NHS
Wirral Clinical Commissioning Group

GOVERNING BODY MEETING – A meeting in public

Tuesday 7th April 2015
Nightingale Room, OMH
2pm

AGENDA

Ref No.	No	Time	Item		Papers
GB15-16/0001	**1.**	**2.00pm**	**PRELIMINARY BUSINESS** (Acting Chair – Dr P Naylor)		
			1.1	**Apologies for Absence**	HM
			1.2	**Chair's Announcements**	
			1.3	**Declarations of Interest**	
			1.4	**Comments/questions from members of the public**	
			1.5	**Minutes and Action Points of Last Meeting – held on 3rd March 2015** (All) • **Action Points**	DRAFT GB Minutes PUBLIC MEETING 03 0
			1.6	**Matters Arising**	
			1.7	**Patient Story** (Lorna Quigley)	
GB 15-16/0002	**2.**		**ITEMS FOR APPROVAL**		
			2.1	**WUTH Trust Quality Report** (Lorna Quigley)	coversheet re - quality GB 07.04.2015. QSG GB Report.docx
			2.2	**Re-commissioning of Direct Access Diagnostics** (Heather Harrington)	Coversheet Recommissioning of D Recommissioning of Direct Access Diagnos
			2.3	**Morecombe Bay Report** (Lorna Quigley)	coversheet re - morcambe GB 07.04.2 Report of the Morecambe Bay Inves
GB 15-16/0003	**3.**		**ITEMS FOR DISCUSSION**		
			3.1		
GB 15-16/0004	**4.**		**ITEMS FOR INFORMATION**		
			4.1	**Quality Performance and Finance- QPF** (Lorna Quigley/Mark Bakewell)	Coversheet PERFORMANCE AND F Slides for GB 07 04 15.pptx
			4.2	**WCCG Corporate Calendar**	Cover Sheet - Corporate Calendar A Corporate Calendar April 2015.xls
			4.3	**Better Care Fund** (Christine Campbell)	Better Care Fund update GB April 2015 Better Care Fund update GB April 2015
GB 115-	**5.**		**ITEMS FOR NOTING**		

Ref No.	No	Time	Item		Papers
16/0005					
			5.1	**Subgroups (Ratified Minutes):** • **QPF of February 2015**	RATIFIED QPF Minutes 24 02 2015.dc
GB 15-16/0006	**6.**		**RISK REGISTER**		
			Current Risk Register		
	7.		**ANY OTHER BUSINESS**		
			7.1		
	8.	**End**	**DATE AND TIME OF NEXT MEETING**		

Tuesday 5th May 2015
2pm – 4pm
Nightingale Room OMH
Please forward any apologies to Allison.hayes@nhs.net

Wirral Clinical Commissioning Group – Future Meetings 2015			
Day	Date	Time	Venue
Tuesday	5th May	2pm – 5pm	Nightingale Room
Tuesday	26th May (EO)	2pm – 5pm	Nightingale Room
Tuesday	2nd June	2pm – 5pm	Nightingale Room

WIRRAL CLINICAL COMMISSIONING GROUP
GOVERNING BODY BOARD MEETING
Minutes of Meeting – Public Session

Tuesday 3rd March 2015
2pm
Nightingale Room, Old Market House

Present:

John Wicks (JW)	Interim Chief Officer
Dr P Naylor (PN)	Acting Chair WCCG
Dr H McKay (HM)	GP Executive
Dr J Oates (JO)	GP Executive
Paul Edwards (PE)	Director of Corporate Affairs
Dr S Wells (SWe)	GP Executive
Graham Hodkinson (GH)	Director of DASS
Simon Wagener (SW)	Lay member (Patient champion)
James Kay (JK)	Lay Member (Audit & Governance)
Dr A Ali (AA)	GP Executive
Andrew Smethurst (AS)	Secondary Care Doctor
Dr D Jones (DJ)	GP Executive
Dr Mark Green (MG)	GP Executive
Lorna Quigley (LQ)	Director of Quality and Patient Safety Outcomes
Andrew Copper (AC)	Head of Strategic Planning and Outcomes
Christine Campbell (CC)	Head of Partnerships
Mark Bakewell (MB)	Chief Financial Officer

In Attendance:

Allison Hayes (AJH)	Board Support/Corporate Officer WCCG

Ref No.	Minute
GB14-15/0067	**Preliminary Business** **1.1 Apologies for absence** Apologies were received from: Iain Stewart, Fiona Johnstone, Karen Prior and Richard Williams.
	1.2 Chairs Announcements Chair welcomed all members to the meeting. 3 members of the public attended the meeting. Chair announced that Dr Susan Wells has been elected as Medical Director of the CCG. The results were announced as follows: • Dr S Wells 58% • Dr S Delaney 37% • Dr M Salahuddin 5% 53 practices voted out of 56 (95% response rate). Chair also announced that Dr Andrew Smethurst has also been appointed Royal College of Radiologists Medical Director for Professional Practice.

Ref No.	Minute
	Chair went on to inform members of the Governing Body of a presentation he had attended in support of the Vanguard Bid for new model for Wirral that supports the Five Year Forward view. **1.3 Declarations of Interest** There were no declarations of interest. **1.4 Comments/questions from members of the public** There were no comments from members of the public. **1.5 Minutes from previous meeting held on 10th February 2015.** The minutes of the previous meeting held on 10th February 2015 were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified. ***Action Points – please refer to separate Action Sheet.*** ***1.6 Matters Arising*** AC informed members of the draft Operational Plan which is to be submitted to NHS England. AC proposed that the final draft is reviewed at the next Governing Body meeting. **1.7 Patient Story** LQ introduced a lady called Paula who explained her positive experience and journey with regards to using Cognitive Behaviour Therapy (CBT). LQ introduced Paul a Primary Care provider who informed members of the benefits of mental health support services available to patients. Suggestions to improve the referral process and waiting times for patients included: • Leaflets in pharmacies • Wider range of information in GP practices • Better communication Members thanked Paul and Paula for presenting their stories to the Governing Body and were hugely appreciative of them taking their time to present at a public meeting.
GB14-15/0068	**2.0 Items for approval** **2.1 Assurance Framework** PE provided members with an updated of the CCGs Assurance Framework. The Assurance Framework was initially developed by the Governing Body in conjunction with Mersey Internal Audit Agency and identifies key risks to NHS Wirral CCG's Strategic Objectives. An informal meeting of Governing Body members was held on 3rd February 2015 to review the Assurance Framework and the paper presented today incorporates the amendments to the Assurance Framework agreed at the meeting held on that date. AC highlighted the importance of the timescales involved being sufficient and it was agreed that an extension to the original timescales regarding the implementation of the new structures of the CCG should be included. Members agreed that the timescales for the engagement elements of the framework would remain the same.

Ref No.	Minute
	Members noted and approved the Assurance Framework update presented at today's meeting. **2.2 Financial Plan** MB presented the group with the CCGs Financial Plan. The report presented sets out an update to the financial planning assumptions for NHS Wirral Clinical Commissioning Group based on the NHS England Boards revised Planning Guidance released in December 2014 and has been refreshed during January / February for the relevant information. Areas of the plan included: • Resources 2015/16 • Surplus Requirements • Forecast Outturn Assumptions • Tariff Assumptions • Growth • Non Recurrent Resources • Contract Values • Prescribing • QIPP • Better Care Fund (BCF) • 2015/16 Revised Planning Assumptions The financial values associated with these planning requirements for 2015/16 are as follows • Surplus (at least 1% of revenue) £4.569m • Non-Recurrent Expenditure £7.14m • Contingency (at least 0.5%) £2.32m The Governing Body were asked to: • Note the financial Planning Assumptions for 2015-16 based on current information and that further iterations will be required as part of contract agreement process. MB went on to update members regarding the QIPP Plan for 2015/16. The report MB presented sets out an update to the financial resources and planning gap for NHS Wirral Clinical Commissioning Group with particular regards to QIPP (the difference between anticipated resources and expenditure planning assumptions. Themes included: • Market/Demand Management • Transformation • Medicines Management • Commissioning Expenditure Review • Commissioning Efficiencies A number of action plans are required to underpin the relevant QIPP planning assumptions and will require lead management / clinical arrangements to ensure delivery of required QIPP challenge in respect of each of the nominated areas. Members went on to discuss tariff assumptions and MB explained that further guidance has been released regarding different tariff options for providers. JK sought clarity around how the figures presented within the QIPP plan are arrived at and MB explained the tangible plans and adjustments that are in place. However, MB highlighted that there is a need to constantly review the planning assumptions detailed within the report.

Ref No.	Minute
	The Governing Body were asked to note the • Headline QIPP plan and development of action plans as appropriate. Members of the Governing Body noted and approved the Financial and QIPP plan.
GB14-15/0069	**3.0 Items for Discussion** **3.1** There were no items of discussion.
GB14-15/0070	**4.0 Items for Information** **4.1 Quality Performance and Finance Report** **Quality Performance** LQ gave a presentation on the activity performance for month 9 (December) and the CCGs dashboard for Quarter 3 (October, November and December) and highlighted the positive areas and the improvements in the challenges that were originally presented. Areas included: • Inpatient and A&E (minor components) Family and friends tests and response scores • Maternity Friends and Family tests • NWAS turnaround • Delivering the same sex accommodation • Diagnostic tests • MRSA & Cdifficile • Referral to treatment – NHS Constitution 4 hour target • Health Care Associated Infection • National Accident and Emergency targets – emergency admissions • Single Item Quality Surveillance meeting Members discussed the impact primary care access schemes have and agreed for the CCG to contact NHS England in order to establish appropriate data in relation to referrals. The Governing Body noted the contents of the Quality and Performance Report. **Finance Report** LM provided information of the Financial performance against budgeted allocation for 2014/15 as at month 10 (January). • 1% Surplus - £4.68m • 2.5% Headroom (non-recurrent resources) - £11.4m • Minimum 0.5% Contingency • CCG hold £3m vs £2.2m (0.5%) Better Payment Practice Code & Cash Management **Year to Date (Month 10) Financial Performance** Planned Year to Date Surplus - (£4.68m) Current Year to Date Surplus - (£1.1m) **NHS Contracts** • WUTH year-end agreement reflected in position £218.2m Outturn - £3.4m

Ref No.	Minute
	underperformance outturn position. • Adverse movement in YTD position reflected in order to reflect pro-rata outturn • Mixture of Performance variation across NHS Contracts • Increase at Countess of Chester FT and Non-Contracted Activity • Reduction on a number of Mersey Contract Providers (e.g RLBGUH, LWH, LHCH) **Non-NHS Contracts** • Increase in Spire (Murrayfield) activity in month £163k adverse variance • YTD position £187k over performance , FOT £359k over performance **Prescribing** • Increase in Prescribing activity in month £221k adverse variance • YTD position £550k over performance , FOT £864k over performance **Commissioned Out of Hospital Care** Slight Deterioration position in respect of Continuing Healthcare / Funded Packages of Care Value of Queries are increasing and Outturn position reflective of inclusion of these issues being resolved Minimal risk coverage should further increases take place during Quarter 4 **Other** Residual Balance of Outturn QIPP Gap £6.3m and Contingency (£3.0m) remains Notified return of resource regarding CHC retrospective top slice £1.1m is now actioned within position Other Performance Indicators **Cash Management & BPPC** The CCG cash balance at the end of January was £62k. This is in line with current NHSE guidance that CCGs aim towards 1.25% month end cash balance. The Governing Body noted the financial report as at month 10 (January). **4.2 Safe Guarding Report** LQ informed members of the Safeguarding Report for NHS Wirral Clinical Commissioning Group. As with all other NHS bodies, WCCG has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people that reflect the needs of the children they deal with; and to protect adults at risk from abuse or the risk of abuse. As a commissioning organisation NHS Wirral Clinical Commissioning Group is also required to ensure that all health providers from whom it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from abuse or the risk of abuse; that health providers are linked into the Local Safeguarding Children and Safeguarding Adult Boards and that health workers contribute to multi-agency working. As part of the Board Assurance framework, the report is to inform the Governing Body of the work that is being undertaken by the safeguarding team and to give assurance of the processes that is in place to safeguard children and vulnerable adults. The Governing Body were asked to note the contents of the report, continue with the current reporting mechanism and to receive the safeguarding annual review at the June Governing Body meeting.

Ref No.	Minute
	Members noted the Safeguarding report and agreed the recommendations as detailed.
GB14-15/0071	**5.0 Items for Noting** **5.1 Subgroups (ratified minutes for noting)** • Audit Ratified minutes of: November 2014 • QPF Ratified minutes of: January 2015 The Governing Body noted the reports of the above subgroup.
GB14-15/0072	**6.0 Risk Register** PE gave an overview of the current risk register and all items were reviewed and noted today. Key areas of focus included: • Finance • Quality Risk Summit/Quality Surveillance Group • NHS 111 PE is to review risks recorded at next QPF.
	7.0 Any other Business Chair announced that an appointment process has taken place in relation to the Chief/Accountable Officer position within the CCG and that Jon Develing has been appointed subject to ratification from NHS England. The Board meeting ended at 16:00pm.
	8.0 Date and Time of Next Meeting *The date and time of the next meeting is **Tuesday 7th April 2015 in the Nightingale Room, OMH** please contact Allison.hayes@nhs.net with any apologies or agenda items.*

Board meeting ended at: 16:00pm

GOVERNING BODY BOARD REPORT COVER SHEET

NHS
Wirral Clinical Commissioning Group

Outcome from the Single Item Quality Surveillance Group meeting with Wirral University Teaching Hospital			
Agenda Item:	2.1	**Reference**	GB15-16/0002
Public / Private	Public	**Meeting Date**	07.04.2015
Lead Officer	Lorna Quigley Director of Quality and Patient Safety		
Contributors			
Link to CCG Strategic System Plan	1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base 4 Provides greater equality of access to all		
Link to current strategic objectives	1 Prevent people from dying prematurely 2 Enhance the quality of life for people with long term conditions 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care 5 Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm		
To approve			
To note	YES		
Summary	Following a non-compliant Care Quality Commission (CQC) inspection, this was reported at Governing Body in January 2015. Governing Body supported the approach for the CCG with support from NHS England to undertake a single item Quality Surveillance group meeting. The purpose of the review is to gain assurance with regard to the quality of services provided by Wirral University Teaching Hospitals NHS Foundation Trust, working collaboratively with NHS Wirral and West Cheshire Clinical Commissioning Groups, NHS England, Public Health England, Local Authority, Regulatory Bodies and the Trust.		
Comments	Governing Body is required to note the contents of the report and actions being taken		
Next Steps	A further single item quality surveillance Group will be established to monitored progress against the actions identified.		

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider the financial impact? NO**

GOVERNING BODY BOARD REPORT COVER SHEET

	The report reviews the quality of service based on quality measures
Value For Money	**Does the report consider value for money? NO** Providing a high quality of service does provide value for money
Risk	**Is there a documented risk assessment? YES** The risk is documented on the CCG's risk register
Legal	**Are there any legal implications and has legal advice been obtained? NO** Legal advice not required for this report.
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? YES** Poor quality does has an impact of patient safety and outcomes and also reputational damage.
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* NO** Providing high quality for all would include those with protected characteristics.
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? YES** The report highlights the staff concerns within the initial CQC visit and report
Partnership Working	**Does the report evidence a partnership working in its development? YES** The Single Item Quality surveillance Group included partners and key stakeholder.
Performance Indicators	**Does the report indicate any relevant performance indicators for this item? YES** Never events are included within the report which form part of the serious incident framework
Sustainability	**Does the report address economic, social and environmental sustainability *(should be addressed for new / change projects)?* NO** This is not a new change project
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 i.e. other papers that are directly related to the current paper under discussion.

Report History/Development Path

GOVERNING BODY BOARD REPORT COVER SHEET

Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**

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).

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

GOVERNING BODY BOARD REPORT

Report Title:	Outcome from the Single Item Quality Surveillance Group meeting with Wirral University Teaching Hospital
Lead Officer:	Lorna Quigley Director of Quality and Patient Safety
Recommendations:	1. Governing Body to note the contents of the report and the actions being taken 2.Governing Body to support the direction of travel that the CCG is undertaking

1. INTRODUCTION

Following a non-compliant Care Quality Commission (CQC) inspection, this was reported at Governing Body in January 2015. Governing Body supported the approach for the CCG with support from NHS England to undertake a single item Quality Surveillance group meeting.

The purpose of the review is to gain assurance with regard to the quality of services provided by Wirral University Teaching Hospitals NHS Foundation Trust, working collaboratively with NHS Wirral and West Cheshire Clinical Commissioning Groups, NHS England, Public Health England, Local Authority, Regulatory Bodies and the Trust.

The meeting took place on Friday 13th February and was attended by both Commissioners and regulators including Care Quality Commission, Monitor and Healthwatch. A quality pack was collated by NHSE using publically available data including Standardised Hospital Mortality Indicators and complaints and incidents.

2. BACKGROUND

On reviewing the information that was provided and listening to intelligence from commissioners and regulators present, those present at the meeting felt that there were a number of key lines of enquiry that required further exploration with the provider:

- Infection prevention control- Public Health England have raised concerns with the trust as part of their escalation process with regard to the lack of implementation of specialist advice, inadequate nursing staff in both clinical areas and within the Infection Prevention Control team. Lack of adequate environmental cleaning within specific areas, Infection control issues related to the WUTH neonatal care unit. Estates and facilities not implementing recommended actions.

- Care Quality Commission report- this responsive visit was undertaken in September following staff whistleblowing. There were a number of areas and wards that where visited as part of the

visit and the Trust was found to not meet the required standard in 4 of the 5 domains that where inspected.

- Staff concerns. - These are not being highlighted internally and staff are using external mechanisms to raise concerns.

    - Never events There have been 5 never events in 2014/15 and 3 in 2013/14. The link was the majority of events took place in theatre.

    - Urgent Care. The non-achievement of the 4 hour target over the year and the impact that this had on the patient experience and outcomes.

As part of the process the provider was invited to make a presentation to the committee, discussions took place based on the key lines of enquiry.

Throughout the session the provider had been open and honest, acknowledging challenges and areas that required improvement. There are robust governance process and systems in place and the provider engages well within the locality. It was acknowledged that was being undertaken in relation to culture and “human factors” to eradicate the never events.

A series of recommendations were made in regard to:

- The need to review the 2014/15 winter escalation plans to ensure that lessons have been learnt and good practice imbedded

- To shift from action planning to focus on outcomes the difference that these make.

- To examine the whistleblowing culture within the trust and that staff should be able to raise issues through their line managers

- To implement the actions that has been identified by PHE and provides evidence of a sustained approach.

Progress against these recommendations will be managed through the contractual process between the CCG and the Trust. The QSG to set up and a follow up meeting to monitor progress against the actions will be held in 6 months’ time

3. CURRENT POSITION

- The 2014 annual staff survey was published in February. It showed Wirral University Hospitals is worse than average in the vast majority of domains, with 17 out of 29 domains being in the worst 20% of Acute Trusts. This is a significant decrease from the previous year’s survey.

- Public Health England have raised with both NHSE and the CCG, new concerns relating to the management of infection prevention and control and behaviors within the team.

4. CONCLUSION

- In light of this new evidence and based on the themes which have been identified in the previous single item QSG, the CCG and NHS England will reconvene a further item single item QSG to review this evidence with the trust.

GOVERNING BODY BOARD REPORT COVER SHEET

NHS
Wirral Clinical Commissioning Group

Re-commissioning of Direct Access Diagnostics			
Agenda Item:	2.2	**Reference**	GB15-16/0002
Public / Private	Public	**Meeting Date**	07.04.2015
Lead Officer			
Contributors	Heather Harrington		
Link to CCG Strategic System Plan	1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base		
Link to current strategic objectives	1 Prevent people from dying prematurely 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care		
To approve	✓		
To note			
Summary	Governing Body is asked to consider re-commissioning options for Direct Access Diagnostics with a view to approving the following recommendations: • support option 3 to re-commission via a prime provider model • support stakeholder engagement (Patients & Providers) • approve next steps		
Comments			
Next Steps	• Discussion with current providers to advise on direction of travel and potential contract extensions. • Draft service specification • Conduct equality impact assessment • Hold patient engagement to influence specification • Hold Provider day(s) to encourage partnership working • Update specification based on stakeholder feedback • Develop tariff for service • Commence PQQ (Pre-Qualification Questionnaire) process • Evaluation PQQ returns • Commence ITT (Invitation to Tender) process • Evaluate ITT responses and invite successful bidders to interview/presentations • Bring summary paper to Governing Body detailing outcome of the tender process • Award contract to successful bidder • Commence 12 week mobilisation phase		

GOVERNING BODY BOARD REPORT COVER SHEET

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider the financial impact? YES** If YES, please summarise the key issues The report considers current financial expenditure and an acknowledgment that further detailed analysis of finance options will be required during development of service specification. If NO, please state why this is not included
Value For Money	**Does the report consider value for money? YES** If YES, please summarise The report includes indication of QIPP project to ensure efficient service, reduction of duplication and ensuring appropriate referral. Further detail will be considered when tariff determined. If NO, please state why this is not addressed
Risk	**Is there a documented risk assessment? NO** If YES, what are the key risks & what is being done to mitigate If NO, please explain why A formal risk assessment hasn't been conducted however the following key risks and mitigations have been noted: • Within the option analysis table, however these can be mitigated in line with current guidance Health Service Regulations 2013. • There is a risk that subcontractors may not be managed effectively. This will be mitigated by a series of questions within the tender process to assess how prime providers would manage subcontractors. This will also be picked up during CCG contract monitoring meetings with the prime provider. • Wirral CCG currently commission NWCSU procurement services however the CSU are unsure whether they can commit to anything post 31st March 2016. If the timescales for this project slip, we may go beyond this timescale. In this case, a project plan will be developed in advance of 31st March 2016 to ensure continuity.
Legal	**Are there any legal implications and has legal advice been obtained? YES/NO** If YES, please summarise the key legal considerations Due consideration will be given to all relevant legislation in the procurement of this service. If NO, please explain why legal advice was not necessary
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? YES**

GOVERNING BODY BOARD REPORT COVER SHEET

	The report notes that patient engagement will be a key part of specification development. It also notes consideration of patient choice and maintaining choice of location. If NO, please explain why Patient and Public views have not been sought
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* YES** If YES, does the report include equality impact assessment and what are the key issues This service will ensure patient choice in terms of location, in line with national guidance. The report notes that an equality impact assessment will be conducted alongside specification development. If NO, please explain why
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? NO** If YES, please explain and summarise the key issues If NO, please state why there are no work force issues The report doesn't explicitly cover this; however, provider engagement is a key part of the process. Implications around CCG workload are noted within the report.
Partnership Working	**Does the report evidence a partnership working in its development? YES** If YES, please describe Partnership working through development of specification – including clinical leads, diagnostics QIPP and patient groups. Limited cross over with Wirral Council regarding diagnostics. The prime provider model also encourages partnership working within service. If NO, please state why
Performance Indicators	**Does the report indicate any relevant performance indicators for this item? NO** If YES, please describe If NO, please explain why At this point the performance indicators have not been set however this will form the next step relating to service specification development.
Sustainability	**Does the report address economic, social and environmental sustainability**

GOVERNING BODY BOARD REPORT COVER SHEET

	(should be addressed for new / change projects)? **NO** If YES, please describe If NO, please why not This will be considered when writing the specification.
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 i.e. 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**
DAD Briefing Paper		WCCG Ops Group	16.12.2014	Consider procurement options for Direct Access Diagnostics. Further information requested.
DAD Briefing Paper amended		WCCG Ops Group	03.02.2015	Further information provided and Ops group felt Option 3 should be recommended to the Governing Body

Private Business

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GOVERNING BODY BOARD REPORT

Report Title	Re-commissioning of Direct Access Diagnostics
Lead Officer	
Recommendations	1.Support recommendation to re-commission via a prime provider model 2.Conduct stakeholder engagement (Patients & Providers) 3.Approve next steps

1. INTRODUCTION

1.1 NHS Wirral CCG currently commissions Direct Access Diagnostics (DAD) from a number of providers via the NHS standard contract. This was initially commissioned via an 'Any Willing Provider' (AWP) tender process in 2011/12. The AWP model has subsequently been replaced by 'Any Qualified Provider' (AQP) model.

1.2 AQP contracts are tenders which 'accredit' multiple Providers as capable of providing services to the NHS for an initial 3 year period. This initial term is then followed by a rolling annual contract with no guaranteed level of activity or income. The original intention of the DAD scheme was that it was fully operational from April 2012, however in practice all the schemes did not mobilise and become fully operational until 10th September 2012, which became the commencement date of the contract.

2. CURRENT PROVISION

2.1 The current providers are as follows:

Provider	**Service**
Care UK	Ultrasound and DEXA
CCC Diagnostics	CT, MRI and Nuclear
Diagnostic World	Ultrasound
Diagnostic Healthcare	Ultrasound and MRI
Kleyn Healthcare	Ultrasound
Priority Links	Ultrasound
Spire Murrayfield	MRI
WUTH	Ultrasound, MRI, CT and Plain Film

2.2 The above contracts are due to end September 2015.

3. FINANCE

3.1 A breakdown of current expenditure is provided below:

AQP Activity Providers	**Current Payment Arrangement**	**AQP Tariff (est. full year spend 14/15)**
Total expenditure	Paid on AQP tariff	**£5,067,783**

3.2 Direct Access Diagnostics will be part of 2015-16 QIPP plan with the aim of reducing activity by ensuring appropriate referrals are made and duplication is eliminated.

3.3 Finance will conduct a detailed analysis to determine the most appropriate tariff alongside specification development.

4. KEY ISSUES / MESSAGES

4.1 The current model can provide some confusion for referrers and patients as there are numerous providers to choose from.

4.2 There are some concerns that activity may be being duplicated by different providers as the services aren't currently streamlined.

4.3 There are currently 8 separate contracts for CCG to manage, each requiring regular contract monitoring meetings.

4.4 The aim is to commission an integrated diagnostics service across Wirral.

4.5 Coverage for the Hospice St John's would be mandated within the specification to ensure continued provision.

4.6 An equality impact assessment will be carried out alongside the production of the service specification to ensure impact on protected groups is considered.

4.7 A re-procurement process will provide Wirral CCG the opportunity to redesign diagnostic services in Wirral and develop care pathways to ensure patients receive most appropriate diagnostic service. This will be done collaboratively with clinical leads, diagnostics QIPP group input and patient and public engagement.

5. PROCUREMENT OPTIONS ANALYSIS

Option	Advantages	Disadvantages	Additional Considerations
Option 1 – Re-procure as an AQP Consider re-procuring the existing services via another AQP but with new specifications / tariffs with multiple potential providers and multiple Lots based on service area e.g Lot 1 – Ultrasound Lot 2 – MRI Lot 3 – DEXA	• Least likely to be challenged due to an open and fair competition process allowing the opportunity for multiple providers to gain access to a contract • Allows service and tariff changes to be implemented immediately • Facilitates	• Will involve a commitment from the CCG to review and evaluate multiple tenders • Will require multiple CCG 'mobilisation' site visits • Will result in multiple contracts that will require the CCG to contract manage a wider provider base • Will involve an annual	• Dependent upon tariff chosen, may require monitor notification • An award notice should be placed on Contracts Finder • Activity should not be capped as this may

	compliance with the Social Values Act by allowing smaller providers the opportunity to bid for entry onto the contract • Enables new providers to be introduced and mobilised through annual competition windows • Zero based contract	'competition window' to comply with AQP guidance therefore annual CCG commitment to evaluations • Cannot limit the number of providers accredited – everyone that passes must be given a contract	be perceived as artificially affecting patient choice
Option 2 - Framework Consider a "Framework" Contract that could be accessed by local GP's on a lotted basis but limiting the number of providers per Lot (minimum 3). This option would need to be given further consideration from CCG and NWCSU staff about the design and approach taken.	• Less likely to be challenged due to an open and fair competitive process allowing the opportunity for providers to win a place on the framework • Allows for redesign to service spec and tariff • Allows providers to specialise and tender for specific services, therefore this should identify the provider best able to provide the service and allow easy demonstration of this. • Facilitates compliance with the Social Values Act by allowing smaller providers the opportunity to bid for 'lots' • Facilitates patient choice of provider but potential to limit the number • Results in service stability for up to 4 years. • Limited risk for CCG as Zero Based Contract	• Introduces potential short term in-stability to service provision during the transition to multiple providers • Will involve a significant commitment from the CCG to review and re-design services and specifications. • Application of TUPE rights not clear for frameworks so may leave providers with legacy costs • Will result in multiple contracts that will require CCG to commission additional contract management of a wider provider base	• Dependent upon tariff chosen, may require monitor notification • An award notice should be placed on Contracts Finder • Activity should not be capped as this may be perceived as artificially affecting patient choice

Option 3 – Prime Provider Go out to Procurement to obtain one provider to provide the entire range of Direct Access Diagnostic services – 3 to 5 years *This could be an integrated model with one prime provider managing subcontractor relationships or one sole provider of everything.*	• Reduced possibility of challenge due to an open and fair competition process • Allows opportunity for service redesign across services. • Tender should identify the provider best able to provide the service and allow this to be demonstrated • Allows the relationship with one provider to develop over time and results in only 1 contract for the CCG to manage	• Introduces potential short term in-stability to service provision during the transition • Will involve a significant commitment from the CCG to review and re-design services and specifications. • Unsuccessful providers may challenge the process as the 'sole provider' is win/lose only • May result in TUPE transfer of staff • Sole provider model would exclude smaller 'niche' or specialist providers from bidding which would need to be justified for Social Values Act compliance • Potential to reduce patient choice which would need to be justified • Relies on the capacity and competency of the prime provider to manage sub-contractors	• Consider sustainability of existing organisations and their ability to continue to provide other services to the CCG but also the wider health economy such as LA's • Dependent upon tariff chosen, may require monitor notification • Cannot mandate a prime provider to sub-contract activity although weighted award criteria can help influence the provider model

5.1 Governing Body is asked to consider the options as presented in the above table, with a recommendation to support option 3 based on the evidence outlined in this paper which is also supported by the discussions with Wirral CCG Operations Group. To support this, further analysis of implications and risks of the prime provider model are detailed below.

6. IMPLICATIONS

6.1 Time implication for CCG staff to redesign the service and update specification. However in the long term, there will be a reduction in the number of individual contracts for CCG to manage. The prime provider will be responsible for managing all subcontractors.

6.2 Potential reduction in patient choice in terms of provider however we will ensure coverage across Wirral. The model encourages use of subcontractors/partners which will enhance patient choice. Our aim through the re-commissioning process is to utilise patient

feedback to mold the specification and drive forward a high quality, streamlined diagnostic service.

6.3 Procurement of a prime provider will take approximately 12 months.

7. RISKS / LEGAL CONSIDERATIONS

7.1 In addition to the risks provided in the options table, please see below including mitigation:

7.1.1 Potential risk of challenge by unsuccessful bidders however the model allows flexibility including the option for smaller providers to join a prime provider to submit an application. As with all tenders, there could be a legal challenge however we will ensure all correct legislation is followed to reduce likelihood of this.

7.1.2 This model relies on the competency of the prime contractor to manage sub-contractors appropriately. There is a risk that this will not be managed effectively. This will be mitigated by a series of questions within the tender process to assess how prime providers would manage subcontractors. This will also be picked up during CCG contract monitoring meetings with the prime provider.

7.1.3 Wirral CCG currently commission NWCSU procurement services however the CSU are unsure whether they can commit to anything post 31st March 2016. If the timescales for this project slip, we may go beyond this timescale.

8. NEXT STEPS

8.1 If approved by Governing Body, the next steps will be:

8.1.1 Discussion with current providers to advise on direction of travel and potential contract extensions.
8.1.2 Draft service specification including all modalities each with appropriate response times
8.1.3 Conduct equality impact assessment
8.1.4 Hold patient engagement to influence specification
8.1.5 Hold Provider day(s) to encourage partnership working
8.1.6 Update specification based on stakeholder feedback
8.1.7 Develop tariff for service
8.1.8 Commence PQQ (Pre-Qualification Questionnaire) process
8.1.9 Evaluation PQQ returns
8.1.10 Commence ITT (Invitation to Tender) process
8.1.11 Evaluate ITT responses and invite successful bidders to interview/presentations
8.1.12 Bring summary paper to Governing Body detailing outcome of the tender process
8.1.13 Award contract to successful bidder
8.1.14 Commence 12 week mobilisation phase

9. CONCLUSION

9.1 Governing Body is asked to consider the options as presented, with a recommendation to support procurement of direct access diagnostics via a prime provider model.

10. APPENDICES *(Must be copied below or available on request – do not embed)*

No.	Title of Appendix

Glossary of terms

AQP – Any Qualified Provider (tenders which 'accredit' multiple Providers)
AWP – Any Willing Provider (tenders which 'accredit' multiple Providers – replaced by AQP)
DAD – Direct Access Diagnostics (diagnostics available for GPs to refer straight into)
ITT – Invitation to Tender (documentation including series of questions for providers to answer. The responses will be evaluated and scored to ascertain the bidders who proceed to presentation stage. The scores are used to determine successful bidder).
PQQ – Pre-Qualification Questionnaire (series of questions asked prior to ITT to assess if a provider meets the mandatory requirements of the specification. Those successful will receive an ITT).
Prime Provider – one provider commissioned to hold a contract with the option to work with partners/subcontractors to deliver the service.

GOVERNING BODY BOARD REPORT COVER SHEET

NHS Wirral Clinical Commissioning Group

Report of the Morecambe Bay Investigation			
Agenda Item:	2.3	**Reference**	GB15-16/0002
Public / Private	Public	**Meeting Date**	07.04.2015
Lead Officer	Lorna Quigley Director of Quality and Patient Safety		
Contributors			
Link to CCG Strategic System Plan	1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base 4 Provides greater equality of access to all		
Link to current strategic objectives	1 Prevent people from dying prematurely 2 Enhance the quality of life for people with long term conditions 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care 5 Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm		
To approve			
To note	YES		
Summary	The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), including the deaths of mothers and babies. Relatives of those harmed, and others, have expressed concern over the incidents themselves and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies. The findings of the report were published on 3rd March 2015.		
Comments	The Governing body to note the report and the recommendations made.		
Next Steps	The CCG to undertake an assessment in relation to commissioned maternity services to review leadership, governance and culture with the provider organisations.		

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider the financial impact? NO** This is a national report reviewing incidents within a service

GOVERNING BODY BOARD REPORT COVER SHEET

Value For Money	**Does the report consider value for money? NO** This is a national report reviewing incidents within a service
Risk	**Is there a documented risk assessment? NO** This is a national report reviewing incidents within a service
Legal	**Are there any legal implications and has legal advice been obtained? NO** This is a national report reviewing incidents within a service
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? YES** This has had a negative impact on public and patients, including reputational damage, serious harm to people using the service
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* NO** This is a national report reviewing incidents within a service
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? YES** Staff have been interviewed as part of the review, there is a negative regarding staff culture
Partnership Working	**Does the report evidence a partnership working in its development? NO** This is a national report reviewing incidents within a service
Performance Indicators	**Does the report indicate any relevant performance indicators for this item? NO** This is a national report reviewing incidents within a service
Sustainability	**Does the report address economic, social and environmental sustainability *(should be addressed for new / change projects)?* NO** This is not a new change project
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 i.e. other papers that are directly related to the current paper under discussion.

Report History/Development Path

GOVERNING BODY BOARD REPORT COVER SHEET

Report Name	Reference	Submitted to	Date	Brief Summary of Outcome

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 an x.

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

GOVERNING BODY BOARD REPORT

Report Title	Report of the Morecambe Bay Investigation
Lead Officer	Lorna Quigley
Recommendations	1. 2. 3.

Aim
The aim of this report is to inform Governing Body of the findings of the investigation and to consider the implications for the system.

Background

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), including the deaths of mothers and babies. Relatives of those harmed, and others, have expressed concern over the incidents themselves and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies.

An independent investigation has been carried out of these events, covering the period from 1 January 2004 to 30 June 2013. The Investigation Panel, which was led by Bill Kirkup CBE included expert advisors in midwifery, obstetrics, paediatrics, nursing, management, governance and ethics. During the period of the review, 15,280 documents from 22 organisations where examined, 118 individuals between May 2014 and February 2015 were interviewed. Family members of those harmed were invited to attend interviews and Panel meetings as observers.

The findings of the report were published on 3rd March 2015.

Findings

The where a number of findings found during the investigation, these have been laid out within the report into 6 discreet areas:

- Dysfunctional maternity unit

The unit is described as dysfunctional to the extent that it damaged its ability to provide safe and effective care. The problems fell in five principal areas. The clinical competence of a proportion of staff fell significantly below the standard required for a safe, effective service. The working relationships between different groups of staff were extremely poor. Maternity care requires close multidisciplinary working, particularly between midwives, obstetricians and paediatricians, to ensure a good outcome for both mother and baby. Midwifery care in the unit became strongly influenced by a small number of dominant individuals whose over-zealous pursuit of the natural childbirth approach led at times to inappropriate and unsafe care. Advice to mothers that it was appropriate to consider delivery at FGH was significantly compromised by a failure to assess the risks properly. The response from unit clinicians to serious incidents was grossly deficient.

- Delayed problem recognition

By the nature of maternity care, on the great majority of occasions the outcome is a healthy mother and baby without the need for significant intervention, because pregnancy and childbirth are inherently normal physiological processes. The safety of maternity units depends on their level of vigilance to detect risk and deviation from the norm, and on their taking effective action when it is found. Population trends in childbirth such as rising maternal age, obesity and diabetes mean that the inherent risks have increased, but even so, tragic outcomes fortunately remain relatively uncommon.

- Response following 2008 events

Although there was evidence of systematic failings in the FGH maternity unit prior to 2008, it is clear that none of it reached senior levels in the Trust, particularly executive directors and the Board itself. Partly, this was due to poorly developed systems of clinical governance within the Trust which meant that there was little formal oversight of safety or other quality matters in clinical services. It is important to note, however, that in this the Trust was little different from many others at the time. Partly, this was due to the nature of the service itself, in which, because childbirth is physiologically normal in the great majority of cases, obvious markers of problems such as deaths remain rare even when quality is poor; hence, high-level figures such as the perinatal mortality rate failed to signal any problems

- Subsequent investigations

Nevertheless, some of the findings, even if only of the last-mentioned report,32 did confirm the impression of the chief executive that all was not well in the maternity unit. He commissioned a report into the management structures around the maternity unit33 which, although slightly tangential to the underlying clinical problems, did point to some of the relationship issues affecting the unit. He also, we heard, took over dealing with some of the complainants and relatives personally: “We had a problem when there was a lot of publicity about the unit. There was a major, major problem with publicity. The Chief Executive, I think, took charge. I think he did everything possible except sacking midwives. I think he was meeting relatives, compensating them, apologising… But he was in charge.”34 We also heard that this left some maternity staff feeling let down that they had been unable to meet bereaved relatives to give their view of what had happened.

- The role of external bodies

The external relationships of the Trust were quite complex and subject to change over the period in question. Services were mainly commissioned by Morecambe Bay Primary Care Trust (PCT) until 30 September 2006, after which North Lancashire PCT commissioned most of the services at RLI and Cumbria PCT most of the services at FGH. Cumbria PCT also had to commission challenging services in the north and west of the county, and we heard that neither PCT was willing to cede ‘lead commissioner’ status to the other. Oversight of the operation of NHS Trusts (that is, Trusts that were not Foundation Trusts) was initially the responsibility of SHAs, in this case the NW SHA, with a role in both strategic direction and monitoring. The SHA’s responsibility for service quality was initially shared with the Healthcare Commission, which also carried out the second stage of the NHS complaints procedure when local resolution was unsuccessful. From 1 April 2009, the Healthcare

GOVERNING BODY BOARD REPORT

Commission was replaced by a new body, the Care Quality Commission (also responsible for the quality and regulation of social care providers), which had operated in shadow form from the preceding autumn. Responsibility for the second stage of the NHS complaints procedure did not pass to the CQC, however, but to the Parliamentary and Health Service Ombudsman (PHSO), who had previously become involved only when the Healthcare Commission did not resolve a complaint. The regulator for Foundation Trusts, other than for the CQC's responsibilities, was Monitor, which also ran the application process by which NHS Trusts were judged suitable or not to become Foundation Trusts

Conclusion

- It is acknowledged that while tragic events remain rare within the NHS, the system needs to learn from the recommendations set out within the report. The DH have yet to make a response on the following the publication of the report, the nursing and Midwifery council (NMC) will continue their investigations of individuals who have been involved. The secretary of State has committed to:
a focus on continuing to promote cultures of openness and transparency
- The development of clearer guidelines for standardised incident reporting which Dr Mike Durkin, Director of Patient Safety NHS England will develop
- A more effective oversight arrangements for midwives building on the Kings Fund review of midwifery regulation for the NMC which recommended that effective local supervision needs to be carried out independently
- The Trust would implement the 18 recommendations assigned to them within the report.

Recommendations

There are a total of 44 recommendations contained within the report 18 of which are specifically related to the Trust and a father 26 for external agencies and wider NHS, GMC, NMC, CQC, DH etc.

- Professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.

- There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.

- NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.

- A review be undertaken of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them to ensure there are educational opportunities. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.

- Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. This is to build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.

- The duty of candour should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.

- A duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission.

- The national policy on whistle blowing to be implemented that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.

- Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.

- Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.

- Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.

- A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to ‘fend off’ inquests, a mandatory requirement not to coach staff or provide ‘model answers’, the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.

- A fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in

unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.

- The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust. An urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.

- Organisations draw up a memorandum of understanding specifying roles, relationships and communication between regulators. Action: Monitor, the Care Quality Commission, the Department of Health.

- A memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.

- The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear. NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.

- The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. The Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.

- Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. An explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.

- Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. Recording systems to be reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.

- There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is no less applicable to maternal and perinatal deaths, and should have raised concerns

in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. Action: the Department of Health.

- Given that the systematic review of deaths by medical examiners should be in place, as above, this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health.

- Systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.

- External reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.

- External reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.

- The importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.

- The development of an investigation framework on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. Action: Department of Health

Next steps
The CCG to undertake an assessment in relation to commissioned maternity services to review leadership, governance and culture with the provider organisations.

PERFORMANCE AND FINANCE REPORT			
Agenda Item:	4.1	**Reference**	GB15-16/0004
Public / Private	Public	**Meeting Date**	April 2015
Lead Officer	Lorna Quigley Director Of Quality and Patient safety Mark Bakewell Chief Financial Officer		
Contributors	Finance and Business Intelligence teams Wirral CCG		
Link to CCG Strategic System Plan	1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base 4 Provides greater equality of access to all		
Link to current strategic objectives	1 Prevent people from dying prematurely 2 Enhance the quality of life for people with long term conditions 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care 5 Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm		
To approve			
To note	Yes		
Summary	Governing body is asked to receive and note the performance report for Month10 (January 2015) and the finance report for Month 11 February 2015)		
Comments			
Next Steps			

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider the financial impact? YES** Pages 8-13 of the report

Value For Money	**Does the report consider value for money? YES** Pages 8-13 of the report
Risk	**Is there a documented risk assessment? YES** Self-assessment page 12 of report
Legal	**Are there any legal implications and has legal advice been obtained? NO** Monthly report to Governing body
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? YES** Achievement against the NHS constitutional standards
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* NO** Monthly report to Governing body
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? NO** Monthly report to governing Body
Partnership Working	**Does the report evidence a partnership working in its development? YES**
Performance Indicators	**Does the report indicate any relevant performance indicators for this item? YES** The report shows the CCG s financial performance and performance against the NHS constitutional standards.
Sustainability	**Does the report address economic, social and environmental sustainability *(should be addressed for new / change projects)?* NO** Monthly report to Governing Body
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 i.e. 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**
Performance report	QPF14-150064	QPF	31/3/15	Paper noted
Finance report	QPF14-15/0065	QPF	31/3/15	Paper noted

Private Business

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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 an x.

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

NHS
Wirral Clinical Commissioning Group

Finance & Performance Update to Governing Body Meeting

7th April 2015

NHS
Wirral Clinical Commissioning Group

Performance Update Month 10

NHS Wirral CCG

CCG Dashboard 2014/15

Health Outcomes Framework/Every one Counts		Target / Threshold	Q1 Apr	May	Jun	Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar
Safe environment and protecting from avoidable harm	MRSA - Incidence of HCAI YTD	0	0	0	0	0	0	0	0	0	1	3		
	C. *difficile* - Incidence of HCAI YTD		8	13	16	23	31	42	46	55	58	68		
	C. *difficile* - YTD Ceiling		4	11	15	19	23	27	35	39	46	50		

NHS Constitution		Target / Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RTT	RTT admitted	90%	93.2%	93.6%	93.8%	91.8%	85.7%	92.0%	90.4%	87.0%	93.5%	92.1%		
	RTT non-admitted	95%	97.4%	97.5%	97.1%	95.5%	94.1%	94.2%	94.7%	95.1%	96.8%	96.8%		
	RTT incompletes	92%	94.9%	95.1%	94.5%	93.4%	93.8%	94.2%	94.6%	94.8%	94.4%	93.2%		
	RTT 52+ week waiters	0	1	1	3	1	0	1	0	0	0	0		
Diagnostics	Diagnostics - 6 weeks+	<1%	3.7%	3.0%	0.9%	1.1%	0.5%	1.1%	0.2%	0.1%	0.3%	0.4%		
Cancer - 2 week	- 2 week wait	93%	97.4%	97.2%	95.6%	96.1%	95.9%	96.9%	96.4%	92.9%	92.8%	91.1%		
	- Breast symptom 2 week wait	93%	96.0%	90.4%	95.9%	96.9%	96.0%	95.1%	93.8%	100.0%	93.8%	100.0%		
Cancer - 31 day	- 31 day first definitive treatment	96%	97.5%	98.1%	98.8%	97.3%	99.3%	97.7%	100.0%	99.4%	98.9%	97.6%		
	- 31 day subsequent treatment - surgery	94%	100.0%	95.7%	92.6%	97.6%	100.0%	93.5%	93.9%	95.0%	96.6%	96.4%		
	- 31 day subsequent treatment - drug	98%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%		
	- 31 day subsequent treatment - radiotherapy	94%	100.0%	100.0%	96.8%	100.0%	98.0%	96.7%	98.6%	97.3%	94.3%	96.6%		
Cancer - 62 day	- 62 day standard	85%	80.9%	85.1%	91.9%	81.7%	88.6%	88.4%	87.2%	84.0%	89.0%	81.1%		
	- 62 day screening	90%	100.0%	91.3%	86.7%	94.1%	93.3%	94.7%	100.0%	100.0%	95.0%	95.0%		
	- 62 day upgrade	n/a	88.0%	73.9%	78.6%	83.7%	87.8%	82.4%	86.5%	85.0%	86.1%	80.8%		
Mixed Sex	Mixed-sex accommodation breaches	0	1		1			1		4		2		
Mental Health	CPA follow up within 7 days	95%		97.5%			97.6%			100.0%				

Other - Activity & Efficiency		Target / Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	- Total elective (YTD)		4,067	8,138	12,424	16,856	20,773	25,100	29,556	33,689	37,525	41,660		
	- Total elective plan (YTD)		4,217	8,454	12,481	16,900	20,940	25,158	29,575	33,412	37,824	42,047		
	- Non-elective (YTD)		3,987	8,115	12,026	16,285	20,295	24,398	28,361	32,329	36,548	40,585		
	- Non-elective plan (YTD)		3,653	7,433	11,085	14,863	18,638	22,290	26,066	29,718	33,491	37,264		
	- Outpatients (YTD)		7,467	14,827	22,751	30,951	37,981	46,642	55,352	63,398	71,219	78,991		
	- Outpatients plan (YTD)		7,866	15,738	23,248	31,471	38,984	46,849	55,071	62,221	70,440	78,302		
	- GP referrals (YTD)		5,035	10,325	15,517	21,091	26,211	31,706	37,706	43,198	48,104	53,753		
	- GP referrals plan (YTD)		5,091	10,195	15,058	20,387	25,255	30,349	35,675	40,305	45,630	50,724		

Category	Outcome indicator	Baseline	Preferred Outcome	Jan 2015	Comment
Patients seen within 4 hours of attending	Arrowe Park	95%	Higher	80.0%	As the WIC is on site this is a combined target
	Arrowe Park (WIC)	95%	Higher	99.9%	
	Combined total	95%	Higher	85.0%	
	Victoria Central Hospital walk in Centre	95%	Higher	99.9%	
	Eastham Walk in Centre	95%	Higher	99.5%	

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	Inpatients Friends and Family test											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	86.3%	88.4%	90.6%	89.0%	6.4%	7.2%	3.4%	4.7%	26.8%	23.1%	21.4%	40.3%
Mid Cheshire Hospitals NHS FT	97.1%	97.4%	96.4%	95.8%	1.1%	0.9%	0.5%	0.3%	50.0%	46.0%	39.4%	35.5%
The Clatterbridge Cancer Centre NHS FT	100.0%	100.0%	94.6%	97.9%	0.0%	0.0%	3.6%	2.1%	35.3%	46.2%	33.9%	26.7%
East Cheshire NHS Trust	89.8%	91.2%	97.4%	97.7%	1.1%	0.0%	0.4%	0.5%	27.7%	3.6%	44.7%	23.5%
Countess of Chester Hospital NHS FT	91.8%	96.8%	96.5%	96.3%	1.4%	0.5%	1.0%	0.5%	23.3%	41.4%	24.4%	50.1%
Warrington & Halton Hospitals NHS FT	94.6%	96.8%	96.3%	95.8%	1.1%	0.8%	1.1%	1.2%	32.8%	31.0%	28.4%	26.7%

	Accident and Emergency: Friends and Family test											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	99.4%	99.2%	99.8%	97.0%	0.0%	0.1%	0.0%	2.1%	28.2%	21.9%	13.9%	21.5%
Mid Cheshire Hospitals NHS FT	87.6%	88.7%	90.8%	93.6%	5.6%	6.1%	6.0%	2.2%	17.5%	15.0%	21.6%	16.0%
East Cheshire NHS Trust	87.4%	85.2%	93.0%	87.6%	7.4%	8.6%	4.6%	7.5%	24.6%	18.3%	17.7%	16.7%
Countess of Chester Hospital NHS FT	80.1%	81.1%	78.3%	83.3%	12.7%	10.9%	14.6%	11.0%	18.6%	14.3%	12.8%	19.4%
Warrington & Halton Hospitals NHS FT	85.5%	87.4%	83.7%	87.0%	2.5%	4.7%	5.1%	3.9%	13.6%	17.9%	16.5%	19.7%

	Maternity: Friends and Family test Question 1											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	24.7%	18.5%	35.1%	13.8%
Mid Cheshire Hospitals NHS FT	92.1%	95.0%	97.7%	94.3%	3.2%	1.7%	0.8%	3.3%	14.5%	14.9%	27.4%	24.0%
East Cheshire NHS Trust	91.2%	100.0%	97.5%	100.0%	0.0%	0.0%	0.0%	0.0%	20.9%	14.3%	52.6%	29.4%
Countess of Chester Hospital NHS FT	100.0%	100.0%	75.0%	100.0%	0.0%	0.0%	0.0%	0.0%	4.2%	1.8%	2.2%	1.2%
Warrington & Halton Hospitals NHS FT	88.5%	92.7%	96.5%	95.0%	1.3%	2.4%	0.0%	0.0%	29.3%	17.7%	25.1%	23.7%

Question 2:

	Maternity: Friends and Family test Question 2											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	95.9%	100.0%	98.2%	98.6%	1.4%	0.0%	0.0%	0.0%	30.5%	32.1%	21.3%	26.7%
Mid Cheshire Hospitals NHS FT	96.9%	80.6%	88.4%	82.6%	3.1%	3.2%	7.0%	4.3%	15.8%	30.2%	40.8%	32.4%
East Cheshire NHS Trust	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	21.2%	18.9%	33.1%	28.9%
Countess of Chester Hospital NHS FT		96.4%	97.6%	100.0%		3.6%	0.0%	0.0%	0.0%	11.4%	17.3%	12.3%
Warrington & Halton Hospitals NHS FT	94.9%	100.0%	100.0%	100.0%	3.4%	0.0%	0.0%	0.0%	30.3%	26.2%	29.8%	17.5%

Question 3:

	Maternity: Friends and Family test Question 3											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	97.3%	95.2%	96.3%	97.1%	0.0%	1.2%	0.0%	0.0%	30.0%	30.6%	20.1%	25.3%
Mid Cheshire Hospitals NHS FT	87.2%	84.1%	88.6%	83.1%	7.7%	9.5%	3.4%	3.4%	19.1%	29.7%	42.9%	28.2%
East Cheshire NHS Trust	92.1%	89.3%	93.0%	89.7%	0.0%	0.0%	0.0%	0.0%	23.0%	19.6%	34.7%	28.9%
Countess of Chester Hospital NHS FT		90.3%	87.8%	89.7%		0.0%	0.0%	0.0%	0.0%	12.7%	16.9%	12.3%
Warrington & Halton Hospitals NHS FT	95.0%	96.9%	97.4%	94.3%	1.7%	0.0%	0.0%	2.9%	33.1%	37.8%	38.2%	22.7%

Question 4:

	Maternity: Friends and Family test Question 4											
	% who recommend				% who don't recommend				Response rate			
Acute Trust	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15	Oct-14	Nov-14	Dec-14	Jan-15
Wirral University Teaching Hospital NHS FT	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	6.0%	7.2%	5.4%	3.2%
Mid Cheshire Hospitals NHS FT	94.3%	83.3%	84.6%	77.8%	2.9%	13.3%	7.7%	16.7%	16.6%	17.2%	12.0%	9.0%
East Cheshire NHS Trust	95.7%	97.3%	97.1%	96.2%	0.0%	0.0%	1.5%	1.9%	27.9%	24.3%	45.3%	35.3%
Countess of Chester Hospital NHS FT	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	1.2%	1.8%	1.3%	2.5%

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Finance Update Month 11

2014/15 Key Planning Requirements

- 1% Surplus - £4.68m
- 2.5% Headroom (non-recurrent resources) - £11.4m
- Minimum 0.5% Contingency
  - CCG hold £3m vs £2.2m (0.5%)

- Better Payment Practice Code
- Cash Management

Month 11 Update

- WUTH Position held on trajectory - £3.07m (M11) - forecast fixed at £3.35m -circa £218m
- Deterioration of performance at CT, Royal Liverpool, St Helens & Knowsley, Liverpool H&C
- Increase in Spire (Murrayfield) activity (£246k YTD, FOT £300k)
- Increase in Prescribing Over Performance (£1.39 YTD, £1.4 6FOT (forecast includes pricing impact estimate)
- CHC / Packages position held but YTD broadly equal to FOT position at £0.55m - minimal risk coverage
- Residual Balance of Outturn QIPP Gap £5.4m and Contingency (£3.0m) remains

- **CCG notified of return of resource regarding CHC retrospective top slice £1.1m in M9 used to support bottom line.**

Month 11 - February

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Year to Date (M11)

Planned ytd Surplus @ £4.68m - (£4.3m)

Revised Pro-Rata @ £2.5m - (£2.3m)

Current ytd Surplus - (£2.3m)

Operational Position - £2.0m

Forecast Outturn Position

(£4.68m) - Planned

(£2.5m) – Reported M7 Onwards

(£2.18m) Movement from Planned

	M11 YTD	M10 YTD	Movement	Forecast Outturn M11	Forecast Outturn M10	Movement
WUTH	(£3.1m)	(£2.5m)	(£0.6m)	(£3.4m)	(£3.4m)	£0.0m
Other NHS	£2.1m	£2.0m	£0.1m	£2.3m	£2.2m	£0.1m
Non NHS	£0.8m	£0.8m	£0.0m	£0.8m	£0.9m	(£0.1m)
Prescribing	£1.4m	£0.6m	£0.8m	£1.5m	£0.9m	£0.6m
CHC	£0.5m	£1.3m	(£0.8m)	£0.6m	£0.9m	(£0.3m)
Other & Identified Slippage	(£1.9m)	(£1.7m)	(£0.2m)	(£2.0m)	(£1.9m)	(£0.1m) *
QIPP	£4.9m	£4.9m	£0.0m	5.4m	£5.6m	(£0.2m)
Contingency	(£2.7m)	(£2.5m)	(£0.2m)	(£3.0m)	(£3.0m)	£0m
Operational Surplus	£2.0m	£2.8m	(£0.9m)	£2.2m	£2.2m	£0.0m
Planned Surplus				(4.7m)	(£4.7m)	£0m
Revised Surplus				(£2.5m)	(£2.5m)	£0m *

Forecast Outturn 2014/15

Forecast Assumptions

- Forecast Surplus (M11 - £2.5m (0.53% of plan) – remains as per M7 revision.
- YTD position reflect challenges of forecast delivery (but in line with forecast assumptions)
- Drivers remain consistent with plan around main expenditure areas
  - Other Mersey Contracts (RLB, STHK, Aintree)
  - Spire
  - Prescribing,
  - Commissioned Out of Hospital Care,
  - QIPP Gap

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Self Assessment at Month 11 (February) 2014/15

Financial performance					
No.	**Indicator**	**Primary / Supporting Indicator**	**Self Assessment Month 9 (Dec 2014)**	**Self Assessment Month 10 (Jan 2015)**	**Self Assessment Month 11 (Feb 2015)**
1	Underlying recurrent surplus	Primary	**Amber**	**Amber**	**Amber**
2	Surplus - year to date performance	Primary	**Amber**	**Amber**	**Amber**
3	Surplus - full year forecast	Primary	**Amber**	**Amber**	**Amber**
4	Management of 2% NR funds within agreed processes	Supporting	**Green**	**Green**	**Green**
5	QIPP ** - year to date delivery	Primary	Amber / Green	Amber / Green	Amber / Green
6	QIPP ** - full year forecast	Primary	Amber / Green	Amber / Green	Amber / Green
7	Activity trends - year to date	Supporting	Indicator - Not yet Available	Indicator - Not yet Available	Indicator - Not yet Available
8	Activity trends - full year forecast	Supporting	Indicator - Not yet Available	Indicator - Not yet Available	Indicator - Not yet Available
9	Running costs	Primary	**Green**	**Green**	**Green**
10	Clear identification of risks against financial delivery and mitigations	Primary	**Green**	**Green**	**Green**
11	This covers internal and external audit opinions, and an assessment of the timeliness and quality of returns	Supporting	TBC - Green	TBC - Green	TBC - Green
12	Balance sheet indicators including cash management and BPCC	Supporting	**TBC - Green**	**TBC - Green**	**TBC - Green**
13	Financial plan meets the 2014 surplus planning requirement	Supporting	**Amber**	**Amber**	**Amber**

Other Performance Indicators

Cash Management

– The CCG cash balance at the end of February was £76k. This is in line with current NHSE guidance that CCGs aim towards 1.25% month end cash balance

Performance Against Better Payment Practice Code (BPPC) ALL

Month	Period Number	Paid Year	Total Number of Invoices Paid	Total Paid Within Target No.	%age	Total Value of Invoices Paid £	Value paid within Target £	%age
APRIL	04	14	859	851	99.07%	35,541,975.01	35,531,503.78	99.97%
MAY	05	14	1181	1173	99.32%	35,967,941.11	35,934,439.00	99.91%
JUNE	06	14	1034	1016	98.26%	34,361,056.48	34,341,056.80	99.94%
JULY	07	14	1294	1288	99.54%	36,872,841.93	36,862,171.57	99.97%
AUGUST	08	14	1082	1075	99.35%	35,004,849.52	34,990,681.87	99.96%
SEPTEMBER	09	14	1107	1081	97.65%	35,907,284.46	35,831,259.72	99.79%
OCTOBER	10	14	985	966	98.07%	35,315,488.67	35,277,394.25	99.89%
NOVEMBER	11	14	1208	1186	98.18%	34,048,782.93	33,938,407.61	99.68%
DECEMBER	12	14	1039	1031	99.23%	34,799,099.14	34,734,998.49	99.82%
JANUARY	01	15	973	959	98.56%	34,104,510.66	33,791,435.67	99.08%
FEBRUARY	02	15	967	964	99.69%	33,783,776.16	33,745,098.90	99.89%
			11729	11590	98.81%	385,707,606.07	384,978,447.66	99.81%

GOVERNING BODY BOARD REPORT COVER SHEET

NHS
Wirral Clinical Commissioning Group

CORPORATE CALENDAR			
Agenda Item:	4.2	**Reference**	GB15-16/0004
Public / Private	Public	**Meeting Date**	07.04.2015
Lead Officer	Paul Edwards, Director of Corporate Affairs		
Contributors			
Link to CCG Strategic System Plan	1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base 4 Provides greater equality of access to all		
Link to current strategic objectives	1 Prevent people from dying prematurely 2 Enhance the quality of life for people with long term conditions 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care 5 Ensuring people are treated and cared for in a safe environment and protected from avoidable harm		
To approve			
To note	Yes		
Summary	The Corporate Calendar maps out the annual cycle of Governing Body business. It shows a clear reporting schedule and timeframes for specific reports related to the business and duties of the CCG. This in turn should provide assurance that key duties are being complied with and how the source of those specific assurances. These are usually from specified reports from identified Lead Officers, or reports and minutes from sub-committees of the Governing Body.		
Comments	No additional comments		
Next Steps			

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider financial impact? Yes** The Corporate Calendar highlights the requirement for Financial Performance reports at each Governing Body meeting via the Integrated Finance and Performance Report

GOVERNING BODY BOARD REPORT COVER SHEET

Value For Money	**Does the report consider value for money? No** Not applicable
Risk	**Is there a documented risk assessment? Yes** The Corporate Calendar highlights the requirement for the CCG Assurance Framework to be presented to the Governing Body on a quarterly basis. This is in addition to the Risk Register which in presented at each Governing Body
Legal	**Are there any legal implications? Yes** The Corporate Calendar highlights the statutory duties required of CCGs and how they are dealt with via the Governing Body.
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? Yes** The Corporate Calendar highlights the requirement for demonstrating engagement in its commissioning activities and this is now incorporated into the Direct Commissioning reports which highlight patient involvement.
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* Yes** The Corporate Calendar highlights the requirement for Equality Reports at defined intervals at the Governing Body.
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? Yes** The Corporate Calendar highlights the requirement for Workforce Reports at quarterly intervals at the Governing Body.
Partnership Working	**Does the report evidence a partnership working in its development? No**
Performance Indicators	**Does the report indicate any relevant performance indicators for this item?** The Corporate Calendar highlights the requirement for Performance reports at each Governing Body meeting via the Integrated Finance and Performance Report
Sustainability	**Does the report address economic, social and environmental sustainability *(should be addressed for new / change projects)?* No**
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*	✔

GOVERNING BODY BOARD REPORT COVER SHEET

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 i.e. 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**
Corporate Calendar	14/15-17 5.1	Governing Body	3rd June 2014	Noted

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 an x.

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

GOVERNING BODY CORPORATE CALENDAR 2015/16

Duties and Responsibilities	Assurance Source/Lead Director	GB Papers/Reports	April	May	June	July	August	September	October	November	December	January	February	March
Use of JSNA	Planning Cycle/Commissioning Intentions/Director of Commissioning	Planning/Commissioning Intentions papers								x	x	x	x	x
Secure Public Involvement	Patient Groups//Specific Consultation Exercises/Director of Commissioning	Direct Commissioning Reports/Reports on specific consultations		x		x		x		x		x		x
NHS Constitution	QPF/Director of Quality and Patient Safety/Director of Commissioning	QPF Minutes/Integrated Finance and Performance Report	x	x	x	x	x	x	x	x	x	x	x	x
Effective Efficient Services	Clinical Senate/QPF	QPF/Clinical Senate Minutes	x	x	x	x	x	x	x	x	x	x	x	x
Continuous Improvement	QPF	QPF Minutes	x	x	x	x	x	x	x	x	x	x	x	x
Primary Care Quality	Direct Commissioning Team/Director of Commissioning	Direct Commissioning Reports		x		x		x		x		x		x
Reduce Inequalities	Strategic Plan/Commissioning Plans/Director of Commissioning	Plan update paper	x			x			x			x		
Involving Pts/Carers	Direct Commissioning Team /Specific Consultation Exercises/Director of Commissioning	Direct Commissioning Reports/Reports on specific consultations		x		x		x		x		x		x
Choices	Direct Commissioning Team/Director of Commissioning	Direct Commissioning Reports		x		x		x		x		x		x
Innovation	Clinical Senate	Clinical Senate Minutes		x		x		x		x		x		x
Research	Aqua/Research Network/Clinical Senate	Clinical Senate Minutes		x		x		x		x		x		x
Education	Director of Corporate Affairs	Organisational Development update paper						x						
Finance	Chief Financial Officer	Integrated Finance and Performance Report	x	x	x	x	x	x	x	x	x	x	x	x
Quality	QPF/Director of Quality and Patient Safety	QPF Minutes/Integrated Finance and Performance Report	x	x	x	x	x	x	x	x	x	x	x	x
Performance	Director of Quality and Patient Safety	Integrated Finance and Performance Report	x	x	x	x	x	x	x	x	x	x	x	x
Information Governance	QPF/Audit Committee	QPF/Audit Minutes			x			x			x			x
Policy Renewal/adoption	Director of Corporate Affairs	As required												
Workforce/HR	Director of Corporate Affairs	Workforce Reports via QPF minutes	x	x	x	x	x	x	x	x	x	x	x	x
Constitutional/Terms of Reference Review	Director of Corporate Affairs	Constitutional amendments papers if required		x					x					
Emergency Preparedness and Resilience	Director of Corporate Affairs	EPRR annual report		x										
Subcommittees	Minutes of Subcommittees	Committee Minutes	x	x	x	x	x	x	x	x	x	x	x	x
Audit Committee Annual Report	Audit Committee Chair/Lead Manager	Audit Committee Annual Report		x										
Remuneration Committee Annual Report	Remuneration Committee Chair/Lead Manager	Remuneration Committee Annual Report		x										
Assurance Framework	Director of Corporate Affairs	Assurance Framework						x						x
Strategic/Commissioning Plan Progress	Director of Commissioning	Plan update paper	x			x			x			x		
Public Sector Equality Duty	Director of Quality and Patient Safety	Equality Duty paper				x				x				x
Final Accounts	Chief Financial Officer	Final Accounts paper		x										
Annual Governance Statement	Director of Corporate Affairs	Annual Governance Statement		x										
Annual Report	Director of Corporate Affairs/Chief Financial Officer	Annual Report		x										
Safeguarding	Director of Quality and Patient Safety	Safeguarding update paper			x			x			x			x
Quality Premium	QPF/Chief Financial Officer	QPF Minutes	x	x	x	x	x	x	x	x	x	x	x	x
Risk Register	QPF/Director of Corporate Affairs	Risk Register	x	x	x	x	x	x	x	x	x	x	x	x
Commissioning Support Unit SLA	Director of Quality and Patient Safety	CSU SLA Performance report		x			x			x			x	

Key

QPF	Quality, Performance and Finance Committee
CSU	Commissioning Support Unit
SLA	Service Level Agreement

Duties and Responsibiities
Annual Governance Statement
Audit Committee Annual Report
Research
Secure Public Involvement
Primary Care Quality
Involving Pts/Carers
Choices
Innovation
Education
Quality Premium
Risk Register
NHS Constitution
Continuous Improvement
Quality
Performance
Information Governance
Effective Efficient Services
Remuneration Committee Annual Report
Emergency Preparedness and Resilience
Reduce Inequalities
Use of JSNA
Finance
Final Accounts
Policy Renewal/adoption
Workforce/HR
Assurance Framework
Constutional/Terms of Reference Review
Annual Report
Public Sector Equality Duty
Safeguarding
Commissioning Support Unit SLA
Strategic Plan Progress

Assurance Source/Lead Officer
Audit Committee
Audit Committee
Clinical Strategy Group/Research Network
Consortia
Consortia
Consortia
Consortia
Consortia/Clinical Strategy Group
Consortia/Head of Corporate Affairs
Quality and Performance Committee
Quality and Performance Committee
Quality and Performance Committee
Quality and Performance Committee
Quality and Performance Committee
Quality and Performance Committee
Quality and Performance Committee/Audit Committee
Quality and Performance Committee/Clinical Strategy Group
Remuneration Committee Chair
Senior Resilience Manager, Commissioning Support Unit
Strategic Plan/Commissioning Plans
Annual Status Review/Commissioning Intentions
Chief Financial Officer
Chief Financial Officer
Head of Corporate Affairs
Head of Corporate Affairs
Head of Corporate Affairs
Head of Corporate Affairs/Head of Performance and Quality/Chief Financial Officer
Head of Corporate Affairs/Head of Performance and Quality/Chief Financial Officer
Head of Quality and Performance
Head of Quality and Performance
Head of Quality and Performance
Commissioning Managers

Papers/Reports
Annual Governance Statement
Remuneration Committee Annual Report
Clinical Strategy Group Minutes
Consortia Reports/Reports on specific consultations
Consortia Reports
Consortia Reports
Consortia Reports
Consortia Reports/CSG Minutes
Organisational Development update paper/Consortia Reports
Quality and Performance Committee Minutes
Risk Register
Integrated Finance and Performance Report
Quality and Performance Committee Minutes
Quality and Performance Committee Minutes
Integrated Finance and Performance Report
Quality and Performance/Audit Committee Minutes
Quality and Performance/Clinical Strategy Committee Minutes
Assurance Framework
Emergency Preparedness and Resilience paper
Strategic Plan update paper
Annual Status Review/Commissioning Intentions
Integrated Finance and Performance Report
Final Accounts paper
Policies as required
Workforce Reports
Assurance Framework
Consitutional Review paper
Annual Report
Equality Duty paper
Safeguarding upate paper
CSU SLA Performance report
Strategic Plan update paper

GOVERNING BODY BOARD REPORT COVER SHEET

NHS
Wirral Clinical Commissioning Group

BETTER CARE FUND UPDATE			
Agenda Item:	4.3	**Reference**	GB15-16/0004
Public / Private	Public	**Meeting Date**	07/04/2015
Lead Officer	Christine Campbell, Head of Partnerships Jacqui Evans, Head of Transformation, Department of Adult Social Services		
Contributors			
Link to CCG Strategic System Plan	**Edit as applicable:** 1 Patient and primary care centric and based on high quality primary care, secondary and community services 2 Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes 3 Commissioned services which have a sound evidence base 4 Provides greater equality of access to all		
Link to current strategic objectives	**Edit as applicable:** 1 Prevent people from dying prematurely 2 Enhance the quality of life for people with long term conditions 3 Helping people to recover from episodes of ill health or following injury 4 Ensuring people have a positive experience of care 5 Ensuring people are treated and cared for in a safe environment and protected from avoidable harm		
To approve			
To note	Yes		
Summary	The Governing body is asked to note the current status of the Wirral Better Care Fund.		
Comments			
Next Steps	Schemes under the Better Care Fund will continue / proceed to implementation, and Wirral CCG and the Local Authority will work together to monitor progress against key performance indicators. Updates will be brought to the Governing Body periodically, and progress will be monitored through the Joint Strategic Commissioning Group and the Health and Wellbeing Board.		

What are the implications for the following (if not applicable please state why):	
Financial	**Does the report consider the financial impact? YES** The total value of the Better Care Fund is around £35m.
Value For Money	**Does the report consider value for money? YES** Each of the schemes included within the Better Care Fund has been assessed against value for money criteria.
Risk	**Is there a documented risk assessment? YES**

GOVERNING BODY BOARD REPORT COVER SHEET

	If the Better Care Fund is not implemented then the CCG and Local Authority will risk not being able to make the transformational change that is required to reduce non-elective admissions.
Legal	**Are there any legal implications and has legal advice been obtained? YES** The Better Care Fund includes mandatory contributions around protection of front-line social care. It also supports the CCG and Local Authority to meet the statutory obligations within the Care Act.
Patient and Public Involvement (PPI)	**Does the report provide evidence whether there could be a positive or negative impact on patients and public? NO** Implementation of individual schemes will include patient and public engagement. The Better Care Fund has been discussed with Consortium patient groups.
Equality & Human Rights	**Does the report provide evidence of whether there could be a positive or negative impact on protected groups *(statutory duty for new / changes to services)* NO** An impact assessment will be carried out in respect of individual schemes. This paper presents an overview of the schemes.
Workforce	**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff? NO** There is a section on proposed implications to provider workforce. This will be discussed through the Better Care Fund Steering Group moving forwards, and in relation to specific schemes.
Partnership Working	**Does the report evidence a partnership working in its development? YES** The Better Care Fund has been developed through partnership working, through the Better Care Fund steering group, Joint Strategic Commissioning Group, and Systems Resilience Group.
Performance Indicators	**Does the report indicate any relevant performance indicators for this item? YES** The Better Care Fund must reduce emergency admissions by 3.5%, along with a range of local indicators.
Sustainability	**Does the report address economic, social and environmental sustainability *(should be addressed for new / change projects)?* YES** Sustainability has been considered in respect of individual schemes.
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*	✔

GOVERNING BODY BOARD REPORT COVER SHEET

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 i.e. 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**

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 an x.

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

GOVERNING BODY BOARD REPORT

Report Title	Better Care Fund Update
Lead Officer	Christine Campbell, Head of Partnerships Jacqui Evans, Head of Transformation – Wirral Department of Adult Social Services
Recommendations	1. The Governing Body is asked to note summary of Better Care Fund progress to date.

1. INTRODUCTION

1.1 The Better Care Fund is a pooled budget and set of planned expenditure that will enable the transformation of health and social care.

1.2 The Better Care Fund plan was signed off with assurance from NHS England in 2014.

1.3 This paper provides an overview of the latest position of the Better Care Fund.

2. KEY ISSUES / MESSAGES

2.1 The Better Care Fund represents partnership working between the CCG, Local Authority and key providers.

2.2 It comprises a number of existing and new investments, which have the primary aim of reducing emergency admissions, along with other locally agreed key performance indicators (KPIs) such as reducing length of stay, and keeping people well within their own homes.

2.3 The economy will be performance measured against its ability to reduce emergency admissions through Better Care Fund investment. This figure was originally set at a target reduction of 5% against 2014/15 baseline, by 31st March 2016. However, in light of A&E performance over the winter period, it has been agreed with NHS England that this will reduce to a target of 3.5%. This remains a significant challenge, equating to a reduction of 6 admissions per day.

2.4 There has been a recent review of the schemes to ensure that they remain aligned with Vision 2018, and are able to be funded through available CCG and Local Authority budgets. As per the latest review, the current total budget stands at just over £35m, with a contingency of around £4m. The areas to be funded through the Better Care Fund are included as Appendix One. The overall budget and schemes are to be signed off by the Health and Wellbeing Board in April 2015.

2.5 This process of reviewing the schemes has resulted in a number of separate schemes being remodeled into a single scheme, driving collaboration and efficiency across all providers to deliver a 7 day response to avoid admissions and enable 7 day discharge. This includes investment in community beds, MDT's and expansion of key community services such as overnight support, mobile nights and reablement.

2.6 The review of schemes has also resulted in a larger contingency which will support both organisations in managing risk throughout the year.

2.7 Resources will be pooled through a Section 75 agreement, which sets out governance arrangements, including how risks such as underperformance, or overspend against individual schemes, will be managed. It has been agreed that resources will be hosted by the Local Authority. The CCG Director of Finance has jointly written the Section 75 agreement, to ensure that appropriate safeguards are in place for CCG resources. This agreement will be signed off by the Joint Strategic Commissioning Group, and subsequently ratified by the Health and Wellbeing Board, in April 2015.

2.8 Given the ambitious transformational programme, implementation and performance management of the schemes are the key priority. The Health and Wellbeing Board will oversee this process, and the Better Care Fund steering group will manage this on an operational basis, reporting monthly into the Joint Strategic Commissioning Group. Individuals in both the CCG and the Local Authority have been identified to lead on individual schemes, and to co-ordinate overall delivery of the programme, and will be responsible for providing periodic updates, including identifying when programmes are not on track for delivery. A performance group has been established with the remit of monitoring progress against the 3.5% target, along with the locally agreed KPIs against individual schemes, which will be reported to NHS England.

2.9 Given that many of the Better Care Fund schemes will support the Unplanned Care programme of Vision 2018, the Systems Resilience Group and Urgent Care Recovery Group will also play a key role in monitoring scheme performance against trajectory.

3. CONCLUSION

3.1 The Governing Body is asked to note the latest position of the Better Care Fund. Further updates will be brought when available, and further information may be obtained through the CCG Head of Partnerships or the Head of Transformation for the Department of Adult Social Services.

4. APPENDICES *(Must be copied below or available on request – do not embed)*

No.	Title of Appendix
1.	Better Care Fund investment areas

Appendix One – Better Care Fund Investment Areas	
Scheme	**Description**
Wirral Independence Service	This is a recommission that will include: ❖ Assistive Technology ❖ Telehealth ❖ Falls Prevention ❖ Emergency Response System ❖ Community Equipment Store ❖ Equipment for Adult Sensory Services
Community care of the elderly service	Existing CCG expenditure on care of the elderly services within the acute trust.
Third sector (CCG)	Existing CCG and DASS third sector expenditure that has been reviewed and which contributes towards the BCF outcomes
Third sector (DASS)	
ICCT 7 day working	To develop existing social services and ICCT staff (community nursing and therapists) to allow cover for 8am – 8pm, 7 days a week
Care homes schemes	Target care homes with the greatest number of admissions to drive up quality standards, i.e. through staff training.
Flexible social care support at night	An overnight mobile domiciliary care and sitting service between the hours of 10pm and 8am, 365 days a year enabling Wirral to make the domiciliary care offer 24/7. The service is able to respond to both planned and unplanned episodes of care and facilitates both admissions prevention and discharges from hospital and care homes.
Care arranging team	To enhance the current team, which arranges and purchases ad hoc care, to ensure a 7 day response to access domiciliary, mobile nights, reablement and short stay services. The team will ensure providers are able to respond urgently to referrals and quality assure the service, releasing professional capacity.

Appendix One – Better Care Fund Investment Areas	
Scheme	**Description**
Care and support bill implementation	Health and social care partners working together to implement changes within the social care bill including: ❖ Considering the impact of the proposed changes on adult social care in Wirral. ❖ Considering all published guidance and regulations. ❖ Anticipating and developing some early plans to implement the potential requirements. ❖ Responding to further direction/guidance as it becomes available. ❖ Highlighting the need for any future policy changes. ❖ Detailed modelling of the financial implications of the proposed changes.
Investment in social services in the community	There has been a national requirement through the BCF to protect front-line social care services.
Carers (joint commission)	A joint CCG and DASS procurement for support and respite for carers
Homeless service	Existing expenditure in a mental health nurse to work solely with the homeless community, and in a joint-funded housing officer to be based within the acute trust.
Intermediate / transitional care	Investment in intermediate / transitional care, including 100 beds, facility to spot-purchase, MDT teams to support beds and prevent admissions / facilitate discharge, plus reablement
Integrated discharge team	Investment in social workers within the hospital discharge team, including 7 day working
IV antibiotics	To extend the current community IV antibiotics service, including a wider range of drugs and implementing an integrated Outpatient Parenteral Antibiotics Team (OPAT)
Early Support Discharge	To implement early supported discharge, with investment in an integrated team of therapist and reablement staff on targeted wards, along with domiciliary capacity, to reduce length of stay for key patient groups.
NWAS – demand reduction schemes	A paramedic car to support NWAS in diverting people to more appropriate places of care
NWAS – street triage	CPNs working alongside the police and ambulance staff overnight in order to reduce unnecessary section 136 assessments and conveyances to A&E.
Dementia LES	Bi-annual assessments of people with dementia by GPs and practice nurses in order to identify any risk or deterioration as early as possible, and sign-post patients to dementia nurses as appropriate.

Appendix One – Better Care Fund Investment Areas	
Scheme	**Description**
Early onset dementia	Existing expenditure in nurses and social workers to support people with a diagnosis of early onset dementia to stay well within the community
Complex needs service	Existing expenditure in a service that offers a multi-disciplinary and case management approach to patients with personality disorder and / or ADHD and other complex needs
Direct joint MH posts	Existing CCG expenditure in social work posts that are integrated with community mental health teams
Dementia nurses	Two dementia nurses that are based primarily on the older people's wards in the acute trusts, to assess and discharge plan for patients with a suspected dementia, and to support families and carers.
DFG & SCG	Statutory contributions for social care
Joint finance post	A joint post to support the financial monitoring and modelling of the BCF once in place

NHS
Wirral Clinical Commissioning Group

WIRRAL CLINICAL COMMISSIONING GROUP
Quality Performance and Finance – informal meeting

Notes & Actions of Meeting

Tuesday 24th February 2015
1pm Room 539, 5th Floor, Old Market House

Present:	Peter Naylor (PN)	Chair WCCG
	Lorna Quigley (LQ)	Director of Quality and Patient Safety
	James Kay (JK)	Lay Member (Audit & Governance) WCCG
	Simon Wagener (SW)	Lay Member (Patient Champion)
	John Wicks (JW)	Interim Accountable Officer - WCCG
	Mark Bakewell (MB)	Chief Financial Officer
	Mark Green (MG)	GP Lead
	Iain Stewart (IS)	Head of Direct Commissioning
	Andrew Cooper (AC)	Head of Strategic Planning and Outcomes
	Christine Campbell (CC)	Head of Partnerships
	Paul Edwards (PE)	Director of Corporate Affairs

Guest Speakers:

Minute Taker/Support:	Allison Hayes (AJH)	WCCG Corporate Officer – Corporate Affairs
In attendance	Dominick Banks	Finance Management Graduate
	Suzanne Crutchley	Senior Information Governance Manager
	Nicky Bradley	Community Primary Manager
	Dr Hannah McKay	GP Lead Urgent Care

Ref No.	Minute
QPF 14-15/0056	**1.0 Standing Agenda Items**
	1.1 Apologies for absence Apologies were received from: Laura Wentworth, Sue Smith, Sue Wells, and John Oates.
	1.2 Declarations of Interest Due to a conflict of interest with GPs JK took over as Chair for item 2.2 (Consortia Schemes) for this part of the meeting and it was agreed that Dr P Naylor should leave the room. This decision was due to his raised conflict in relation to a minor surgery service run from his practice. It was highlighted that a review of the schemes detailed within the paper should be taken back to the Approvals committee at a later date, to which members agreed. Dr M Green was advised that he was able to stay in the room and contribute to the discussion but should not be part of the voting/decision making process. This was to support the clinical advice around this subject and he had no overt pecuniary interest.
	1.3 Minutes of Previous meeting from 27th January 2014 The minutes from the previous meeting held on 27th January were agreed as true and accurate record, notwithstanding typographical and grammatical errors. ***Action - AJH to send ratified minutes from 27th January to GB in February*.** Actions from the previous meeting – please refer to action sheet. **Outstanding Actions**

Ref No.	Minute
	Members discussed the outstanding actions from the previous meeting. **Matters Arising** LQ provided an update regarding the Single Item Quality Surveillance Group Meeting with the Community Trust, which was held on Friday 13th February 2015. Main themes and key lines of enquiry included: • CQC report • Infection prevention control • Never events • Culture • Staff engagement Members discussed the themes and the plans for future staff engagement and culture. JK highlighted the lack of confidence within the plans and suggested that further monitoring is required in relation to the proposed actions. LQ went on to inform members that the action plans will be presented to Governing Body at a later date. And progress will be monitored via the quality contract meeting with WUTH. A follow up event take place with NHSE within 6 months. Members noted the Single Item Quality Surveillance Group Meeting update.
QPF 14-15/0057	**2.0 Items for approval**
	2.1 Policy for Management of Subject Access Requests (SARs) LQ presented the policy for Management of Subject Access Requests (SARs) on behalf of Paul Edwards and asked the QPF Committee to: • Review and approve the changes to the Subject Access Requests management policy, following the transition of the management to the CCG from North West Commissioning Support Unit and the internal changes within the CCG. SW sought clarity around access to patient records by the police and it was agreed for LQ to ask PE to give SW clarity on this matter outside the meeting. Members agreed to report future requests to access of records by the police at QPF meetings. ***Action PE to give SW clarity on section 6.3 of the policy outside of the meeting*** **2.2 Consortium Schemes 2014/16** Due to a conflict of interest with GPs JK took over as Chair for this part of the meeting and highlighted that a review of the schemes is to be taken back to the Approvals committee at a later date, to which members agreed. *(See notes regarding conflicting of interest).* It is to be noted that Dr P Naylor left the room at this point with regards to the Dermatology service due to a conflict of interest. CC informed members that a review has been undertaken by the Chairs and Chief Officers of the former Consortia to determine future commissioning arrangements for schemes commissioned using the service development budget. The majority of schemes have already come to an end; however there are some that will require on-going funding in 2015/16, and

Ref No.	Minute

others that will be served notice.

Each Consortium has had access to a service development budget in 2014/15, which has enabled the commissioning of services or investment in schemes on a non-recurrent basis in order to test innovations that could potentially be rolled out on a Wirral-wide basis. Given the recent constitutional and structural change, there will no longer be service development budgets nor delegated commissioning responsibility at a consortium level. A decision must therefore be reached regarding the future arrangements for any investments made by the Consortia in 2014/15.

Previously such decisions would have been made by the Consortium Executive Boards. However, given that these Boards no longer have a role within the CCG Governance structure; responsibility was given to the Chairs and Chief Officers of each Consortium to determine future arrangements for each scheme. This took into account the outcomes and value for money of each scheme, the feasibility and value in rolling each scheme out Wirral-wide, and the risks of not continuing with any particular scheme (albeit several schemes had already been either discontinued, or notice had been served).

Each Consortium has used its delegated budgets to invest in schemes that were designed to up skill general practice, and to pilot services on a small scale that could potentially be rolled out Wirral-wide. There are several schemes that have come to an end but where the learning from these will be invaluable to future pathway development and planning.

There are several schemes that, whilst valued by members, were not felt to be sufficiently value for money, or did not provide significant enough outcomes, to justify continuing the scheme and making it available to all Wirral practices and patients

Wirral Alliance Schemes

Name of Scheme	Further Description	Investment in 2014/15	Arrangements for 2015/16
Acupuncture	General Practice based acupuncture service	£900	Scheme has already ended
Practice training Fund	Budget delegated to practices for training	£10,000	The Head of Direct Commissioning is making arrangements for a General Practice training plan for 2015/16
COPD PACE 3	Educational resource for COPD	£3150	This was a one-off investment – no need for future funding
Professional development nurse service	The Consortium commissioned a professional development nurse on a sessional basis to support practices	£19,200	The current contract ends 31.03.15. The Quality Directorate is currently developing a strategy for nursing, and will incorporate any learning from this scheme.
Telehealth / falls pick-up	Telehealth available to support those with COPD / heart failure	£4351	This was a one-off investment. There is a Wirral Independence tender currently underway which will incorporate telehealth, therefore there

Ref No.	Minute

			is no need for continued commissioning.
Greasby Joint Injection service	Joint injections commissioned from General Practice	£3000	Notice has been given to the provider as joint injections will form part of a Wirral-wide minor surgery specification that is currently being developed, and there is access to joint injections through current minor surgery services, and the Minor Surgery DES.
Diabetes Specialist Nurse Service	A contract variation has been made with the WUTH contract, for two Diabetes Specialist nurses to support patients within the Wirral Alliance practices	£11,000	This variation has been added to the WUTH baseline and therefore does not require additional investment. Consideration will need to be given to whether it is appropriate for one group of patients only to access this service. A Wirral-wide community diabetes model is being explored, but will not be in place for the new financial year.
Phlebotomy	Three Alliance practices opted out of the Wirral Community Trust phlebotomy service, and additional resources were required to fund this activity.	£21,000	This resource will need to be identified for 2015/16.
Interpretation services	Access to interpretation and translation for patients accessing General Practice	£8500	This is being considered as part of the third-sector review.

Wirral Health Schemes

Name of Scheme	Further Description	Investment in 2014/15	Recommendation
MSK	Musculoskeletal (MSK) service commissioned from the community trust, offering access to opinion prior to intervention	£99,127	This came to an end in December 2014. Learning from this scheme will be brought into the MSK Value Stream Analysis (VSA) event taking place shortly.
Dermatology	Additional dermatology access commissioned from one General Practice	£10,333	This has come to an end as a non-recurrent investment. Dermatology services are available through Wirral Hospital Trust, and Peninsula Health.

Ref No.	Minute			
	Telehealth / falls pick-up	Telehealth available to support those with COPD / heart failure	£42,000	This was a one-off investment. There is a Wirral Independence tender currently underway which will incorporate telehealth, therefore there is no need for continued commissioning.
	Phlebotomy	Three WHCC practices opted out of the Wirral Community Trust phlebotomy service, and additional resources were required to fund this activity.	£42,000	This resource will need to be identified for 2015/16.
	Diabetes Specialist Nurse	This was commissioned as a non-recurrent investment from Wirral Hospital Trust, providing an intermediate diabetes service to WHCC patients	£31,392	This will come to an end 31.03.15. Learning will be fed into future diabetes commissioning developments.
	Care Home scheme	General Practices were commissioned to provide additional support to care home patients	£150,000	This will come to an end 31.03.15. Provision for care home support has been made through the Better Care Fund
	Diabetes Housebound	Nursing support commissioned for diabetic housebound patients	£15,000	This will come to an end 31.03.15. Learning will be fed into future diabetes commissioning developments.
	Interpretation services	Access to interpretation and translation for patients accessing General Practice	£18,519	This is being considered as part of the third-sector review.
	Heavy Menstrual Bleeding service	A General Practice based service to offer assessment and intervention for women experiencing heavy menstrual bleeding	£2000	This service will continue as part of a Wirral-wide practice-based gynaecology service (specification being finalised), as it delivers services that are accessible and at a reduced price compared to national tariff.
	Primary Care Mental Health Waiting List	Additional resources were made into primary care mental	£37,589	This was a one-off investment. A new service will be in place for primary care mental health from July 2015 and so it

Ref No.	Minute

initiative	health to improve waiting times		is not thought that further investment of this kind will be required.
Joint Injection service	Joint injections commissioned from general practice	£15,280	This particular service has already come to an end. Joint injections will be part of a Wirral-wide enhanced minor surgery specification that is being developed.
Adult asthma scheme	Scheme with pharmaceutical support to educate patients around asthma management	No cost as done through pharma support	This scheme has come to an end and the learning from this will be fed into the follow-on work for the Respiratory VSA.

Wirral GPCC Schemes

Name of Scheme	Further Description	Investment in 2014/15	Recommendation
Community Minor Surgery	Enhanced minor surgery scheme commissioned from general practice, including joint injections	£16,000 (likely to be overspent)	This service will continue and will be opened up Wirral-wide (subject to agreement with the provider) whilst the specification for a Wirral-wide enhanced minor surgery service is being developed.
Community Gynaecology	Shelf pessaries and coils (for gynaecological purposes) fitted within general practice	£2000 (likely to be overspent)	This service will continue as part of a Wirral-wide practice-based gynaecology service (specification being finalised), as it delivers services that are accessible and at a reduced price compared to national tariff.
Teledermatology	Camera attachment on an iPhone to take images of skin lesions that are sent to a dermatologist remotely for an opinion.	£20,050	It is recommended that this is discontinued. Further detail is provided below.
Phlebotomy	Several WGPCC practices opted out of the Wirral Community Trust phlebotomy service, and additional resources were required to fund this activity.	£45,173	This resource will need to be identified for 2015/16.
Telehealth / falls	Telehealth available to support those with	£42,000	This was a one-off investment. There is a Wirral Independence tender

Ref No.	Minute

pick-up	COPD / heart failure		currently underway which will incorporate telehealth, therefore there is no need for continued commissioning.
ECG service	ECG service provided through minor injury centres. Same-day reporting available.	£60,000	Notice has been given to the provider, and it is not recommended that this service continues. Further detail is provided below.
Minor Injury service – April – August 2014	Provision of a minor injury and illness service from three General Practice sites between April – August 2014 (the service is still operational but funded through CCG reserves	£226,247	These services are being reviewed as part of the Wirral-wide urgent care review. Therefore CCG resources will need to be identified to fund these services pending the outcome of the review.
Practice training budget	Budget delegated to practices for training	£150,000	The Head of Direct Commissioning is making arrangements for a General Practice training plan for 2015/16
Interpretation services	Access to interpretation and translation for patients accessing General Practice	£29,011	This is being considered as part of the third-sector review.

Members of QPF were asked to note the review of each Consortium scheme that has been commissioned or implemented in 2014/15, and to approve the planned future arrangements for each.

Action - MB to develop a decision tracking tool in relation to the decisions made and an approvals committee would be convened to deal with conflict of interests

It was also asked to note the rationale behind the decision to not extend the ECG and Teledermatology services beyond the end of the financial year, and those schemes highlighted as having future resource implications.

Members agreed to the rationale behind the decision to not extend the ECG service.

It was noted that in the absence of outcome data regarding Teledermatology services. Members agreed to discontinue this service, however, if outcome data came to light to the contrary. This would be considered.

Members discussed and noted the consortium schemes and agreed the recommended direction of travel as set out within the paper presented today.

Dr P Naylor returned to the meeting.

Ref No.	Minute
	2.3 Wirral Minor Aliments Treatment Protocol Chair welcomed Dr Hannah McKay and Nicola Bradley to the meeting who went on to inform members of the Wirral Minor Aliments Treatment Protocol. It is to be noted at this point that the GPs present at the meeting declared their interest relating to the service; however it was agreed for them to stay in the meeting and to make comment. This ruling was made by the Chair in conjunction with the Lay Member for Audit and in agreement with the whole group. This decision was taken as there was no direct pecuniary interest and their contribution was felt to be of value to the discussion. The paper presents the proposed process for ratifying Level 1 treatment protocols for use by Community Pharmacists providing treatment to patients under the Think Pharmacy Minor Ailments Service Members sought clarity around the financial implications of the service and NB explained the financial aspects of the service. Chair sought further information around level 1 conditions and the evidence behind these and requested that any treatments to be commissioned are required to be evidence based in the future. It was agreed that those of questionable evidence would be reviewed. Members agreed to the process that had been undertaken for ratifying level 1 treatment protocols for community pharmacies
QPF14-15/0052	**3.0 Items for Discussions**
	3.1 Performance Reports LQ presented the Key Performance Indicator Report to the group for the period of December 2014 and committee members were asked to note the following: **Referral to treatment target (RTT)** No issues, all pathways at an aggregate level are meeting the standards for the month. Admitted breaches in: • Other (89%) Non Admitted breaches in: • All treatment functions met 95% target Incomplete: Cardiothoracic Surgery 81.8% and General medicine 83.3% **Over 52 week waiters** No issues – no patients waiting 52+ weeks. Performance will continue to be monitored to identify any future breaches. **A&E waiting times** This has been below target at 89.6% (YTD actual). A&E at Arrowe Park fell short of the target in December; however WIC performance has met the target. **C Difficile/MRSA** In December there were three new cases at WUTH of CDifficile and 2 new cases of MRSA. Other areas included:

Ref No.	Minute
	• Same sex accommodation – 0 breaches • Family and Friend Tests Maternity & A&E Inpatient WUTH • Reducing Healthcare acquired infections • Emergency Ambulance • Cancer Members noted the current performance report. **3.2 Finance Reports** MB presented the Finance report to the group. The report sets out the financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of January (Month 10) within the 2014/15 financial year and performance against the measures outlined in the CCG Assurance Framework for 2014/15. As at the end of January (Month 10) the year to date position for Wirral CCG shows an operational over performance against required surplus of £2.844m. This is an adverse movement from the previous month of £0.809m which is mainly due to the reflection of the year end agreement with Wirral University Teaching Hospital Foundation Trust (WUTH) in the year to date position offset by £1.1m return of CHC resource. Areas included: • NHS Contracts • Non NHS contracts • Prescribing • Commissioned out of hospital • Third sector • Intermediate care • Locally enhanced services • QIPP • Running costs • Risks • Balance Sheet NHS Wirral CCG's Quality, Performance and Finance Committee were asked to note: • The CCG financial position as at the end of January 2015 • CCG forecast outturn position maintained at M10 supported by CHC M9 adjustment • Performance against indicators based on the information available • The associated financial risks within the declared position including the impact of potential resource allocation issues. Members of the QPF committee noted the Financial report presented at today's meeting. AC and CC left the meeting at this point.
QPF14-15/0053	**4.0 Items for Information and Noting**

Ref No.	Minute

4.1 Contracting Issues

- **CWP** – MB reported on behalf of CC that late publication and tariff guidance are reported to be causing problems.
- **CT** – MB reported on behalf of AC that late publication and tariff guidance are reported to be causing problems.
- **WUTH** – MB provided members with an update regarding WUTH.
- **WLA** – IS provided an update regarding Wirral Local Health Authority.

4.2 Complaints Update

LQ reported on the complaints and MP enquiries received by NHS Wirral CCG. Highlights included:

- CHC complaints and response timescales
- MP Enquiries
- On-going/new/closed complaints

Members discussed a closed complaint regarding inappropriate behaviour at St Catherine's Hospital and it was agreed that an immediate response is required in relation to this complaint.

Action – PE/LW to respond to complaint as detailed above.

All complaints and MP enquiries received will continue to be managed and monitored in line with the agreed policies and procedures by the CCG's Corporate Team and this update report will continue to be presented at this committee on a monthly basis going forward, together with an aggregated report of learning and themes on a quarterly basis.

Members noted the current complaints update.

4.3 FOI (Freedom of Information) Update

LQ reported that there has been a reduction of FOI requests and that future FOIs are now being dealt with the CCG in house.
The report detailed the number of FOI requests received and closed during the reporting period of December 2014. The report also provides a brief description of each request, details the types of applicants, the average response time and reasons for delay, where possible.

JK requested further information regarding the costs of FOIs to the CCG and it was agreed that future annual reports would be presented to the QPF committee detailing the total costs in dealing with FOIs to the CCG.

Members noted the FOI report presented today.

4.4 Serious Incidents

LQ provided the committee with details of the new serious incidents reported in December.

Reporting Organisation	Incident Type	Number
Clatterbridge Cancer Care NHS Foundation Trust	None to report	0
TOTAL		**0**
Cheshire and Wirral	Unexpected Death (general)	1

Ref No.	Minute

Partnership NHS Foundation Trust – Wirral		
	Serious Incident by Inpatient (in receipt)	1
	Unexpected Death of Outpatient (in receipt)	1
	Serious Incident by Outpatient (in receipt)	1
TOTAL		**4**
Wirral University Teaching Hospital NHS Foundation Trust	Pressure Ulcer – grade 3	1
	Accident Whilst in Hospital	1
	Safeguarding vulnerable child	1
	Surgical error **(Never Event)**	1
	Delayed diagnosis	3
	Slips/Trips/Falls	2
TOTAL		**9**
Wirral Community NHS Trust	Child Death	1
	MRSA Bacteraemia	1
	Pressure Ulcer – Grade 3	2
	Dental Extraction Child **(Never Event)**	1
TOTAL		**5**
Wirral CCG	None to report	
TOTAL		0
Independent Contractor: One to One Midwifery	None to report	
TOTAL		**0**
GRAND TOTAL		**18**

The Quality Performance and Finance committee are asked to note the Serious Incidents reported onto the StEIS system in January 2015 as detailed in the table above. All Serious Incidents will be managed via the serious incident review group to ensure:

- the incident has been adequately investigated
- the root causes and contributory factors have been identified
- the recommendations and action plan adequately address the root causes and contributory factors
- the action plan has been completed in a timely manner
- All lessons learnt are shared appropriately

Members noted and discussed the Serious Incidents report presented today.

Action – LQ to provide a year-end review of Serious Incidents at Aprils QPF.

Ref No.	Minute
	4.5 Information Governance Report SC presented a report of Wirral CCGs information governance. The purpose of the report is to assure the Wirral Clinical Commissioning Group with the Information Governance processes in place, to demonstrate that the correct support and programmes of work are underway to meet the Information Governance Toolkit Requirements by 31st March 2015. SC also presented an Annual Senior Information Risk Owner Report. Discussions took place around future training arrangements for the CCGs Caldicott Guardian and it was agreed that immediate training arrangements will be made. The QPF Committee were asked to note the Information Governance process and assurance arrangements in place. Members also noted the Annual Senior Information Risk Owner Report. MB thanked SC for her work and support.
QPF14-15/0054	**5.1 For Noting**
	5.1 Aggregate Report LQ disseminated the Aggregated report to members and it was agreed that this item would be deferred to March's QPF meeting for further discussion. **5.2 Subgroups (ratified minutes)** • CT Contract monitoring minutes of: 12.01.2015 – noted • CWP Contract meeting of 11.12.2014 - noted
QPF14-15/0055	**6.0 Risk Register**
	Members discussed the current risk register and all items were reviewed and noted accordingly. ***Action - PE is to update the current risk register and provide a report detailing the recommendations made by the QPF committee to the Governing Body.***
	7.0 Any Other Business
	There were no other times of business. Chair thanked members for their attendance and the meeting closed at: 15:55pm.
	Date and Time of next meeting
	The date and time of the next QPF meeting is scheduled for: **Tuesday 31st March at 1pm in Room 539 OMH** ***Please forward any apologies to Allison.hayes@nhs.net***