attend. Focus will be given to personalised care planning and individualised assessments.

Outpatient letters

5. The committee were advised that the Trust is not currently compliant with the following requirement in the standard NHS contract: where there is information which the GP needs quickly in order to manage a patient's care, the provider must communicate this by issue of a clinic letter within 10 days of attendance (reducing to within 7 days from 1 April 2018). From 1 October 2018, clinic letters must be sent by direct electronic transmission as structured messages using standardised clinical headings.

6. The Trust has trialled a number of IT solutions to support this and a number of specialties are compliant but this is not universal across the hospital. The Trust were asked formally at the November Quality and Performance meeting for an action plan that identifies options for achieving this requirement. From a patient perspective this can impact on the quality of care they receive when they attend primary care if there is a lack of timely information available on the outcome of an appointment with a specialist consultant.
7. The committee will be updated on the options identified by the Trust to achieve compliance following receipt of the plan.

CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST

Step 4 Psychotherapy Service

8. The Serious Incident Review Group reviewed a detailed Root Cause Analysis report into the death of a person who had been on a waiting list for Step 4 Psychotherapy Service. There is no evidence that this contributed to the person's death but it did highlight that after 7 months this person had still not been seen by specialist psychotherapy services.
9. The committee were advised that subsequent to this investigation the waiting times for these vulnerable people had improved significantly and a different waiting list management system was now in place for patients who need Step 4 interventions. All new referrals are now seen within 4 weeks, and therapy in the form of group work is now offered to all patients. Staff within the service have reported and confirmed those patients are now seen far quicker than previously. The Serious Incident Review Group was encouraged by the positive changes that had been made in the management of people who need Step 4 Psychotherapy.

Regulation 28 Preventing Future Deaths Notice

10. The Trust has been issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner. The Coroner has the authority to ask organisations for assurance about actions they intend to take if they believe there is a risk of a future death in similar circumstances unless changes are made. This relates to a patient in their care from Wirral but the need to change practice applies to the whole organisation as it relates to the transfer of clinical information between providers when someone transfers in or out of area. It has a similar theme to a Regulation 28 previously issued to the Trust for a West Cheshire patient and as such the Trust have been asked to present a written update on this matter to the next Quality and Performance meeting.

UNIQUE CARE

11. Unique Care provides support to people living in their own homes. It is a provider that has been used by our Continuing Healthcare Service. We have met with them to seek assurance that changes had been made subsequent to them being issued with a Regulation 28 Preventing Future Deaths Notice by the Coroner.
12. The meeting also included the expectations on the provider to produce an improvement plan to address the failings identified in the Care Quality Commission inspection <http://www.cqc.org.uk/location/1-3574002080>.
13. It was agreed that it is the responsibility of Unique Care and Care Quality Commission to agree an Improvement plan. It was agreed that we would arrange a follow up meeting in January 2018 and include our partners from Cheshire West and Chester Local authority. It was confirmed that West Cheshire Clinical Commissioning Group would not commission any packages with Unique Care until assurances are provided to actions being taken to meet the failings in the Care Quality Commission regulatory breaches and current inadequate rating.

ST CYRIL'S INDEPENDENT HOSPITAL REHABILITATION UNIT

14. The provider received a full inspection by the Care Quality Commission in March 2017 and was rated overall Inadequate and had ratings of inadequate in all 5 domains. The Care Quality Commission has undertaken 2 further focussed inspections in June 2017 and August 2017. These reports have also been published, and whilst they don't provide a change to the rating they identified a number of improvements.
15. The provider has worked closely with the Clinical Commissioning Group and Care Quality Commission to improve the quality of care. Senior nurses from the Quality and Safeguarding team undertook an unannounced early morning visit, and a subsequent two day visit, found evidence of recent improved clinical leadership plus sustained improvements in other aspects of care delivery. The voluntary suspension to admissions is no longer in place. The level of enhanced surveillance has been reduced and the Quality Surveillance group will not reconvene until the end of quarter 4.

INFECTION PREVENTION AND CONTROL

Gram-negative blood stream infections

16. The key infection control priority going forward is the national ambition to reduce gram-negative blood stream infections by 50% by 2021. The two year Quality Premium Scheme for 2017/19, identifies a reduction target of 10% in all E. coli blood stream infections reported by clinical commissioning groups, independent of the time of onset of infection. The local Quality Premium target for E.coli blood stream infections is no more than 203 cases of infection. Year to date at October 2017 we have reported 128 cases.

Methicillin Resistant Staphylococcus Aureus (MRSA)

17. In October there has been 1 case of pre-48 hours MRSA. In line with national requirements a post infection review has been completed by the community Infection Prevention Control team and the report will be shared by Public Health at the clinical commissioning group Serious Incident Review Group.

SAFEGUARDING CHILDREN

Child Protection - Information Sharing

18. As reported in previous updates the Child Protection – Information Sharing (CP-IS) is a nationwide system that enables child protection information to be shared securely between local authorities and NHS Trusts across England. NHS organisations must take all reasonable steps towards implementing Child Protection – Information Sharing, as set out in the NHS Standard Contract.
19. The Child Protection – Information Sharing project connects local authority children’s social care systems with those used by NHS unscheduled care settings, such as Accident and Emergency departments, walk in centres, out of hour’s services and maternity units.
20. It ensures that health and care professionals are notified when a child or unborn baby with a child protection plan or looked after child status is treated at an unscheduled care setting. Work to implement the system in West Cheshire continues. The following provides an update on the current position:
 - a) Cheshire West and Chester - successfully implemented CP-IS and went live in October 2017.
 - b) Countess of Chester Hospital NHS Foundation Trust - Work continues to implement the system. Significant progress has been made by the Trust to ensure systems and processes are in place and staff are fully briefed in the use of CP-IS. NHS Digital continues to link with the Trust during this implementation stage.
 - c) Cheshire and Wirral Partnership NHS Foundation Trust - The Out of Hours service is supported by an IT system that requires a national update to allow alignment with CP-IS. NHS Digital is seeking information on alternative actions for consideration by the Trust if the delay on the Adastra update continues. Due to these delays the Trust is currently unable to provide an implementation date at present.

Joint Targeted Area Inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester

21. Between 25th and 29th September 2017, Ofsted, the Care Quality Commission, Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services and HMI Probation undertook a joint inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester. This inspection included a ‘deep-dive’ focus on the response to our children experiencing neglect.

22. Joint Targeted Area Inspections (JTAs) are carried out under section 20 of the Children Act 2004. They are an inspection of multi-agency arrangements for:
- the response to all forms of child abuse, neglect and exploitation at the point of identification
 - the quality and impact of assessment, planning and decision making in response to notifications and referrals
 - protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers (evaluated through a deep dive investigation into the experiences of these children)
 - the leadership and management of this work
 - the effectiveness of the Local Safeguarding Children Board in relation to this works
23. The final letter of findings was received by all partners on 10th November 2017. The inspectors found a number of key strengths in how we work together in Cheshire West and Chester to keep our children and young people safe and in particular in this inspection how we are working together to improve our responses to children who suffer neglect.
24. The letter also includes detail on areas for improvement across the partnership. A number of ways in which we respond to children experiencing neglect have been identified for further development and improvement to ensure all partners and professionals have a consistently timely and appropriate response in Cheshire West and Chester.
25. The letter is published on the inspectorate websites and can be accessed [here](#).
26. The committee were briefed on the next steps we have to take as a partnership. The Director of Children's Services will prepare a written statement of proposed action, responding to the findings outlined in the final letter. This will be a multiagency partner response. The response must set out the actions for the partnership and, where appropriate, individual agencies and be returned to Ofsted on behalf of the partnership by 13th February 2018. A multi-agency improvement plan is under development and was considered by the partners at the Local Safeguarding Children Board on 27th November 2017. Our Designated Nurse has co-ordinated a response on behalf of our local NHS which includes our Trusts and GPs.
The findings of this inspection will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

CHILDREN IN CARE

27. The Children in Care population for Cheshire West and Chester has reduced slightly during Quarter 2 from 494 at the end of March 2017 to 479 at the end of September 2017. Overall, the rate is stable and comparable to figures reported for the year 2016-17.

Health Assessments

28. Procedures are in place to monitor adherence to statutory timescales and quality of all Health Assessments for West Cheshire Children in Care. Table 1 shows the Health Assessment data recorded on the local authority monthly performance report for Quarter 2 2017-18 for all children in care for 12 consecutive months or more. In summary the percentage of children with an up to date health assessment for Quarter 2 was 86.8% compared to 80.4 % for Quarter 1.

Table 1 Source: Cheshire West and Chester Local Authority

| Performance Indicator (snapshot) | England (latest) | Statistical Neighbour (Latest) | North West (Latest) | CWAC Q1 | CWAC Q2 | Direction of Travel (against previous quarter) |
|---|------------------|--------------------------------|---------------------|---------|---------|--|
| % of children looked after for at least 12 months with recent health assessment | 90% | 87.2% | 91.5% | 80.4% | 86.8% | ↑ |

Initial Health Assessments

29. The Countess of Chester Hospital NHS Foundation Trust has reported a significant improvement in performance for the completion of Initial Health Assessments within the 20 day statutory timescale. Table 2 shows that at the end of Quarter 2, 90% of Initial Health Assessments had been completed within 20 days. The percentage of Initial Health Assessments requested within 48 hours of a child being placed in care has improved from the figures for the end of Quarter 4 2016-17 (50%), however Quarter 2 has seen a slight reduction from Quarter 1 at 68.4% to 66.6%. As reported in previous quarterly updates from the committee, completion of Initial Health Assessments within statutory timescales is dependent on multiagency systems working efficiently, promptly and in partnership.
30. Following completion of the root cause analysis in March 2017 due to the concerns regarding poor compliance with statutory timescales for Initial Health Assessments, effective partnership working between the Designated Doctor and Nurse for Children in Care and senior managers from Children's Social Care has resulted in the improved performance for both the timeliness of requests and completion of Initial Health Assessments during the second quarter of 2017-18.
31. The root cause analysis recommended that there must be a consistent integrated Initial Health Assessment pathway and escalation process in place which is followed robustly. As a result further challenge by the Designated Nurse has been escalated via the Children's Trust to health and social care partners to ensure that the pathway and process are followed robustly.

Table 2 Source: Countess of Chester NHS Hospitals Trust Safeguarding Assurance Framework

| | Q3 2016/17 | Q4 2016/17 | Q1 2017/18 | Q2 2017/18 | Direction of travel |
|-----------------------------------|---------------|---------------|---------------|---------------|------------------------|
| Percentage Requested in timescale | 56% | 50% | 68.4% | 66.6% | ↓ |
| Percentage Completed in timescale | 84% | 75% | 78.9% | 90% | ↑ |

Review Health Assessments

32. During the first half of 2017-18 the percentage of Review Health Assessments completed by Cheshire and Wirral Partnership NHS Foundation Trust on West Cheshire Children in Care within statutory timescales initially dipped to 82.1% at the end of Quarter 1 but improved to 89.2% by the end of Quarter 2, as shown in Table 3.
33. There was a steady improvement in the percentage of Review Health Assessments completed within timescale for West Cheshire children in care placed out of area from 34.2% at the end of Quarter 4 (2016-17) to 63.6% at the end of Quarter 2 (2017-18). This can largely be attributed to the more formal and robust escalation pathway that is in place (as reported in the update from the Committee in June 2017) and the Committee were advised that this process will continue to be monitored regularly. In addition to implementation of the escalation process, the Designated Nurse has been in communication with the Operations Manager in an area that was repeatedly breaching timescales for the completion of Review health Assessments for Cheshire West Children in Care. The Designated Nurse has received assurance that the reasons for these breaches have been identified and addressed, and agreement has been reached on future action should this situation arise again.

Table 3 source: Cheshire and Wirral Partnership NHS Foundation Trust Safeguarding Assurance Framework

| | Quarter 4 (2016-17) | Quarter 1 (2017-18) | Quarter 2 (2017-18) | Direction of travel |
|--|------------------------|------------------------|------------------------|------------------------|
| West Cheshire Children in area | 88.6% | 82.1% | 89.2% | ↑ |
| West Cheshire children out of area | 34.2% | 48.9% | 63.6% | ↑ |
| Children placed in West Cheshire area by other Local Authorities | No data | 76.9% | 84.6% | ↑ |

34. The Designated Nurse has received assurance from Cheshire and Wirral Partnership NHS Foundation Trust that all children in care placed in West Cheshire by other Clinical Commissioning Group's receive an equitable service which includes the completion of high quality Review Health Assessments in statutory timescales. The information is included in Table 3.

Designated Nurse Children in Care

35. The committee have previously highlighted a risk to the governing body in relation to our part time vacancy for a Designated Nurse Children in Care. This risk has now been mitigated as a re-design of posts across the 4 Cheshire clinical commissioning groups allowed for the creation of a full-time Designated Nurse Children in Care post and they commenced on 1st November 2017. The post is hosted by NHS Vale Royal Clinical Commissioning Group. In addition a new 0.6 WTE Band 4 Administrator was developed to support this Designated Nurse post.

PATIENT EXPERIENCE

36. The Patient Experience Team received 222 contacts from July 1st 2017 to 31st October 2017. These contacts included members of the public raising complaints and concerns, providing comments on services or requesting advice and signposting. The patient, relative and carer experiences encompassed a wide range of provider and commissioned services.

Complaints

37. During the four month period from the July 1st 2017 to 31st October 2017, the Patient Experience team received 10 new complaints, 6 of which were from solicitors writing on behalf of clients to dispute a continuing healthcare checklist assessment; two were from relatives of patients in receipt of complex care. The remaining two complaints were from a patient who had experienced problems at the dressings clinic at Ellesmere Port, and another who had cause to complain about staff attitude at a local GP Surgery.
38. During this period 15 complaints were closed.

MP Enquiries

39. The team received 21 enquires from local MPs from July 1st 2017 to 31st October 2017, which is a significant increase on the previous quarter. The issues raised on behalf of their constituents were as follows:
- a) Availability of medications/equipment since consultation
 - b) Lack of support from mental health services
 - c) Issues from patients wanting funding for knee operations
 - d) Issues raised regarding the dressings clinic at Ellesmere Port
 - e) Patient Transport Issues

- f) Issues with Wales/England cross border issues
- g) Request for update on local cancer services
- h) Request for an update on the situation regarding the new health centre at Tarporley

Patient Advice and Advice (PALS) Queries:

40. A total of 183 contacts were made to the service from July 1st 2017 to 31st October 2017. Key themes during this period were:
- a) *Referral Support Service:* the Patient Experience Team received 11 calls from people who had been unable to contact the referral support service to book an appointment, indicating that this is still an issue. Measures have been taken to try and resolve the situation the situation.
 - b) *Medicines Management:* there were several contacts from local people who voiced their concern that the medicines management changes were affecting them personally.
 - c) *Continuing Healthcare:* several queries were received regarding the Continuing healthcare service, these ranged from request for contacts to how to apply for funded nursing care.
 - d) *Other enquiries:* these ranged from people who had found it difficult to register at GP Practices to issues around access to mental health services.

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. Review the concerns and positive assurance highlighted in the update provided by the Designated Nurse for Safeguarding Children and identify any further actions for the quality improvement committee
- c. Note the update from the patient experience service that identifies the concerns and queries raised with our organisation

Paula Wedd
Director of Quality and Safeguarding
January 2018

GOVERNING BODY REPORT

- 1. Date of Governing Body Meeting:** 18th January 2018
- 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 13th December 2017. The key items for the governing body to note are:

 - As at the end of November 2017 we are 43% compliant with the national information governance toolkit version 14.1. However, this is expected to improve as evidence is submitted within quarter 4 and it is forecast that we will be fully compliant as at 31st March 2018.
 - We are on course to deliver 2017/18 Internal audit Plan. Significant assurance has been provided in respect of the following audit reviews:
 - Programme management office.
 - Mental health commissioning.
 - Financial accounting shared services.
 - Clinical commissioning group internal financial systems.

The audit committee considered an updated Scheme of Reservation and Delegation to include the Joint Commissioning Committee authorities and to include post names rather than post-holder names.
- 4. Recommendations** The governing body is asked to:
 - note the key items of business discussed on 13th December 2017;
 - consider the recommendation of the audit committee regarding the proposed changes to the Scheme of Reservation and Delegation, for ratification and recommending to Membership Council
- 5. Report Prepared By:** Gareth James
Chief Financial 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 from 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 13th December 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 December 2017 audit committee are summarised in paragraphs 4 to 10.

EXTERNAL AUDIT

4. Representatives from Grant Thornton provided the committee with an update on progress in delivering their responsibilities as our appointed external auditors. The substantive issues covered by the reported were as follows:
 - **Audit of 2017/18 financial statements;** planning for the 2017/18 year-end audit has started. Interim fieldwork will take place in January 2018 and will include review of our control environment and financial systems and early work on emerging accounting issues.

- **Value for money;** initial risk assessment is underway to determine whether we have made proper arrangements for securing economy, efficiency and effectiveness in our use of resources. At the end of 2016/17 we received a partially qualified value for money opinion.

The committee discussed the potential impact of a well-publicised national prescribing issue (described as ‘no cheaper stock obtainable’) which will have a £2.3 million impact on our financial performance. Grant Thornton confirmed they will provide a national stance on this for consideration during the year-end audit.

INTERNAL AUDIT

5. Mersey Internal Audit Agency provided an update in respect of assurances, key issues and progress towards delivery of the 2017/18 internal audit plan. Significant assurance has been provided following completion of the following planned audit reviews:
 - Programme management office.
 - Mental health commissioning – Cheshire and Wirral clinical commissioning groups.
 - Financial accounting shared services.
 - Clinical commissioning group internal financial systems.
6. An update was also provided on the continuing healthcare and complex care review that was undertaken on behalf of Cheshire and Wirral clinical commissioning groups. The review was awarded limited assurance due to 4 high risk recommendations. Although the committee were able to consider the management responses that had been provided by the shared continuing healthcare and complex care team, the committee requested further assurance from the programme board that the recommendations have been actioned. This assurance has since been received.
7. Assurance was provided that, although there is delay in several reviews, we are on course to deliver the annual internal audit plan.

INFORMATION GOVERNANCE

8. Significant progress has been made towards compliance with the 2017/18 information governance toolkit (version 14.1). At the end of November 2017 we are 43% compliant, which is higher than at the same point last year (which was 13%). Following release of the toolkit, any evidence that needs to be updated has been removed from toolkit evidence meaning that the score to date is artificially low. Remaining evidence will be updated and/or submitted in quarter 4.

9. New General Data Protection Regulations (GDPR) come into effect in May 2018. GDPR will replace the Data Protection Act 1998 and has the following 6 principles:
 - Fair, lawful and transparent.
 - Information is only used for legitimate and lawful purposes.
 - Data held is adequate, relevant and limited to what is necessary.
 - Accurate and up to date.
 - Information is kept in a form which permits patient identification for no longer than is necessary.
 - Data processing in a secure manner.
10. Midlands and Lancashire Commissioning Support Unit provided an update on our readiness to adopt these new arrangements. A detailed implementation plan has been agreed and assurance was provided that we are on course to remain compliant with regulations. A further update will be provided to future committee meetings.

SCHEME OF RESERVATION AND DELEGATION

11. The following amendments to the scheme of reservation and delegation were considered by the Audit Committee and are proposed to the Governing Body: removal of individual staff names to post names, changes to names of some posts, the addition of an 'ad-hoc healthcare' limit of £55k to the Director of Quality and Safeguarding to reflect budgetary control over the CHC and Complex Care budgets and additions regarding the establishment of the Joint Commissioning Committee for the Cheshire Clinical Commissioning Groups and the functions of responsibility, including level one and level two decisions.
12. A full version of the updated scheme of reservation and delegation is provided by the following link [here](#).

RECOMMENDATIONS

13. The governing body is asked to note the key items of business discussed at the audit committee on 13th December 2017.
14. The Governing Body is asked to consider the recommendation of the audit committee regarding the proposed changes to the Scheme of Reservation and Delegation, for ratification and recommending to Membership Council.

Gareth James
Chief Finance Officer
January 2018

GOVERNING BODY REPORT

| | |
|--|--|
| Date of Governing Body Meeting: | 18 th January 2018 |
| Title of Report: | Finance, Performance and Commissioning Committee Report |
| Key Messages: | <p>At the end of October 2017 we have reported an in-year deficit of £1.6 million although we continue to report that this position will be recovered and that we will, therefore, deliver financial balance as at 31st March 2018.</p> <p>We have also reported a risk-adjusted forecast deficit of £1.784 reflecting our likely year-end position. The reported position currently excludes the local impact (estimated to be £2,3 million) of a national issue resulting in a significant increase in price of certain prescribed medicines due to a national shortage of supply. This is described as 'no cheaper stock obtainable, or NCSO.</p> <p>Since the December committee meeting the financial positions to the end of November 2017 (month 8) and December 2017 (month 9) have been reported to NHS England. Despite an underlying improvement, the month 8 and 9 reported positions reflect a significant deterioration due to the inclusion of the NCSO pressure in the risk-adjusted forecast.</p> <p>NHS England continue to give a very clear message that they expect the financial plan to be delivered.</p> <p>At the end of month 7, £4.9million efficiency savings have been made against our target of £5.1million.</p> <p>At the end of September 2017, we were failing to deliver six constitutional performance measures (Referral to Treatment, Cancer, Accident and Emergency, Ambulance calls, diagnostics and dementia).</p> <p>Good progress is being made with implementation of Integrated Personalised Commissioning, with the targets set by NHS England in April 2017 being met.</p> |

The committee were briefed on the public health services commissioning report. There is a proposed reduction in spend which will impact the wellbeing service most significantly as well as sexual health and substance misuse services but public health are confident that effective services can still be delivered within this.

Recommendations:

The governing body is asked to:

- Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 7th December 2017.
- Note the financial position to the end of October 2017 and progress against the 2017/18 Financial Recovery Plan.
- Note the position against national/local performance targets.
- Note the progress made with the Integrated Personalised Commissioning implementation and the need to think how it will need to be overlaid onto the new model of care for integrated care.
- Note the update on public health services commissioning including that the Sexual Health and Substance Misuse Services will be put out for tender with a view to going live in April 2019.
- Note the concern raised in relation to Cheshire & Wirral Partnership Trust adult and older people's specialist mental health redesign.

Report Prepared By:

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

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 31/03/18 | The report provides an update on financial performance for the period ended 31 st October 2017. | No change |
| 2 | Delivery of 2017/18 financial plan (and comply with legal directions) | The report provides an update on financial performance for the period ended 31 st October 2017. | 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 7th December 2017. The report also provides an update on the financial position to the end of December 2017 (month 9).
2. Details of the key issues discussed are provided in the following paragraphs:

FINANCE AND CONTRACTING PERFORMANCE FOR THE PERIOD ENDED 31st OCTOBER 2017

3. The committee received an update on financial performance and delivery of the 2017/18 financial recovery plan at the end of October 2017.
4. After 7 months of the financial year the reported financial position has improved with the following being reported to NHS England:
 - In-year deficit of £1.6 million.
 - Continued forecast delivery of financial balance as at 31st March 2018.¹
 - Likely year-end forecast of £1.784 million deficit; reported as a risk-adjusted deficit.
5. This represents an improvement from the reported month 6 position previously agreed by the governing body (in-year deficit of £1.674 million and risk-adjusted forecast deficit of £2.0 million).
6. There remains a clear expectation that we will mitigate all financial risk and deliver year-end financial balance. The committee considered the following 3 areas that need to be delivered if financial balance is to be achieved at 31st March 2018:
 - ***Delivery of financial recovery savings between November 2017 and March 2018;*** our financial recovery plan identifies approximately £4.6 million savings before the end of the financial year. A significant proportion of these schemes will not result in an impact on the 'bottom line' financial position, in the main, due to the block contract with the Countess of Chester hospital and other in-year pressures. Our likely year-end forecast assumes a relatively prudent 'bottom line' impact of £2.1 million split across prescribing, non-block healthcare contracts and continuing and complex healthcare packages.

¹ There is a national expectation that this position will improve by £1.672 million, our contribution to the national risk reserve (otherwise described as our non-recurrent headroom).

- **National solution to the 'no cheaper stock obtainable' (NCSO) prescribing issue²**; there is a national problem relating to reduction in supply and the resulting increase in cost of some drugs known as the no cheaper stock obtainable concession, whereby contractors are permitted to dispense more expensive alternative products. Our estimate of the local in-year financial impact is £2.4 million. In accordance with NHS England guidance, this pressure is currently excluded from our reported financial position.
- **Further mitigations**; resolution to the above issues and no further unforeseen financial pressures, we will deliver our likely year-end forecast of £1.784 million deficit. As described above, there is significant pressure from NHS England to further mitigate the position and deliver financial balance. To facilitate, the following additional mitigations are being pursued:
 - Additional prescribing schemes; current estimated impact of £150,000.
 - Repatriation of activity to utilise 'blocked' activity at the Countess of Chester Hospital.
 - Additional complex care reviews.
 - Resolution to a dispute with NHS England in relation to funding of specialised critical care activity (£1.3 million).
 - Other non-recurrent support.

7. The committee also received more detailed updates on the following high-risk budget areas:

- **Prescribing**; we continue to report over delivery of the prescribing savings target with a forecast underspend against the prescribing budget (based on 5 months prescribing information). However, this position assumes that there will be a national solution to the NCSO issue. Approximately £2.4 million is, therefore, currently excluded from our forecast.
- **Secondary care contracts**; at the end of October 2017 we are reporting a pressure against the secondary care contracts budget of £2.416 million with a year-end forecast pressure of £2.451 million. This forecast assumes delivery of savings against non-block contracts of £625,000.

After 6 months of the year there is an under spend against the block contract with the Countess of Chester NHS Foundation Trust of £1.857 million covering most points of delivery. However, our analysis shows that GP referrals have increased and the numbers of patients waiting for treatment has increased by 4.4% since last year. The committee received updates on the other contracts that are reporting an over performance.

²**Generic Medicines & the NCSO Concession**: When stock of a product in Part VIII of the Drug Tariff has gone short in the market or the product has been discontinued by the manufacturer, and there is a more expensive alternative product available in the market, it is possible to apply to the Department of Health to grant the NCSO ('No Cheaper Stock Obtainable') concession which will allow contractors to dispense a more expensive alternative product.

- **Continuing healthcare and complex care;** the 2017/18 financial plan allows for 5.4% growth in the continuing healthcare and complex care budget. However, a financial recovery target of £549,000 has also been netted off this budget, resulting in a net uplift of 2.9%.

During the month 6 review we made significant improvements to the systems and processes supporting financial management and forecasting. At the end of October we are reporting a year-to-date pressure of £522,000. We are, however, reporting that this will be mitigated in full and that we will deliver a year-end under spend. During October 2017, the net number of CHC and complex care packages reduced by 2 cases.

8. Summary financial performance against our financial duties at the end of October 2017 is reflected in the following table:

| <u>West Cheshire Clinical Commissioning Group Financial Performance Summary - 31st October 2017</u> | | | |
|---|---|---------------------|----------------------|
| Performance measure | Description | In-Year Performance | Forecast Performance |
| Delivery of financial duty | Operate within allocation | AMBER | AMBER |
| Delivery of NHS 'business rules' | CCGs expected to deliver minimum 1% surplus | RED | RED |
| Delivery of financial recovery plan | Delivery of 2017/18 FRP | AMBER | AMBER |
| Running cost allowance (RCA) | Financial duty to operate within RCA | GREEN | GREEN |
| Capital allowance | Operate with capital allocation | N/A | N/A |
| Better payment practice code | Payment of 95% of invoices within 30 days | GREEN | GREEN |

FINANCIAL PERFORMANCE FOR THE PERIOD ENDED 31ST DECEMBER 2017

9. Since the December committee meeting the financial positions to the end of November 2017 (month 8) and December 2017 (month 9) have been reported to NHS England. The movements in reported positions can be summarised as follows:

| Description | Month 7* £M | Month 8 £M | Month 9 £M |
|----------------------------|----------------|---------------|---------------|
| In-year position | 1.600 | 2.863 | 3.466 |
| Forecast year-end | 0 | 0 | 0 |
| Risk-adjusted deficit | 1.784 | 4.172 | 4.137 |
| NCSO (excluded from above) | 2.388 | 0 | 0 |

*Reported to the finance, performance and commissioning committee in December 2017.

10. Despite an underlying improvement, the month 8 and 9 reported positions reflect a significant deterioration due to the inclusion of the NCSO pressure in the risk-adjusted forecast. This follows revised guidance from NHS England. Excluding NCSO, our risk adjusted forecast deficit at the end of December 2017 has reduced to £1.749 million.

FINANCIAL RECOVERY PLAN DELIVERY

11. It was reported that good progress continues to be made in delivery of the projects within the Financial Recovery Plan. At the end of month 7, £4.9million efficiency savings have been made against our target of £5.1million
12. The full Financial Recovery Plan tracker can be found [here](#).
13. High level programme progress since the last meeting is outlined below:

| Programme area | Key highlights | Key programme risks |
|-----------------------|--|---|
| Primary Care | <p>Repeat Prescribing</p> <ul style="list-style-type: none"> Those practices delivering the highest level of savings have been provided with additional funding to further increase the hours focused on repeat prescribing. Highest weekly total to date Week 28: £31,281. Current Gross Total stands at £709,662 <p>Support and Escalation</p> <ul style="list-style-type: none"> The Primary Care Support and Escalation Process is demonstrating a positive impact on patient quality care and avoidance of inappropriate hospital attendances. Current year health economy estimated cost savings from this work equates to £118k. Further work has taken place offering patients the Countess as a first choice instead of other hospital providers. | <p>Support and Escalation</p> <ul style="list-style-type: none"> A significant proportion of the savings against this project have also been accounted for in planned care projects, this has now had to be factored in to the overall financial position |
| Starting Well | <ul style="list-style-type: none"> A presentation on the developing 'South of the Mersey' model for women and children's services across West Cheshire and Wirral was made to the Cheshire & Mersey Summit and received strong support. This was also presented to the Membership Council in November. <p>Maternity</p> <ul style="list-style-type: none"> Progress is now being made with the implementation of shared care pathways between the Countess and One to One Midwifery. | <ul style="list-style-type: none"> The Countess have failed to extend the paediatric consultant advice line hours due to lack of consultant capacity. The CCG have asked them to explore operating this in conjunction with Wirral University Hospital Trust. |
| Urgent care | <p>Accident and Emergency</p> <ul style="list-style-type: none"> There has been good feedback from patients, staff and NHS England regarding the Urgent Treatment Centre. We are currently directing approximately 30 patients a day to be cared for in the Centre (rather than A&E) with an ambition to increase this to approx. 50. | <p>Patient Transport Service</p> <ul style="list-style-type: none"> An improvement action plan has been implemented in a bid to improve performance with bi-weekly review meetings |

| | | |
|----------------------------|---|---|
| | <ul style="list-style-type: none"> • The local A&E Delivery Board has bid for an additional £800K for additional capacity to support delivery of the A&E 4hr target. They have since received £500K (however there is an expectation that this will improve their overall position) • The regional Emergency Care Improvement Programme are currently working in the Countess to identify opportunities to improve performance. Initial findings indicate the need for improved communication/links between Emergency Department and wards and strong clinical leadership. <p>Intermediate Care</p> <ul style="list-style-type: none"> • The local A&E Delivery Board has bid for an additional £1m for additional community capacity to support the achievement of the Delayed Transfers of Care target. This has since been approved. • The Care Homes Local Enhanced Service went live in December | <p>Intermediate Care</p> <ul style="list-style-type: none"> • Despite the additional therapeutic capacity the Length of Stay in Bluebell and Poppy wards at Ellesmere Port Hospital is higher than target. This is partly as a result of pressures on care home and social care capacity. • There is an ongoing lack of EMI Nursing beds in the system and the additional Better Care Funding has not been sufficient to engage care homes in offering these beds. This is resulting in ongoing spot purchasing. |
| <p>Planned Care</p> | <p>Urology</p> <ul style="list-style-type: none"> • The Countess are collaborating with Wirral University Hospital on the development of more defined non-elective pathways, reducing emergency admissions and ‘hot’ clinics. <p>Diabetes</p> <ul style="list-style-type: none"> • Significant progress is being made in referrals to the National Diabetes Prevention Programme (102 last month against a target of 71). <p>Cancer</p> <ul style="list-style-type: none"> • The Clinical Commissioning Group has appointed a new Clinical Lead for Cancer Dr Dan Kelly. Good progress is being made with the ovarian and prostate cancer pathways to move diagnostics earlier in the pathway. • The integration of Meditech with ICE results reporting system has been resolved after considerable delay. <p>Dermatology</p> <ul style="list-style-type: none"> • A prescribing change, supported by secondary care and the intermediate service, is being explored that offers significant savings. <p>Musculoskeletal</p> <ul style="list-style-type: none"> • Due to the changes that have been made to the pathway a reduction is being seen in the | <p>Cancer</p> <ul style="list-style-type: none"> • The Countess have served notice to Wrexham in relation to the provision of Upper GI surgery. We are yet to understand the full implications of this change and will explore with NHS England the alternative options for West Cheshire patients. |

| | | |
|--|---|--|
| | <p>number of MRIs. This will now be progressed to greater ownership of wider diagnostics. Within Physiofirst, efficiencies are expected from reducing duplication of assessments.</p> <p>Neighbourhood care</p> <ul style="list-style-type: none"> • Mental health integration into the community care team will be in place from Dec to support the wider integrated care team with advice/guidance and to reduce referrals/admissions. A positive Quarter 2 review meeting was held with NHS England. | |
| Medicines Management | <ul style="list-style-type: none"> • The full Financial Recovery Plan savings for medicines management optimisation have now been achieved (as the programme was front-loaded). The team will now focus on supporting the optimisation of prescribing through the redesign of planned care pathways. | |
| Continuing Health care and Complex care | <ul style="list-style-type: none"> • The Local Authority are supportive of the approach to reviewing all out of area, s117 and previously non-CHC assessed complex care patients, including provision of social care capacity. | <ul style="list-style-type: none"> • Although the costs involved in the reviews completed to date are significant, the ability to implement changes within the financial year are uncertain due to the length of time patients have been unassessed/reviewed, families wishes and availability of alternative placements locally. |

14. The Committee also received an update on wider (non-FRP) commissioning issues.

- The Planned Care Programme Board considered the evaluation of the referral support system Accenda against the updated electronic referral system (eRS). Considering the functionality of both systems, it was proposed that we move to eRS in April 2018. This has since been approved at the Clinical Commissioning group Quality and Performance Countess contract meeting.
- The Clinical Commissioning Group are developing a 'Beyond Place of Safety' bid in collaboration with service user forums.
- Liaison Psychiatry: As agreed at the August Cheshire & Wirral Partnership Trust contract meeting, investment is being made into Phase one of Liaison Psychiatry (towards Core 24) of £116,850 (full year effect). Core 24 investment has a further two phases of required investment. To date a new team manager and two band six Nurses have been recruited.

- Two Dementia Nurses have been recruited to be based in the Countess Dementia team. One further Nurse will be based in Ellesmere Port Hospital.
- Leadership of the Learning Disabilities Transforming Care Partnership moved from Dianne Johnson to Hazel Richards, Director of Nursing and Quality (NHS England) at the beginning of November. There will now be a review of all work streams and governance, taking stock of progress to date and outlining key actions in next 6 months.

PERFORMANCE

15. At the end of September 2017, we were failing to deliver six constitutional performance measures (Referral to Treatment, Cancer, Accident and Emergency, Ambulance calls, diagnostics and dementia). A summary of performance is provided [here](#).
16. These were all discussed with the Countess at the Quality and Performance contract meeting in November.
17. In relation to cancer it was noted that they are focusing on the first 38 days of the pathway to ensure they have control over the element the Trust can influence. If the target then continues to be missed, discussion with the tertiary Trusts (in conjunction with NHS England) is required.
18. In relation to diagnostics, it was recognised that performance against echocardiography is now improved however there is an issue with capacity for gastroscopies, cystoscopies and colonoscopies, which is being addressed.
19. In relation to Referral to Treatment, there was a discussion regarding the Trust's ambition to look to achieve the target, even with the additional patients choosing to be treated at the Countess. It was recognised that some specialties continue to perform at above 92% to compensate for those specialties that consistently struggle to achieve the target.
20. The Committee challenged what further needed to be done to improve performance. In terms of where we are likely to be able to influence improved performance, it was felt this is most likely to be in diagnostics and cancer through the Clinical Commissioning Group clinical leads and the pathway redesign underway.
21. The Committee also discussed the measures within the Integrated Assurance Framework where we are in the bottom quartile or where performance is deteriorating; including Injuries from falls for people aged >65yrs plus, ambulatory care sensitive admissions, Anti-microbial resistance broad spectrum prescribing, hospital bed use following emergency admissions. It was noted that Business Intelligence are reviewing and streamlining the performance report, to include the Integrated Assurance Framework information

INTEGRATED PERSONAL COMMISSIONING AND PERSONAL HEALTH BUDGET UPDATE

22. It was noted that good progress is being made with implementation of Integrated Personalised Commissioning, with the targets set by NHS England in April 2017 being met. The personal health budgets offer began with continuing healthcare and complex care and work is now progressing with personal wheelchair budgets. The committee asked if the next update could contain some examples of where personal health budgets have been used successfully.
23. Integrated Personalised Commissioning specific training has been provided to the current provider of carers support to ensure that we are offering all of the key features required for a person to be in receipt of an Integrated Personal Commissioning budget.
24. The Committee discussed how going forward Integrated Personal Commissioning could be integrated into business as usual but also for the Committee to think about how this approach could be overlaid on the model for the Integrated Care Partnership (as there is an offer from NHS England for support to sites developing integrated care systems).

PUBLIC HEALTH SERVICES COMMISSIONING

25. Donald Read, Consultant in Public Health at Cheshire West and Chester Council briefed the committee on the public health services commissioning report which was taken to the Council Cabinet last week where the recommendations were approved.
26. There is a proposed reduction in spend which will impact the wellbeing service most significantly as well as sexual health and substance misuse services but public health are confident that effective services can still be delivered within this. Smoking cessation and weight management services will be provided although they are not nationally mandatory.
27. Health Checks will remain with primary care and public health are keen to see an increase in uptake and spread, and have discussed with the Clinical Commissioning Group the potential to include health checks within the Primary care the CQUIN. Free activity passes for over 75s are ceasing and will be replaced with a £9 a month offer (as this is not currently a widely used service.) The savings in funding will be used for falls prevention.
28. The Sexual Health and Substance Misuse Services will be put out for tender with a view to going live in April 2019.
29. It was agreed that the Committee would receive a further update at a future meeting on the total use of the public health grant.
30. The committee felt that there could be further engagement with partners regarding public health commissioning and that it could be usefully discussed at the West Cheshire Senate.

ADULT AND OLDER PEOPLE'S SPECIALIST MENTAL HEALTH REDESIGN

31. The adult and older people's specialist mental health redesign paper was received at the first meeting of the Cheshire Clinical Commissioning Groups' Joint Committee. West Cheshire Clinical Commissioning Group noted that they did not feel that the paper had been taken through our governance processes. The view was it should be brought to this committee to see if there were any further actions needed. The paper has been through East Cheshire's Overview and Scrutiny Committee, Cheshire and Wirral Partnership believe it has been discussed at our contract meetings with them but no written evidence can be found of this.
32. There are issues of sustainability and service provision at the Macclesfield site, and there is an ambition to provide a model of enhanced community care. However, the model would involve use of inpatient beds at Bowmere.
33. AL expressed concern that the clinical commissioning group had not been involved in the development of something that could be quite innovative and we cannot be assured that this will not have an impact on our local population in terms of access to inpatient beds at Bowmere. The redesign is on the agenda for our formal meeting with Cheshire and Wirral Partnership Trust next week assurance will be sought that there will not be an impact on our local population's access to inpatient beds at Bowmere.

RECOMMENDATIONS

34. The governing body is asked to:
 - Note the business discussed and decisions made at the finance performance and commissioning committee meeting held on 7th December 2017.
 - Note the financial position to the end of October 2017 and progress against the 2017/18 Financial Recovery Plan.
 - Note the position against national/local performance targets.
 - Note the progress made with the Integrated Personalised Commissioning implementation and the need to think how it will need to be overlaid onto the new model of care for integrated care.
 - Note the update on public health services commissioning including that the Sexual Health and Substance Misuse Services will be put out for tender with a view to going live in April 2019.
 - Note the concern raised in relation to Cheshire & Wirral Partnership Trust adult and older people's specialist mental health redesign.

Gareth James
Chief Finance Officer

Laura Marsh
Director of Commissioning

January 2018

GOVERNING BODY REPORT

1. **Date of Governing Body Meeting:** 18th January 2018
2. **Title of Report:** 2017/18 Governing Body Assurance Framework
3. **Key Messages:** This report presents the 2017/18 governing body assurance framework.
4. **Recommendations** The governing body is asked to consider and approve the 2017/18 governing body assurance framework proposed by the Executive risk sponsors, noting the summary of changes from the previous assurance framework (to the governing body in November 2017) and the addition of one new risk.
5. **Report Prepared By:** Debbie Bryce
Head of Governance
January 2018

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP GOVERNING BODY 2017/18 GOVERNING BODY ASSURANCE FRAMEWORK

INTRODUCTION

- The **2017/18 governing body assurance framework** is aligned to the NHS England Improvement Assessment Categories. In-line with the clinical commissioning group's risk management strategy, the departmental risk registers have been reviewed and updated in January 2018.

REVIEW

- For ease, a summary of the changes to the governing body assurance framework, since the governing body in November 2017 are provided below.

| Risk Number 2016/17 | Risk Number 2017/18 | Risk Sponsor/Owner | Summary of risk changes | Change to risk rating |
|---------------------|---------------------|-----------------------|---|--|
| 1. | - | Chief Finance Officer | <u>Financial Sustainability</u> Failure of the clinical commissioning group to deliver financial duties - risk that the revised <u>2016/17</u> financial forecast will not be delivered. | Risk was archived in July 2017 |
| 2. | 1. | Chief Finance Officer | <u>Financial Sustainability</u> At the end of December 2017 we continue to report an in-year deficit but that this will be recovered and we will achieve financial balance as at 31 st March 2018. However, following NHS England guidance, our financial risk relating to the national 'no cheaper stock obtainable' issue is reported in our risk-adjusted forecast. If there is not a national resolution to this issue the clinical commissioning group will not deliver its financial duties. | No change (<i>risk impact was increased from 4 to 5 last month</i>) |

| Risk Number 2016/17 | Risk Number 2017/18 | Risk Sponsor/Owner | Summary of risk changes | Change to risk rating |
|---------------------|---------------------|--|---|--|
| 3. | 2. | Chief Finance Officer | <u>Organisational Governance</u> Unchanged | Unchanged |
| 4. | 3. | Chief Finance Officer | <u>Information Governance</u> (The Commissioning Support Unit are leading us through the training and process of the introduction of the new General Data Protection Regulations in May 2018) | Unchanged |
| 5. | 4. | Director of Quality & Safeguarding | <u>Safe/effective/harm-free care from Providers</u> Unchanged | Unchanged |
| 6. | 5. | Director of Quality & Safeguarding | <u>Safeguarding Vulnerable Children</u> Recent joint targeted area inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester has provided significant assurance in respect of neglect | Residual risk likelihood reduced from 3 to 2 |
| 7. | 6. | Director of Quality & Safeguarding | <u>Safeguarding Vulnerable Adults</u> Unchanged | Unchanged |
| 8. | 7. | Director of Quality & Safeguarding | <u>Safe/quality services during financial recovery</u> Unchanged | Unchanged |
| 9. | 8. | Chief Executive Officer (previously Director of Commissioning) | <u>Integrated Care Development</u> Unchanged | Unchanged |

| Risk Number 2016/17 | Risk Number 2017/18 | Risk Sponsor/Owner | Summary of risk changes | Change to risk rating |
|---------------------|---------------------|---|--|---|
| 10. | 9. | Director of Commissioning | <u>Delivery of Financial Recovery Plan (programmes)</u> Unchanged | Unchanged |
| 11. | 10. | Chief Finance Officer & Director of Commissioning | <u>NHS Constitutional Performance Targets</u> Need to deliver key targets in order to progress with integrated care system. Quarter 3 failure to deliver the A&E standard, referral to treatment and cancer 62 day target. | Unchanged |
| 12. | 11. | Chief Executive Officer | <u>Sustainable Leadership (to deliver the West Cheshire Way)</u> Unchanged | Unchanged |
| 13. | 12. | Chief Executive Officer | <u>Delivery of Organisation Improvement Plan</u> NHS England has begun the process to take the Clinical Commissioning Group out of formal directions (Nov 2017). | Impact rating reduced from 4 to 3 and likelihood rating reduced from 2 to 1 |
| - | 13 | Chief Executive Officer | <u>Integrated Care (capacity and capability)</u> Change to narrative for gaps in controls. (new risk in Nov 2017) | No change |

| Risk Number 2016/17 | Risk Number 2017/18 | Risk Sponsor/Owner | Summary of risk changes | Change to risk rating |
|---------------------|---------------------|-----------------------|--|-----------------------|
| - | 14 | Chief Finance Officer | <u>Financial Sustainability (reimbursement of Hospice payroll costs)</u> Unchanged (new risk in Nov 2017) | No change |
| - | 15 | Chief Finance Officer | <u>Cyber Security</u> Risk that the CCG does not have a robust cyber security framework in place. SLA monitoring of Midland and Lancashire Commissioning Support Unit who provide our IT services. NHS Digital review will conclude in February 2018 | New risk |

RECOMMENDATIONS

- The governing body is asked to consider and approve the 2017/18 governing body assurance framework proposed by the Executive risk sponsors, noting the summary of changes from the governing body in November 2017 and the addition of one new risk.

Gareth James
Chief Finance Officer
January 2018

GOVERNING BODY REPORT

| | |
|--|--|
| DATE OF GOVERNING BODY MEETING: | 18 th January 2018 |
| TITLE OF REPORT: | Clinical Commissioning Group Policies and Governance Documents |
| KEY MESSAGES: | This report provides one 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 Governing Body and Committees Coordinator |

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY
CLINICAL COMMISSIONING GROUP POLICIES
AND GOVERNANCE DOCUMENTS

INTRODUCTION

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

POLCIES AND GOVERNANCE DOCUMENTS

2. As a part of the clinical commissioning group’s governance process, a governance plan was created to schedule an annual review of policies and governance documents. Provided below is the policy/governance document for ratification, 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. | NHS Continuing Healthcare Commissioning Policy | | November 2015 | Gareth James Chief Finance Officer 01244 385259 garethjames@nhs.net |

RECOMMENDATION

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

Gareth James
Chief Finance Officer
January 2018

| | |
|--|--|
| Date of Governing Body Meeting: | 18 th January 2018 |
| Title of Report: | Minutes of Governing Body Sub-Committees and Committees of the Clinical Commissioning Group. |
| Key Messages: | To provide an overview of business and actions/decisions made by the sub-committees of the governing body and Committees of the Clinical Commissioning Group (Joint Commissioning Committee and Primary Care Commissioning Committee). |
| Recommendations: | The governing body is requested to receive and note any significant issues arising from, and the minutes of, the sub-committees and Committees of the Clinical Commissioning Group |
| Report Prepared By: | Christine France Governing Body and Committees Coordinator |

NHS WEST CHESHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BODY

MINUTES OF GOVERNING BODY SUB-COMMITTEES AND COMMITTEES OF THE CLINICAL COMMISSIONING GROUP

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, along with committees of the Clinical Commissioning Group. 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 November 2017 Chester City Locality GP Network meetings are available [here](#).

Rural Locality GP Network

4. The approved minutes from the October and November 2017 Rural Locality GP Network meetings are available [here](#).

Ellesmere Port and Neston Locality GP Network

5. The approved minutes from the November 2017 Ellesmere Port and Neston GP Locality Network meeting are available [here](#).

PRIMARY CARE COMMISSIONING COMMITTEE

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

QUALITY IMPROVEMENT COMMITTEE - [minutes](#)

7. An update of the December 2017 meeting is contained within the quality improvement committee report.

FINANCE PERFORMANCE AND COMMISSIONING COMMITTEE – [minutes](#)

8. An update of the November and December 2017 committee meetings is contained within the finance, performance and commissioning committee report.

AUDIT COMMITTEE – [minutes](#)

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

CHESHIRE CLINICAL COMMISSIONING GROUP'S JOINT COMMISSIONING COMMITTEE

10. An update of the November 2017 meeting of Cheshire Clinical Commissioning Groups' Joint Commissioning Committee is available [here](#).

RECOMMENDATION

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