Wirral Clinical Commissioning Group

Governing Body Board Meeting – A meeting in public

Tuesday 8th January 20123
1300 - 1500
Duncan Meeting Room, Old Market House

AGENDA

Ref No	Time	No	Papers	
	1300	**1.**	**PRELIMINARY BUSINESS**	
GB12-13/119		**1.1**	**Apologies for Absence**	
GB12-13/120		**1.2**	**Chair's Announcements**	
GB12-13/121		**1.3**	**Declarations of Interest**	
GB12-13/122		**1.4**	**Comments/questions from members of the public**	
GB12-13/123		**1.5** **1.6**	**Minutes of previous meetings:** • **Meeting held on 4th December 2012** **Matters Arising/Actions Points:** • **Meeting held on 4th December 2012**	final minutes of Public GBB meeting 4t Draft Actions Points from PUBLIC GBB Mee

	1315	2.	ITEMS FOR APPROVAL	
GB12-13/124		2.1	**Constitution – agreement of amendments** (Phil Jennings)	Cover sheet Constitution - agreem Comments from the CCG constitution.doc
GB12-13/125		2.2	**Remuneration Committee Terms of Reference** (Phil Jennings)	Remuneration Terms of Reference cover s Remuneration Committee Terms of F
GB12-13/126		2.3	**Site Visit Action Plan** (Lorna Quigley)	cover sheet authplan.doc Authorisation report.doc Outstanding Issues - Site Visit Appendix 1 f
			ITEMS FOR INFORMATION AND NOTING	
GB12-13/127		3.1	**Chief Clinical Officer's Report** (Abhi Mantgani)	Clinical Chief Officers Reportcover sheet.d CCG update Jan (2) (2).doc
GB12-13/128		3.2	**2013/14 Planning Process** (Alex Dalgarno)	Cover Governing Body Planning Paper. 2013-14 Planning Process Paper.doc
GB12-13/129		3.3	**Finance Planning Guidance Implications** (Mark Bakewell)	GB Headline Plan Assumptions cover sh Headline Financial Plan to GB 8th Januar
GB12-13/130		3.4	**Finance & Performance Report** (Mark Bakewell)	M8 Finance Cover Sheet 8th January 20 Month 8 Finance Report- Wirral CCG.d M8 Performance Appendices GB Wirral
GB12-13/131		3.5	**Minutes for Noting** • Wirral GP Commissioning Consortium of 20th November 2012.	WGPCC Executive Board Minutes 20 11

			• Wirral Health Commissioning Consortium of 21st November 2012. • Wirral Alliance Commissioning Consortium of 8th November 2012. • Quality, Performance & Finance Committee of 29th November 2012 • Audit & Governance of: 27th June 2012 25th July 2012 31st October 2012 • Approvals Committees of: 17th August 2012 14th September 2012 19th October 2012	Wirral Health Executive Board Minu WACC Executive Board Meeting -FINAl Draft minutes of QPF 29th November 2012 Agenda Item 6.3 - DRAFT Minutes Gove DRAFT Minutes - Governance Audit - 2 Task and Finish Group Mtg 31102012 Approvals Commitee Meeting (AJH) - DRAF Minutes from Meeting 140912 - Fina Final Approvals Minutes 19 October 2
	1430	**4.**	**RISK REGISTER**	
GB12-13/132 GB12-13/133		**4.1** **4.2**	**Review of Current risks** **(All)** **Items to be included onto the Risk Register** **(All)**	Copy of RiskRegister V3-0 update 3rd Janu
	1445	**5.**	**ANY OTHER BUSINESS**	
GB12-13/134				
		6.	**DATE AND TIME OF NEXT MEETING**	
			The date of the next meeting is: Tuesday 5th February 2013, 1300 – 1500. Duncan Meeting Room, Old Market House. Please forward apologies to: Julie.stamper@wirral.nhs.uk	

Wirral Clinical Commissioning Group
Governing Body Meeting

Minutes of Public Meeting Held on

Tuesday 4th December 2012 at 1300
Nightingale Meeting Room, Old Market House

Present:

Dr P Jennings (PJ)	Designated Chairman WCCG
Dr A Mantgani (AM)	Designated Accountable Officer WCCG
Dr S Wells (SWells)	GP Executive Wirral Health Consortium
Lorna Quigley (LQ)	Chief Officer WCCG
James Kay (JK)	Lay Advisor (Audit & Governance)
Mark Bakewell (MB)	Interim Chief Finance Officer WCCG
Fiona Johnstone (FJ)	Director of Public Health
Christine Campbell (CC)	Acting Chief Officer Wirral GP Consortium
Simon Wagener (SW)	Lay Advisor (Patient Champion)
Dr J Oates (JO)	Chair Wirral GP Consortium
Dr A Smethurst (AS)	Secondary Care Doctor
Dr P Naylor (PN)	Chair Wirral Health Consortium
Andrew Cooper (AC)	Chief Officer Wirral Health Consortium
Dr M Green (MG)	Chair Wirral Alliance Consortium
Iain Stewart (IS)	Chief Officer Wirral Alliance Consortium

In attendance:

Julie Stamper (JS)	Board Support Assistant (minute taker)

Apologies:

Mr A Dalgarno (AD)	NHS CWW
Dr A Ali (AA)	GP Executive Wirral GP Consortium

REF NO	MINUTE	ACTION
1.	**PRELIMINARY BUSINESS**	
GB12-13/106	Apologies for absence were noted as above.	
GB12-13/107	**Chair's Announcements**: No announcements.	

Signed: Chair

GB12-13/108	**Declarations of Interest**: There were no declarations of interest declared.	
GB12-13/109	**Comments/questions from members of the public**: There were no members of the public in attendance.	
GB12-13/110	**Minutes of Previous Meeting**: **6th November 2012**: Agreed as an accurate record. **20th November 2012**: Agreed as an accurate record. **Matters Arising/Actions Points**: • GB12-13/096 – Organisational Development Plan has been amended. • GB12-13/096 – Individual development plans are to be discussed in the KLOE's. • GB12-13/097 – BME Plan – SW to meet with PN. • GB12-13/099 - Update on 111 Project. Discussed at QPF recently. No further forward. Some further information has been received. Sarah Quinn and Jenny Shaw are putting together a project plan. Working with the Community Trust. Transition issues have been identified and this is being worked upon. JK asked for an update in January's meeting. • GB12-13/099 – IG is on the Risk Register. All on track. • Cost efficiencies have been added to the Risk Register. • FJ asked for the previous minutes to be re-articulated regarding Consortia linking in with Public Health. PJ to discuss with FJ.	**AC** **PJ/FJ**
2.	**ITEMS FOR APPROVAL**	
GB12-13/111	No items for approval today.	
3.	**ITEMS FOR INFORMATION**	
GB12-13/112	**Finance & Performance Report**: MB gave an update on the year to date financial situation performance. The report sets out the financial position for Wirral CCG as at the end of October (Month 7) within the 2012/13 financial year. As at the end of October (Month 7), the year to date position is an over-spend of £0.5m with over performance against commissioning expenditure of £1.07m offset by an under performance against running costs of £0.58m.	

Signed: Chair

	The year to date variance position between Governing Body and the combined consortia is an overspend at Divisional level of £3.99m with the Governing Body underspent by £3.49m. The overall CCG performance position in relation to NHS contracts shows an overspend at month 7 of £5.26m primarily being due to over performance on the Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) contract of £5.13m at Divisional level. The year to date position is based on actual activity as at Month 6. £4.1m over performance with a pro-rata adjustment to equate to month 7 position and application of estimated contract adjustments for re-admissions/out-patient follow-up ratios as appropriate. Prescribing expenditure is currently providing the CCG with a year to date underspend of £1.58m. There is an over performance of those budgets managed at Governing Body level of £121k due in the main to Amber Drugs which is being offset by underperformance at Divisional level of £1.7m. The performance position is based on five month's actual data with two month's estimated costs for September and October. Commissioned "out of hospital" budgets are £889k overspent at month 7. The main drivers for the over performance remain within the Continuing Healthcare section with Older People (£180k) and Physical Disabilities (£149k), and all Joint Funded packages (£427k) being offset by underperformance on Funded Registered Nursing Care (FRNC) of £146k. Reserves are underspent by £3.89m at month 7 which is due to the release of the contingency element and a number of earmarked reserves which are available for release. There is an underspend of £577k in relation to running costs at month 7 mainly due to clinical backfill reported at consortia level. A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position. MB then detailed the forecast outturn position as at month 7. Although a number of commissioning budgets are over performing as at the end of October 2012, the CCG remains on target to achieve a balanced position against its allocation. One of the key performance drivers to the financial performance position remains around the WUTH contract and as such, given the current intelligence regarding contract performance, has been extended within the forecast outturn position to the value of £8.0m (previous month £7.0m). MB then detailed the risk assessment of each of the areas highlighted within the financial plan regarding packages of care, prescribing, WUTH and cost efficiencies. With regards to future CIP savings, these are set at £14m per year. If this is not achieved it is then rolled over to the next year. Therefore future financial years will become more challenging. Following the authorisation visit on the 13th December, there will be an	

Signed: Chair

	opportunity to discuss the block contracts and the impact that these will have on the , on £20m of savings that need to be made year on year.	
GB12-13/113	**Minutes for Noting**: • Wirral GP Commissioning Consortium of 23rd October – noted. • Wirral Health Commissioning Consortium of 17th October – noted. • Wirral Alliance Commissioning Consortium of 6th September and 4th October - noted. • Quality, Performance & Finance Committee of 31st October – noted.	
4.	**RISK REGISTER**	
GB12-13/114	**Risk Register**: Updated at recent Quality, Performance & Finance Committee meeting. There are 7 risks still identified which have been brought forward from the previous meetings. A trend line analysis has been added. WGPCC risk being unable to utilise its total allocation of efficiency resources to slippage in several schemes becoming operational. This risk will need to be reviewed at WGPCC Executive Board meeting.	**CC**
5.	**ANY OTHER BUSINESS**	
GB12-13/115	No other business discussed at today's meeting.	
6.	**DATE AND TIME OF NEXT MEETING**	
	The next meeting of the Governing Body Board will take place on **Tuesday 8th January 2013, 1300 – 1500** Duncan Meeting Room, Ground Floor, Old Market House. Please email apologies to: Julie.stamper@wirral.nhs.uk	

Signed: Chair

Governing Body Board Meeting
Held on Tuesday 4th December 2012

Action Point – Public Meeting

Item Number	Action Points	Responsibility	Due Date
	PUBLIC MEETING		
GB12-13/110	JK asked for an update to be provided at the next meeting regarding the 111 Project.	Andrew Cooper	January 2013
GB12-13/110	FJ asked for the previous minutes to be re-articulated regarding consortia linking in with Public Health. To discuss with PJ.	Phil Jennings/ Fiona Johnstone	
GB12-13/114	WGPCC risk being unable to utilise its total allocation of efficiency resources to slippage in several schemes becoming operational. To be reviewed at WGPCC Executive Board meeting.	Christine Campbell	

Wirral Clinical Commissioning Group

Constitution- Agreement of Amendments			
Agenda Item:	2.1	**Reference:**	GB12/13-124
Report to:	Governing Body	**Meeting Date:**	8th January 2013
Lead Officer:	Dr Phil Jennings		
Contributors:	Mrs Lorna Quigley		
Governance:	**Link to Commissioning Strategy**	N/A	
	Link to current governing body Objectives	The CCG is required to have an agreed constitution as part of the authorization process	
Summary:	This document is a collation of the responses received from stakeholders to the draft Wirral CCG constitution. The Governing body is asked to consider the comments received and amend the draft as it sees fit in order to produce a final version		
Recommendation:	**To Approve**	√	
	To Note		
	Comments		
Next Steps:	A final document will be circulated to practices for signature		

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	N/A
Value For Money	N/A
Risk	The CCG must have an agreed constitution to progress through authorization
Legal	It is a legal requirement to have an agreed constitution under the Health and Social Care Act 2012
Workforce	N/A
Equality & Human Rights	N/A
Patient and Public Involvement (PPI)	The document includes responses received from all stakeholders
Partnership Working	The constitution details the CCG commitment to partnership working
Performance Indicators	N/A
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	**YES**

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) 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. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of "prejudicial" is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

Comments from the CCG constitution

Paragraph	Issue Raised	Suggested Amendment	Recommendation to Governing Body
1. Introduction and Commencement			
1.2.3	The first comment is wrong – they will not all necessarily be general practices	None	National template component. All Wirral CCG members **are** General Practices
Consultation Schedule	Distribution of draft constitution	Schedule amended to indicate which stakeholders received constitution	Approve Change
2. Area Covered			
No amendments received			
3. Membership			
3.1.1	Practices to be listed in a separate schedule	None	National Template component requiring the list of practices
3.1.1	Moreton misspelt	Correct spelling	Approve Change
3.1.1	The 3 West Kirby Practices will be one in April	None	There are a number of planned practice changes. The constitution reflects the situation at the time of signing
3.1.1	Agreement required re process when practices move between divisions	None	This area is covered in the consortia (divisions) terms of reference
3.1.1	Agreement required re what proportion of member practices need to be in agreement before the constitution is signed off	None	Further national guidance is awaited on this subject
4. Mission, Values and Aims			
4.5.1	Reference to patients and public required in terms of development of Mission, Values and Aims	Include details of engagement process during development of Mission, Values and Aims	Approve Change
5. Functions and General Duties			
4.2.1-5.4.2	These pages are not strictly necessary … all of it can go in a	None	National Template Component. The CCG is required to include these

	separate policy document		sections
5.1.2 a) iii	Operating within budgets?	None	The consortia have delegated responsibility for managing their own budgets
5.1.2 b) i	Should this be the responsibility of the CCO?	None	The CCO has overall accountability, however, additionally there is an executive lead on the GB for equality
5.2.1 c)	Do we need to extend this to include collaborative contracting and support for providers across the health economy	None	This is a matter for the consortia boards to address within their terms of reference
5.2.1 a)	Should this duty be carried out by an officer but supported and challenged by a Lay Advisor?	None	The Lay Member for public and patient involvement is a requirement under the act. He will be supported and challenged by all members of the governing body
5.2.1 c)	Would separate plans conflict/confuse patients and the public	None	The majority of commissioning is performed on a Wirral wide basis. The federated structure exists to allow consortia to additionally commission schemes to meet their local needs
5.2.4 d)	Does more detail about the assurance framework need to be added	None	The assurance framework remains under development and will be published separately
5.2.6 a)	Should this be the responsibility of the CCO?	None	The CCO has overall accountability, however, additionally there is an executive lead on the GB for reducing inequality
5.2.7 b)	Should more detail be added re involvement in service redesign/third sector/equality	These areas can be included	Approve Change
6. Decision Making			
Fig 1.	Should the approvals committee be shown as one of a set with the Rem and Audit committees?	None	This has been submitted and discussed at the site visit
6.1	Should there be a formula for	None	This is addressed in the

	patients in the consortia versus seats on the board		memorandum of understanding
6.2.2	Assumed Liberty or Earned Autonomy	Agreed and use one term or another throughout document	Agree Term to use
6.2.2 *final para*	Should it be adverse impact? Should there be an arbitrations process	None	The term ‘adverse’ is open to interpretation. The appeals/arbitration process is detailed in Appendix C (2.3 Pg 62)
6.3.1 e)	The CCG probably needs to elaborate on how this is effectively achieved	Expand as agreed	Agree more detail for this paragraph
6.3.3	Clarification of term ‘collaboration’. Taken from template 6.7.3 Rem Com TOR		
6.6.1	The GB has responsibility for … better to say its functions shall include	None	National template component
6.6.2	The CCG should have some engagement with the LMC	None	There is no statutory requirement for the GB to include an LMC member.
6.6.2	Arrangements for the executive nurse on the board need to be clarified – if the corporate chief officer is to fulfill this role then they should become a voting member		
6.7.4	Remuneration Committee	Agreed TOR to be included	TOR agenda item for 8.1.13 GB
6.7.6	Which members of QPF are permitted to vote	TOR require amendment	Agree Change
6.7.8	Composition of Consortia Boards needs defining	None	This is covered in the terms of reference for each board
6.7.9	QIPP chairs appointment: should we specify that these post will be appointed from April Onwards?	Refer to CSG TOR and amend as necessary	TOR indicate QIPP chairs are appointed for 6 months. TOR not explicit re appointments
6.7.12	Suggest substituting 3x consortia patient reps for 2x non execs		
7. Roles and Responsibilities			
7.1	The CCG needs to make sure they	GP consortium leads requires	There are no practice representatives

	allow for proxies if any practice representative is not present	proxy amendment	on the GB. When a GP lead cannot attend he/she can nominate another consortia board member to deputise
7.2.1	This is very onerous for the chair	None	National Template Component. These roles and responsibilities are defined nationally and are not subject to local change
7.3	What happens if the chair and deputy chair are conflicted?	Amendment required	The remaining GB will need to nominate another temporary chair
7.3.1	Inconsistency between the terms deputy chair and assistant clinical chair. Also 7.10 conflicts this	Consistent usage required 7.10 c) and d) needs amending	Agree amendments
7.7	Agreement required re accountability of chief officers	Clarity required regarding CO line management	Agree amendments
7.8	Agreement required re conflicts of interests given the incumbent is married to a GP	None	This is covered in the register of interests. There is no direct conflict in the roles as described
8. Standards of Business Conduct and Conflicts of Interest			
8.2 a)	Inclusion of words 'any possibility of'	Remove 'any possibility of'	Approve Change
8.2 j)	Agreement required re whether the Approvals Committee should be invoked in all cases where there are GPs making proposals or decisions which might result in payments to themselves or their practices …	To discuss	To discuss
9. The group as an Employer			
No amendments received			
10. Transparency, Ways of Working and Standing Orders			
No amendments received			
Appendix A - Definitions			
No amendments received			
Appendix B - Membership			
No amendments received			
Appendix C- Standing Orders			

Lay Member Tenure	The Lay Member roles are here defined as lasting 2 years with possible continuance, whereas previous guidance has stated 4 years. Could you clarify which is the case?	That the Lay Members role be constant throughout the document	Approve Change
Appointment of Committees and Sub Committees	The CCG has not set out structures for these and the positions. These should be clear		
Vote for chair	Should all GB members get a vote for chair	None	
Mandate for chair	Should all practices have a say who is elected chair	None	
Chair Tenure	Clarify term of office	None	2 years
Future CCO	Clarify eligibility. Is it acceptable to state that the individual must come from a specific consortium?		
Consortium Leads Removal from Office	Agreement required		
Lay members Removal from Office	Agreement required		
Registered Nursed Tenure	Agreement required		
Secondary Care Doctor Tenure	Agreement required		
Secondary Care Doctor Removal from Office	Agreement required		
Chief Officer Appointment	Clarify Appointment Process		
Arbitration/Disputes	Clarify Process		
Extra Ordinary Meetings	Clarify circumstances to call an extra ordinary meeting		
GB GP Numbers needed to be quorate	This will mean if no alliance rep present all GB meetings will be not quorate	Suggest at least 4 GP members from at least two consortia	Agree Change
Suspension of standing orders	Agree if the Audit committee will be responsible for reviewing suspended standing orders		

Appendix D – Scheme of Reservation and Delegation			
Responsibility for preparing the overarching SORD	Should this be the CCO or the Chair?		
Approval of Operating Structure	Should this be the GB?		
SORD / Accountability	Is there enough detail in the SORD regarding accountability?		
IFR	Should there be a limit for individual funding requests?		
Non Elected GB Member recruitment and removal	Should the approval processes for recruiting and removal of non elected members of the GB be carried out by the Chair? Is it not done by the external appointments commission?		
Approving arrangements for FOI, Complaints, Clinical Concerns	Should this be the GB?		
Impact Assessment Tool	Should include: All non elective care issues Revised threshold of £250k Where it would enable greater strategic planning Where any individual consortia requested any item from the three to be discussed		
Appendix E – Prime Financial Policies			
General	More detail required regarding who they are for, who should read them, where they can be found on the website		
Assurance/Risk	More detail required regarding risk assurance and management		
Fraud and Corruption:	Bribery Act	Suggested Amendment: The GB shall ensure that its members and, as far as reasonably practicable the CCG as a whole,	Approve Amendment

		conduct all business with due consideration of general duties and obligations arising from the Bribery Act 2010	
Appendix F- Nolan Principles			
No amendments received			
Appendix G- Key Principles of the NHS			
No amendments received			
Appendix H- Terms of Reference			
Remuneration Committee	Terms of Reference	Agreed TOR for inclusion	Approve Amendment
QPF Committee	TOR 2nd Para	Does this require more definition around which functions may be delegated and within what constraints	
Miscellaneous Comments Received			
Executive Summary	The document is long and user unfriendly … an executive summary is required to point colleagues to more relevant areas … we suggest the summary is kept to a minimum (10pages?)	Executive Summary to be edited once amendments agreed	
Savings Allocations	There was unanimous support from WHCC practices for Option 3 of the paper i.e. all efficiency savings generated across the CCG are returned to the Governing Body for redistribution. Governing Body should retain a 'top-slice' Circa 30%. Savings to be calculated at a practice level but distributed via each consortia. Ideally there would be a recognition for proven effort (ie reduction in activity)		
LMC	The constitution should contain a statement to ensure some sort of		

	engagement with Wirral LMC that will allow for consultation with the LMC on all decisions which affect member practices		
LMC	There should be recognition in the CCG constitution of the LMC being the local representative body of GPs and practices		

Wirral Clinical Commissioning Group

Remuneration Committee Terms of Reference			
Agenda Item:	2.2	**Reference:**	GB12/13-125
Report to:	Governing Body	**Meeting Date:**	8th January 2013
Lead Officer:	Dr Phil Jennings		
Contributors:	Mr James Kay		
Governance:	**Link to Commissioning Strategy**	N/A	
	Link to current governing body Objectives	The remuneration committee is a mandatory requirement for the CCG as part of the Health and Social Care Act 2012	
Summary:	This document is the proposed terms of reference for the CCG remuneration committee. The Governing body is asked to ratify the terms of reference in preparation for authorisation.		
Recommendation:	**To Approve**	√	
	To Note		
	Comments		
Next Steps:	The CCG continues to operate under the terms of the PCT cluster remuneration committee until April 2013. The CCG remuneration committee will be required to meet at least once before this point to agree remuneration awards prior to authorisation.		

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What are the implications for the following (please state if not applicable):	
Financial	The remuneration committee shall be required to determine pay and conditions for CCG employees with reference to the running cost allowance .
Value For Money	The remuneration committee shall recommend pay awards with reference to national pay guidance for specific roles taking into account any local factors that might influence these decisions.
Risk	The CCG is required to maintain its running costs within an agreed allowance
Legal	The remuneration committee is a mandatory requirement of the CCG under the Health and Social Care Act 2012
Workforce	Terms and conditions for staff employed by the CCG shall be determined by the remuneration committee
Equality & Human Rights	N/A
Patient and Public Involvement (PPI)	N/A
Partnership Working	N/A
Performance Indicators	N/A
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	**YES**

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Wirral Clinical Commissioning Group

NHS Wirral Clinical Commissioning Group Remuneration Committee

Draft Terms of Reference

1. Introduction

The Remuneration Committee (the Committee) is established in accordance with NHS Wirral Clinical Commissioning Group's (the CCG) Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the SHA Cluster's Constitution and Standing Orders.

2. Membership

Two Lay Advisors

Governing Body Registered Nurse

Chairman of the Governing Body

The Chair of the Committee will be the lay member with a lead for governance and audit.

Only members of the governing body may be members of the remuneration committee – paragraph 6(4) of schedule 2 only refers to committees or sub- committees other than the audit or remuneration committees.

Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Clinical Chief Officer, a Human Resources representative from the CSU and external advisers may be invited to attend for all or part of any meeting as and when appropriate, however they should not be in attendance for discussions about their own remuneration and terms of service.

3. Secretary

The Chief Operating Officer will make arrangements to ensure that the Group is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and Group members.

4. Quorum

The quorum necessary for the transaction of business is two, one of whom must be a lay advisor.

5. Frequency and notice of meetings

The Committee will meet at least annually and whenever deemed necessary by the Governing Body following the publication of new guidance or a change in circumstances which may affect the remuneration provision.

6. Remit and responsibilities of the Committee

The committee shall make recommendations to the governing body on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the

NHS pension scheme, on the recommendation of the Chief Clinical Officer

The committee will also:

- determine the remuneration, conditions of service and any severance payments of the senior team and members of staff Grade 8 and above as recommended by the Chief Clinical Officer.
- review the performance of the Chief Clinical Officer and determine any annual salary award or severance payments as recommended by the Chair of the Governing Body

7. Relationship with the Governing Body

The minutes of the Committee shall be formally recorded by the Committee Secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Board, or require executive action.

The Committee will produce an annual report on the decisions it has taken and submit for the Board's consideration.

8. Policy and best practice

The Committee will:

- comply with current disclosure requirements for remuneration;
- seek independent advice about remuneration for individuals when necessary
- ensure that decisions are based on clear and transparent criteria

The Committee has full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

9. Conduct of the Committee

When discharging functions delegated to it by the Governing Body the committee and its individual members must:

- comply with the Group's principles of good governance
- operate in accordance with the Group's scheme of reservation and delegation
- comply with the Group's standing orders
- comply with the Group's arrangements for discharging its statutory duties
- where appropriate, ensure that member practices have had the opportunity to contribute to the Group's decision making process

[Date Agreed]

Wirral Clinical Commissioning Group

<table>
<tr><th colspan="5">Authorisation Report from site visit 13th December 2013</th></tr>
<tr><td>Agenda Item:</td><td>2.4</td><td>Reference:</td><td colspan="2">GB12/13-127</td></tr>
<tr><td>Report to:</td><td>Governing Body</td><td>Meeting Date:</td><td colspan="2">8th January 2013</td></tr>
<tr><td>Lead Officer:</td><td colspan="4">Lorna Quigley</td></tr>
<tr><td>Contributors:</td><td colspan="4"></td></tr>
<tr><td rowspan="2">Governance:</td><td>Link to Commissioning Strategy</td><td colspan="3"></td></tr>
<tr><td>Link to current governing body Objectives</td><td colspan="3">To become a statutory organisation in April 2013, the CCG has to undergo a process of authorisation.</td></tr>
<tr><td>Summary:</td><td colspan="4">The paper outlines the outcome of the authorisation visit of the 13th December 2012, describes the next steps of the process and seeks the Governing Body’s approval for the action plan that has been developed in response to the report.</td></tr>
<tr><td rowspan="3">Recommendation:</td><td colspan="3">To Approve</td><td>x</td></tr>
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<tr><td>Comments</td><td colspan="3">Further information on the recommendation if necessary ie. if there are specific items to approve/note in addition to the report itself</td></tr>
<tr><td>Next Steps:</td><td colspan="4"></td></tr>
</table>

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):		
Financial	None identified within the paper.	
Value For Money	None identified within the paper.	
Risk	If the action plan is not agreed and implemented, there will be a risk of the CCG not becoming an authorised organisation in April 2013.	
Legal	The report is based on the requirements laid out in the Health and Social Care Act 2012.	
Workforce	Some of the actions identified within the action plan will develop the skill set of the Governing Body.	
Equality & Human Rights	Some of the key pieces of work identified within the plan will ensure that inequalities and human rights are addressed.	
Patient and Public Involvement (PPI)	Some of the key actions to be undertaken within the plan will build upon and improve patient and public engagement.	
Partnership Working	The report has identified some areas of development regarding partnership working. The action plan would strengthen this.	
Performance Indicators	The action plan includes timeframes which will be monitored by the Area Team to ensure compliance by April 2013.	
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - [Freedom of Information Exemptions]*		✔

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) 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. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

Authorisation Report
From the site visit 13th December 2012

1. Purpose

The purpose of this report is to inform the Governing Body of the content of the assessment report from the expert panel site visit held on the 13th December 2012, the next steps within the process and agree the action plan.

2. Introduction/context

Following the desktop exercise that was undertaken in November of the 119 key areas that all Clinical Commissioning Groups are assessed against, 61 areas were rated green and 58 rated red. The red areas were formulated into key lines of enquiry for the site visit and focussed on:

- Health inequalities and engagement
- QIPP and Financial planning
- Governance
- Quality and Safeguarding
- Clear and credible plans
- Organisational development

3. Position

During the period of the site visit, the expert panel assessed the evidence submitted and the responses given in the key lines of enquiry and rated the CCG as having 99 Greens and 20 reds.

In summary the report advised:

The CCG had spent time on agreeing its membership and acknowledged the work that has been undertaken in bringing the three pathfinders together. In view of this, progress on documentation and integration is not as advanced as other CCG's. Now the Governing Body is appointed, the hard work can continue, to achieve authorisation.

3.1 Notable areas of strength where also identified and included:

- The Approvals Committee demonstrates good practice and rigour with potential conflicts of interests; in addition to identifying innovation across the CCG.

- The mission and vision has been developed using an intensive process and the Governing Body can explain why each word was used.

- There is good patient engagement and the in-touch website is used daily for comments, complaints and concerns.

- The good working relationship with the Commissioning Support Unit, and the clarity regarding what services are required.

- The full appointment of the Governing Body.

- Members of the CCG have a good track record of delivery.

3.2 There are some remaining gaps areas for development that the CCG need to achieve for authorisation.

- The need for an integrated plan, which is based on the joint health and wellbeing strategy and joint strategic needs assessment.
- Provide evidence to demonstrate how QIPP plans have changed from PCT plans.
- The mission, vision and value needs to be communicated to the public.
- The publication of the complaints policy on the CCG website.
- The development of processes and policies including: an early warning system for failing services, risk sharing agreements with other parties, an assurance framework.
- A skills audit to be undertaken with the Governing Body members which will provide members with an individual plan.
- Agreement and amendments to the constitution including working with the HWB and NHSCB.

3.3 Some areas for development beyond authorisation requirements were advised;

- The CCG would benefit from greater involvement with a wide range of health and social care professionals to gain insights and skills.

- The engagement would be strengthened by developing systems for linking engagement to priorities.

- The need to work with other CCGs to assist with large scale change and greater patient choice.

- The CCG may want to review their election to the Governing Body so that they can assess the competencies of future members.

- The CCG should consider having an on-going review of their organisational design to ensure it is fit for purpose, and may benefit form additional support to do this.

4. Next steps

The CCG has been given an opportunity to comment on the report regarding factual accuracy and any other comments. This will be used to develop the Final Evidence Report that will go forward to the authorisation decision making process.

A proposed action plan has been developed to address the requirements identified in the outstanding issues, including timescales. This is to be submitted to the National Commissioning Board on 2nd January 2013. (Appendix 1)

5. Recommendations

The Governing Body is asked to note the contents of the paper, and approve the action plan.

Outstanding Issues from Site Visit				
Threshold for Authorisation	**Rationale for red rating and distance from threshold**	**Outstanding Issues (including CCG's proposed plan and timescale to meet requirements, if applicable and discussed at site visit)**	**Action**	**Action By/Date**
1.2 - C	The constitution contains a list of member practices who will sign up to the constitution. -- At site visit, the CCG suggested that the constitution is out for consultation and so is not yet finalised. Only after it has been finalised can it then be signed off by the member practices as per the submitted list - then the threshold can turn back to green.	The constitution is out for consultation and so not yet finalised. Once this has been done it can be signed off and turned back to green.	Sign off required	4/02/13 member practices
1.4.1 - A	The CCG has presented its vision and priorities to the Health and Wellbeing Board but further evidence is required to show communication with local authority partners and clear joint planning. -- At site visit the CCG stated that it regularly attends the Health and Wellbeing Board It has not yet developed its own plan so it can not demonstrate joint planning with the LA.	Further evidence is needed of communication with local authority partners and clear joint planning.	Alignment with HWB prioritsion plans. Stakeholder event to launch plan.	Gov Body Jan/Feb 13
1.4.1 - B	It is unclear how far the CCG has gone yet to engage widely as their plan is going to the board for approval at the end of October. --- At site visit the CCG could not demonstrate how the CCG's vision and mission is communicated to the public.	The CCG has clearly outlined its vision in its "Engagement and Communication strategy", however further clarification is needed to confirm how that vision has been communicated to stakeholders, patients and the public.	Communications Strategy to go out to stakeholders for comments	LQ January 2013.

2.1.1 - B	The CCG plan to rely heavily on analysis in order to identify the health needs of constituent communities and groups. As yet the analysis has not taken place due to the local timeframe. -- At site visit the CCG does not yet have an agreed integrated plan and the panel did not have sight of the draft plan to identify if they have addressed the issues in the JSNA.	Further evidence is required to show a detailed analysis of JSNA priorities in the operational plan or commissioning intent, including children and young people, learning disabilities, drug use as reflected in the JSNA evidence.	Align plan with JSNA. Recheck aligment with JHWS following prioritisation exercise	MB Dec 2012 February 2013.
2.1.2 - C	The production of JHWS is not until January 2013 therefore there is no evidence to asess. There is a lack of detail in the op plan of alignment with JSNA priorties although the commissioning intent does outline some of the JSNA commissioning priorties intent by the CCG which demonstrates CCG intention to have intergrated commissioning. --- At site visit the CCG still does not have a JHWS.	The JHWS is being produced in January 2013 so currently the CCG does not meet the threshold.	Dependant upon the JHWS	HWB January 2013.
2.4.2 - B	While the CCG shows awareness of a clear and transparent complaints policy, further clarification is required to confirm how actions taken as a result of complaints are communicated to the public. --- At site visit the CCG stated that the complaints policy is not on their website.	The CCG needs to publish their complaints policy on their website.	publish complaints policy	CSU Jan 2013

3.1.1 - B	The CCG has provided an Operational Plan for 12/13 which includes a section on finance. There is however no reference to the the NHS Outcomes Framework, the Commissioning Outcomes Framework or the Mandate. Further information is required. --- At site visit the CCG does not have its own CCG integrated plan as it is currently continuing with the PCT plan.	Further evidence is required to demonstrate how the health system will be improved in 14/15. Further evidence is required to show that the CCG has triangulated workforce, activity and finance in its plans. Further evidence is required to show that the CCG has taken in to account headroom in to its QIPP planning. Further information is required to clarify the end state that the CCG is aiming to achieve and how it will be achieved. Further information is required to demonstrate stakeholder sign up to the plans and in particular, how the CCG is working with neighbouring CCGs to deliver QIPP. Further evidence is required to demonstrate how the relevant 13/14 national requirements will be met by the plan	Check/refresh Gannt chart for strategic plan	GB March 2013
3.1.1 - C	The Headline Financial Plan sets out a high level financial plan for the years 13/14 and 14/15. The plan is based on delivering financial balance but is lacking in detail, particularly around QIPP plans. The plan sets out the an indicative running cost allowance but does not provide any evidence that the CCG will be able to work within the budget set. --- At site visit the CCG did not have its own financial plan, as it is using the PCT plan. There is no evidence that this plan has been refreshed. There is evidence of the running costs that are within the envelope.	Further information is required to demonstrate that the CCG has taken all factors (including cost pressures, contingencies etc) into account in framing the financial plan. The CCG needs to provide a draft financial plan which is linked to their intergrated plan.		Mar-13

3.1.1 - D	QIPP is integrated into the headline financial plans for 13/14 and 14/15 but there is no evidence to support the development of QIPP plans being integrated into individual provider contracts. -- At site visit the CCG has not completed its own plans and did not articulate why the QIPP target has increased or what changes it plans to make.	Further detail is needed on the QIPP plans to demonstrate that they have been integrated into service and provider based contracts	Process to be imbedded into contracts with plans and montioring against theses	Chief Officers. March 2013
3.1.1 - E	The CCG has identified the need for integrated plans and integrated commissioning. However, the JHWS is currently under development and the first draft is not due for publication until January 13. -- At site visit the CCG does not have its own plan or a JHWS so can not meet this threshold.	Further evidence is required to demonstrate that the CCGs plans support the delivery of the JHWS and integrated commissioning.	Plan and Gannt chart to refelct process	Jan/Feb 2013
3.1.3 - A	Most of the priorities are high level statements of intent and do not amount to clear commissioning plans linked to a JSNA or ASR review priority. Further evidence is required to demonstrate that there is a golden thread between the JSNA priorities and commissioning intentions. -- At site visit the CCG demonstrated how it had used the JSNA in previous plans and are continuing the work, however its plans have not been agreed and there was no evidence of commissioning intentions.	Further evidence is required to demonstrate that there is a golden thread between the JSNA priorities and commissioning intentions/plans.	Development of Commissioing intentions based on JSNA	Chief Offcers. March 2013

4.2.1 - A	The multitude of responsibilities for QIPP delivery could lead to confusion and the role of each group in QIPP delivery needs to be clarified. --- At site visit the CCG stated that risk is a standing agenda item on all their committees. There is a risk register for each consortia and these are fed into a central risk register. QIPP risks are presented and discussed at the QP&F committee. However the CCG does not yet have an assurance framework.	The CCG needs to provide evidence of an assurance framework.	Assurance framework to be developed	MB/ JK/MIAA. February 2013
4.2.1 - E	The SLA with the CSU contains details of a core offer and additional services that could be available to support the CCG including "design and implementation of early warning systems..." however, it is not clear whether this offer is part of the SLA. --- At site visit the CCG could not give sufficient evidence of a systematic and proactive process to identify early warnings of a failing service.	Further evidence is required to show that the CCG has arrangements in place to proactively identify early warnings of a failing service, including the support arrangements with the CSU.	process to be developed with the CSU to reflect this	LQ February 2013.

4.2.1 - G	Further evidence is required to demonstrate that the CCG has arrangements for the provision of internal and external audit services and that there are arrangements for carrying out financial reporting through financial spine services. Further evidence is required to demonstrate that the CCG has arrangements for the management of any charitable funds and that the CCG has arrangements for the provision of counter fraud services. Further evidence is required to demonstrate that the CCG has arrangements for the provision of payroll and banking facilities services and what, if any, risk sharing arrangements are in place with other CCGs. --- At site visit the CCG stated that there was no risk sharing arrangements with other CCGs in place. Evidence was provided for the other issues.	Further evidence is required to demonstrate that the CCG has arrangements for appropriate risk-sharing with other CCGs.	Risk sharing agreement to be expolored/developed with other CCG's	MB. February 2013
4.2.3 - B	The CCG has clearly been involved in the strategy for developing a Wirral JHWS, the first draft being produced by January 2013. Therefore, given that the JHWS has not yet been produced, the CCG has not yet been able to identify opportunities to reduce inequalities. --- At site visit the CCG stated that the JSNA identified issues with older people. An example was given of how it has provided health checks for males over the age of 50 and addressed the diabetes issues for the Chinese and Bangladeshi communities. However there is not yet a JHWS or integrated plan to meet this threshold.	Further evidence is required to demonstrate how the CCG has used the JHWS to identify opportunities to reduce inequalities	Development of the plan following the JHWS prioritisation process	HWB Feburay 2013.
4.2.3 - C	Further information is required to show how the demographical insights are feeding in to the integrated plan and shaping decisions made by the CCG. --- At site visit the CCG had not agreed its own integrated plan.	Further information is required to show how this insight is feeding in to the integrated plan and shaping decisions made by the CCG.	included in the plan	February 2013.

5.2 - C	Further evidence is required to demonstrate an understanding of accountability and decision making processes in the HWB. This could come from attaching a copy of the HWB Terms of Reference. -- At site visit the CCG stated the Terms of Reference have only just been agreed. The CCG needs to provide evidence of this agreement, and this needs to be reflected in the constitution.	Further evidence is required to demonstrate an understanding of accountability and decision making processes in the HWB. This could come from attaching a copy of the HWB Terms of Reference.	Amendments made to the Constitunion to relfect this	February 2013.
5.4 - D	At site visit the CCG did not have a plan for commissioning beyond 2013/14.	Further evidence is required from the OD Plan to demonstrate that the CCG has plans in place for formally procuring any commissioning support services, to ensure that between 2013-16 it puts in place the arrangements to go through a compliant procurement process.	more work required in OD plan to reflect this.	March 2013.
5.5 - B	Whilst the constitution states that the CCG will work with the NHS CB to improve the quality of primary care services, further evidence is required to show that there is a mechanism for working in partnership with NHS CB. -- At site visit the CCG had not amended their constitution and the constitution is still out to consultation.	Further evidence is required to show that there is a mechanism for working in partnership with NHSCB to improve quality of specialised services. Constitution needs to be amended to include this.	Amendments made to the Constitunion to relfect this	COMPLETED
6.4 - E	At site visit the CCG stated that it plans to do a skills audit but this has not yet started.	Further evidence is required from the OD Plan to demonstrate that the CCG has assessed the skills possessed by governing body members and has a plan to build governing body competencies/skills where required.	to be reflected in the OD plan	February 2013.

Wirral Clinical Commissioning Group

Clinical Chief Officers Report

Agenda Item:	3.1	**Reference:**	GB12/13-128
Report to:	Governing Body	**Meeting Date:**	8th January 2013
Lead Officer:	Abhi Mantgani		
Contributors:	Lorna Quigley		
Governance:	**Link to Commissioning Strategy**		
	Link to current governing body Objectives		
Summary:	. This report undertakes to provide an overview of important clinical commissioning group business which has not been provided in other papers to the Governing Body.		
Recommendation:	**To Approve**		
	To Note	x	
	Comments	The governing body is asked to note the contents of this report.	
Next Steps:			

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	Not applicable
Value For Money	Not applicable
Risk	Not applicable
Legal	Not applicable
Workforce	Not applicable
Equality & Human Rights	Not applicable
Patient and Public Involvement (PPI)	Not applicable
Partnership Working	Not applicable
Performance Indicators	Not applicable
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step

Private Business

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If you require any additional information please contact the Lead Director/Officer.

Wirral CCG
Clinical Chief Officer's Report
January 2013

Purpose

The purpose of this report is to provide an update to the Governing Body with regard to national policy, local developments and the progress to date made by the CCG, that has not been provided in other papers to the Governing Body.

Department of Health Review: Winterbourne View Hospital

The final report into the events at Winterbourne View Hospital was published on 10th December, and has set out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice.

The programme of action includes:

- by spring 2013, the Department of Health will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide
- by June 2013, all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014
- by April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice

As a consequence, there will be a dramatic reduction in hospital placements for this group of people the Care Quality Commission will strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families a new NHS and local government-led joint improvement team will be created to lead and support this transformation.

This programme is backed by a concordat signed by more than 50 partners, setting out what changes they will deliver and by when. The government will publish a progress report on these actions by December 2013.

The final report into the events at Winterbourne View Hospital states that staff routinely mistreated and abused patients, and management allowed a culture of abuse to flourish. The warning signs were not picked up, and concerns raised by a whistleblower went unheeded.

The report also reveals weaknesses in the system's ability to hold the leaders of care organisations to account. In addition, it finds that many people are in hospital who don't need to be. People with learning disabilities or autism, who also have mental health conditions or challenging behaviour can be, and have a right to be, given the support and care they need in the community, near to family and friends. The Clinical Commissioning Group will be considering the implications of this report via its joint commissioning arrangements with Wirral Borough Council and will need to implement local actions which will include:

• no one is sent out of area inappropriately into in-patient services for assessment and treatment;

• people can move on from these services quickly to more appropriate care;

• for the small number of people for whom in-patient services may be needed for a short period, the focus is on providing good quality care, as locally as possible and moving on to more appropriate settings as quickly as possible;

• engaging people with learning disabilities and their family carers in developing person-centred approaches across commissioning and care;

• build understanding of the reasonable adjustments needed for people with learning disabilities who have a mental health problem so that they can make use of local generic mental health beds;

• commission the right model of care to focus on the needs of individual people, looking to avoid the factors which might distress people and make behaviours more challenging, building positive relationships in current care settings;

• focus on early detection, prevention, crisis support and specialist long term support to minimise the numbers of people reaching a crisis which could mean going into hospitals;

• work together to plan carefully and commission services for the care of children as they approach adulthood to avoid crises;

• commission flexible, community-based services.

The CSU on behalf of the CCG completed the annual self–assessment which benchmarked the CCG's progress against some of the actions above. This was verified by the NHS North West and has shown there are gaps in services that are provided. A comprehensive action plan is being developed in order to ensure that the deficits are addressed.

Proposals for Learning Disabilities Services

Cheshire and Wirral Partnership Trust (CWP) has notified the CCG of its intention to go to formal consultation in relation several proposals for Learning Disabilities services. In order to meet its Cost Improvement Programme, and to bring services in line with national requirements, particularly following the Winterbourne view report, the principal changes that the Trust is proposing are to:

- reconfigure its community teams in terms of bases and skill-mix
- reduce the provision of bed based in-patient services. In the short term, this would include closure of the assessment and treatment unit, Kent House

The consultation is due to commence on the 9th January, with CWP due to present to the CCG on the 8th January.

Community Mental Health Team proposals

Following the public consultation around proposals to reconfigure Community Mental Health Teams, the results have been evaluated by Liverpool John Moores University, and the Trust is working on an implementation plan. The principal change proposed is to move towards a recovery-focussed model and case management, which involves a reduction in senior clinician time, and discharge of clients where ongoing clinical input is no longer appropriate. The CCG is currently reviewing the outcome of the evaluation to ensure the proposed service will continue to meet commissioner requirements and provide the same high quality outcomes.

Patient and Public Involvement

The CCG has been engaging in a number of ways including:

Advertorial was placed in the Wirral Globe December, there is another planned for the New Year.

Stakeholder event held 5th December attended by 40 delegates ranging which included statuary organisations and voluntary community and faith groups.

Consortia Patient Participation Groups: these groups continue to meet regularly. Several activities have taken place over the past month, including:

- WGPCC working with its Patient Council members to develop a campaign to reduce wasted appointments
- Chief Executive of Wirral NHS Community Trust attended the last meeting of the WGPCC Patient Council to listen to patients' views on services delivered by the Trust. A senior representative of Wirral Hospital Trust is due to attend its January meeting.
- WHCC patient Forum meeting took place on Tuesday, 4th December 2012. This meeting included a presentation on commissioning and an update on projects such as Pathways to Life. A member of the Patient Forum has agreed to participate in the Programme Board of the Pathways to Life Project, with the first meeting having taken place on 20th December. The next meeting of the Patient Forum is on the 8th January 2013.
- The Alliance Patient Engagement Group is now well-established with regular attendance at the monthly meetings of 2 patients per practice - they are currently reviewing their terms of reference as they continue to increase their understanding of the commissioning agenda and how they want to be involved to support decisions; they are also working with the Alliance management team on what they want on their agenda, i.e. presentations; information provision; feedback from practice patient groups etc.

Each Consortium is working to promote involvement and engagement beyond its groups. This includes the use of postcards called 'Your GP Needs You', specifically designed to capture patient contact details and promote different ways of getting involved.

The CCG is exploring different media in order to communicate with patients and public. This has included social media with the development of a twitter account.

The draft constitution has been put onto the CCG website to give members of the public the opportunity to comment, in addition to it being sent to stakeholders. Four comments have been received via the in-touch website.

Increased access to Unplanned Care

Two of the Consortia are using their commissioning resources to provide additional access to unplanned care within general practice. This includes Urgent Care models at 4 Alliance practices to test out different ways of influencing patient behaviour to attend General Practices instead of hospital, for non-emergency attendances. WGPCC has expanded its number of Minor Injury and Illness Services to include bases at Moreton Health Clinic, Kings Lane MC, and Holmlands MC. Both Consortia developments will hopefully reduce inappropriate hospital attendances and increase patient access.

Service Developments

In order to improve quality of care and facilitate access, a new service specification has been developed for podiatry and orthotics. Following the successful of moving its physiotherapy services to an AQP contract, in vastly improving access and reducing waiting times, WGPCC is also planning to procure the podiatry element of the specification via an AQP process. This will ensure value for money, as the resources follow the patient, and enable alternative providers to deliver services to patients.

A shared care model for alcohol is being rolled out across Wirral practices, with CWP supporting each practice with a named link for patients with alcohol issues. This scheme will be evaluated during this quarter to determine the impact upon A&E and improvement in patients' health.

The shared care model for dementia care is now in place, with the Memory Assessment Service discharging patients into primary care once the patient has been assessed, diagnosed and stabilized on any medication. The next step is to model this change in pathway on capacity and demand to ensure that the service has sufficient capacity to see new patients as quickly as possible. A dementia strategy is being developed which we hope to consult on and launch to the public in Spring 2013.

Meetings attended by Senior Management team members

Health and Wellbeing Board - This was attended by the Chief Clinical Officer and one of the Consortia Chairs. A review of the membership is being undertaken. The results of the prioritisation exercise were presented.

The Chair and the Chief Officer of WHCC have both participated in authorisation site visits in Hastings and Teesside. This provided the CCG with useful insight into how the panel would operate and what was required of the CCG to facilitate a smooth visit.

The Corporate Chief Officer and WGPCC Commissioning Manager attended a joint LINks and Older People's Parliament coffee morning event which was looking at the issues relating to discharge from WUTH. This was also attended by the CEO of WUTH and its Director of Nursing.

Recommendations

The board is asked to receive this report and note the contents.

Dr Abhi Mantgani
Chief Clinical Officer

Wirral Clinical Commissioning Group

Everyone Counts: Planning for Patients 2013/14 CCG Requirements and Timelines			
Agenda Item:	3.2	**Reference:**	GB12/13-129
Report to:	Governing Body	**Meeting Date:**	8th January 2013
Lead Officer:	Alex Dalgarno		
Contributors:			
Governance:	**Link to Commissioning Strategy**	Guidance will be reflected in the Commissioning Strategy.	
	Link to current governing body Objectives	Underpins Governing Body objectives.	
Summary:	The NHS commissioning Board published its planning guidance, "Everyone Counts: Planning for Patients", on 18 December 2012. This paper outlines the main points and the timelines and requirements placed upon the CCG from this guidance.		
Recommendation:	**To Approve**		
	To Note	✓	
	Comments		
Next Steps:			

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	None. Paper reflects National planning guidance only.
Value For Money	Paper reflects National planning guidance only
Risk	Paper reflects National planning guidance only
Legal	Paper reflects National planning guidance only
Workforce	Paper reflects National planning guidance only
Equality & Human Rights	Paper reflects National planning guidance only
Patient and Public Involvement (PPI)	Paper reflects National planning guidance only
Partnership Working	Paper reflects National planning guidance only
Performance Indicators	Paper reflects National planning guidance only
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This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**

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2013/14 Planning Paper Process

Introduction

On 18th December 2012, the NHS Commissioning Board published its planning guidance for 2013/14. Called 'Everyone counts: Planning for Patients 2013/14', the document outlines the incentives and levers that will be used to improve services.

This paper summarises the key points and details the planning timetable to the end of May 2013.

Key Headlines

The approach set out in this planning framework is aimed at securing three important objectives:

- balancing change and continuity: as 2013/14 sees widescale organisational change at a time of increasing financial pressures;
- making assumed liberty a reality through creating the time and space for clinical commissioning groups to drive local health priorities within a framework driven by Health and Wellbeing Boards;
- balancing annual requirements with the longer term: to assure ourselves that the health service is sufficiently robust to deal with the challenges of increasing demand when limited resource growth is likely to be a feature for several years ahead.

The principles behind the new approach to planning clinical led-commissioning from April 2013 are stated as:

- empowered local clinicians delivering better outcomes;
- increased information for patients to make choices;
- greater accountability to the communities the NHS serves.

The document notes that the new arrangements offer local communities their first ever opportunity to "drive NHS planning." The Board emphasises that it "will not second-guess local priorities" and points to Health and Wellbeing Boards as offering "a dynamic environment." However it is suggested that a "robust, joined-up approach" towards local planning should incorporate the following:

- involvement of all partners;
- comparison with other areas on outcomes indicators;
- identification of those "getting a raw deal from health and care";
- community engagement;
- development of priorities based on outcomes and groups that require the most support;

- integration of commissioning budgets where appropriate;
- contractual alignment; and mutual accountability.

“Offers”

The guidance sets out five "offers" from the Board to support commissioners to produce better health outcomes:

- seven day working
- more transparency and choice
- listening to patients and increasing their participation
- better and more consistent data
- safer care.

Outcomes

The Board has developed a Clinical Commissioning Group Outcomes Indicator Set, which includes NHS Outcomes Framework indicators that can be measured at clinical commissioning group level and additional indicators developed by NICE and the Health and Social Care Information Centre. These indicators were published alongside the guidance.

The document reiterates the top-line areas identified across the five domains in the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The guidance states that within each of these domains, tackling health inequalities and being focused on advancing equality will drive everything we do. Each domain will address inequalities so that those most in need have most to gain from the interventions we make. It is highlighted that attainment against NHS Constitution waiting times rights and pledges will form an integral element of quality premium payments. The document then outlines a number of areas where improvements are expected:

- "Zero tolerance" of referral to treatment (RTT) periods exceeding 52 weeks, with contractual fines issued in such circumstances.
- To support greater achievement of 18 week RTT,
- All handovers between an ambulance and A&E should occur within 15 minutes,
- No patient should be waiting on a trolley in A&E for longer than twelve hours.
- No patient should suffer two cancellations of an urgent operation.
- CCGs should ensure full roll-out of improving access to psychological therapies (IAPT) by 2014/15, with a recovery rate of 50 per cent also expected.

Tools and Levers

- Only one-fifth of payments for Commissioning for Quality and Innovation (CQUIN) payments are tied to national objectives.

- Quality Premiums will be paid in 2014/15 to those CCGs that "improve or achieve high standards of quality" in the four measures identified in the NHS Outcomes Framework during 2013/14. The Premium will also incorporate three local measures, agreed with the Board and in each case underpinned by robust data. (CCGs will be ineligible for a Premium if they have overspent against their approved Resource Limit during 2013/14 or if they have failed to achieve NHS Constitution pledges and rights).

- CQUIN payments will only be issued to those providers meeting at least the minimum requirements in Innovation, Health and Wealth.

Finances – Key Points

- Each commissioning organisation should plan to make a cumulative surplus at the end of 2013/14 of at least 1 per cent of revenue, including any historic surplus not drawn down. This surplus will be carried forward into 2014/15.

- Commissioners should plan to be in 2 per cent recurrent surplus by the end of 2013/14; further guidance on this will be published in January. Clinical commissioning groups (CCGs) will be expected to ringfence these funds and only make expenditure commitments against them which are non-recurrent and are approved by the Board's Local Area Teams.

- In addition, CCGs are asked to hold a contingency of at least 0.5 per cent of revenue within their plans to mitigate risks within the local health economy.

- Primary care trust accumulated surpluses up to the level of the 2012/13 operating plans will be attributed to individual CCGs and direct commissioning units in proportion to the final 2012/13 baselines.

- The national provider efficiency requirement for 2013/14 tariff setting is 4 per cent. This is a net adjustment of -1.3 per cent, once offset against estimated cost inflation of 2.7 per cent. This is also the base assumption for discussions about prices for off tariff services.

- The 30 per cent marginal tariff for non-elective admissions will continue, with the 70 per cent balance spent locally in relevant demand management schemes, jointly owned by commissioners and providers.

Planning Timetable

Date	Activity
w/c 17 December 2012	Allocations published. Planning guidance published. Draft supporting information published. Draft NHS Standard Contract published.
25 Jan 13	CCGs to share first draft of plans with Area Team Directors to include: •“Plan on a Page” including (i) key elements of transformational change; (ii) key risks; (iii) confirmation that national requirements will be met; •trajectories on relevant measures in Section 2 plus three local priorities; •activity plans–summary at commissioner level; •financial information
By 8 Feb 2013	Area Directors to provide feedback to CCGs.
11 Feb - 29 Mar 2013	Discussions to support Area Team Director assurance of plans
31 Mar 2013	CCG contracts signed off.
5 April 2013	Final CCG plans shared with Area Team Director.
8 April - 19 April 2013	Board analyses CCG plans and plans for direct commissioning with a view to identifying risks to delivery.
22 April – 10 May 2013	Board confirms that plans add up to a position that delivers the mandate and improves patient outcomes within allocated resources
By 31 May 2013	Each clinical commissioning group publishes its prospectus for its local population

Recommendation

The Governing Body is asked to note the key points from the 2013/14 Planning Guidance and the required planning timetable.

Wirral Clinical Commissioning Group

Financial Planning Assumptions 2013/14 Financial Year			
Agenda Item:	3.3	**Reference:**	GB12-13/129
Report to:	Governing Body	**Meeting Date:**	8th January 2013
Lead Officer:	Mark Bakewell		
Contributors:			
Governance:	**Link to Commissioning Strategy**	Sound financial control is essential to the CCG strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year.	
	Link to current governing body Objectives	To achieve financial control total with sound financial management.	
Summary:	This report updates the CCG on the financial planning assumptions contained with the NHS CB planning guidance (Everyone counts: Planning for Patients 2013/14)		
Recommendation:	**To Approve**		
	To Note	✓	
	Comments		
Next Steps:	Full Financial plan to February Governing Body Meeting		

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What are the implications for the following (please state if not applicable):	
Financial	The report sets out the financial planning assumptions for the CCG for 2013/14 financial year
Value For Money	All expenditure plans are subject to an ongoing value for money review
Risk	Work is still being undertaken to assess risks of new financial allocation and expenditure plans
Legal	Legal advice is sought on financial issues as and when required.
Workforce	The financial plan includes budgeted "running costs" expenditure and is reflective of the respective workforce implications in these areas
Equality & Human Rights	Financial Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure
Patient and Public	Budgets include funding to ensure continued involvement of patients and public in CCG decisions.

Involvement (PPI)	
Partnership Working	The CCG works with a number of NHS Trusts and the Local Authority on a number of its commissioning budgets.
Performance Indicators	The plan reflects the planned achievement of statutory financial duties.
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - [Freedom of Information Exemptions]*	

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Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**

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NHS Wirral Clinical Commissioning Group

Updated Financial Planning Assumptions 2013/14

Introduction

1. This report sets out the headline financial planning assumptions for NHS Wirral Clinical Commissioning Group based on the NHS Commissioning Boards Planning Guidance (Everyone counts: Planning for Patients 2013/14) released late in December 2012

2. A full and comprehensive financial plan will be submitted to the CCG's February Governing Body as there are a number of queries outstanding with regards to the expenditure requirements given the new system from April in particular regarding Specialist Services.

Financial Allocation

3. The financial allocation for NHS Wirral Clinical Commissioning Group for the 2013-14 financial year is as follows (with notes as appropriate for each of the adjustments

	£ million
PCT Baseline (CCG Element exc Running Cost)	£463.155
Less Specialised Services Adjustment *1	(£25.154)
Less PCT 2% Headroom Adjustment *2	(£2.842)
Adjusted CCG Baseline	£435.159
2.3% Uplift	£10.009
2013-14 Revenue Allocation (Commissioning)	**£445.168**
2013-14 Running Costs Allocation	**£8.000**
2013-14 Total Recurrent Resource Allocation	**£453.168**

Headline Requirements

4. Each commissioning organisation should plan to make a cumulative surplus at the end of 2013/14 of at least 1 per cent of revenue, including any historic surplus not drawn down. This will be carried forward into 2014/15.

5. A key measure of financial resilience of the organisation will be the recurrent, or underlying, financial position after stripping out non-recurrent income and expenditure. Commissioners should plan to be in 2 per cent recurrent surplus by the end of 2013/14

6. In 2013/14, there is a requirement across all commissioning organisations to set aside 2 per cent of funding for non-recurrent expenditure. Clinical commissioning groups are expected to ring fence these funds and make expenditure commitments against all or part of them only following appropriate approval via NHS Commissioning Board Area Teams

7. Clinical commissioning groups are asked to hold a contingency of at least 0.5 per cent of revenue within their plans to determine locally the contingency required to mitigate risks within the local health economy. This is in addition to 2 per cent ring fenced non-recurrent funds

8. The financial values associated with these planning requirements are as follows

	£ million
Pt 4 Surplus (at least 1% of revenue)	(£4.452)
Pt 5 Recurrent Surplus (2% Headroom)	(£8.903)
Pt 6 Non-Recurrent Expenditure	£8.903
Pt 7 Contingency (at least 0.5%)	£2.226

Historical surpluses and deficits

9. Ownership of historical surpluses and deficits at 31 March 2013 will see Primary Care Trust accumulated surpluses up to the level of the 2012/13 operating plans attributed to individual clinical commissioning groups and direct commissioning units in proportion to the final 2012/13 baselines. Strategic Health Authority surpluses will be managed at a national level. Any 2012/13 deficits will also be the responsibility of relevant clinical commissioning groups and direct commissioners.

10. The maximum expected level of the national surplus drawdown will be finalised with the Department of Health by the end of April 2013. Commissioners are asked to include proposals for access to historical surpluses, if required, in their operating plans.

11. The plans will be assessed with reference to the impact on outcomes and subject to the maximum drawdown available. Any surplus drawdown will be deployed across three areas:
    - Clinical commissioning group allocated share of drawdown;
    - Direct commissioning; and
    - System requirements including existing Strategic Health Authority commitments.

12. Wirral Primary Care Trust is currently forecasting a £3.088m underspend against its resource limit for the 2012-13 financial year (in line with its SHA Control Total).

13. It is reasonable to assume that if national surplus drawdowns are available then the CCG may receive a further £2.3m in non-recurrent resource (75% of the PCT share) which in line with the above will need to develop some proposals to access the available funding.

14. Wirral Primary Care Trust also placed a lodgement of £13.9m with the Strategic Health Authority for the 2012/13 financial year as per regional system requirements. In light of the above and again subject to national availability it is reasonable to assume the CCG may receive a further £10.4m of non-recurrent resource (75% assumption)

Other Allocations

15. Funding for social care transfer to local authorities will be paid directly by the NHS Commissioning Board but Local Authorities will be required to work with CCG's via

health and Wellbeing Boards to agree how the funding is used for maximum impact (£859m nationally in 2013/14 and £900m in 2014/15)

16. Funding for re-ablement, the overall provision will remain at same levels (£300m nationally). Both the administration and management will reside with the CCG, including the decision on how/ if to be provided via local authorities

2013-14 Financial Resources Summary

Recurrent

Programme Budgets	£445.168m
Running Costs	£8.000m
Total	**£453.168m**

Non-Recurrent

Programme Budgets	
Return of PCT surplus (share of)	£2.316m
Return of PCT lodgement (share of)	£10.434
Total	**£12.750m**
2013-14 Resource Available	**£465.918m**
Less Surplus Required (1%)	(£4.452m)
2013-14 Expenditure Budgets	**£461.466**

Recurrent Expenditure Budgets	
Programme Budgets *1 / *2	£431.813m
Running Cost Budgets	£8.000m
Total	**£439.813m**

*1 (taking account of 2% recurrent headroom = (£8.903m) and recurrent surplus of (£4.452m))
*2 (also includes 0.5% contingency)

Non-Recurrent Expenditure Budgets	
Programme Budgets	**£21.653m**
Consisting of	
Return of PCT surplus (share of)	£2.316m
Return of PCT lodgement (share of)	£10.434m
2% Headroom (spend non-recurrent)	£8.903m

Recommendation

49. That Wirral CCG is asked to note the updated planning assumptions regarding the overall financial budget for 2013/14 and that further updates will be provided as further information is received regarding outstanding issues

Mark Bakewell
Chief Financial Officer - Wirral Clinical Commissioning Group
3rd January 2013

Wirral Clinical Commissioning Group

Finance Report Month 8 – November, 2012/13 Financial Year				
Agenda Item:	3.4		**Reference:**	GB12-13/130
Report to:	Governing Body		**Meeting Date:**	8th January 2013
Lead Officer:	Mark Bakewell			
Contributors:				
Governance:	**Link to Commissioning Strategy**	Sound financial control is essential to the CCG strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year.		
	Link to current governing body Objectives	To achieve financial control total with sound financial management.		
Summary:	This report updates the CCG on the financial performance against budgeted allocation for 2012/13 as at Month 8 (November) 2012			
Recommendation:	**To Approve**			✓
	To Note			
	Comments			
Next Steps:	Continuation of performance monitoring through the remainder of the financial year			

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What are the implications for the following (please state if not applicable):	
Financial	The report sets out the financial performance within the CCG for 2012/13 financial year
Value For Money	All expenditure plans are subject to an ongoing value for money review
Risk	The report details the key financial risks for the financial year and these will be monitored in year as part of the reporting process
Legal	Legal advice is sought on financial issues as and when required.
Workforce	The financial plan includes budgeted "running costs" expenditure and is reflective of the respective workforce implications in these areas
Equality & Human Rights	Financial Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure
Patient and Public Involvement (PPI)	Budgets include funding to ensure continued involvement of patients and public in CCG decisions.

Partnership Working	The CCG works with a number of NHS Trusts and the Local Authority on a number of its commissioning budgets.
Performance Indicators	The plan reflects the planned achievement of statutory financial duties.
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Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Financial Plan		Governing Body	8th May 2012	

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Wirral Clinical Commissioning Group

NHS Wirral Clinical Commissioning Group

Finance Report for the period 1st April 2012 to 30th November 2012

Introduction

1. This report sets out the financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of November (Month 8) within the 2012/13 financial year.

Resources

2. The total budget allocated to Wirral CCG for the year is £467 million from within the overall PCT baseline of £660 million. Based on the federated model approach a number of budgets are aligned to the Governing Body (£136m) to be managed on an economy wide basis and the remaining budgets devolved to the combined consortia (£331m). This is usually where practice level information is available and performance is based on actual activity (using GP Registration for individual patients).

Financial performance

3. As at the end of November (Month 8) the year to date position for Wirral CCG is an over spend of £1.08m with over performance against commissioning expenditure of £1.8m offset by an under performance against running costs of £0.71m

4. This compares to the October Month 7 position of £0.5m overspend, with the overall movement of being mainly due further increase to over performance on t he Wirral University Teaching Hospitals FT contract (WUTH) being offset by further under spends on prescribing budgets, continued release of contingency reserves and further release of earmarked reserves

5. The year to date variance position between Governing Body and the combined consortia is an overspend at divisional level of £5.55m with the Governing Body underspent by £4.47m.

6. A year to date overall Financial Summary for Wirral CCG is available in Appendix 1. The table below shows the performance variances at month 8:

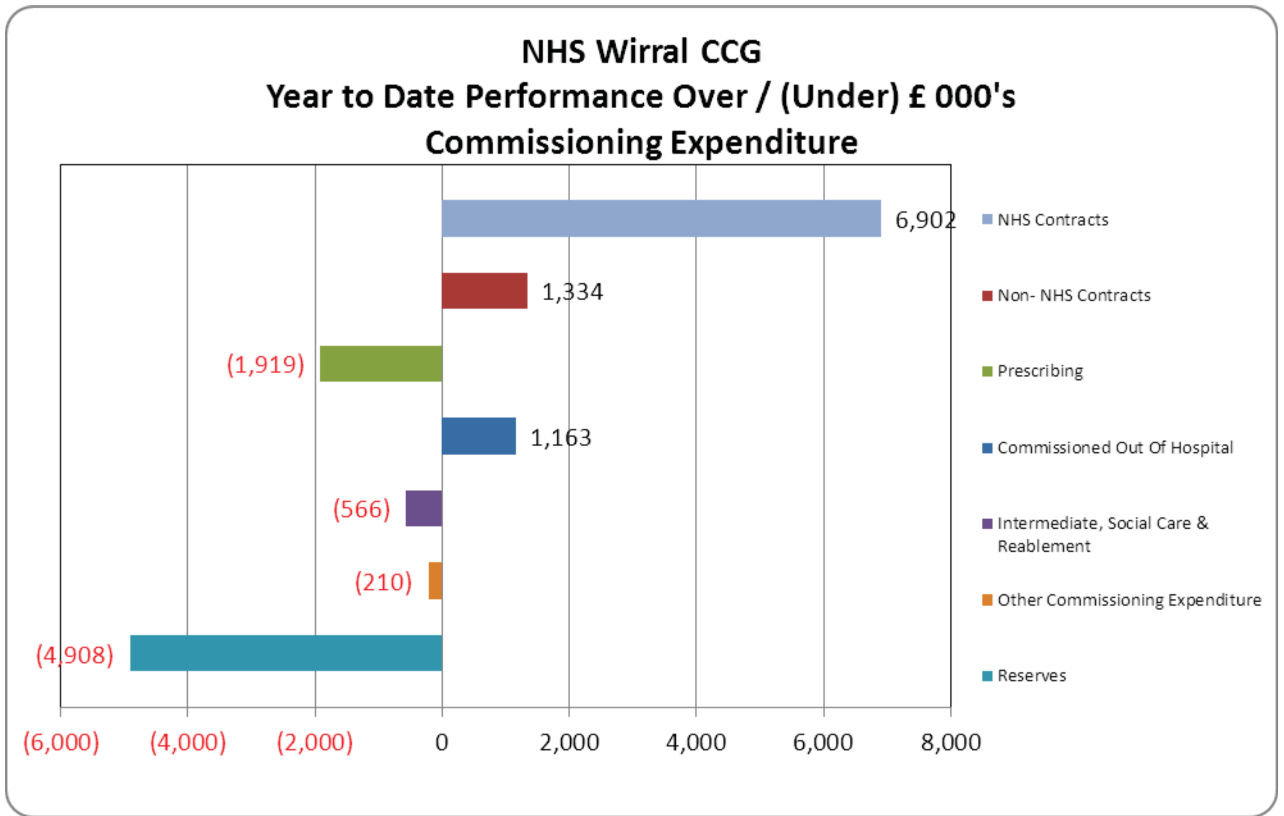
YTD variance	Combined Consortia £ 000	Governing Body £ 000	Total Wirral CCG £000
Commissioning Expenditure	5,879	(4,082)	1,798
Running costs	(326)	(389)	(715)
TOTAL	**5,552**	**(4,470)**	**1,083**

7. Appendix 2 shows the Divisonal Financial Summary including a summary for each of the consortia. The performance variance year to date for the consortia is shown in the table below:

YTD variance	WGPCC £ 000	WHCC £ 000	WACC £ 000	Total Wirral CCG £000
Commissioning Expenditure	205	5,721	(7)	5,879
Running costs	(175)	(102)	(50)	(326)
TOTAL	**30**	**5,619**	**(57)**	**5,552**

8. Narrative regarding financial performance is reported on an exception basis according to variation against planned levels of expenditure. More detailed information is included in Appendices 3 to 6.

9. Year to date variance from budget for the CCG is analysed below:



NHS Contracts

10. The overall CCG performance position in relation to NHS contracts shows an overspend at month 8 of £6.9m (previous month £5.26m) primarily being due to over performance on the Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) contract of £6.53m (previous month £5.13m) at divisional level.

11. The year to date position is based on actual activity as at Month 7 (as per table below) £5.58m over performance with a pro-rata adjustment to equate to month 8 position and application of estimated contract adjustments for re-admissions / outpatient follow-up ratios as appropriate (again based on the month 7 actual activity position).

WUTH Point of Delivery	YTD Actual Performance as at M6 Sept 2012 Over / (Under) £ 000's	YTD Actual Performance as at M7 Oct 2012 Over / (Under) £ 000's
Elective	917	1,223
Non-Elective	1,446	2,044
Outpatient Attendances	831	1,084
Outpatient Procedures	562	696
A&E	(4)	(13)
PbR Total	**3,752**	**5,034**
Non-PbR Total	408	550
POD Total	**4,160**	**5,584**

12. The point of delivery above shows over performance across the majority of areas. The most significant financial pressure is focused on the non-elective performance at the provider, however there are signs that the elective over performance is beginning to increase to a material level and referral information from earlier in the year would suggest this is likely to increase

13. Further work is being currently being undertaken to investigate the underlying causes and divisional / practice reviews are being conducted to review at a detailed level.

14. Performance on other NHS contracts shows a combined overspend of £372k (previous month £134k) with over performance on the North West Ambulance Service contract of £135k, Warrington and Halton Hospital £57k, Countess of Chester £116k (previous month £34k), and Central Manchester £40k being offset by continued underperformance on the Clatterbridge Cancer Centre (CCC) contract of £142k.

Non-NHS Contracts

15. At month 8 Non NHS Contracts are over spent to date by £1.33m (previous month £984k). The movement in month is primarily due to the reported utilisation of the two AQP's radiology and physiotherapy. It is anticipated that under performance will be seen to compensate this in other areas. Other existing performance factors are outlined below.

16. Firstly the backlog of patients transferring to "Spire" due to 18 week RTT targets from earlier in the financial year (£159k). Specialist Care (Health Treatment Panel) is also overspent £101k.

17. Over performance against planned levels of activity also exist and continue against the Independent Midwifery One to One provider £368k for ante / post natal care, Spa Medica (Ophthalmology Cataracts) £260k, and the "Spire" contract for patient choice referrals (non RTT Backlog patients) £128k.

18. Under performance continues on the Assura Ophthalmology contract £77k year to date.

Prescribing

19. Prescribing expenditure is currently providing the CCG with a year to date underspend of £1.92m (previous month £1.58m). There is an over performance of those budgets managed at Governing Body level of £68k due in the main to Amber Drugs which is being offset by underperformance at divisional level of £1.99m. The performance position is based on six month's actual data with two months estimated costs for October and November.

20. The year to date divisional underspend is primarily due to cost growth, a substantial drop in generic drug prices and the delay in the transfer of prescribing dementia drugs to primary care.

Commissioned Out of Hospital

21. Commissioned "out of hospital" budgets are £1.16m overspent at month 8. The main drivers for the over performance remain within the Continuing Healthcare section with Older People (£233k), Mental Health (£229k) and Physical Disabilities (£202k), and all Joint Funded packages (£651k) being offset by underperformance on Funded Registered Nursing Care (FRNC) of £167k.

Reserves

22. Reserves are underspent by £4.9m at Month 8 which is due to the release of the contingency element and a nu mber of earmarked reserves which are available for release.

Running Costs

23. There is a year to date underspend of £715k in relation to running costs at month 8, a favourable in month movement of £138k This is primarily due to under performance on the Commissioning Support Unit (CSU) costs at Governing Body level (£445k) and clinical backfill reported at consortia level (£267k). A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position.

Forecast Outturn

24. Although a number of commissioning budgets are over performing as at the end of October 2012 the CCG remains on target to achieve a bal anced position against its allocation although there is a r eal increase in the risk of delivery of achieving this if forecast levels of over performance continue to rise.

25. One of the key performance drivers to the financial performance position remains around the WUTH contract and as such, given the current intelligence regarding contract performance, has been extended within the forecast outturn position to the value of £8.5m (previous month £8.0m) and should be noted that a further increase was partially expected before an expected improvement in quarter 4 based on reductions in GP Referrals

26. This has been offset by a slight deterioration in other nhs and non-nhs contracts in terms of the forecast position of £0.5m and further improvement in the prescribing position (£0.7m) and forecast requirements of the reserves budget (£0.3m)

27. Management of the year end position given the current assumptions would be set out as per the below:

NHS Wirral Clinical Commissioning Group				
Financial Summary - 2012/13				
Month 8	**Annual Budget**	**Forecast Variance**	**Forecast Variance M7**	**move-ment**
Clinical Commissioning Groups(CCG)	£ 000's	£'000	£'000	£'000
NHS Contracts	330,235	9,166	8,210	956
Non-NHS Contracts	12,565	2,001	1,788	213
Prescribing	59,815	(3,362)	(2,703)	(659)
Commissioned Out of Hospital	29,194	1,227	1,225	2
Intermediate, Social Care & Reablement	8,847	(392)	(532)	140
Other Commissioning Expenditure	8,635	(343)	(206)	(137)
Reserves	8,201	(7,362)	(7,061)	(301)
Total CCG Commissioning Expenditure	**457,491**	**935**	**721**	**214**
Running Costs	**9,939**	(935)	(721)	(214)

Overall CCG		467,430	0	0	0

28. It should be not ed that the performance position however does restrict the ability to support new additional commissioning investments and as such the relative value in the contingency and other reserve has been released to offset the contract over performance although his becomes less of a factor as the financial year progresses

Financial Risk

29. The CCG's Financial Plans identified the main areas of financial risk in terms of performance for the year and an overall CCG Risk with regards to financial performance.

Original Risk Identified	Potential Risk Value	Degree of Forecast Risk	Current Forecast Performance	Degree of Forecast Risk
Packages of Care	£1.0 million	[Amber]	£1.2m	[Amber]
Performance on Secondary Care Contracts (WUTH)	£3.0 million	[Amber]	£8.5m	[Red]
Prescribing	£1.2 million	[Amber]	(£3.3m)	[Green]
Cost Efficiencies	£6.2 million	[Amber]	Linked to other risks as embedded within contracts but managed via contingency	[Amber]

Degree of Forecast Risk – Assessed as

Red Over performance > 2%
Amber Over performance > 1%
Green Minimal Risk (Forecast Underperformance or low value)

30. Risks will be subject to constant review as more information becomes available regarding performance against planned levels of expenditure.

Conclusion

31. The Governing Body is asked to note:

- the financial position as at the end of November 2012
- the requirement for the CCG to review its uncommitted spending plans to judge for potential slippage in order to help support the levels of overperformance
- the potential risks identified for 2012/13 financial performance and contingency reserves held to mitigate against performance issues.
- the forecast outturn position for 2012/13

Mark Bakewell
Chief Financial Officer
NHS Wirral Clinical Commissioning Group

2nd January 2013

NHS Wirral Clinical Commissioning Group

Financial Summary - 2012/13

Month 8	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	330,235	217,869	224,772	6,903	5,264	1,639	9,166
Non-NHS Contracts	12,565	8,068	9,403	1,335	981	355	2,001
Prescribing	59,815	39,791	37,873	(1,920)	(1,582)	(338)	(3,362)
Commissioned Out of Hospital	29,194	19,304	20,467	1,163	889	274	1,227
Intermediate, Social Care & Reablement	8,847	5,845	5,279	(566)	(458)	(108)	(392)
Other Commissioning Expenditure	8,635	5,203	4,992	(210)	(129)	(81)	(343)
Reserves	8,201	5,599	691	(4,908)	(3,892)	(1,017)	(7,362)
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**457,491**	**301,680**	**303,477**	**1,798**	**1,073**	**725**	**935**
Running Costs	**9,939**	**6,613**	**5,898**	(715)	**(577)**	(138)	(935)
Overall CCG	**467,430**	**308,293**	**309,375**	**1,083**	**495**	**587**	**0**

NHS Wirral Clinical Commissioning Group

Governing Body Financial Summary - 2012/13

Month 8	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	67,974	44,923	44,984	61	(1)	62	248
Non-NHS Contracts	3,622	2,412	2,512	100	123	(23)	(62)
Prescribing	9,533	6,052	6,120	68	121	(53)	(192)
Commissioned Out of Hospital	29,194	19,304	20,467	1,163	889	274	1,227
Intermediate, Social Care & Reablement	8,847	5,845	5,279	(566)	(458)	(108)	(392)
Other Commissioning Expenditure	88	24	24	0	1	(1)	0
Reserves	8,201	5,599	691	(4,908)	(3,892)	(1,017)	(7,362)
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**127,459**	**84,159**	**80,077**	**(4,082)**	**(3,217)**	**(864)**	**(6,534)**
Running Costs	**8,182**	**5,448**	**5,059**	(389)	**(282)**	(107)	(508)
Total Governing Body CCG	**135,641**	**89,607**	**85,137**	**(4,470)**	**(3,499)**	**(971)**	**(7,042)**

NHS Wirral Clinical Commissioning Group

Divisional Financial Summary - 2012/13

Month 8	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	262,260	172,947	179,788	6,841	5,265	1,576	8,919
Non-NHS Contracts	8,944	5,656	6,891	1,235	858	377	2,063
Prescribing	50,282	33,739	31,752	(1,987)	(1,702)	(284)	(3,170)
Commissioned Out of Hospital	0	0	0	0	0	0	0
Intermediate, Social Care & Reablement	0	0	0	0	0	0	0
Other Commissioning Expenditure	8,547	5,179	4,968	(211)	(131)	(80)	(343)
Reserves	0	0	0	0	0	0	0
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**330,033**	**217,521**	**223,400**	**5,879**	**4,290**	**1,589**	**7,469**
Running Costs	**1,757**	**1,165**	**838**	(326)	(295)	(31)	(427)
Total Division CCG	**331,789**	**218,686**	**224,238**	**5,552**	**3,995**	**1,558**	**7,042**

Wirral Clinical Commissioning Group

WIRRAL GP COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Tuesday 20th November 2012, 7pm
Nightingale Room, Old Market House

Present:	Dr John Oates	(JO)	Chair
	Dr Navaid Alam	(NA)	GP Lead
	John Callcott	(JC)	Non Executive Advisor
	Christine Campbell	(CC)	Chief Officer (Acting)
	Ann Riley	(AR)	Nurse Member
	Dr Pankaj Srivastava	(PS)	GP Lead

In attendance:

Carol Diamond	(CD)	Commissioning Support Manager
Anita Fletcher	(AF)	WGPCC Administrator
Kerry Hogan	(KH)	Commissioning & Engagement Support Manager
Paul McGovern	(PM)	Commissioning Support Manager
Sarah Quinn	(SQ)	Commissioning Manager

Ref No.	Minute
WGPCC/EB/ 12-13/0058	**1.1 Apologies for absence** Apologies were received from Dr Akhtar Ali, Chandra Dodgson, Karen Hornby, Dr Denyse Kershaw, Dr Andy Lee, Dr Hannah McKay, Dr Abhi Mantgani, Lysa Morton and E ddy Shallcross.
	1.2 Declarations of interest No declarations of interest were made.
	1.3 Public Comments/Questions There were no members of the public present.
	1.4 Minutes and Action Points of the last meeting JC asked for his apologies to be included within the minutes from the last meeting; following this amendment the minutes were agreed to be a true record of the meeting. Action Points Discharge form glossary – This will be developed through the next Discharge meeting. Care home paper – this will be brought to the next meeting. Primary Care Mental Health Proposal – This will now be addressed within the CAMHS team. Text messaging – KH has informed the other consortia of this proposal. Members were advised that Wirral GP Commissioning Consortium will still go ahead with this service no matter what the decision is from the other two Consortia.

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Ref No.	Minute
	Patient representative – this had been raised at the WGPCC Patient Council Executive Board. No-one had initially come forward although there had now been interest shown from a few people. This will be taken to the next Patient Council Executive Board with the target implementation date of January 2013. Over 65s Local Enhanced Service – the template had been issued to the vast majority of practices, only those practices on Synergy are unable to use them; these practices have designed their own template. Use of unutilised Commissioning Resources – A meeting had been set up between Carol Diamond and Paul Wormald from the Performance Intelligence team and a proposal would be brought to the next meeting of the Practice Members' Forum Use of Commissioning Resources Invoicing Arrangements – An email had been sent to practices advising that they could send an invoice in for the full amount and scheduled monthly payments would then be set up. Quality Performance Indicators 2012-13 Update Report – Following the issue of a letter to Dr Martin and Dr Salahuddin, a discussion had taken place between Dr Salahuddin and JO and further information has been sent to the practice. PS had met with Dr Martin and it was agreed that Dr Martin or the Practice Manager would contact CC to discuss. Reassurance was given to both GPs that the areas were just being highlighted and it was not a performance issue with either practice. Cancer Incentive Scheme – Members were advised that the clinical engagement budget would be used to support this. CC and CD would have a discussion to take this forward. <u>Matters Arising</u> There were no matters arising from the minutes that were not covered within the agenda
	1.5 Minutes for Noting An extraordinary Board meeting of the Wirral GP Commissioning Consortium had taken place to discuss the Constitution. Each of the Consortia Executive Boards had been tasked to formulate a response on the document. The Board agreed that overall the constitution was extremely comprehensive, but that the autonomy of the Consortia was an area to be strengthened, and also there were some key areas absent, such as the procedure for practices moving between Consortia. This had been discussed at the Governing Body meeting that day, and the views of this Board had been put forward. The Constitution would be issued to practices on Monday 26th November for comments. A letter had been sent to the CCG Chair from the LMC requesting sight of the Constitution before it was issued to practices. As there would be no opportunity to send the document to the LMC before then, it would be sent out at the same time as Member Practices. The second issue raised by the LMC was around having a seat at the CCG Governing Body Board, this had been discussed previously and the position of the Board remained. It is not appropriate for any professional body to be formally represented at the Board, but that any member of the LMC could attend as a member of the public. It had been proposed that a meeting would take place with professional groups and the Governing Body Board so they were appraised as to what is going on, and it is made clear that the Governing Body is committed to an ongoing positive relationship with local professional bodies. As the Constitution is a weighty document, when issued there will be a cover sheet advising of the areas that are mandated, and drawing people's attention to the pertinent points.

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Ref No.	Minute
	The Wirral GP Commissioning Consortium Executive Board will have a role to ensure member practices are engaged With the constitution, and the Board will work with those that are not engaged to try and resolve issues. Practices have to be signed up, if not they will be referred to the National Commissioning Board. It is not essential for all areas for authorisation to be rated as green in time for the site visit but the CCG has to show that plans are in place for all areas to be complete by 1st April 2013. Andrew Cooper, Chief Officer of Wirral Health Commissioning Consortium had attended a site visit in another area, and had gained some useful insight at this meeting, which will be shared with the Board members. A suggestion was made that the QIPP teams will look at Wirral Local Enhanced Services for next year as there will be the need to ensure they are viable and still necessary. This will be discussed at an Operational Group meeting. Members were advised that Dr Andrew Smethurst, the Secondary Care GP, had been appointed and had attended the last Governing Body Board meeting.
WGPCC/EB/ 12-13/0059	**2.1 Use of Commissioning Resources** CD explained that with regard to the use of commissioning resources she had been reminding practices by phone calls, emails and visits, and had had a really good response. There were a couple of practices who had not submitted as yet but proposals were in the pipeline. However, there were still a lot of uncommitted commissioning resources. Emails had been issued again advising that if proposals were not received by the end of November, the resource would be available for other practices to bid for. Members were advised that it was difficult to give an up to date figure on total resources remaining. It was agreed that the deadline of 30th November would be adhered to strictly, as practices have had ample notice to spend this resource, and many reminders. With Board support, a letter would be issued to practices saying that all proposals have to be in by 30th November and any money left will be looked at for investing in areas that would benefit patients to reduce waiting times. A proposal for any unutilised resources will be brought to the Practice Members' Forum on the 5th December.
	2.2 Primary Care Mental Health Progress Report November 2012 Members were advised that a paper was taken to the October 2012 Wirral GP Commissioning Consortium Executive Board, updating Board members on the progress of the three accredited PCMH providers for the Consortium against key performance indicators. The Board noted that MHCO and CWP are meeting the waiting time and DNA targets. However, it was noted that Peninsula Health LLP has consistently failed to meet these targets, although an improvement has been demonstrated in September 2012. Peninsula had been asked to report on waiting times and was currently reporting as meeting the 20 day target. However, Members were advised that they Peninsula is struggling with targets in the Step 3 area, and there were some concerns over data accuracy KH wanted the Board to be made aware of this; a report on the waiting time performance review summary was tabled at the meeting. Members were informed that steps have been put in place to target this. It had been agreed that a bi-weekly meeting for exception reporting would take place; it was also agreed that more engagement with practices would occur. CC agreed that there was the need to continue with the same level of monitoring, and that this should remain as

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Ref No.	Minute
	a risk for the Consortium. There has been pressure on CBT availability; a number of therapists have now been recruited and this situation is improving, but still needs to be monitored. The Board noted the performance to date, including mitigating actions undertaken and planned in relation to exception reports.
	2.3 Project Scorecard PM explained that during the course of this financial year Wirral GP Commissioning Consortium has begun to put in place a number of new service developments which will contribute to achieving key objectives set out in the Operational Plan. The range of projects and services identified for performance monitoring range from previous pilot projects which have been continued as they continue to develop and establish their full contribution to the strategic objectives and operational plan. Other services that have been put forward for monitoring of performance and activity range from the introduction of new Qualified Providers aimed at providing greater choice and capacity in areas of therapy and diagnostics, to others such as the Tele-derm service and the Community Gynaecology service that have come through the commissioning suggestions of Member Practices. Members were advised that reporting would be undertaken on two key performance indicators demonstrating service performance in relation to patient access and waiting times. Each service will be RAG rated accordingly and arrow indicators will highlight whether performance trends are increasing or declining month by month. PM explained that all the Commissioning Managers were working on putting a QIPP value to all of the areas. CC advised that this was a really good start but would like to focus on quality and outcomes rather than just counting numbers. We should also focus on areas that it is not taken for granted that providers will be able to meet. PM asked if members could provide feedback to him outside of the meeting, and will come back with a revised version
WGPCC/EB/ 12-13/0060	**3.1 WGPCC Nursing Staff Training Programme** Executive Board members were informed the submitted paper outlines a proposal for resource to support the implementation of a nursing staff training programme for the Wirral GP Commissioning Consortium. There is a risk that nursing staff do not access the training required to fulfil their role. Therefore, to mitigate against this risk, a Consortium-wide training programme will be delivered subject to approval by the Board regarding associated costs. KH and AR had been working on the development of this programme in 14/15 areas as set out in the paper. A quote has been received from a training provider to deliver the full training package outlined, and is £62,000. It was iterated that no decision has been made to commission any provider – this information was sought as a guide on price only. It is hoped that some training will be delivered free of charge, through voluntary sector, Community and Wirral Hospital Trust, and pharmaceutical companies. KH and AR have worked very closely to highlight the key aims and

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	were due to meet with Dr Lee the following week to discuss further. There are approximately 100 nurses who would need to access the training, with no more than 30 per session to ensure that each session is as interactive as possible. Members felt this was an excellent scheme for taking forward for front line staff. AR advised that the programme would be fully evaluated. KH advised that she would be presenting this programme at the next Practice Manager Forum. It was agreed that the proposal could not be approved at this time due to the fact that the meeting was not quorate. In principle, members present: - supported the training nursing staff programme - supported the proposed two dates per training course - supported the maximum commitment of £62,364.00 to fund the WGPCC Nursing Staff Training Programme - supported the recommendation to identify nursing staff with expertise/interest in the training need areas identified, to help construct outline training agendas. It was hopeful that by the next meeting further information will be available.
WGPCC/EB/ 12-13/0061	**4.1 Financial Budget 12/13** Executive Board Members were asked to note that the paper provided showed the overall Wirral Clinical Commissioning Group position and not Wirral GP Commissioning Consortium; month 7 data for this Consortium was not currently available. A request was made for the resources remaining to be committed to be added to the risk register. Members were advised that the finance summary paper was a first cut and a full breakdown would be available over the next week for distribution. **Action** – Wirral GP Commissioning Consortium uncommitted resources to be added to the risk register.
	4.2 Patient Council and Engagement Update KH updated Board members in the absence of ES. The last Patient Council meeting had focused on a 111 update. Simon Gilby, Chief Executive of Wirral Community NHS Trust attended to give an overview of the services that the Trust provides and to take patients' questions. It has been a very good meeting and had been really useful for Patient Council members. Wirral Hospital Trust had been invited to present at a meeting but no response had been received to date. Work is currently being undertaken with the Communications Team on DNAs across practices. PS and Patient Council members have flagged this as something to focus on. Positive reinforcement as to how many patients attend appointments is being looked at rather than from a negative perspective. This is due to be launched on 13 January 2013. You Tube videos to raise the focus of the importance of attending appointments will be shown in practices. Development of the scheme will be presented to the Practice Manager Forum, then the Patient Council Executive Board. Information will also be sent to virtual members and to practices for

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Ref No.	Minute
	their own Patient Participation Group in practice. A request was made for the campaign to include a request for updated landline and mobile phone numbers from patients, and it was agreed this would be linked into the “Your GP Needs You” campaign.
	4.3 Executive Nurse Update AR explained that she had been working with KH on the nursing staff training programme. There had been poor attendance at the last two Nurse Forum meetings with no-one attending one of these. The HCA Forum meetings were well attended. It was suggested that the next PLT afternoon could involve a feedback session to nurses. The route to nurses can be difficult; sometimes information is not fed in. Nurses are a key group that the Consortium struggle to engage with. It was agreed that this would be looked at for the February PLT session.
	4.4 Practice Manager Update No update was available as KH and LM were not present at the meeting. CC raised concern at the lack of engagement with the Practice Manager community, and it was agreed that the Board should be doing more to find out if they could be involving and engaging Practice Managers in a better way. It was agreed that JO and CC will hold an extraordinary Practice Manager Forum to have an open and honest discussion with the Managers about the relationship between practices and the Consortium.
	4.5 Items for Risk Register It was agreed that the Wirral GP Commissioning Consortium commitment of resources would to be added to the risk register and . the ability of Peninsula Health LLP to meet its contractual targets for waiting times was to remain on the register.
WGPCC/EB/ 12-13/0062	**5. Any Other Business** A proposal for the provision of an ECG service in one of the new minor injury services was raised. There would be no extra funding required as the resources have already been committed by this Board, but access would be improved as the service would just be operating from an additional location. Any practice would need to approach CC with a view to taking this forward. Any contractual agreement would be between the practice and the ECG provider, so there would be no risk to the Consortium. This service would run until the end of March 2013.
WGPCC/EB/ 12-13/0063	**6. Private Business** There was no private business discussed.
	7. Date and Time of Next Meeting The date and time of the next meeting is Tuesday 18th December 2012, 7.00pm in the Nightingale Room, Old Market House, Birkenhead. Please send any apologies to Anita Fletcher on anita.fletcher@wirral.nhs.uk

The meeting finished at 8.40 pm

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Wirral Clinical Commissioning Group

WIRRAL HEALTH COMMISSIONING CONSORTIUM
EXECUTIVE COMMITTEE
Minutes of Meeting

Wednesday 21st November 2012
Albert Lodge - Victoria Central Health Centre

Present:	Dr Pete Naylor (Chair)	Chair
	Dr Paula Cowan	GP Executive Lead
	Dr David Jones	GP Executive Lead
	Dr Sue Kidd	GP Executive Lead
	Dr Sean Magennis	GP Executive Lead
	Dr Sue Wells	GP Executive Lead
	Anita Swift	Practice Manager Representative
	Carol Heath	Practice Nurse Representative
	Brian Knight	Patient Forum Representative

In Attendance:

	Sheena Hennell	Commissioning Manager
	Jenny Shaw	Operational Manager
	Wendy Holmes	Executive Assistant

Ref No	Minute
WHCC/EB/ 12-13/0061	**1.1 Apologies for Absence** Apologies were received from Dr Shyamal Mukherjee, Graham Hodkinson, Councillor Phil Davies, Andrew Cooper and Louise Morris.
WHCC/EB/ 12-13/0062	**1.2 Declarations of Interest** There were no declarations of interest. The Chair welcomed Dr Sue Kidd, newly elected to the Executive Board Committee until April 2013 and Jenny Shaw, Operations Manager, covering maternity leave and in attendance to observe. Introductions were made around the table.
WHCC/EB/ 12-13/0063	**1.3 Public Comments/Questions** One member of the public attended the meeting. No comments were received.

Ref No	Minute
WHCC/EB/ 12-13/0064	**1.4 Minutes from the last meeting** With the exception of one amendment made to item 2.1 Pathways for Life Pilot, to read "ICE are *in discussions* with Department of Health on this project", the minutes from the last meeting were reviewed and accepted as an accurate reflection. Matters Arising No matters were arising. Actions Outstanding Actions – Falls Pick-Up Service: The Commissioning Manager advised that she would request an update from the Commissioning Support Manager. Item to remain as an outstanding action. 2.1 – Demonstration of Pathways for Life website at GP Members Committee: The Commissioning Manager agreed to contact the Chair of the committee to arrange demonstration. It was suggested that this could be done at the Cluster meetings next week. 2.1 – Patient Forum involvement with ICE Web Developers: Item to remain as an outstanding action. 4.1 – Audiology overspend to be investigated: Item to remain as an outstanding action. 4.1 – Practice visit reports to be sent to Board: It appeared that one or two Board members had not received the reports. Information to be resent out. It was agreed that practice visit reports should be taken to Performance and Finance Committee and also Informal Board meetings for review/discussion.
WHCC/EB/ 12-13/0065	**2.1 Practice Equipment** An amended paper on Practice Initiated Equipment Ideas was circulated to the Board, with further equipment added to the table in paragraph 4. The Board noted the appendix outlining practices that had responded to the requirements survey for 24 hour blood pressure monitors and adult pulse oximeters. The total figure to supply practices with their requests was advised at £77,180.57. An issue with M-Pulse Paediatric Finger Pulse Oximeters was raised. A number of practices have complained that the units do not work and have returned them. It was agreed that the Commissioning Manager would contact the Practice Manager at West Kirby Health Centre for more information on the issues. A discussion followed on alternative units that were available on the market. The Board agreed a figure of up to £250 per unit for purchasing more robust and reliable units. A refund would be granted for faulty equipment. The Board was advised that the Nonin 9550 unit for adults was far superior, reliable and accurate model. The Board agreed that the monitors could be ordered and an alternative unit should be sourced, in order to build up stocks across the consortium practices to provide an equitable number.

Ref No	Minute
WHCC/EB/ 12-13/0066	**2.2 Practice Nurse Education Programme** The Chair advised the Board that this item was being presented on behalf of Sue Smith, the key support for Practice Nurse education. The Practice Nurse Forum have suggested that it would be beneficial to have a 12 month structured education programme in place for Practice Nurses utilising identified protected learning dates. Associated costs to the consortium would be for speaker fees and any other adhoc costs as necessary. Venue and refreshments would be covered by pharmaceutical sponsorship. It will be imperative that practices release their nurses for the sessions. Advanced planning will be required to give plenty of notice for managing clinics. Attendance will need to be recorded at the events to address any problems with non-attendance from practices. It was highlighted that there is a minority group of Practice Nurses that do not attend any educational sessions and this is difficult to manage. The Operational Manager agreed to liaise with Sue Smith regarding this matter. The Board agreed to the proposed education programme. ***Action** – Attendance register to be in place to record attendance – Jenny Shaw / Sue Smith.*
WHCC/EB/ 12-13/0067	**2.3 Project Brief – WHCC Over-performance** A proposal for Data Analyst support for 6 months to provide information and data analysis on WHCC activity was presented to the Board. The job description has yet to be agreed for the band. Proposed costs are £10k, based on a Band 7 salary broken down over several months. A report will be produced to look at overspend. Dr Jones queried whether clinical support was required and offered his support if need be. The Board agreed that this was a sensible approach to gain an understanding of reasons for £3.3m overspend.
WHCC/EB/ 12-13/0068	**3.1 WHCC Commissioned Services – Interim Report** The Commissioning Manager asked for feedback/questions on the WHCC Commissioned Services Summary Activity Report contained in the meeting papers. One member of the group queried for the 26 Telehealth patients whether the consortium was paying for equipment or just patients? The response was that it is for patients only for 3 months. There were concerns that the equipment is not being used, although it was acknowledged that it will take some time for the service to establish itself. Zero GP and Community Matron referrals have been received to date. The service has been promoted during practice visits. Wirral GP Commissioning Consortium is now working with WHCC, equipment will be pooled to reach a larger population. Bursary money is also being used to raise awareness on Wirral.

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	A discussion followed on the disappointing referral rate from Community Matrons and it was queried whether this issue should be brought up with Community Trust. The Practice Nurse representative agreed to highlight this subject at the next Practice Nurse Forum. It was felt that a service directory to aid GPs when referring patients would be of great benefit. The Board requested a report on spend in order that this could be discussed further at the next meeting. It was agreed that a report should be presented at Business Development Group monthly and to the Executive Board Committee on a quarterly basis for information. Dr Jones asked for feedback on Admission Prevention clarity between District Nurse role and admission avoidance and stated that practices have been refused some referrals, i.e. COPD monitoring to avoid admission. A discussion followed on the fine line between DN role and Admission Prevention Service. There are issues with DN capacity / staffing. It was agreed that it would be beneficial if evidence was collated and a meeting arranged to discuss the service. The service specification is vague and work is taking place with Community Trust on the implementation plan. Falls Response Service didn't gain much response. Now larger caseload and so the service is starting to take effect. Assistive technology is available if patient is referred. This service will be expanded to other consortia. ***Action*** *- Practice Nurse representative to highlight telehealth service at the next Practice Nurse Forum.* ***Action*** *– Commissioning Support Manager to produce a table of data on telehealth spend for discussion at next meeting.* ***Action*** *– Dr Jones to feedback issues encountered with Admission Prevention Service to Commissioning Support Manager.* ***Action*** *- Discuss at next Cluster meeting referrals that have been turned down by Admission Prevention Services/District Nurses – GP Executive Leads.* ***Action*** *- Monthly activity summary report to be produced for Business Development Group and quarterly for Exec Board – Commissioning Support Manager.* ***Action*** *- Performance monitoring figures to be provided for discussion by Chief Officer.*
WHCC/EB/ 12-13/0069	**4.1 Finance Update** The Chair led on this item, due to apologies received from the Finance Lead. The Board was advised that the position has not improved on last month. The overspend position doesn't yet reflect the amount of work that is taking place. Data highlights areas that practices have little or no control over. Two update sessions are scheduled to take place in January 2013. Following discussion, it was felt that a gynae service is required within primary care. The

Ref No	Minute
	Commissioning Manager volunteered to take the issues forward and look at pathways. A discussion followed regarding consultant to consultant referrals. Dr Cowan highlighted a particular case to the Board. It was agreed that any issues should be raised with Dr Naylor to take to contract meetings. A further discussion took place on referrals for surgery. Patients must be made aware of the 18 week timeline once they have been referred in order to avoid being discharged and then re-referred later in the year for surgery. Finance division comparison figures are available for information within the Governing Body minutes attached to the meeting papers.
WHCC/EB/ 12-13/0070	**4.2 Items for Risk Log** Community Nursing not being equitable across Wirral to be added to Risk Log. ***Action*** *– Chief Officer to add Community Nursing to Risk Log.*
WHCC/EB/ 12-13/0071	**4.3 Risk Register** No comments were received.
WHCC/EB/ 12-13/0072	**5.1 Subgroup Minutes for Noting** The minutes from the September meetings of the sub-committees were noted. The Practice Manager Representative advised that a phlebotomy specification review is currently taking place with Community Trust and queried whether there had been any feedback on this. The Commissioning Manager was requested to investigate and feedback comments to the Practice Manager Representative. ***Action*** *– Commissioning Manager to seek feedback from CT on phlebotomy service specification review.*
WHCC/EB/ 12-13/0073	**6. Summary of Actions** Please refer to action points attached.
WHCC/EB/ 12-13/0074	**7. Summary of Financial Approvals** The Commissioning Manager agreed to feedback items to be added to the Summary of Financial Approvals sheet.
WHCC/EB/ 12-13/0075	**8. Any Other Business** The Practice Manager Representative made a plea for protected time for non-clinical

Ref No	Minute
	staff training as staff miss out on customer service training etc. It was advised that at Practice Managers' Forum it had been agreed to run in-house training sessions on Protected Learning Time Event days for non-clinical staff as PLT topics were not always applicable for practice staff. It was queried whether all practices undertake such training on PLT sessions when Out of Hours is provided for practices. This issue will be discussed by the Training Forum. The Practice Manager Representative agreed to raise the issue of non-clinical training at the next Practice Managers' Forum. A list of training required for CQC to be sent to Grace Price-Jones to take to Training Forum for approval / discussion.
	Date and Time of Next Meeting The date and time of the next meeting is Wednesday 19th December 2012, 1.00pm at Albert Lodge, Victoria Central Health Centre. Please send any apologies to Wendy Holmes on wendy.holmes@wirral.nhs.uk

Wirral Clinical Commissioning Group

WIRRAL ALLIANCE COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Thursday 8th November 2012
St Hilary Group Practice, Wallasey

Present:

Dr Mark Green	St Hilary Group Practice (Chair)
Dr Bryan Conlan	The Orchard Surgery
Dr Helen Downs	Civic Medical Centre
Dr Jane Hortop	Spital Surgery
Dr M Salahuddin	Gladstone Medical Centre
Dr Richard Williams	Riverside Surgery
Dr Ivan Camphor	Heatherlands Medical Centre
Iain Stewart	WACC Chief Officer
Michael Roach	Non-Executive Advisor

In Attendance:

Paul Wormald	Strategic Information Analyst
Louise Morris	Finance Link, CWW CSU
Allan Stewart	Practice Manager Representative
Dr James Kingsland	Strategic Advisor
Sheena Wood	Commissioning Manager
Allison Hayes	Executive Assistant
Peter Norman	Head of Contracting Procurement, CWW CSU

Ref No.	Minute
WACC/EB/ 12-13/0027	**Preliminary Business** **AQP Contracting Presentation** The Chair introduced Peter Norman, Head of Contracting & Procurement who provided a brief update on the provision of healthcare services through (AQP) Any Qualified Provider. Members discussed the processes and services of AQP and the impact on patient choice. Chair thanked Peter for his update. **1.1 Apologies for absence** Apologies were received from Dr Gillian Francis and Fiona Johnstone.
	1.2 Declarations of interest Dr Helen Downs declared her interest with regards to the Prescribing Support proposal. **1.3 Minutes and Action Points of Previous Meeting/Matters Arising** The minutes from the previous meeting held on 4th October 2012 were agreed as a true record of the meeting and were proposed by Dr Conlan and seconded by Dr Salahuddin.

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Ref No.	Minute
	Action Points – Please refer to the attached sheet. **1.4 Chair Report** Chair provided a group with an update regarding the Governing Body draft constitution, scheme of delegation, communication and engagement strategy, recent appointments and CCG Quality, Performance and Finance update. Chair reported back to the group on the overall outcomes of recent practice visits and highlighted the high degree of engagement and interest by all practices. He expressed his gratitude to all practices and described how there were key learning points raised at every visit which can be shared.
WACC/EB/ 12-13/0028	**Items for Discussion** See notes with regards to AQP Contracting Presentation.
WACC/EB/ 12-13/0029	**Items for Approval** **3.1 Practice Based Prescribing Support Coordinator Proposal** Members agreed to the proposal recommended by the Clinical Working Group. Board members were asked to consider financial options for this proposal. A non-recurrent commitment of £77,000 was agreed, shared on a pro-rata basis for each practice. Board agreed to submit proposal to CCG Approvals Committee.
WACC/EB/ 12-13/0030	**Items for Information** **4.1 Quality, Performance and Finance** Finance Link, CWW CSU provided a summary of the latest Finance position of the Alliance as at the end of September (month 6) within the current 2012/13 financial year. A discussion took place regarding recurring and non-recurring budgets. Strategic Information Analyst provided a summary of the latest Performance report. **4.2 Risk Register** Members discussed the contents of the current risk register. Members agreed to add the following issue: - CWW CSU Medicines Management change in Advisor support to Thursdays and Fridays only. **ACTION : Chief Officer to update register**
WACC/EB/ 12-13/0031	**5.0 Subcommittees minutes for noting** The minutes from the subcommittees meetings were noted.
	6.0 Summary of Actions Please refer to action points attached.
	7.0 Any other Business

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Ref No.	Minute
	Members raised some concerns from practice patient representatives about the development of the Alliance Patient Engagement Group. Chair and Chief Officer are attending the next meeting on 20th November and will discuss with the Group. **Action: Chair and Chief Officer to discuss development progress with Patient Engagement Group.** Chair to raise concerns with the Governing Body regarding the financial summary information detailed in the last Governing Body minutes. Strategic Advisor to prepare refined suggestions for CCG Activity audit LES for the next meeting. New Minor Illness Services – Chair updated the group on the recent CCG press release about the new Minor Illness Services and explained why clarification was required on the contractual arrangement in place to facilitate non-registered patients accessing these general practice services. Members directed the Chair to communicate with the CCG Chair and C hief Clinical Officer.to seek clarification.
	Private Business None.
	8.0 Date and Time of Next Meeting The date and time of the next meeting is ***Thursday 6th December 2012, 3pm at Civic Medical Centre, Bebington CH63 7RX.*** Please send any apologies to Allison Hayes on allison.hayes@wirral.nhs.uk

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Wirral Clinical Commissioning Group

Quality, Performance & Finance Committee

Minutes of Meeting Held on Thursday 29th November 2012
1.00 – 5.00pm, Room 539, Old Market House

Present:

Dr P Jennings (PJ)	Chair, Wirral CCG
Dr A Mantgani (AM)	Accountable Officer, Wirral CCG
Mark Bakewell (MB)	Chief Finance Officer, Wirral CCG
Andrew Cooper (AC)	Chief Officer, Wirral Health Commissioning Consortium
Dr P Naylor (PN)	Chair, Wirral Health Commissioning Consortium
James Kay (JK)	Lay Member (Audit & Governance)
Shanila Roohi (SR)	Medical Director/Caldicott Guardian
Dr J Oates (JO)	Chair, Wirral GP Commissioning Consortium
Lorna Quigley (LQ)	Chief Operating Officer, Wirral CCG

In attendance:

Julie Stamper (JS)	Board Support Assistant (taking minutes)
Suzanne Crutchley (SC)	Information & Corporate Governance Manager, CWW CSU

Ref No	ITEM	ACTION
QPF12-13/038	**PRELIMINARY BUSINESS**	
38.1	**Apologies for Absence**: Apologies were received from:- • Paul Arnold, Deputy Director of HR, NHS Warrington • Iain Stewart, Chief Officer, Wirral Alliance Commissioning Consortium • Simon Wagener, Lay Member (Patient Champion) • Christine Campbell, Chief Officer, Wirral GP Commissioning Consortium	
38.2	**Declarations of Interest**: There were no declarations of interest today.	

38.3	**<u>Minutes of Previous Meeting</u>**: Page 2, 32.2 - incorrect action. Should have said MB not PJ/JK. Page 4, 33.2 - Divisional reports – should be Andrew Cooper, Christine Campbell and Lorna Quigley. Page 4 – WUTH's financial plan – remains outstanding. The rest of the minutes were recorded as a true record and were signed off by the Chair **<u>Actions List from Previous Meeting</u>**: 32.1: Information Governance/FOI Policy – on today's agenda. 32.2: Need to reflect that we are putting a plan together. This is part of the Contract Negotiation process. 33.3: Intensive Support Visits – on today's agenda. 34.5: Serious Incidents was taken to Governing Body Board on 6th November. 35.1: Risk Register – on today's agenda. 36.1: No progress has been made. JK to organise a meeting with AM and SW to discuss bariatric surgery/savings etc. Need more information on the subject. PN will give JK a copy of a briefing guide. 36.2: QIPP – on today's agenda.	**JK/SW** **PN**
QPF12-13/039	**ITEMS FOR APPROVAL**	
39.1	No items for approval.	
QPF12-13/040	**ITEMS FOR DISCUSSION**	
40.1	**<u>Information Governance Report Update</u>**: SC attended the meeting today to give an update on the CCG's position in relation to Information Governance. **<u>FOI Policy</u>**: This is a refreshed policy to ensure everything is on track. Specialist knowledge sits with SC. Processes for FOI's were clarified to the Committee today. AM asked for assurance for him to ensure SC has had site of a response before he signs it off. The FOI Policy will go to the Governing Body Board for approval. **<u>Subject Access Request Policy</u>**: To go to the Governing Body Board for approval.	

	SC sends her apologies for the December meeting. MB will present the Information Governance on her behalf.	**MB**
40.2	**Performance Reports**: LQ talked us through the reports. **WUTH:** Month 7 reporting – month on month increase with GP referrals. Consultant to Consultant referrals have increased by 5% during October. This will form part of contract discussions. Out-patient first appointments are over performing against the SLA, and for October, performance is up against the previous month by 3%. **Other Trusts:** Month 6 reporting – first out-patient appointments and follow up out-patient appointments are over-performing. Nothing else to report with regards other providers. **Mental Health reporting:** Month 6 reporting – work still going on around IAP services. Good performance at present, but still on the Risk Register. **Operating Framework:** We are achieving our RTT 18. Urolgy and Gastroenterology are struggling around the 18 weeks targets. WUTH is being monitored. Extra capacity has been put into place. Diagnostic waits are 6 weeks or more. There is pressure on the two specialties at the moment. There is an action plan in place to include additional lists. By November, 99% of their waiting list will have waited less than 18 weeks. **GP referrals** - AM happy to pick up and see if this can be delivered via Spire to take the pressure off. Ask GP's to refer to Spire rather than WUTH. LQ and MB will raise at the WUTH Monitoring meeting today and ensure these issues are incorporated into QIPP meetings.	
40.3	**Intensive Support Visit Update**: PJ updated the Committee regarding the Intensive Support Visit at Greasby Health Centre. This included looking through the clinical system on a case by case basis. PJ circulated his report which was reviewed by the Committee. PJ has carried out two visits so far, with another 4 to be done. He has written to Board members asking for assistance and reiterated that time out of practices will be paid (2 sessions). This will be checked and confirmed. PJ agreed to give a further update at the next Committee meeting in December. The Committee noted the comments of the report.	 **PJ**

40.4	**Finance Update**: MB gave an update on the year to date financial situation performance. The report sets out the financial position for Wirral CCG as at the end of October (Month 7) within the 2012/13 financial year. As at the end of October (Month 7), the year to date position is an over-spend of £0.5m with over performance against commissioning expenditure of £1.07m offset by an under performance against running costs of £0.58m. The year to date variance position between Governing Body and the combined consortia is an overspend at Divisional level of £3.99m with the Governing Body underspent by £3.49m. Details of the financial performance were then reported on an exception basis according to variation against planned levels of expenditure. The overall CCG performance position in relation to NHS contracts shows an overspend at month 7 of £5.26m primarily being due to over performance on the Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) contract of £5.13m at Divisional level. The year to date position is based on actual activity as at Month 6. £4.1m over performance with a pro-rata adjustment to equate to month 7 position and application of estimated contract adjustments for re-admissions/out-patient follow-up ratios as appropriate. Prescribing expenditure is currently providing the CCG with a year to date underspend of £1.58m. There is an over performance of those budgets managed at Governing Body level of £121k due in the main to Amber Drugs which is being offset by underperformance at Divisional level of £1.7m. The performance position is based on five month's actual data with two month's estimated costs for September and October. Commissioned "out of hospital" budgets are £889k overspent at month 7. The main drivers for the over performance remain within the Continuing Healthcare section with Older People £180k) and Physical Disabilities (£149k), and all Joint Funded packages £427k) being offset by underperformance on Funded Registered Nursing Care (FRNC) of £146k. Reserves are underspent by £3.89m at month 7 which is due to the release of the contingency element and a number of earmarked reserves which are available for release. There is an underspend of £577k in relation to running costs at	

	month 7 mainly due to clinical backfill reported at consortia level. A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position. MB then detailed the forecast outturn position as at month 7. Although a number of commissioning budgets are over performing as at the end of October 2012, the CCG remains on t arget to achieve a balanced position against its allocation. One of the key performance drivers to the financial performance position remains around the WUTH contract and as such, given the current intelligence regarding contract performance, has been extended within the forecast outturn position to the value of £8.0m (previous month £7.0m). MB then detailed the risk assessment of each of the areas highlighted within the financial plan regarding packages of care, prescribing, WUTH and cost efficiencies. In conclusion, MB is asking the Committee to note the financial position.	
40.5	**QIPP Update**: MB gave an update on the QIPP Report. The report sets out the QIPP position for NHS Wirral CCG as at the end of October (month 7) within the 2012/13 financial year. As part of the operational plan for each financial year, a subsequent cost improvement plan is developed in order to deliver the required cash releasing savings. As 2012/13 was the last year of the PCT, the cash releasing savings spanned across a wide range of areas including the full year impact of prior schemes and some new areas as developed by the consortia within the CCG. The detailed schemes that make up the £6.2m required QIPP savings are from urgent care, long term conditions, planned care, mental health and non-clinical services. Monitoring and recording data needs to be improved. We have to give assurance to the SHA that we are following the correct processes and that it is being followed up through the Quality, Performance & Finance Committee. The CCG remains hopeful that QIPP delivery will still be achieved by the end of the financial year and that those schemes that are amber level of risk will either be turned to green or can be offset by further impact of additional schemes being implemented by the	

	CCG and its respective divisions. In conclusion, the Committee was asked to note the progress to date on the QIPP Programme and the current assessment of delivery of risk around the QIP Programme.	
40.6	**Prescribing Update**: Judith Green gave an overview of the report. The report sets out to describe the prescribing performance for Wirral CCG from 1st April to 31st October 2012. The prescribing annual budget for the practices is £59.6m. The reported forecast outturn as at October shows an un der performance of £2.65m against the prescribing budget. This is largely due to a substantial fall in generic drug prices and delayed launch of high cost drugs as Dabigatran and Ticagrelor. Actual cost growth for Wirral CCG for the period of April to July 2012 compared to the same period of the previous year, is reported as -3.7%. This is significantly below Northwest and National average (-3.5% and -2.5%) respectively. There are some identified cost pressures for the financial year. These include increased amber spend, rise in cost of anti-epileptic prescribing and delayed launch of Dabigatran and Ticagrelor. Prescribing expenditure is currently showing a y ear to date underspend of £1.52m. There is an over performance of those budgets managed at Governing Body of £175k due in the main to Amber Drugs which is being offset by underperformance at Divisional level of £1.70m. The performance position is based on five months actual data with two months estimated costs for September and October. Following discussion with the Accountable Officer, Chair and Chief Officer in April, the work programme within this financial year has focused on action across the indicator set. This work has continued alongside the efficiency projects as well as a Wirral wide review of practice repeat prescribing systems. It was suggested that an a udit be carried out to prove National Guidelines are being adhered to by practices. T his would be a commissioning project. JG to write to the Department of Health. JG asked the Committee to note the explanation of the budget under performance, the identified cost pressures for Quarters 3 and 4 (2012/13) and the progress to date on QIPP.	

QPF12-13/041	ITEMS FOR INFORMATION	
41.1	**CWP**: The minutes of the CWP and NHS Wirral CCG Contract Monitoring meeting held on 27th September were duly noted. JO provided an update on behalf of CC:- • CC is due to meet with the Quality Leads and will update us. • Update regarding Kent House. The elderly assessment unit has been closed temporarily because of a shortage of staff. Anyone from Wirral requiring a bed would need to be transferred to Macclesfield. There has been a proposal put forward to close Kent House. This needs to be flagged up as a risk. Investigating quality issues more fully. • LQ has discussed Kent House with CC. There appears to be a disregard to the commissioning processes. Kent House say they are still providing the service but from a different base. They are paid as part of the block contracting. • Contract query. LQ to take this forward and will write to the Chief Executive to arrange an urgent meeting to include MB. Feedback to CC.	**CC** **LQ/MB**
41.2	**CT**: The minutes of the CT and NHS Wirral CCG Contract Monitoring meeting held on 17th July were duly noted. AC advised that 111 remains a big issue with the PCT. Lots of work has been done. Model one came this week and model 2 was agreed not to re-triage patients. Due to attend a finance meeting around contract values and how much we need to take out. Negotiations taking place in the couple of weeks. This has gone out to all practices. Contract Manager will be visiting GP Forums. Starting to get anxious regarding transition issues and current CCT contract. AC has been Invited to the next CCT meeting to discuss public health services and the health visiting service which sits on the National Commissioning Board.	
41.3	**WUTH**: The minutes of the WUTH and NHS Wirral CCG Contract Monitoring meeting held on 30th August were duly noted. LQ discussed in 40.2 (Performance Reports).	
41.4	**CCC**: The minutes of the CCC and NHS Wirral CCG Contract Monitoring meeting held on 20th July were duly noted. MB gave an overview in IS absence. Discussion going on to	

	discuss tariffs etc.	
41.5	**National Performance Measures:** For information. LQ has shared with the provider organisations and asked for information ahead of time. This will give us an idea of what we are being managed on. This was noted by the Committee today.	
41.6	**Wirral Individual Funding Requests Panel – notes from meeting held on 12th November 2012**: LQ felt it was important to be aware of decisions being made and requests being put through. S R advised it is to keep us informed. The table on pages 1 and 2 shows us what has happened with individual requests. We are the lowest and show that we have a good robust process in place. Any issues will be raised at the Clinical Strategy Group. **IFR Performance Monitoring Report (2012-13)**: Noted for information.	
41.7	**Serious Incidents**: A discussion took place around serious incidents. The report is 2 months combined (Sept-Nov). Within the period 14th September to 19th November 2012, NHS Wirral CCG had 21 new serious incidents reported on the Strategic Executive Information System (StEIS) being investigated and performance managed. The National Patient Safety Agency has identified some incidents which are described as Never Events. These are largely preventable events which, if all the appropriate procedures are followed, should not occur. In Department of Health standard contracts with local NHS care providers, there is a requirement to eliminate Never Events. There is a financial consequence for providers if they fail to comply with this requirement. A serious incident requires the provider organisation to undertake a root cause analysis within 45 working days of the incident occurring, develop a remedial action plan and provide on-going evidence of implementation of the action plan. Four root cause analysis have been received; 3 from WUTH and 1 from CWP. Two of these are grade 3 pressure ulcers which were on different wards. Staff will be given further training. One was a death in the community with no factors involved, the cause being drugs and alcohol. The other one was an unexpected death. LQ assured the Committee that information is getting through the	

	system in a timely fashion. The issue was highlighted regarding extensions on time being asked for time and time again after the 45 days had expired. This is not good practice. As a CCG the bottom line lies with us. AC feels that there are more serious incidents which haven't been highlighted on the system. LQ to chase up. The Department of Health have issued new guidance - A Never Events Framework. This talks about responsibility in organisations with reporting serious incidents and never events. Gives information on not reporting and the consequences thereof.	**LQ**
QPF12-13/042	**RISK REGISTER**	
42.1	**Risk Register**: MB presented the Risk Register, advising that it has been updated following recent meetings across the Board. There have been 4 new items added since last month; the IG Toolkit, commissioned out of hospital budgets, impact of local authority budget cuts and risk of consortium being unable to utilise its total allocation of efficiency resources due to slippage in several schemes becoming operational. We need to use the risk management processes and assurance framework appropriately to ensure compliance with the Risk Register. JK mentioned that work is being analysed and a response being drafted to the local authority regarding the risk to local authority budget cuts. MB in discussions.	**MB**
QPF12-13/043	**ANY OTHER BUSINESS**	
43.1	• **Risk Register**: There has been a change in financial policy from the Department of Health which may have an impact on us. CCG's will now inherit from PCT's. Work is being done at the moment regarding the PCT balance sheets. If the PCT can put provisions in, then the CCG will inherit this too. Appears that the situation is changing. • **One to One Service**: SR forwarded an email to Rose Curtis, which has subsequently been forwarded to AM and MB. • **Maternity**: PJ gave a brief update.	

QPF12-13/044	**DATE AND TIME OF NEXT MEETING**	
	The next meeting is scheduled for: Tuesday 18th December 2012, 1.00 – 5.00pm, Room 539, Old Market House. Apologies/agenda items to: Julie.stamper@wirral.nhs.uk	

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Wirral Clinical Commissioning Group
Governance & Audit – Task & Finish Group
Minutes of Meeting

27th June 2012
Room 509 at Old Market House

Present:	James Kay	Chair – NEA – Vice Chair CWW PCT Cluster
	Mark Bakewell	Interim Chief Finance Officer - Wirral Commissioning Group
	Andrew Cooper	Interim Chief Officer - Wirral Health Commissioning Consortium
	Lorna Quigley	Interim Chief Officer- Wirral Clinical Commissioning Group
	Helen Jones	Project Manager– CWW Commissioning Support Services
	Anne-Marie Harrop	Audit Manager, Mersey Internal Audit Agency
	Robin Baker	District Auditor – Audit Commission
In attendance:	Zerina McCarthy	Secretary

Item No.	Agenda Items
GA/12-13/ 1.1	**Apologies** Apologies had been received from Liz Temple-Murray.
GA/12-13/ 1.2	**Declarations of Interest** Members were invited to register any potential Conflicts of Interest, none were received.
GA/12-13/ 1.3	**Minutes from the Last Meeting** The Minutes of the last meeting were accepted as a true and accurate record of proceedings. Action Points 2. Membership The Chair asked as to whether the CCG were in need of their own Counter Fraud Specialist Officer or whether CCG could use the services of CSS. The Interim Chief Finance Officer advised that CCG would potentially be looking to buy into the wider service offered by the CSS. The Chair advised that there was a definite need for the Counter Fraud

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	Strategy to be part of the CCG policies and procedures. This would be taken forward as part of the organisational development process The Project Manager from the CSS advised the group Members that the old PCT policy had been amended to reflect the changes to CCG and discussion took place that as interim measure the PCT Cluster already had in place the statutory framework for this financial year and therefore the CCG were covered until the end of March 2013. The WHCC Chief Officer asked if this would include referral to the Bribery Act and again this would from part of organizational development process The Interim Chief Financial Officer advised on a development of an overarching work plan over the next 6 months. The work plan will be added onto the Authorisation Plan to be reviewed and monitored. The work plan will become a 'standing agenda' on the Task and Finish Group. 3. <u>Terms of Reference (TORs)</u> The TORs have been forwarded to be included on the next Governing Body Board Meeting – Item closed 4.1 <u>Development of CCG Assurance Framework</u> The Interim Chief Financial Officer advised the group that long term work was in progress on the Development of the CCG Assurance Framework which included the Vision, Mission and Values. MB advised that there will be open discussions around the Vision, Mission and Values during the months of July and August. The Audit Manager advised that the PCT Cluster had been given assurance that this Group had now been formed and areas are being monitored. The WHCC Chief Officer reminded and advised the Members that the 1st Stakeholder event was due to take place today at the Floral Pavilion, New Brighton with many of our stakeholders confirming attendance. 4.2 <u>Accountability Arrangements</u> On agenda

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	4.3 Draft Constitution Update MB & AC agree to supply a GANTT Chart/Project Plan on the authorization program for the next meeting – On agenda 4.4 Authorization Development Plan Concern was raised by the Chair as to whether there was an adequate level of human resource with the CCG in relation to the current workload. This needs to be recorded as a potential risk. Risk has been recorded – item closed 5. Working Group Action Plan and Milestones On agenda
GA/12-13/ 2.1	**Proposed Work Plan**
	Development of CCG Assurance Framework The Interim Chief Financial Officer advised that the assurance framework was one of a number of pieces of work that were key, as part of the development programme for the CCG for the next few months and as such has been identified in the work plan once the mission /visions / values process has been completed The Chair requested that the GANTT and Risk Register charts were produced on A3 size papers for ease of reading. MB informed the group that advice and comments would be sought on the Risk Register from the Audit Manager over the next week so an amalgamation of existing registers could took place The PCT's Appointed Auditor advised at what level should a risk is evaluated, i.e. Divisional Level or CCG Board. The Audit Manger advised that she will undertake a review of the whole process, looking at who will be responsible for each area. A document should be implemented to capture risks at Operational level. The process will be audited to give assurance to the CCG Board. Once the template is approved as a mechanism it is proposed to carry out the following actions: ➢ transfer template to Divisions ➢ migrate up to a Master template ➢ scoring risks ➢ to be incorporated into the Assurance Framework The Audit Manager advised that until 1st April 2013 the group should link into the Cluster's methodology.

	The Chair proposed setting up team building/workshop/educational sessions to advise and support those involved in the Risk Register process, informing of what a Risk Register is and the importance of it. The PCT's Appointed Auditor stated that it was challenging for the CCG Board Members however it was imperative that discussions took place around the Risk Identification process. The Chair reiterated the enthusiasm from the CCG Board Members in getting this right first time. **Action:** Further work to be undertaken. Programme in Progress around Assurance Framework, Risk Register, Risk Management Process – Standing Agenda Item GANTT Chart The Chair advised that the use of colour within the GANTT Chart could be amended to provide a more effective monitoring tool. The Chair suggested that the use of 'milestones to achieve' would give a much clearer indication on the progress of works and use the 'RAG Colour rating' in a separate column. Anything not on schedule for the agreed milestone will need to be either amber or red. Red identified a need for an action plan and Amber requiring at least some action to achieve the milestone. The PCT's Appointed Auditor stated that it was helpful to distinguish between these categories. Further discussion then took place with regards to some of the components within the authorization process and the Interim Chief Financial Officer advised that the CCG would be looking to review a number of documents from 1st / 2nd wave applicants rather than recreate from the basic documents provided. Updates are to be provided at future meetings **Action:** The Interim Chief Officer and the Project Manager to review the GANTT Chart and amend as necessary. **Action:** Secretary to include as a standing agenda item Accountability Arrangements The Interim Chief Financial Officer informed the Members progress was being made with regards the Draft Scheme of Delegation process including the operational detail which identifies the particular cost centre management and respective budget holders. MB also advised that discussions had been taking

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<table>
<tr><td></td><td>place with CSS to decide as to what potential processes could be delegated to them as part of the delegation process to make this a viable operational process.

The Chair asked MB as to how CSS would be monitored to ensure that what they are providing to CCG is not being shared elsewhere.

MB advised that this was part of the ongoing discussions that are taking place with the CSS to understand their service provision and the implicated costs and that relevant KPI's etc would be monitored closely particularly during this difficult transition process

The Chair advised that during the discussions with CSS, MB to ensure that the length of contract agreed is not long term

MB informed the Group that he would update the working group at the next meeting with the relevant draft documentation for discussion

Action: MB to update and provide draft documentation at next meeting

<u>DRAFT Constitution update & Authorisation Development Plan</u>

The Interim Chief Financial Officer informed the Group that 1 meeting per month of the Operational Team had been dedicated to the Authorisation Development Plan.

The Chair asked if the CCG had any Quality Manuals i.e. Standing Operating Procedures in situ. The Interim Financial Officer advised that this would be more a requirement of the CSS and that they would be required to have this level of detail. The Audit Manager stated that this would be part of audit plan for the CSS and via the provision of 3rd party assurance to the CCG.

The Interim Chief Officer advised that she was in the process of pulling together the documents to form the Constitution and that with a wave 4 deadline of December 2012, documentation needed to be uploaded by November 2012.

Action: The Interim Chief Officer to produce a headline GANTT chart to assist the group in the overall milestones for the various workstreams

<u>Information Governance</u>

The Chair that this item is deferred until the next meeting</td></tr>
<tr><td>GA/12-13/ 3.1</td><td><u>Terms of Reference (TORs)</u>

The Terms of Reference were included by the Chief Financial Officer as information only as this group were still in an evolving phase.</td></tr>
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	The Chair questioned the initial membership of the Group and felt that the Interim Chief Officer and the Interim Chief Financial Officer should not be regarded as voting Members. Once this action had been completed they are then to be presented to the next Governing Body Board on the 3rd July 2012. It was also agreed that the TORs should be forwarded to the next Cluster / Audit Committee meeting. **Action:** Secretary to redraft TORs and add to the next Governing Body Board agenda for approval. TORs also to be sent the next Cluster Audit Committee meeting.
GA/12-13/4	**Summary of Actions** Please refer to the action points attached as per Annex A.
GA/12-13/5	**Any Other Business** The Chair invited the RB to give an update on the external audit arrangements. RB advised that he was currently the appointed auditor for the PCTs and that the 2011/12 audit has been completed and signed off for the PCTs. However, the 2012/13 process is somewhat more complicated with the Government announcing the abolition of the Audit Commission and a procurement process had been undertaken to provide new arrangements going forward. Grant Thornton have been appointed as the new auditor for the north west region and this is currently out for final consultation with stakeholders. Until the consultation process is completed in September 2012 the Interim Auditor will continue to be RB and as the CCG is formally a sub-committee of the Cluster PCT, the usual audit arrangements will apply including IFRS and value of money opinion.. The PCT value for money audit will inevitably include the CCG's progress to date including the progress of its authorisation application and RB advised that this should be highlighted to the Governing Body from an awareness point of view **Action:** That the PCT's Appointed Auditor and Audit Manager are invited to attend the Governing Body Board Meeting in November 2012 to update on arrangements and progress of internal / external audit plans The Interim Chief Financial Officer touched on segmental reporting, stating that he would welcome some advice with regards to the approach to be taken and what information the CCG / PCT may be required to provide RB advised that Public Health without doubt should be a separate segment.

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<table>
<tr><td></td><td>MB assured the group that the financial reporting mechanisms was structured to support the segmental reporting arrangements however other reporting requirements may not be as adaptable.

Action: Pre-discussion to be arranged with the Interim Chief Operating Officer and the Chair prior to inviting audit colleagues to the November Board meeting.

<u>Annual Governance Report</u>

RB is to e-mail through to the Chair and Interim Chief Financial Officer the Annual Governance Report

RB advised that out of the 4 PCT audits, Wirral was the most challenging process given some of the changes within the finance team. Those areas that were drawn to the auditors attention were;

➢ CT staff retaining access to Ledger post separation
➢ More work was needed around payroll reconciliation that envisaged due to lack of assurance from a systems compliance point of view
➢ Asset infrastructure and existence of buildings and land, including a complicated land deal on the Victoria Central Hospital site

RB advised that there was uncertainty around the land deal, partly due to the turnover of staff and lack of organisational memory. Recommendations and responses had been raised at the Cluster Audit meeting as part of governance report and WCCG should note the relevant issues for future consideration

The Chair advised that the CCG were in need of some level of assurance from the Cluster Director of Finance and the CSS Director of Finance regarding the issues presented

Action: The Annual Governance Report is to be emailed to the Chair and Interim Chief Financial Officer.</td></tr>
<tr><td>GA/12-13/6.</td><td>Date of Next Meeting

There being no further business to discuss the meeting closed at 1105hrs.

The next Audit & Governance task and finish meeting is scheduled to take place on 25th July 2012 at 0930hrs.</td></tr>
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James Kay
Chair

July 2012

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Wirral Clinical Commissioning Group

Wirral Clinical Commissioning Group
Governance & Audit – Task & Finish Group
Minutes of Meeting

25th July 2012
Room 539 at Old Market House

Present:	James Kay (JK)	Chair – NEA – Vice Chair CWW PCT Cluster
	Mark Bakewell (MB)	Interim Chief Finance Officer – Wirral Clinical Commissioning Group
	Lorna Quigley (LQ)	Interim Chief Officer- Wirral Clinical Commissioning Group
	Helen Jones (HJ)	Project Manager– CWW Commissioning Support Services
In attendance:	Abhi Mantgani (AM)	Accountable Officer (Designate), Wirral Clinical Commissioning Group
	Zerina McCarthy (ZM)	Secretary

Item No	Ref No.	Agenda Items	Action
GA/12-13/6		**Preliminary Business**	
	6.1	**Apologies for Absence** Robin Baker – District Auditor – Audit Commission Andrew Cooper – Interim Chief Officer - Wirral Health Commissioning Consortium Liz Temple-Murray – Audit Manager – Audit Commission Anne-Marie Harrop – Audit Manager, Mersey Internal Audit Agency	
	6.2	**Declarations of Interest** Members were invited to register any potential Conflicts of Interest, none were received.	
	6.3	**Minutes of the Previous Meeting – 27th June 2012** The following amendments are recorded:	

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		GA/12-13/2.1 Development of CCG Assurance Framework Typing error in 3rd paragraph, 2nd sentence – Manger Page 4, 6th paragraph, additional sentence to be added – This to include the Governing Body Board Members. **Action:** Subject to these amendments the minutes of the 27th June 2012 were accepted as a true and accurate recording of proceedings.	**ZM**
	6.4	**Matters Arising** The Committee noted that the majority of actions identified for completion on the action plan for July 2012 had been met with the exception of the following: GA12-13/2.1 Proposed Work Plan ➢ Development of a CCG Assurance Framework **Action:** Date for completion amended to November 2012 GA12-13/5 Any Other Business ➢ Annual Governance Report **Action:** Report to be forwarded to AM & JK Uncertainty surrounding an element of the land at VCH had been resolved at the final stage of the PCT Audit. It is envisaged based on current guidance that Wirral Clinical Commissioning Group (WCCG) will not own any land or assets and based on current situation will not be factor going forwards **Action:** Review of progress of related issues in PCT Audit Tracker and MB to clarify with PCT Locality DOF with regards to current situation.	**ZM** **ZM** **MB**
IG12-13/7		**Items for Discussion**	
	7.1	**Development of CCG Assurance Framework** Governing Body Board Development days have been arranged for its Members. Unfortunately the Northwest	

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		Leadership Academy are unable to provide a facilitator for the 'Diagnostic' session on the original date, 11th September but have offered the 18th September as an alternative. **Action:** ZM to contact Northwest Leadership Academy to agree and confirm alternative date.	 **ZM**
	7.2	**Accountability Arrangements** 2012/13 is a period of transition between the PCT and WCCG. As part of CCG development programme there is a need to review the key financial documents including the current Corporate Governance Manual that was approved by Cluster PCT board in November 2011 and reflect some required changes to the current form to ensure that it is fit for purpose for the WCCG on an interim basis in 2012/13 financial year. MB had prepared for the Committee a draft proposal for the interim period which is to be tabled to the next Cluster Board in September 2012 requesting some amendments to the roles and delegated limits for the WCCG. The document identified the current, interim proposals and the potential CCG Authorisation delegated limits post April 2013. The Committee noted the proposals regarding the interim delegated limits and that they have been forwarded to Cluster board for approval. MB advised that proposed 2012/13 arrangements underpins a wider piece of work in support of the key financial documents including scheme of delegation (as tabled as draft version for discussion), and at a more detailed level the authorised signature process. . AM advised that further discussions were required regarding the level of delegation to divisional level. It would be a balancing act between enabling the divisional elements to drive forward with their respective commissioning strategies however respecting wider financial impact and stability of the economy A process would need to be agreed whereby if any of the divisions wished to commit resource over and above a certain level it would need to be signed off by organisation and through the Accountable Officer.	**AM**

		Once the Audit Committee has been established the Divisional Authority Limits would need to be reviewed and agreed. Discussion then took place with regards to the draft scheme of delegation and roles and responsibilities <u>Appendix D – Scheme of Reservation & Delegation</u> MB advised that this was a longer term piece of work. The document is considered evidence as part of the authorisation process and needs to be reviewed. AM expressed concerns that the decision to approve the appointment of Governing Body Board Members was ticked as 'Reserved to the Member Practices' but should be the responsibility of the Governing Body. There was a need for clarity surrounding the Glossary of 'Approved'. 'Agreed', 'Recommended' and 'Suggested'. **Action:** Amend document to reflect Governing Body and query the level of amendments that can be made to the document MB to continue to develop SORD alongside other key financial documents for CCG AM asked if a 2 tick system could be incorporated to reflect the decision of the committee (e.g. Governing Body) and identified individual.	**MB**
	7.3	**Authorisation Plan Update** As advised at the previous meeting the Authorisation Plan GANTT chart had been amended to reflect the recommendations made. An additional paper of a high level GANTT chart had been provided to identify the 4 key areas surrounding authorization. On the 360 degree stakeholder survey confirmation of stakeholders would be completed by September 2012.	
	7.4	**Information Governance** The purpose of report presented to the Group was to provide	

		assurance that the WCCG has been assessed to demonstrate its capability to meet the Information Governance Toolkit requirements, as part of authorisation. The NHS Commissioning Board confirmed on the 14th June 2012 that CCGs will need to be aware of information governance requirements, know where they are up to, and have a definite plan going forward with a view to being compliant with the toolkit, that is set at Level 2 across the board by 1 April 2013. An action plan has been drawn up in order that the WCCG will reach Level 1 compliance for all Requirements by 31st October 2012. Further actions will be set to ensure that Level 2 compliance for all Requirements is reached by 31st March 2013, which will thereby ensure that the WCCG is compliant from 1st April 2013. **Action:** The Group agreed to invite the Head of Information Governance, CWW Commissioning Support Services to the Governance & Audit meeting in September and February 2013 to give assurance that the WCCG will achieve by October 2012 and March 2013 the Levels set by the NHS Commissioning. **Action:** Head of Information Governance and the Project Manager from CWW Commissioning Services to be invited to a WCCG Operational Team Meeting.	**ZM** **ZM**
GA/12-13/8		**Items for Approval**	
	8.1	There were no items submitted for approval.	
GA/12-13/9		**Items for Information**	
	9.1	**Risk Register** MB advised that he had discussions with MIAA regarding a refresh to the Risk Register template to ensure that it was fit for purpose, following discussions this was ready to be implemented and populated from the existing risk register templates from divisions and governing body discussions. A Master (combined) Risk Register will be in place combining the three divisional registers and will be regularly presented to	

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		the various committees including Governance & Audit Committee. **Action:** Combine existing registers There will need to be a process of scoring the existing risks and one for going forward once risk are identified.	**HJ/LQ/MB**
	9.2	**Schedule of Meetings** The schedule of meetings and dates for submission of Committee papers was noted by the Group.	
GA12-13/10		**Summary of Actions**	
	10.1	A summary of actions as per Annex A are attached.	**ZM**
GA12-13/11		**Any Other Business**	
	11.1	There being no further business to discuss the meeting concluded at 1015hrs	
GA12-13/12		**Date of Next Meeting**	
	12.1	The next governance and audit working group is scheduled to take place on Wednesday 29th August 2012 at 0930hrs in Room 539	

James Kay
Chair

August 2012

Wirral Clinical Commissioning Group

Wirral Clinical Commissioning Group
Governance & Audit – Task & Finish Group
Minutes of Meeting

31st October 2012
Room 539 at Old Market House

Present:	James Kay (JK)	Chair – NEA – Vice Chair CWW PCT Cluster
	Simon Wagener	Lay Member Patient Champion
	Mark Bakewell (MB)	Interim Chief Finance Officer – WCCG
	Abhi Mantgani (AM)	Accountable Officer (Designate) – WCCG
	Anne-Marie Harrop (AMH)	Audit Manager Mersey Internal Audit Agency
In Attendance:	Jo Scott	Board Support Assistant – WCCG

Item No	Ref No.	Agenda Items	Action
GA/12-13/19		**Preliminary Business**	
	19.1	**Apologies for Absence** Andrew Cooper — Interim Chief Officer - Wirral Health Commissioning Consortium Lorna Quigley — Interim Chief Operating Officer - WCCG	
	19.2	**Declarations of Interest** Members were invited to register any potential Conflicts of Interest, none were received.	
	19.3	**Minutes of the Previous Meeting – 25th July 2012** The minutes of the previous meeting were signed as a correct and accurate record. It was decided to go forward with an Action Log. MB confirmed that due to timescales level 1 will be in by December 2012 and Level 2 in by March 2013. Push forward with Level 1 and Level 2. Chairperson made a decision for the Actions to be listed as a separate document. No extra appendix been added. Below more operational not in	**JS**

		documentation. Role of consortium and governing body statutory responsible this needs to be done at Governing body level and fed back to the group.	
	20.1	**Review revised Audit Terms of Reference** The following amendments are recorded: Cluster Audit Committee – Action came out of it. AD because of changes not clear from Audit Tracker. ***Action – Alex to work with Director of Finance on tidying up on Audit Tracker.*** Information Toolkit to go To QPF today (31st October) to be discussed	**AD**
	20.2	**Scheme of Delegation Update** Discussions around the SORD. Main text goes back to the Constitution and until this is in place, everything else will follow suit. Chair – Governance sits along have what we can do and what we can't do. Some change on words and extra boxes added, still work to be done on Constitution. MB took away the notes AD – Going back to the plan. NHS CP- Appendix without reference is a very strict criteria. Model constitution has to be in place by operational group and who the accountable bodies are.	
IG12-13/7		**Items for Discussion**	
	20.3	**Review Organisation Chart including sub-committee** PJ chair of WCCG working on new Organisation chart. Questions arose. Around who is the Responsible Officer Engagement – final version to be available by next meeting on 28th November 2012. AO to lead and take back needs clarification, should have one lead. SOR – key hasn't been resolved. Presentation all links together need to know how all fits together.	
	20.6	**Authorisation Update** Desktop Review	

GA/12-13/21	**21.1**	**Items for Approval**	
		There were no items submitted for approval.	
GA/12-13/22	**22.1**	**Items for Information**	
		Risk Register AD – Risk Register Structure – no indication of travel of risks. Arrows help. Waiting on strategic objectives before framework can be put in place. QPF – revised version to go to next Operational Group Meeting	
GA12-13/23	**23.1**	**Any Other Business**	
		No Other Business was discussed.	
GA12-13/24	**24.1**	**Date of Next Meeting**	
		The next Governance and Audit Working Group is scheduled to take place on 28th November 2012 at 09.30hrs in Room 539.	

Wirral Clinical Commissioning Group

WIRRAL CLINICAL COMMISSIONING GROUP
APPROVALS COMMITTEE
Minutes of Meeting

Friday 17th August 2012
Room 539, 5th Floor, Old Market House

Present:

Dr A Mantgani (AM)	Designated Accountable Officer WCCG
John Callcott	Non Executive Advisor NHS Wirral
James Kay (JK)	NEA Vice Chair CWW PCT Cluster (Chair)
Lorna Quigley (LQ)	Chief Officer Wirral Clinical Commissioning Group
Mike Roach (MR)	Non-Executive Advisor NHS Wirral
Mark Bakewell (MB)	Chief Finance Officer WCCG

In Attendance:

Zerina McCarthy	Secretary

Ref No.	Minute
AC/12-13/1	**Preliminary Business** **1.1 Apologies for absence** No apologies had been received. It was noted that Fiona Johnson Director of Public Health would be invited to future meetings. **1.2 Minutes and Actions from previous meeting** No previous minutes and actions have been recorded.
AC/12-13/2	**Items for Discussion** **2.1 Terms of Reference** Members of the committee were asked to note the Terms of Reference. These will be subject to change following the appointment of the Lay members.
AC/12-13/3	**Items for Approval** **3.1 Prescribing Incentive Scheme** Committee members were asked to review the Prescribing Incentive Scheme Proposals of each division and the contents of a proposal in which each consortia, in conjunction with Medicines Management have developed an incentive scheme with the aim to encourage practices to continue to engage in cost effective prescribing. PDF Agenda Item 3.1 - PDF Prescribing Incer The Approvals Committee approved the proposal.

Ref No.	Minute
	3.2 Choose & Book LES The committee were asked to consider the above LES which is designed to identify the responsibilities and operational requirements for the correct use of Choose and Book and to incentivise its use. There are benefits for the health economy in the implementation of this scheme. Agenda Item 3.2 - Approvals Committee After reviewing the papers and the proforma; The Approval Committee approved the proposal. **3.3 Alcohol Support LES** Members of the committee were asked to consider the Alcohol service development to support long term recovery of patients that have been identified with alcohol- related health and social care issues. Agenda Item 3.3 - Alcohol Service Devel After reviewing the papers and the proforma; The Approval Committee approved the LES. **3.4 COPD LES** Members of the committee were asked to consider the COPD LES. The aim of the LES is to target early detection of COPD and ensure appropriate management plans are put in place to support patients. Agenda Item 3.4 - Approvals Committee After reviewing the papers and the proforma; Members of the Committee approved the COPD LES. **3.5 Community Surgery Service** Dr Mantgani declared an interest in this item, as if approved Miriam Medical Centre would house the community surgery service. The chair asked for the recording of the interest and stated that the Dr Mantgani was at the committee as a presenter and did not have a vote, therefore a decision was made that the decision making process would be robust. Committee Members were asked to approve the awarding of the Community Minor Surgery contract to Miriam Medical Centre. Agenda Item 3.5 - Community Surgery S After reviewing the papers and the proforma ; Committee Members approved the Community Surgery Service. **3.6 WGPCC Minor Injury Service** Members were asked to approve WGPCCs Minor Injury Service. Discussions took place around

Ref No.	Minute
	the service and members of the committee agreed to support the continued commissioning of the Minor Injuries Services operating at Miriam medical Centre and Parkfield Medical Centre until 31st March 2013. PDF Agenda Item 3.6 - Minor Injury & Illness After reviewing the papers and the proforma; Committee Members approved the extension to the minor injury service **3.7 Over 65's Healthcheck** Discussions took place around WGPCCs Over 65's Healthcheck proposal and committee members were asked to approve the implementation of an over 65s health check and post discharge follow up for all WGPCC practices, to approve investments to support the scheme and to approve the proposed payment schedule in respect of the investments being made. PDF Agenda Item 3.7 - Over 65s Health Chec After reviewing the papers and the proforma ; Members of the Approvals Committee approved the proposal. **3.8 Patient Engagement LES** Members discussed the proposal regarding the above LES which will provide a framework for WGPCC constituent practices to target patients to get involved through a number of different media in order to inform them about the consortiums commissioning priorities. PDF Agenda Item 3.8 - Patient Engagement i After reviewing the papers and the proforma; Members of the committee agreed the Patient Engagement LES. **3.9 WGPCC Housebound Patients with LTCs** The group discussed the contents of the proposal for the management of long term conditions in housebound patients and were asked to support the investment in order to gain a better understanding of the needs of housebound patients and to reduce health inequalities. PDF Agenda Item 3.9 - Long Term Conditions After reviewing the papers and the proforma; Committee Members approved the proposal.
AC/12-13/4	**Items for Information** **4.1** No items were discussed
AC/12-13/5	**Any Other Business** **5.1** No items were discussed
AC/12-13/6	**Date and Time of Next Meeting**

Ref No.	Minute
	6.1 The date and time of the next meeting well be convened when needed.

Wirral Clinical Commissioning Group

WIRRAL CLINICAL COMMISSIONING GROUP
APPROVALS COMMITTEE
Minutes of Meeting

Friday 14th September 2012
Room 539, 5th Floor, Old Market House

Present:		
	Dr A Mantgani (AM)	Designated Accountable Officer WCCG
	Mr J Callcott	Non Executive Advisor- NHS Wirral
	James Kay (JK)	NEA Vice Chair CWW PCT Cluster (Chair)
	Lorna Quigley (LQ)	Chief Officer WCCG
	Mike Roach (MR)	Non-Executive Advisor NHS Wirral
	Mark Bakewell (MB)	Chief Finance Officer WCCG

Ref No.	Minute
A/C12/13/7	**Preliminary Business** **1.1 Apologies for absence** No apologies had been received. **1.2 Minutes and Actions from previous meeting** It was commented by the committee that the previous minutes where missing detail around the proposals and the decision making process. It was agreed that the following statement would be added after each approval. ….after reviewing the papers (attached) and proforma this proposal was approved. It was also agreed that the proposal and proforma would be embedded within the minutes. **Action: Agreed amendments would be made to current minutes and future minutes.** Terms of Reference The chair informed the meeting that the governing body has agreed in principle the formation of the Approvals Committee and the terms of reference will be established on the appointment of the 2 lay members. It was agreed that an interim set of terms of reference would be developed for the next meeting. These would include: quoracy, voting members and the role and responsibilities of the Committee, the core of which was managing actual or potential conflicts of interest. **Action;** **Draft interim Terms of Reference to be developed and sent to members for comment before the next meeting.**

Ref No.	Minute
	1.3 Declarations of Interest None
AC/12-13/8	**Items for Approval** **Application for Accreditation of GPSI** An application had been received via one of the divisions for the re-accreditation of a GPwSI to undertake Dermatology procedures. This approval in the past would have been undertaken by the Primary Care Management Board (PCMB) and approved by the Professional Executive Committee (PEC); these fora no longer exist and so a discussion took place about how such applications should be handled in the new structures. It was agreed that these should roles should be accredited without the intervention of the Approvals Committee unless there is a conflict of interest issue to address. **Action: Refer back to CCG.** **WHCC- Asthma proposal** The case was presented by the Clinical Accountable Officer on behalf of WHCC. The aim of the proposal is to reduce emergency admissions by providing a "back to basics" practice based education training programme facilitated by practice nurses. This proposal goes beyond the requirement of the GMS contract. After reviewing the papers and proforma, this proposal was agreed. C:\Documents and Settings\LQuigley\My
AC/12-13/9	**Items for Information** **4.1** No items were discussed
AC/12-13/10	**Any Other Business** **5.1** Mike Roach suggested that a briefing session on options for tendering and AQP. This was to be taken forward as part of the board and lay member development process. **Action: briefing session to be arranged.**
AC/12-13/11	**Date and Time of Next Meeting** **6.1** The date and time of the next meeting will be 9. 30 on the 19th of October in Old Market House.

Ref No.	Minute

Wirral Clinical Commissioning Group

WIRRAL CLINICAL COMMISSIONING GROUP
APPROVALS COMMITTEE
Minutes of Meeting

Friday 19th October 2012
Room 539, 5th Floor, Old Market House

In Attendance:	Dr A Mantgani (AM)	Designated Accountable Officer WCCG
	Simon Wagner	Lay Advisor designate WCCG
	James Kay (JK)	Lay Advisor designate WCCG (Chair)
	Lorna Quigley (LQ)	Chief Officer WCCG
	Mike Roach (MR)	Non-Executive Advisor NHS Wirral
	Mark Bakewell (MB)	Chief Finance Officer WCCG
Present:	Joanne Scott	Board Support Assistant

Ref No.	Minute
AC/12-13/12	**Preliminary Business** **1.1 Apologies for absence** Apologies were received from the following members of the Committee:- John Calcott, Phil Davies, Fiona Johnstone **Chair** Announced a Good News Story and Congratulated: AM who received an award for GP of the Year. Miriam Health Centre for practice of the Year. Philomena Potts who received practice Nurse of the year AM thanked the chair for this acknowledgment. **1.2 Minutes and Actions from the meeting of the Approvals Committee on the 14th of September** These were checked for accuracy: The Action on page 2 to should read "…*refer back to Primary Care."* not to the CCG. A further update was given in relation to this item. AM had spoken to the Deputy Director of Primary Care and this will be taken forward by his team The Chair signed off the minutes of the previous meeting as an accurate record

Ref No.	Minute
	Actions: MR asked for an update in relation to his suggestion made in Any other business of the last meeting re procurement and AQP training for committee members. **Action:** AM agreed to arrange that a member from the Contracts Department would be invited to give a brief half hour session on procurement and contracting in relation to AQP. It was noted that there would be potentially be 2 papers coming to future committees which could result in adopting an AQP approach. **2. Interim Approval Committee - Terms of Reference (V3) (TOR)** The Chair opened the discussion by giving some background to the development of the terms of reference of this Interim Committee. He informed the Committee that the document under discussion was a product of the proposal presented to the Governing Body to establish the Interim Committee, Guidance issued by the NHS National Commissioning Board on dealing with Conflicts of Interest (Oct 2012) and further internal discussions. **Action:** A copy of the NHSNCB Code of Conduct (October 2012 document) will be circulated for reference to the Committee for the next meeting.(JS) The proposed terms of reference were discussed page by page with a number of adjustments made which would be implemented into a final draft for agreement by the Governing Body. **Action:** Forward amended Terms of Reference to the Governing Body (MB) **Frequency and notice of meetings.** **Action:** Approvals Committee meetings would be put in diary every 3rd Friday in the month. If there were no agenda items submitted for approval by 7 days before the meeting, the booking would be cancelled until the following month. It was also agreed that ad hoc meetings may be required and this will be at the discretion of the Chair. (JS) **Action:** JS to circulate dates of future meeting dates prior to the next meeting. **Item 2.1 Template** JK has produced a new template to capture the information required to assist the committee in its decision making process. This template was based on the version issued by the NHSNCB with local amendments. This was discussed by the committee and a number of further improvements suggested The committee accepted the improvements to the template which would be used with effect from the next meeting with chief officer's being made aware of the new template.

Ref No.	Minute
	Action: Revised template to be circulated to Chief Officers to use from the next meeting onwards. (JS)
AC/12-13/13	**Items for Approval** **3.1 Dementia LES** AM presented this proposal which has been discussed at the governing body and will be taken up as a Wirral wide initiative. The LES will reduce waiting times for initial memory assessment, and will ensure that patients are seen by the right people, at the right time. It was considered by the Dementia Task and Finish Group that GPs would be t he most appropriate providers to deliver the annual review to patients, as it involves a medication review and assessment of the patient's clinical condition, which requires a detailed knowledge of the patient's other co-morbidities. T he patient's GP would be bes t-placed to have this knowledge and therefore the most appropriate to deliver the review. The Chair questioned whether this additional workload could be managed in Primary Care with c challenges to capacity and the need for new training. AM assured the committee that GP's are currently working to this time frame and have the ability to flex their capacity to meet the demand. After reviewing the papers and template supplied, this proposal was approved by the Committee. **3.2 Mental Health & Long Term Conditions** AM presented this proposal on behal f of WHCC. The aim of this was to provide psychological support to patients who have long term conditions. The paper detailed the costs and health outcomes of the relationship between long term conditions (LTC) and mental health. It proposed a Loc al Enhanced Service for improving the identification of patients experiencing both LTCs and co-morbid mental health problems. After reviewing the papers and t he template provided, the proposal was approved by the committee. **3.3 Home Pilot Incentive over 65** AM presented this proposal on behalf of WGPCC. The aim of this scheme is to give additional GP support to nursing and residential homes to prevent unnecessary admissions/re-admission to hospital. The paper outlined the proposal for a pilot scheme to provide enhanced primary care support to Nursing/Residential Home patients during both In-hours and Out-of-Hours (OOH)

Ref No.	Minute
	MR questioned if this was a similar scheme that had been undertaken in the past, that had relied on one individual to undertake these reviews. AM acknowledged that it was similar, however by having the practice taking responsibility this was a more sustainable model. After reviewing the papers and template provided, this proposal was approved by the Committee.
AC/12-13/14	**Items for Information** No items were discussed
AC/12-13/15	**Any Other Business** No other business was discussed.
AC/12-13/16	**Date and Time of Next Meeting** The next meeting is Friday 16th November 2012 at 9.30am in Room 539, Old Market House.

RISK REGISTER - Master

Risk ID	Date	Source	Risk Description	Organisational Objectives (reference to detail)	Impact	Likelihood	Current Matrix Score	Previous Matrix Score	Trend	Driver for Change in Trend	Rationale	Key Control Established	Key Gaps in Control (reference to evidence)	Assurance on Controls (reference to evidence)	Gaps in Assurance (reference to evidence)	Action	Owner	Date of next review	Date of last review	Status
1	3.07.2012	Gov Body	Increase in activity for GP's as a result of the introduction of NHS111		3	3	9.00	9.00				Current provision of primary care / urgent care services - ability to absord additional activity	Unknown impact of 111 Service Impact	Monitoring of Primary Care/ urgent care activity and performace of NHS111 through information flows	Timely impact on monitoring of primary care activity	Monitor Information regarding implemention of 111	Governing Body	As further information becomes available	Jul-12	On-going
2	Ongoing	CSS	Reduction in local expertise and organisational memory due to PCT staff leaving		2	3	6.00	8.00				CSS / CCG Transitional Arrangements, Procedure Notes, CSS SLA, Legacy Documentation, Appropriate Handover	Individuals leaving before handover process is complete	CSS SLA Arrangements ensuring continuity, locality link involved in CSS Operational Group Meetings	SLA still in infancy	Continue development of SLA, transitional arrangements, clarity of responsibilities	Chief Officers	As further information becomes available	Nov-12	On-going
3	24.07.12 / 28.08.12 / 27.09.12	Gov Body / QPF / WHCC	Overperformance on WUTH Contract	Financial Management	4	5	20.00	15.00				Financial / Activity Reporting through QPF / Gov Body. Divisional Reporting / Practice Level Reviews - Action Plans	Ability to influence contract performance - Implementation of Action Plans	Regular Monitoring through committee / gov body structure, Use of Contigency Funds / Planned Slippage to offset	Ability to influence behaviour	Review performance areas, initiate action plan to address performance issues	Divisions	Jan-13	Dec-12	On-Going
4	28.08.12	QPF	Inability to monitor CT contract performance / outcome measures due to unavailability of information	Quality / Financial Management on Cost Per Case / Impact on Future Commissioning Intentions	2	4	8.00	8.00				CT Contract Monitoring / (Contract Query raised), Refinement of KPI's	Ability to influence provider behaviour	Regular Monitoring through contract monitoring process and subsequenty committee / gov body structure with ability to withold payment for non-provision of information as required	Ability to influence behaviour	Review contract query outcome, monitor action plan,	AC / TK	Jan-13	Dec-12	On-Going
5	27.09.12	QPF	Contract Variation to Wirral NHS Community Trust Contract regarding implementation of NHS 111 to NHS Direct	Future Commissioning Arrangement regarding 111 service provision	2	5	10.00	10.00				CT Contract Monitoring / (Contract Query raised), Part of NHS 111 Steering Group	Ability to influence implementation of NHS 111 Service, financial assumptions made with NHS 111 project	Urgent Care Meetings, Feedback from NHS 111 Workstream , Regular Monitoring through contract monitoring / negotiation process and subsequenty committee / gov body structure	Ability to influence implementation of NHS 111 Service	Continue workstream on progression of NHS 111 Service with NHS Direct and contract negotiations with Community Trust	AC	Jan-13	Sep-12	On-Going
6	27.09.12	QPF	Child Health Information System (CHIS) - Imminent Risk of Crashing	Provision of relevant Information System supporting appropriate statutory requirements	4	3	12.00	12.00				CT Contract Monitoring, CHIS Replacement Project via WHIS/ CICT	Lack of clarity regarding Responsible Officer / Availability of Project Plan	Regular Monitoring through committee / gov body structure, also raised via Public health Governance Group	Ability to prevent system failure	Ascertain Project plan, responsible Officer, Contigency Plan / Backup Scenario	Rosemary Curtis ?	Jan-13	Sep-12	On-Going

7	24.10.12	WGPCC	WGPCC will fail to meet IAPT waiting time targets due to performance of one provider		2	5	10.00	10.00				Action plan agreed with provider, including weekly submission of data and bi-weekly monitoring meetings	Provider dealing with old waiting list as well as new patients referred	Action plan dealing with both groups of patients will be monitored and reviewed by board on a monthly basis	Demand continues to rise for this service	Action plan agreed with Provider	Christine Campbell / Dr Oates	Jan-13	Dec-12	On-Going
8	31.10.12	QPF	Non-Compliance with Information Governance Standards by March 2013	Statutory Responsibility	4	2	8.00	8.00				IG Toolkit Assessment Work Programme to ensure compliance with required level by March 2013	Development of IG Policies / Procedures and implementation within CCG	Regular Monitoring through QPF and Audit Committee Meetings & Information Governance Manager work Programme through CSU SLA	Ensure Implementation of required standards	IG Toolkit Monitoring Programme	SIRO (CFO)	Jan-13	Dec-12	On-Going
9	06.11.12	Gov Body	Commissioned Out of Hospital Budgets, increase in package costs, Restitution Cases	Achieve Financial Balance	3	4	12.00	12.00				Financial / Activity Reporting through QPF / Gov Body. CSU SLA Monitoring Process	Time lag in information recieved, external stakeholders pursuing restitution cases	Regular Monitoring meetings with CSU, Top 10 package reviews, pro-active approach to new cases	Ability to influence behaviour	Review performance areas, initiate action plan to address performance issues	Governing Body	Jan-13	Dec-12	On-going
10	20.10.12	Gov Body	Impact of Local Authority Budgets Cuts	Financial Management / Service impact across Economy	3	5	15.00	15.00				Impact Assessment of Chief Executive Options Appraisal on NHS Budgets	Quantify Impact	Financial Planning and Budget Setting Process	Ability to manage impact of cuts	Action Plan for impact assessment	Governing Body	Jan-13	Nov-12	On-going
11	20.10.12 & 24.12.12	WGPCC	Risk of Consortium being unable to utilise its total allocation of efficiency resources due to slippage in several schemes becoming operational	Financial Management	2	0	0.00	6.00		WGPCC review of expenditure plans		Expenditure being monitored and support offered to practices around use of resources	Not all practices able to commit resources by deadline and WGPCC unable to commit resources to schemes before end of April	Plan being developed for alternative use of uncommitted resources before end of March 2013	WGPCC practices will need to agree proposals	Proposal taken to member practices for use of unutilised resources at practice member forum 5.12.12. New Investment Areas agree	Christine Campbell	Dec-12	Nov-12	Completed
12	06.12.12	WACC	Investment in agreed projects being concluded by end March 2013	Non-Recurring investment plans	2	3	6.00	0.00		New Item		Weekly reviews of plans	Timescales for financial commitment to be made - by end February	Reviewed by WA Board on regular basis	Ability to implement investment schemes	Monitor Scheme slippage by CFO on monthly basis	Iain Stewart	Feb-13	Jan-13	On-going
13	06.12.12	WACC	CCG Constitution - refusal to sign agreement by some member practices	CCG Authorisation	3	3	9.00	0.00		New Item		Provision of up to -date information on progress of authorisation	Clarity on signed requirement for authorisation	Regular updates to Governing Body	Ability to influence behaviour	Identify key outstanding / unresolved issues	Dr Mark Green	Feb-13	Jan-13	On-going
14	06.12.12	WACC	Impact of NHS 111 on patient safety and demand shift to practices	Urgent Care Strategy	3	3	9.00	0.00		New Item		GP membership of QIPP Team to influence implementation	Centralised aspects of service that cannot be influenced	Regular updates to 111 Steering Group /QIPP Workstream & Governing Body	Ability to influence behaviour and implement robust service model	Continue workstream on progression of NHS 111 Service with NHS Direct and contract negotiations with Community Trust	Dr Bryan Conlan	Feb-13	Jan-13	On-going
15	06.12.12	WACC	Forecast overspend as at end March 2013	Financial duty to balance	2	3	6.00	0.00		New Item		Demand management initiatives in place	Time-lag for initiatives impacting on outcomes	Reviewed by WA Board / QPF committee on regular basis	Increased Activity continues to rise / demand mgt schemes have little / no effect	Review over performance areas, initiate action plan to address performance issues	Iain Stewart	Feb-13	Jan-13	On-going

Insert Rows Above This Line Only

Gov Body
WACC
WGPCC
WHCC
PFQ
G&A
CSG
CSS

Completed
On-going
Outstanding

Impact Values	
Negligible	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Probability Values	
Rare	1
Unlikely	2
Possible	3
Likely	4
Almost Certain	5

Green/Yellow/Red Threshold Values	
Green - maximum score	4
Yellow - minimum score	5
Yellow - maximum score	12
Red - minimum score	15