## AGENDA

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>No</th>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB14-15/0019</td>
<td>1.</td>
<td>2.00pm</td>
<td>PRELIMINARY BUSINESS (Acting Chair – Dr P Naylor)</td>
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<td></td>
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<td></td>
<td>1.1 Apologies for Absence</td>
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<td>1.2 Chair’s Announcements</td>
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<td>1.3 Declarations of Interest</td>
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<td>1.4 Comments/questions from members of the public</td>
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<td>1.5 Patient Story (Lorna Quigley)</td>
<td>Presentation on the day</td>
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<td>1.6 Minutes and Action Points of Last Meeting – held on 3rd June 2014 (All)</td>
<td>DRAFT GB PUBLIC MEETING minutes 03 (of WCCG - PUBLIC GB)</td>
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<td>DRAFT Action Points</td>
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<td>GB 14-15/0020</td>
<td>2.</td>
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<td>ITEMS FOR APPROVAL</td>
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<td></td>
<td>2.1 Presentation on Wirral CCG Priority Work streams</td>
<td>JD Governing Body Master (4).pptx</td>
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<td></td>
<td></td>
<td></td>
<td>(Iain Stewart, Christine Campbell, Andrew Cooper, Jon Develing)</td>
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<td>2.2 5 Year Strategic Plan</td>
<td>FINAL GB Strategic Plan Cover sheet 1st June 2014.pdf</td>
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<td></td>
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<td>(Jon Develing)</td>
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<td>GB 14-15/0021</td>
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<td>ITEMS FOR DISCUSSION</td>
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<td>GB 14-15/0022</td>
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<td>ITEMS FOR INFORMATION</td>
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<td>4.1 Military Veteran Health</td>
<td>FINAL Military Vets Cover Sheet 01.07.20. Health - CWW CCG.pdf</td>
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<td></td>
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<td>(Margi Butler)</td>
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<td>4.2 WACC Consortia (Iain Stewart/Mark Green)</td>
<td>FINAL WACC Quarterly Report - Cov Report Q4 2014.xls</td>
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<td>4.3 Quality Performance and Finance-QPF</td>
<td>FINAL Integrated Performance and Fina010714 (Month 2).ppt</td>
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<td></td>
<td>(Lorna Quigley &amp; Mark Bakewell)</td>
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<td>GB 14-15/0023</td>
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<td>ITEMS FOR NOTING</td>
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<td>Ref No.</td>
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<td>Time</td>
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<td>Papers</td>
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<td>Subgroups (Ratified Minutes):</td>
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<td>Wirral GPCC Consortium of:</td>
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<td>Wirral Alliance Consortium of:</td>
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<td>WGPCC Executive Board Minutes 13 05 1</td>
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<td>RATIFIED WACC Executive Board Meeting</td>
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| GB 14-15/0024 | 6. | RISK REGISTER | | |
|               |   | Current Risk Register | Circulated to members separately | |

| 7. | ANY OTHER BUSINESS | |
|    | 7.1 | |

| 8. | End | DATE AND TIME OF NEXT MEETING |
|    |     | Tuesday 5th August 2014 |
|    |     | 2pm – 4pm |
|    |     | Duncan Room OMH |
|    |     | Please forward any apologies to Allison.hayes@nhs.net |
|    |     | **Latest submission date for papers is Friday 25th July 2014** |

Wirral Clinical Commissioning Group – Future Meetings 2014

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
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<tbody>
<tr>
<td>Tuesday</td>
<td>5th August</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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<tr>
<td>Tuesday</td>
<td>2nd September</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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<td>Tuesday</td>
<td>7th October</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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Preliminary Business

1.1 Apologies for absence

Apologies for Absence were received from: Fiona Johnstone, Graham Hodkinson Dr Sue Wells, Dr John Oates and Dr Pete Naylor.

1.2 Chairs Announcements

Chair welcomed all members to the meeting. 3 members of the public attended the meeting.

Chair announced that, as people would be aware from statements the CCG has issued to its staff, practices and stakeholders, there have been a number of concerns raised with NHS England related to the leadership of the organisation. As a result, NHS England will be undertaking a Capability Review to investigate all of these issues. Whilst this review is taking place, the Chair and Chief Clinical Officer have voluntarily agreed to step aside from their CCG roles and the CCG has voluntarily requested support from NHS England. With this in mind, NHS England have asked Jon Develing, Regional Director of Operations and Delivery (NHS England North), to act as the interim Accountable Officer whilst the review takes place. Chair asked Governing Body members to join him in warmly welcoming Jon to the organisation and today’s meeting.
JK stated that in the CCG constitution, it is usual for him to act as Chair in some circumstances (e.g. when there is a conflict of interest) and for Dr Pete Naylor to act as Chair in others. For the period of the investigation, PN will act as the Chair of the CCG, but is on holiday at the moment. With that in mind, it was proposed to Governing Body members last week that, if no other GP members expressed an interest (given CCGs are clinically led), JK would act as Chair for today’s meeting given that there are circumstances where this is permissible. This was supported by Governing Body members and hence JK stated he would be chairing the meeting today.

1.3 Declarations of Interest

There were no declarations of interest.

1.4 Comments/questions from members of the public

There were no comments made by the members of the public.

1.5 Patient Story

LQ gave an overview of a patient story which highlighted a patient’s family’s experience of End of Life care.

1.6 Minutes from previous meeting held on 6th May 2014.

The minutes of the previous meeting held on 6th May 2014 were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified.

2.0 Items for approval

2.1 Financial Plan

MB gave an overview of the Financial Plan and sought approval from the Governing Body in relation to the following areas:

i. Approve Budgeted Expenditure Plans
ii. Note the updated budgetary assumptions for the 2014-15 financial year
iii. Approve the financial management arrangements for budgetary control between federated (governing body) budgets and consortia level.
iv. Note use of earmarked reserves (both recurrent / non-recurrent)
v. Note the financial risks in particular regarding QIPP gap and potential CCG actions
vi. Approve Planning assumptions to reduce financial expenditure to close QIPP Gap
vii. Note the challenges with regards to running cost allocations in 2015-16
viii. Approve the use of the available fair share toolkit to apportion budgets between consortia as applicable

The report sets out the summary financial plan for the CCG for 2014/15 including level of required surplus. It proposes financial management arrangements for splits between Governing Body (Federated Levels) and Consortia Levels and proposes the basis for the apportionment of Consortia Level budgets on a “fair-share” basis.

The report sets out the budgeted expenditure plans for NHS Wirral Clinical Commissioning Group based on the NHS England Boards revised Planning Guidance (Everyone counts: Planning for Patients 2014/15 – 2018/19) released late in December 2013. Headline Financial plans have been presented to the Quality, Performance and Finance Committee and Governing Body between January and March based on the application of the guidance received. The paper presents the final budget values for the 2014-15 financial year and associated risks.
Ref No. | Minute
--- | ---
 | JK sought clarification regarding point 15 of the report relating to residual contract funding issues with regards to the funding/transfer of vascular surgery and MB clarified this.
 | AA requested information regarding fair shares allocation and MB clarified the methodology used.
 | LQ gave an overview of the financial consequences and impact of requirements on service providers in relation to Deprivation of Liberty (Court Ruling).
 | HM highlighted the high level of risk with regards to the training of staff to carry out deprivation of liberty assessments.
 | JK highlighted the current situation in relation to the WUTH contract and informed members that further discussions will take place in Private Business.
 | AS sought clarification regarding the 3 options detailed below and sought clarity regarding, what has been brought to the table regarding QIPP.
 | **Options**
 | • The use of the contingency of £3m which would leave the CCG with a gap of £1.1m in our planning assumptions and no contingency if anything else happened
 | • As per planning paper, the CCG keep the contingency set aside but develop QIPP plans to reduce expenditure (again as detailed in the paper)
 | • That the CCG choose to not commit certain resources that are earmarked (for example LES / non-recurrent investments etc) to plug the gap
 | MB clarified that all resources need to be reviewed and some are not yet physically allocated out to practices or schemes.
 | DJ suggested that realistic plans need to be in place. MG agreed with DJ and stated that GPs are already working hard at a grass roots level in relation to demand management. HM questioned how much harder can GP colleagues work in managing their referrals.
 | JD offered some perspectives indicating that the plan is a sound and reasonable plan and delivers its statutory functions but there is a risk on QIPP and he does not believe that the QIPP plan is developed enough at the moment. He went on to suggest that there is a real need to focus on QIPP and Christine Campbell is to lead on this. The CCG needs a plan that is robust and requires ownership and understanding, but that can deliver considerably more than what it is currently stated and therefore delivery needs to be closely monitored.
 | CC highlighted the need to be vigilant as to how the CCG communicate any pause on committing resources, particularly if verbal assurances had been given to practices.
 | RW echoed CCs comments and suggested that the money for primary care is ring fenced.
 | JK suggested that the CCG need to be mindful of the language they use as it would not be appropriate to ‘ring fence’ resources for general practice. JK emphasized that any money spent needs to deliver the right outcomes and that they benefit the patients of the Wirral. The whole budget is for patient outcomes and the delivery of them.
 | LQ queried if points 5 & 78 of the recommendations will this be included on the risk register and MB confirmed that they would.

The Governing Body approved the Financial Plan.
2.2 2 & 5 Year Plan

MB provided members with details on the development of the CCGs strategic plan and updated members in relation to:

1. An independent review of the planning documentation by GE Healthcare Finnamore (GEHCF)
2. Summary of the findings from the review
3. The plan for taking the recommendations forward

The objective of the review was to provide a summary set of observations and recommendations intended to strengthen Wirral CCGs medium and long term planning submission.

Plans were reviewed against NHS guidelines as well as general good practice in planning and delivery. Staff were engaged as part of the review process and findings were fed back to the team as a group.

Based on the brief review conducted, there were a number of substantive recommendations:

• The strategic vision is fairly well described and spans the guidance requirements. It would be significantly enhanced if the narrative emphasised the compelling case for change right across the local health and social care economy
• The major strategic components appear ‘bottom up’ in nature – they would benefit from being scaled and aligned top down to help steer effort into the areas that will contribute to the strategy the most
• The financial story behind the strategy does not yet fully articulate the route to sustainability for the system. This can be more firmly underpinned by tighter definition of activity changes and associated benefits at work-stream and project level
• Project plans are developing at a level. The required maturity would be prompted by the use of outcome based planning approaches, and the testing and risk adjusting of plans using constructive criteria.
• The coherency and progress of the transformation programme would be enhanced by having a clear and agreed framework of governance and performance tracking, appropriate to the level of complexity and risk being managed
• Enablers have been identified at a high level – to ensure that they align and support delivery it is recommended that they are treated as major programme elements and resourced and controlled as key part of the overall programme

AS questioned were the primary care access scheme featured in the update and MB stated that there are no specific details regarding how 8-8 or 7 day working will be delivered.

JD stated that CCGs have been asked to deliver a robust 2 and 5 year plan at the same time as other planning processes such as specialised commissioning are taking place. Alignment was therefore critical to all planning processes. The CCG need to reverse engineer and look at what they want the economy to look like in the future and then plan on how to get there. JD indicated that there will be another submission of the strategic plan later on in the year and went on to suggest that members of the public, the NHS, Local Council, MPs need to sign up to the plans. JK sought clarity around public engagement process in relation to this. PE gave an overview of how the engagement process has been implemented and how the CCG will progress with future engagement events.

JD highlighted the importance of the need for a revised Strategic Plan to be brought back to the Governing Body in July.
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<th>Ref No.</th>
<th>Minute</th>
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<td>RW highlighted the importance of recognising clinical input and representation.</td>
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<tr>
<td>The Governing Body approved the update regarding the process of the planning process.</td>
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2.3 Annual Reports, Annual Governance Statements and Financial Statements

PE gave an overview of the Annual report and the Annual Governance Statement, highlighting the achievements of the CCG. He stated that the majority of the report was related to 2013/14 and was positive in describing how far the CCG had come in its first year. However, he did note that the Annual Report also reflects the current leadership situation mentioned by the Chair at the start of the meeting.

SW raised an issue with regards the wording related to ‘self care’ and suggesting a more encouraging and less forceful approach. HM and AC agreed with SW and members agreed that the wording of the document should be changed and that appropriate language should be used.

PE is to amend the document in time for submission.

MB highlighted the challenges the CCG have faced during its first year of operations and highlighted the impact on guidance and issues relating to the accounts preparation which should not be underestimated. MB apologised to members for the various amendments that have been recently communicate and thanked Emma Shanks and Laura Wentworth for their support in producing the reports and documents.

MB went on to inform members of a number of key issues which have been discussed during the Audit Review, in particular the accounting treatment with regards to the use of the CCG ledger to host the Isle of Man commissioning arrangement on behalf of Cheshire and Merseyside Commissioning Support Unit, which has resulted in one material misstatement that was adjusted and one unadjusted item as per the Audit Findings Report.

MB highlighted the importance of recognising the Audit Committees involvement of the production of the report. JK feels that this is an accurate representation of the accounts which provide assurance for members to rely on.

MB asked the Governing Body to support that the reports form the basis of the CCGs final reports and to acknowledge the process and outstanding work in relation to the final steps. MB clarified that members who are not present at today’s meeting have also been consulted and MB read out the responses from: Dr S Well, Dr P Naylor and Dr J Oates.

**Dr S Wells** – ‘I have read all the information sent and I am happy I see no significant omissions’.

**Dr J Oates** – ‘I would confirm that as far as I am aware there is no relevant audit information of which the Clinical commissioning Group’s external auditors is unaware. I have taken all steps I can to confirm this’.

**Dr P Naylor** – ‘I have reviewed these documents and I am happy there is nothing else I need to add at this stage. It is fine for you to document that there is no additional audit requirement from me’.

In summary the Governing Body were asked to approve relevant sections of the CCGs financial statements as detailed below, the annual Report, annual Governance Statement, Letter of Representation subject to

- Approval of arrangements for Interim Accountable Officer by NHS England
Subject to any financial amendments/adjustments as per discussions with the External Audit Committee and NHS England

Statements:

Statement of Comprehensive Net Expenditure
Statement of Financial Position
Statement of Changes to Tax payers Equity
Statement of Cash Flows

The Governing Body accepted the Annual Accounts as they had been presented.

**External Audit Findings Report**

Robin Baker and Liz Temple Murray gave an overview of Grant Thornton's audit findings for NHS Wirral Clinical Commissioning Group. The report highlighted the key issues affecting the results of WCCG and the preparation of the CCG’s financial statements for the year end March 2014. It was also used to report audit findings to management and those charged with governance in accordance with the requirements of International Standard on Auditing 260.

Areas Included:

- Executive Summary
- Audit Findings
- Value for Money
- Fees, non-audit services and independence
- Communication of audit matters

Discussions took place around how the CCG had achieved its QIPP target as reported and MB clarified these findings.

The Governing Body were asked to note the content of the report and the proposals made by Grant Thornton, the sign off of the Letter of Representation and the formal declarations of interests.

The Governing Body noted the content of the report, the sign off of the Letter of Representation and the formal declarations of interests.

**Letter of Representation**

The Governing Body noted and supported the Letter of Representation.

Chair thanked Grant Thornton for their support and leadership and gave thanks to Mark Bakewell and Paul Edwards.

**3.0 Items for Discussion**

There were no items of discussion

**4.0 Items for Information**

**4.1 Performance Report – QPF**

LQ gave a presentation on the activity performance for month 12 (March) and highlighted the positive areas and the improvements made in relation to the challenges that were originally presented.
Areas included:

- Family and friends
- NWAS turnaround
- Delivering the same sex accommodation
- Diagnostic test
- MRSA
- Referral to treatment – NHS Constitution

Clinical exceptions were discussed and LQ clarified how these are dealt with.

JD suggested that there should be a focus on A&E and that an A&E recovery plan is required.

The Governing Body noted the contents of the Quality and Performance Report.

4.2 WHCC Consortia Report

Each Consortium has been asked to prepare a report on a quarterly basis detailing how it has contributed to key CCG priorities, including:

- patient engagement
- contribution to QIPP (Quality, Innovation, Productivity and Prevention)
- GP Practice education and training

The report demonstrates to patients, stakeholders and the public the range of innovative activities taking place at a Consortium level, and the contribution made to the overall CCG Strategic plan and priorities through the Consortia and their member practices.

AC gave an updated and reported the activities undertaken by Wirral Health Commissioning Consortium since their last submission in January 2014.

The Governing Body noted the contents of WHCC report and gave thanks to the consortia for their work.

5.0 Items for Noting

5.1 Corporate Calendar

PE gave an overview of the Corporate Calendar.

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 delivered with and the source of specific assurances. These are usually from specified reports from identified Lead Officers, or reports and minutes from sub-committees of the Governing Body.

Members of the Governing Body noted the Corporate Calendar.

5.2 Subgroups


Wirral GPCC Consortium of 11.03.2014 – noted.

Audit Committee of 03.04.2014 – noted.
6.0 Risk Register

PE gave an overview of the current risk register and all items were reviewed and noted. Three new items were added to the Risk Register:

1. Review into leadership capacity and capability and risk to organisation stability and reputation
2. Risks to the delivery of the Financial Plan
3. Risks to the achievement of the 4 Hour Target

7.0 Any other Business

Chair thanked members for their attendance.

The Board meeting ended at 17:00pm.

8.0 Date and Time of Next Meeting

The date and time of the next meeting is **Tuesday 1st July 2014 at 2pm – 5pm in the Nightingale Room, OMH** please contact Allison.hayes@nhs.net with any apologies or agenda items.

Board meeting ended at: 17:00pm.
## Wirral Clinical Commissioning Group

### Governing Body

**Draft Action Points re Meeting of 3rd June 2014 (Public Session)**

**Duncan Room, OMH**

**2pm**

### Outstanding Actions from: 6th May

<table>
<thead>
<tr>
<th>Topics Discussed</th>
<th>Item Number/Ref</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
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</thead>
<tbody>
<tr>
<td>CSU SLA</td>
<td>• GB 12-13/164</td>
<td>• CSU SLA to be reviewed on a quarterly basis and presented to Governing Body by Lorna Quigley, with procurement options considered as part of the review process</td>
<td>• Lorna Quigley</td>
<td>• August 2014</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>• GB 13-14/014</td>
<td>• PE to bring Assurance Framework back to Governing body on a quarterly basis – follow up for May 2014.</td>
<td>• Paul Edwards</td>
<td>• July 2014 – separate meeting</td>
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### New Actions from: 03.06.2014

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<tr>
<th>Topics Discussed</th>
<th>Minute</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
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<tbody>
<tr>
<td>Minutes and Action Points of the last meeting</td>
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<td>• AJH/PE to rectify grammatical errors and agreed amendments to minutes of 6th May and the EOGB on 27th May 2014</td>
<td>• AJH/PE</td>
<td>• 01.07.2014</td>
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### Agenda Items for next meeting / Decisions to note for next meeting / Date & time of next meeting

The date of the next meeting is Tuesday 1st July 2014 at 2pm at OMH, Duncan Room. Agenda items and apologies are to be sent to: Allison.hayes@nhs.net
Governing Body update on Priority Work streams
Overview

Assess
• Where are we now?
• What are we doing?
• What are we not doing and what do we need to do?

Prioritise
• Annual Report ✓
• External Audit Report ✓
• Letter of Authorisation ✓
• Contract Agreement ✓
• Q4 Assurance ✓ Overall Assurance
• Wider Clinical Engagement Further development required
• Communications Further development required
• Development of Vision 2018 Good progress being made

Do
• 3 critical work streams (Commissioning Plan/Urgent Care/QIPP )
• New ways of working
• Undertake review of commitments
• Begin strategic investments of uncommitted resource
Commissioning Plan

- Strategic Plan
- Operations Plan
- Better Care Fund
- Primary Care Strategy
- NHS Constitution

WHAT
- Planned Care
- Unplanned Care
- LTC/Complex Needs

HOW

WHEN

Commissioning (Delivery) Plan
# Commissioning Plan

*(illustrative screenshot using Primary Care)*

## COMMISSIONING INTENTIONS 2014/18

**PLANNED/UNPLANNED/LONG-TERM CONDITIONS/COMPLEX NEEDS**

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<th>WHAT</th>
<th>HOW</th>
<th>INTENTIONS</th>
<th>WHEN</th>
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<tr>
<td>WIDER PRIMARY CARE</td>
<td>Improve access to general practice, both in terms of actual and perceived access</td>
<td>Invest non-recurring monies into enhancing in-hours service provision in general practices</td>
<td>2014/15</td>
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<td>Proactive coordination of care for complex patients and those with a long term condition.</td>
<td>Reduce emergency admissions by 15%</td>
<td>Procure new PCMH service with minimum recovery rate of 50% Year 1 rising to 65% by Year 3 and Entering Treatment proportion of 15% by Year 1 rising to 20% by Year 3</td>
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<td>Address physical, mental health and social care needs holistically.</td>
<td>Reduce planned care by 20%</td>
<td>Invest in Dementia service within general practices to achieve diagnosis rates 60%/65%/70%/75%</td>
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<td>Fast and responsive access to care to reduce emergency admissions.</td>
<td>Reduce care home admissions by 10%</td>
<td>Renew BME Health Link Worker service</td>
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<td>Promote health and well-being and offer rapid access to diagnosis.</td>
<td>Improve recovery rates for primary care mental health</td>
<td>Establish a shared care worker for mental health to act as caseworker/service navigator</td>
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<td>Support patients and carers to manage their own health and well-being.</td>
<td>Increase diagnosis rates for dementia</td>
<td>Initiate estates review with NHS England Area team</td>
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<td>Reduce the number of people attending A&amp;E</td>
<td>Establish 4 fully operational ICCTs</td>
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<td>Improve clinical outcomes for patients with at least one long-term condition</td>
<td>Determine general practice configuration to co-produce with ICCTs</td>
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<td>Increase cancer screening rates</td>
<td>Extend NHS Health checks to specifically include SEMI</td>
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<td>Increase immunisation rates for vulnerable groups</td>
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</tr>
</tbody>
</table>
Urgent Care

• Current situation
  – Current offer – confusing?
  – Quality and Patient Experience
  – Cost
  – Utilisation Management Review
Urgent Care

• What does good look like?
  – Operational resilience and capacity planning for 2014/15

• Urgent Care Plan
  – Why?
  – Components & Objectives
    • Short-term – A&E focus
    • Longer term – strategic direction for Urgent Care
Urgent Care

• System Resilience Groups
  – Build on the successes of Urgent Care Working Groups
  – Whole System Focus
  – Promote collaboration and support integration
  – Funding for winter
Quality Innovation Productivity & Prevention

Quality
Innovation
Prevention
Productivity

COMMISSIONING
Urgent Care
Financial Balance
Re-Investment
Transformation Wirral Vision 2018
PLAN

QIPP
QIPP Financial Targets

- QIPP Target (financial plan) £4.14 million
- QIPP Target (current) £ 5.38 million
- QIPP Target (aspiration) £10 million
Objectives linked to Commissioning Plan

• Urgent care - care closer to home
  – improved patient experience
  – improved patient journey
  – improved NHS targets
  – improved outcomes

• Elective care
  – timely and appropriate
  – right place and right time
  – improved outcomes
Transformation /Reinvestment

- Reduce Inequalities
- Empower public in their own care
- Seamless Health & Social Care
- Increase Independent Living
- Reduce avoidable admissions
- Improved patient Experience
- Improved outcomes
Next Steps

• CCG has embraced new ways of working
• There is the potential and appetite to take this further forward
• Organisational development is paramount
  – Process of listening and engaging with colleagues members and the governing body
  – Consortia approach facilitated authorisation but may not be the model for delivery going forward
• New work stream to look at this which will be led by Interim Accountable Officer
5 Year Strategic Plan

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>2.2</th>
<th>Reference:</th>
<th>GB14-15/0020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body</td>
<td>Meeting Date:</td>
<td>1st July 2014</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Jon Develing, Interim Accountable Officer</td>
<td></td>
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</tr>
<tr>
<td>Contributors:</td>
<td>Paul Edwards, Head of Corporate Affairs</td>
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<tr>
<td></td>
<td>Lorna Quigley, Head of Quality and Performance</td>
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<tr>
<td></td>
<td>Mark Bakewell, Chief Financial Officer</td>
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<tr>
<td></td>
<td>Anna Rigby, Vision 2018 Programme Manager</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Wayne Greenwood, GE Healthcare Finnamore</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Link to current governing body Objectives</td>
<td>To achieve financial control total with sound financial management.</td>
<td></td>
</tr>
<tr>
<td>Summary:</td>
<td>This report updates the CCG on the strategic planning process</td>
<td></td>
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<tr>
<td>Recommendation:</td>
<td>To Approve</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>To Note</td>
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<tr>
<td></td>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Steps:</td>
<td>To continue to improve alignment with providers and co-commissioners</td>
<td></td>
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</tr>
</tbody>
</table>

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

What are the implications for the following (please state if not applicable):

| Financial | The plan includes the headline financial planning assumptions for the CCG for the next 5 years |
| Value For Money | All expenditure plans are subject to an ongoing value for money review |
| Risk | Work is still being undertaken to assess risks of expenditure plans and will also form part of the Assurance Framework review being undertaken in July 2014 |
| Legal | The plan includes delivery of aspects of the CCG’s Statutory Duties |
| Workforce | The plan references the importance of engagement with the CCG and partner organisations’ workforce in the development of the plan. Delivery plans of specific redesign projects and initiatives will require a full workforce impact assessment. |
| Equality & Human Rights | The plans includes the demographic and population characteristics of Wirral that underpin commissioning and the delivery plans of specific projects and initiatives will require a full impact assessment as part of the Programme Office |
### Patient and Public Involvement (PPI)

The plan describes how patients and citizens have been involved in the development of the plan.

### Partnership Working

The plan recognises the links to the wider ‘Vision 2018’ planning processes, which includes partnership working with Wirral Local Authority and local providers.

### Performance Indicators

The plan outlines high level outcome indicators over the 5 year period.

---

**Do you agree that this document can be published on the website?**

(If not, please note that it may still be subject to disclosure under Freedom of Information - [Freedom of Information Exemptions](#))

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

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
</tr>
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<tbody>
<tr>
<td>2 and 5 year plan update</td>
<td>GB 14-15/0014/2.2</td>
<td>Governing Body</td>
<td>3rd June 2014</td>
<td>Approved</td>
</tr>
</tbody>
</table>

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**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

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

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.
If you require any additional information please contact the Lead Director/Officer.
2014–2019
Strategic Plan
**Foreword**

**Our Mission Statement is:**

‘Your partner in a healthier future for all’

---

This document describes the strategic plan for NHS Wirral Clinical Commissioning Group (Wirral CCG) for the period 2014 – 2019. As the main commissioners of health services for the people of Wirral we describe here how we intend to meet the needs of our population now and in the future including the way we will change how these services are delivered.

In preparing this plan we have worked with our member GP practices, partners in hospitals and community settings and colleagues in the local authority and other NHS bodies to agree between us how health services should develop in the coming years and also to bring care provided by health and social services closer together in an integrated way.

Our combined knowledge has shown us that we face many challenges on Wirral looking forward. Our population is ageing; more of us are living longer with long term medical conditions; there continues be a large gap in life expectancy between the richest and poorest areas of the borough; we rely heavily on health
services provided in an acute hospital setting; too many of our senior citizens become permanent occupants in nursing or residential homes.

When we consider these facts at a time when public organisations are facing an unprecedented challenge to operate more efficiently it is clear to us and our partners that we will need to make significant changes in order to continue to provide services that meet expectation and demand, remain safe and reliable and are sustainable financially for the future.

Wirral CCG: Who we are and our Vision

The CCG is a membership group made up of the 58 GP practices on Wirral. We are different to commissioning organisations of the past in that our leadership is made up of clinicians. We practise in the GP surgeries of Wirral and continue to see first-hand what is working well and also what needs to be improved. We use this personal experience to lead the CCG both in its day to day operation and its planning for the future. experience to lead the CCG both in its day to day operation and its planning for the future.

Our vision statement is:

‘Wirral CCG commits to improve health and reduce disease, by working with patients, public and partners, tackling health inequalities and helping people to take care of themselves’

This short statement reveals a lot about what we believe in. We consider that good health starts with the individual. We will promote ways for people to keep themselves healthier for longer and manage their own health needs. We say ‘partner’ because it’s our job to ensure that a health service is ready to help you should the need arise.

We must also ensure that the service is simple and quick to access, is safe and high quality and provides good value for money. ‘Partner’ also has a broader meaning to us in that we recognize that only by working together can we
improve the health of Wirral. Throughout our plan you will see reference to ‘integration’. This means professionals in hospital and community settings working together but also health, social care and other public services combining their efforts to provide solutions to the challenges we face.

We are fully aware that there continues to be an unacceptable difference in rates of disease and death between parts of Wirral. Although we have seen some improvements in these factors recently Wirral’s health is not getting better as quickly as other areas of England so the CCG remains focused on tackling this over the coming years.

We are confident that our plan sets out a clear case for change on Wirral. Over the next five years we will work with our partners to deliver transformation while remaining true to our vision. At every step we will use our experience as clinical leaders to refer back to what our patients are telling us to ensure that we continue to meet the needs of the people of Wirral.
<table>
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<th>Contents</th>
</tr>
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<tr>
<td><strong>Foreword</strong></td>
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<td>2. The case for change</td>
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<td>3. Our vision for 18/19</td>
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<td>4. The plan</td>
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<td>A. Quality and outcomes</td>
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<tr>
<td>B. Sustainability</td>
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<tr>
<td>5. Key programmes of change</td>
</tr>
<tr>
<td>6. Commitment and ownership</td>
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</tbody>
</table>
Executive Summary

Our strategy will require continuous and significant service review and transformation

This Strategic Plan (and its associated operational plans) have been developed in the context of very demanding requirements from government both in terms of patient and service user expectations and anticipated resource availability.

The key goal is to continue to deliver high quality services during a time of significant financial challenge and a changing NHS landscape.

The focus of the CCG will be to deliver financial sustainability; to deliver national requirements such as those outlined in the Everyone Counts: Planning For Patients Guidance; and continue to deliver improved quality, evidenced by improving safety, effectiveness and patient experience. This will be the focus for the CCG during the period of this plan and beyond.

In addition to national developments and priorities we will focus on local service redesign which will address the specific health needs in Wirral reflecting the sometimes different requirements of its registered population.
In summary we see the Wirral health care system/service in 5 years’ time as one that:

- Is patient and primary care centric and based on high quality primary care, secondary and community services
- Has rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes
- Has commissioned services which have a sound evidence base
- Provides greater equality of access to all

We will focus on the national and local priorities as appropriate, in order to:

- Prevent People from dying prematurely
- Enhance the quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Ensuring people are treated and cared for in safe environment and protected from avoidable harm

We have identified specific local priorities including:

- Meeting the needs of our ageing population
- Supporting Alcohol prevention and treatment services
- Improving Mental Health services with particular prioritisation of dementia
This strategy is at a point in time in terms of its development and alignment. Alongside the development of the CCG Strategic Plan the CCG is working with partners on the development of a system wide vision for the health and social care economy which is called Vision 2018. In recent weeks prior to submission the CCG and its partners across health and social care have begun a process designed to strengthen planning and delivery of the Vision 2018 system plan by streamlining the structure of programmes and establishing tighter governance protocols.

This process will include more detailed development and agreement of the precise activity and finance characteristics of the local health economy in 18/19 to be sustainable. It will also define in greater clarity the nature and scale of improvement the individual programmes need to achieve in support of the strategy.

Therefore the CCGs key change programmes described later in this document are representative in terms of purpose and content, but will continue to be refined as partners in the system develop plans and mobilise resources. The CCG will also work closely with neighbouring CCGs so as to address wider quality and sustainability challenges.

The emerging shape of the Vision programme and its high level alignment with CCG planning is described in the governance section towards the end of the document. The intention is to harmonise effort into one single plan for the system.

Partners across the health and social care community in Wirral have met to discuss and review assumptions underpinning the development of their Strategic Plans. Partners acknowledge that whilst there may not be a fully developed set of agreed commissioning intentions, organisations have developed their plans having made informed assumptions about capacity and demand and the impact this will have on organisational activity and finances.
Whilst there is a shared acceptance of the broad strategic direction of travel in relation to the need to transform care outside of the traditional settings, plans to deliver this are at a very early stage of development and therefore will continue to develop in the following iterations.

Partners do acknowledge that activity and financial assumptions will vary across each organisation at the point in time of the submission of strategic plans and have agreed to commence a process of review of these assumptions over the next few months, alongside the strategic review which has taken place of the structure and processes in place to support the Vision 2018 programme.
The case for change

Wirral faces new challenges

Context

Wirral is a borough of contrast and diversity in both its physical characteristics and social demographics. There are both rural areas and townships, urban and industrialised areas in a compact peninsula of 60 square miles. The borough has parks, countryside and over 20 miles of coastline.

Wirral currently experiences a variety of challenges specific to its locality and demography, as well as future pressures which face health and social care systems nationally.

The anticipated severity of these pressures acting in conjunction means that the nature and scale of change required is significant and unprecedented.

This section describes the case for change to:

1. Improve quality of care and outcomes for patients
2. Transform healthcare provision so that it is financially sustainable
The case for change: Context

Commissioning environment

NHS Wirral Clinical Commissioning Group is a federated model comprising 3 commissioning consortia as follows:

<table>
<thead>
<tr>
<th>Division</th>
<th>Number of Practices</th>
<th>Number of Patients (approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral Health Commissioning Consortium (WHCC)</td>
<td>25</td>
<td>165,000</td>
</tr>
<tr>
<td>Wirral GP Commissioning Consortium (WGPCO)</td>
<td>25</td>
<td>126,000</td>
</tr>
<tr>
<td>Wirral Health Alliance (WHA)</td>
<td>7</td>
<td>40,000</td>
</tr>
</tbody>
</table>

The configuration of each of the consortia follows with no discrete geographical boundary.

In total we look after the health needs of approximately 330,000 people within Wirral.

Local providers

NHS Wirral CCG commissions its services through a range of NHS and Non-NHS providers with the contract monitoring and negotiation process being led by clinical commissioners.

Wirral CCG commissions services from the following providers -

- Acute: Wirral University Teaching Hospital NHS Foundation Trust
- Mental Health: Cheshire and Wirral Partnership NHS Foundation Trust
- Community: Wirral Community Trust
- Social Care: Wirral Borough Council
- Primary Care: 57 GP practices

Other providers:

- 94 pharmacies
- 45 dentists
- 33 opticians
The case for change: Overview

Overview

Health services that were set up to provide care - to help sick people get well, are finding it harder to meet the changing nature of need, including an ageing population and increasing numbers of people requiring long-term care.

Services available to respond to these demands, particularly in the acute setting, are often not the most appropriate response to the care needs of patient and individuals. In many cases those individuals are the same people requiring support from local authority social services and mental health to help them stay independent and well.

Traditional models of care are currently not set up to cope with the needs of patients in a cost effective and sustainable way. Broadly speaking within a population or given locality, five percent of the population will consume 45% of the health resource. These are patients with complex chronic conditions (elderly, adults and children)

However, although these people use well over half of the care resources, they often do not receive the optimum care for their needs.

- Typically, patients have poor experience of care that:
  - Does not support their independence and control
  - Is fragmented and difficult to navigate.

And, poor outcomes:

- A poor quality of life for both the patients and their carers.
- Too many people living with preventable ill-health and dying prematurely.
- Avoidable emergency and residential care admissions/ readmissions.

So, there is a need to adapt the care system to better meet the changing needs of individuals, families and communities today - to put in place proactive, on-going and integrated care.
The case for change: 1 Quality and outcomes

Population profile

Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole.

The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2011 and 2021 it is estimated that this population group will have increased by 17.4%.

The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% increase.

The biggest decrease is in the 35-59 year age group, from 108,548 in 2008 to 82,061 in 2021.

Births reached a 15 year high in 2011.

The Index of Multiple Deprivation (IMD) places 30 of Wirral’s LSOAs in the lowest 5% in England and 23 Lower Super Output Areas (LSOA) in the 3% most deprived nationally.

The Employment domain of the IMD 2010 indicates that Wirral performs poorly on this indicator. This is an indication of the scale of the challenge faced in Wirral and the need for a focused and coordinated approach to tackling work-lessness and economic inactivity.

Wirral has a predominance of ‘Mosaic’ groups which are at the polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is quite pronounced in Wirral.
The case for change: 1 Quality and outcomes

Deprivation

The Index of Multiple Deprivation (IMD) IMD 2010 shows that Wirral is the 60th most deprived of the 326 districts in the country and is therefore in the bottom 20% nationally. There has been no change on previous data (IMD 2007).

The IMD places 30 of Wirral’s Lower Super Output Area’s (LSOA) in the lowest 5% in England and 23 LSOAs in the 3% most deprived nationally as described in the table below.

Life expectancy

In 2008-10, life expectancy in Wirral was 77.0 for men and 80.8 for women. However life expectancy varies across the peninsula and an example of this is displayed by the map below, comparing life expectancy by Wirral Railway Station for the male Wirral population.
The case for change: 1 Quality and outcomes

The gap in life expectancy between Wirral and England continued to widen in 2008-10. Amongst women in Wirral, life expectancy has actually decreased slightly for the last two time periods recorded (2007-09 and 2008-10).

The gap in life expectancy between the most and least affluent within Wirral was 14.6 years for men and 9.7 years for women (Marmot Indicators, 2012).

The Marmot Indicators (2012) also showed that Wirral had the largest gap in Disability Free Life Expectancy (DFLE) for males and females of any authority in England (20.0 years for men, 17.1 years for women).

The main contributors to the gap in life expectancy between Wirral and England were chronic liver disease for men and lung cancer for women. Mortality from chronic liver disease in Wirral men in both the under 75s, and those of all ages, is higher than England. The main contributor to liver disease is alcohol.

Diversity

Wirral Black & Minority Ethnic (BME) population issues are difficult to isolate. Information relating to ethnicity in Wirral is limited. Wirral is by no means unique in this respect; many other areas are faced with this issue due to the limitations and relative inconsistencies in the recording of BME population data.

This possible lack of local data on the health and wellbeing needs of the increasing range of Wirral BME communities can in part be addressed by reviewing national data as it is likely to present a similar picture for Wirral residents.

National and previous local evidence might suggest that BME groups may not be accessing health and social care services in accordance with their level of need or in a timely manner.

Research suggests poorer communication, undue expectation, possible stereotyping, need for further training and cultural awareness
The case for change: 1 Quality and outcomes

that can combine to impact on BME residents in relation to their service provision and access

Census 2011 shows us an increase in the BME population, from 3.46% in 2001 to 5.03% in 2011 (From 10,900 people in 2001 to 16,101 people in 2011)

More BME residents live in Birkenhead and Tranmere ward than any other part of Wirral followed by Claughton, Rock Ferry and Hoylake & Meols.

Key issues and concerns

Wirral has many very high differentials between incomes in different parts of Wirral. This produces very marked impact on health experiences across virtually all indicators.

Wirral has the largest gap in disability free life expectancy of any authority in England for males and females.

There are about 38,000 recorded carers in Wirral representing about 12% of the population compared to a national average of 10%

Dementia is a key and worsening problem for Wirral with an estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next 8 years.

Alcohol is a significant problem for children and young people on Wirral. Death rates from digestive diseases mainly caused by alcohol are increasing very rapidly in the most deprived areas.
30,000 over 65s reported in the 2001 Census that they were living with a Limiting Long Term Illness.

The most deprived areas have much higher emergency hospital admission rates than the rest of Wirral.

Lifestyle behaviours such as smoking and drinking too much alcohol, as well as obesity, contribute to health inequalities, and these behaviours are all more prevalent in Wirral’s most deprived areas.

Birkenhead, Tranmere, Bidston, Seacombe and Rock Ferry have between 50% and 70% of older people living in deprivation.
The chart below shows the distribution of the CCGs on each Outcomes Framework indicator in terms of ranks. NHS Wirral CCG is shown as a red diamond. The yellow box shows the inter quartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

<table>
<thead>
<tr>
<th>Outcome Indicator</th>
<th>CCG and cluster distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</td>
<td></td>
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<tr>
<td>1.1 Under 75 mortality rate from cardiovascular disease</td>
<td></td>
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<tr>
<td>1.2 Under 75 mortality rate from respiratory disease</td>
<td></td>
</tr>
<tr>
<td>1.3 (proxy indicator) Emergency admissions for alcohol related liver disease</td>
<td></td>
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<tr>
<td>1.4 Under 75 mortality rate from cancer</td>
<td></td>
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<tr>
<td>2 Health related quality of life for people with long term conditions</td>
<td></td>
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<tr>
<td>2.1 Proportion of people feeling supported to manage their condition</td>
<td></td>
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<tr>
<td>2.3i Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)</td>
<td></td>
</tr>
<tr>
<td>2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</td>
<td></td>
</tr>
<tr>
<td>3a Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td></td>
</tr>
<tr>
<td>3b Emergency readmissions within 30 days of discharge from hospital</td>
<td></td>
</tr>
<tr>
<td>3.1i Patient reported outcome measures for elective procedures – hip replacement</td>
<td></td>
</tr>
<tr>
<td>3.3iii Patient reported outcome measures for elective procedures – knee replacement</td>
<td></td>
</tr>
<tr>
<td>3.3iiii Patient reported outcome measures for elective procedures – groin hernia</td>
<td></td>
</tr>
<tr>
<td>3.2 Emergency admissions for children with lower respiratory tract infections</td>
<td></td>
</tr>
<tr>
<td>4ai Patient experience of GP services</td>
<td></td>
</tr>
<tr>
<td>4a(ii) Patient experience of GP out of hours services</td>
<td></td>
</tr>
<tr>
<td>4a(iii) Patient experience of NHS dental services</td>
<td></td>
</tr>
<tr>
<td>5.2i Incidence of Healthcare associated infection (HCAI): MRSA</td>
<td></td>
</tr>
<tr>
<td>5.2ii Incidence of Healthcare associated infection (HCAI): C Difficile</td>
<td></td>
</tr>
</tbody>
</table>

![Chart showing distribution of CCGs](chart.png)
The case for change: 1 Quality and outcomes

QOF disease prevalence

The table below shows the prevalence (number and percentage) of diseases covered by the QOF for the practices in this CCG in 2010/11. The chart shows the distribution of the CCG’s practices’ prevalence in terms of ranks. Individual practices are shown as vertical bars with the height of the bar proportionate to each practice’s population. The blue box shows the range of the middle 50% of practices in the CCG. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average.

<table>
<thead>
<tr>
<th>QOF Disease Register</th>
<th>Number (%) and practice ranks chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease</td>
<td>13,769 (4.1%)</td>
</tr>
<tr>
<td>Stroke or Transient Ischaemic Attacks (TIA)</td>
<td>7,359 (2.2%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>49,411 (14.9%)</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>7,396 (2.2%)</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>11,484 (3.5%)</td>
</tr>
<tr>
<td>Cancer</td>
<td>5,894 (1.8%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,979 (0.9%)</td>
</tr>
<tr>
<td>Asthma</td>
<td>21,109 (6.3%)</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>2,632 (0.8%)</td>
</tr>
<tr>
<td>Heart Failure Due to LVD</td>
<td>1,512 (0.5%)</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>732 (0.2%)</td>
</tr>
<tr>
<td>Dementia</td>
<td>1,902 (0.6%)</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>6,326 (1.9%)</td>
</tr>
<tr>
<td>Cardiovascular Disease Primary Prevention</td>
<td>4,342 (1.3%)</td>
</tr>
<tr>
<td>Diabetes Mellitus (17+)</td>
<td>16,122 (6.0%)</td>
</tr>
<tr>
<td>Epilepsy (18+)</td>
<td>2,512 (0.9%)</td>
</tr>
<tr>
<td>Depression (18+)</td>
<td>38,138 (14.4%)</td>
</tr>
<tr>
<td>Chronic Kidney Disease (18+)</td>
<td>13,193 (5.0%)</td>
</tr>
<tr>
<td>Obesity (16+)</td>
<td>34,063 (12.5%)</td>
</tr>
<tr>
<td>Learning Disability (18+)</td>
<td>1,500 (0.6%)</td>
</tr>
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The case for change: 1 Quality and outcomes

Summary

In arriving at our strategic priorities, a rigorous prioritisation process was agreed by the Wirral Health and Wellbeing Board and the JSNA Executive Group. The prioritisation process was undertaken between October and December 2012. It was systematic and transparent, supported by public and stakeholder consultation, which helped identify the most important priorities for local people. These were:

- Ageing Population
- Alcohol
- Mental Health
- Poverty
- Life Skills

Subsequently a prioritisation methodology was agreed and working principles established. The process identified a priority order and the Health and Well-being Board subsequently agreed the three strategic health priorities for Wirral to be:

- Coping with the demands and pressures of an ageing population
- Dealing with the health impacts from high incidence of alcoholism
- Reducing physical health inequalities of those suffering mental health issues
Overview

The Wirral health economy faces significant financial pressures - those experienced currently requiring additional support, and those anticipated into the planning period for which there is unlikely to be support available from external sources.

This means that the basis upon which Wirral provides and funds services will need to change radically so that it can continue to provide for the care needs of the community now and into the future.

The start pointing point is that our current funding position requires a significant proportion of non-recurrent support. Therefore year on year unrestrained growth in expenditure is not a sustainable basis for the CCG and wider system to plan against.

Existing clinical models of service provision across the economy manage current demand sub optimally and produce outcomes for patients which are below the standards we aspire to for our population. Significant investment is going to be required to redesign and rebalance the system so that it is both effective and affordable.

Future funding is however likely to be flat in terms of growth meaning that the system needs to look very different to protect the integrity and viability of services and the organisations responsible for their provision.

For us to manage pressures in a sustainable way the shape and size of existing providers will need to change dramatically, with more care being provided outside of acute settings and greater emphasis on community partners to manage and reduce overall demand entering into the care system.

We will need to work collectively across the health and social care system to share resources and remove unnecessary duplication. Patient centred care provision will mean cross organisational boundaries and funding mechanisms need to change to facilitate and incentivise this.
Wirral CCG’s spending 14/15

Wirral CCG plan to spend £444m of recurrent funds this year on healthcare provision.

The diagram below illustrates the CCG’s spending on health by high level category of care –
The case for change: 2 Financial sustainability

Funding allocations

Funding for the CCG’s programme of expenditure is anticipated to remain flat over the planning period to 2018/19 as shown below (excluding impacts of Better Care Fund).

Note that the CCGs high level financial plan assumes a contribution of 4% annual efficiency across all spend areas. Efficiency not realised will add to the pressures below.

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<tbody>
<tr>
<td>Allocation Growth</td>
<td>2.14%</td>
<td>1.70%</td>
<td>1.80%</td>
<td>1.70%</td>
<td>1.70%</td>
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<tr>
<td>Assumed Cost Efficiency</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Total</td>
<td>6.14%</td>
<td>5.70%</td>
<td>5.80%</td>
<td>5.70%</td>
<td>5.70%</td>
</tr>
</tbody>
</table>

Pressures

Pressures on the system are expected to continue to rise at a faster rate than funding.

The CCG is anticipating pressures using the following growth assumptions –

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<tbody>
<tr>
<td>Inflation</td>
<td>2.50%</td>
<td>2.90%</td>
<td>4.40%</td>
<td>3.40%</td>
<td>3.30%</td>
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<tr>
<td>Medical Technology (New Prescribing)</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Demographic Pressures</td>
<td>0.14%</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.15%</td>
</tr>
<tr>
<td>Non-Demographic Pressures (e.g. Acute Demand)</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Non-Demographic Pressures (e.g. Out of Hospital Demand)</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Specific Developments - e.g Better Care Fund Impact</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Cumulative Cost pressures</td>
<td>6.64%</td>
<td>7.05%</td>
<td>8.55%</td>
<td>7.55%</td>
<td>7.45%</td>
</tr>
</tbody>
</table>
The case for change: 2. Financial sustainability

Forecast gap in funding

The combination of inflation and activity growth will accelerate the gap between funding and required expenditure, particularly if assumed efficiencies are not managed year on year.

Unmet efficiencies in one year are then compounded in the next by growth itself and the inflated costs prevailing in the second year.

The worst case is one where no action is taken and inflation and growth compound year on year over the planning period.

This would produce a significant gap in funding, estimated at £140m in 18/19 as illustrated below.

(As a system, social care pressure also needs to be factored for).
The case for change: 2 Financial sustainability

The challenge to balance CCG funding

The impact of unchecked cost inflation and activity growth will add an estimated £140m of spending requirement, meaning that in 18/19 the CCG would require a budget of approximately £595m.

Assuming growth in allocations and full achievement of 4% efficiency will still leave a remaining estimated gap of £36m to balance the CCGs finances.

Plan for balancing CCG finances to 2018/19 (£m)

- 13/14 Base: £455
- Cost inflation: £80
- Activity growth: £60
- 18/19 forecast: £595
- Allocation growth: £24
- Efficiency at 4%: £80
- Remaining gap: £36
The case for change: 2 Financial sustainability

Implications

The high level financial forecast indicates that the system needs to deal with the pressures using a very different clinical and commercial model. Delivering efficiency alone will not be sufficient to meet rising costs and growth which are roughly equivalent to 30% of the original baseline 14/15 budget.

There is a recognition that the solution will involve greater collaboration and integration across health and social care to manage demand in a different way. This will be facilitated and incentivised by the use of the Better Care Fund (implications described later in the Plan section).

In summary, to be affordable and sustainable the system as a whole requires a cohesive and single plan which will seek to service demand using less clinical intensive resources and outside of traditional acute settings. We will harness and build greater capacity within primary care and community partners to avoid and redirect care appropriately, with increasing emphasis on people being enabled to take greater responsibility for their care needs.

Further explanation is provided within the Plan section later in this document.
Our Vision for 18/19

Building care around the needs of patients

Context

The Wirral Health & Social Care Economy requires significant transformation over the next 5 years in order to meet the challenges faced.

The vision for transformed delivery is for care to be built around the needs of the patient population, providing support for patients to look after their own health and wellbeing, whilst improving access to appropriate services as required.

This will comprise a system of wider integrated primary and community based services, supported by a smaller but more specialised acute care setting. Services delivered within the community will include specialised care that was previously provided within a hospital setting.

Wirral CCG is committed to incorporating the concept of “Hospitals without Walls” in developing an integrated care model. The hospital setting will be supported to develop a higher level of speciality and technology to support more complex
conditions with the opportunity to develop into a specialist hub across the region for particular specialities as appropriate.

The economy’s vision will ensure that commissioning of health and social care will be provided on an integrated basis ensuring the best alignment of physical and mental health care services.

In this section we will describe an overview of our vision for the future, beginning with the patient and working back to the characteristics we feel are important to make this a reality.

The Wirral Vision in 2018/19 will be based on the creation of a sustainable and high quality health and social care economy built around the following key characteristics:

- Wider primary care, provided at scale
- Integration of care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care
Through a patient’s eyes in 2018...

As a Wirral resident, I will be able to understand how and when to access healthcare, or find this information easily. I will be able to ring 111 if I am not sure of the best service to meet my needs, and will be able to find a directory online which will explain what local services are available to me, and how I access these.

If I am suffering from a minor illness, such as a cough, cold or headache, it is very unlikely that I will need to visit my GP Practice. I will be able to find information on the internet that is reliable and easy to understand, and will explain how I can take care of myself, or I will be able to visit a local pharmacy any day of the week to talk to someone about the best way to treat my illness and look after myself so that I can get better as quickly as possible.

If my pharmacy cannot help, or I have a minor injury or illness that I cannot treat myself, then I will be able to visit a Walk-in Centre and see a senior nurse without needing an appointment - it is not likely that I will have to wait any more than 20 minutes. The nurse will more than likely be able to treat me on the spot without needing to send me to any other services, and will be able to prescribe medication if this is what I need.

The nurse treating me at the Walk-in Centre will be able to see a summary of my GP record, and so will know instantly if I am allergic to anything, or if there is anything they may need to take into account.

They will also be able to see if I need to have any basic tests done that may be useful to my GP in managing any long-term health needs that I may have, for instance, if I am eligible for a flu vaccination, or if my blood pressure needs to be monitored. My GP will receive the results in a couple of days, and it will save me making an appointment.
The nurse may actually be able to help me over the telephone, without needing to come to the surgery at all.

The staff at my GP Practice will be skilled to advise on and treat a wider range of healthcare problems than ever before. It is likely that my GP Practice will be working with those locally to make sure that these skills are shared, and that even if my own practice cannot offer a particular service, I will be able to access it locally.

So, if I am suffering from a minor skin complaint, my GP may either have had special training to deal with this him or herself, or will ask me to attend a local surgery where there are staff that have this expertise. This will mean that hospital services are able to see those with the most complex and serious of problems, and will mean that I can have an appointment quickly, and in my community.

If I do need to see a specialist, I will be offered choice, and will be given information about
anything unexpected from happening to my health. My care will be proactive rather than kicking in once I have suffered a crisis or a setback.

My care will be personalised to me, taking into account as far as possible any particular needs that I may have. I will have a personalised care plan that is available to all the people looking after me: I will be treated as a whole person, rather than just for the condition that I have.

If I am over 75 and have a long term health condition, I will know the name of a senior clinician – either a doctor or senior nurse – who will take the responsibility for organising my care.

Whatever my age, I won’t be left on my own to navigate my journey, or the journey of a loved one, through the health and social care system. I will know who to contact to find out at any stage what is happening with my treatment or care; this will be made as easy as possible for me, as I will be able to contact the surgery by waiting times and location so that this will be an informed choice.

There may be new services at my GP Practice that I do not recognise, such as physiotherapy, and counselling. For many services, I will be able to choose between a range of providers, so I can choose the one that best meets my needs. If this is not at my own GP Practice, it will be within my own community.

If I have a long term health condition, I will be given lots of information so that I understand what my body is going through, the effect this will have on my health, and what I can do to make this condition more manageable. Those caring for me will work together and will share essential information about me, so that I do not have to have the same tests done twice, and that I do not have to wait too long for the right care. I may be offered access to technology to use in my own home to help me to monitor and take control of my health. Any readings will be shared with those looking after me, so that they can work together to identify and prevent
e-mail, and receive information relating to my care via SMS.

My mental health will be considered alongside my physical health at all times; for instance, if I have a long term health condition such as diabetes, those involved in my care will consider how this is affecting my mental health, and I will be offered support if it is needed.

I will know how to get involved in the planning of healthcare services locally and will be given the opportunity to be part of a patient group – both for my general practice, and for those that are responsible community and hospital healthcare services. I will be given the choice to attend meetings to share my views, or, if I provide my e-mail address, will be sent regular information about health and social care locally, and be given the opportunity to share my views.

I will be treated with dignity, respect, care and compassion at all times. The buildings that I visit to see a healthcare professional will be fit for purpose, clean, safe, and accessible.
Our vision - key characteristics

Wider primary care, provided at scale

Our vision is one of primary care communities, where the majority of healthcare – whether that is routine or unplanned care, is delivered outside of hospital and specialist settings, close to people’s homes. Communities will be built around GP Practices and will see healthcare and social care professionals working together to prevent ill health, provide fast and responsive access to advice and treatment for medical conditions, and supporting those with long term conditions and complex needs to manage their condition and have greater independence.

Primary Care teams will play a key role in navigating and co-ordinating the journey of patients through the system, working alongside community staff such as nurses and therapists, and specialists such as consultants, along with mental health practitioners and social workers, and other organisations such as pharmacies, opticians, and the voluntary sector, to provide care and support that is tailored to the individual, and not to the organisations that provide it. By working together we will keep people healthy and happy in their own homes and communities for as long as possible, so that going to hospital or being admitted to a care home is something that is the exception and not the norm.

If we are to deliver the transformational change of ‘wider primary care, delivered at scale’, with GP Practices placed at the heart of this primary care system, then we will need to facilitate an environment where there is much greater co-operation between services, with general practices working together and alongside a range of other health, social care and voluntary sector organisations to jointly own and deliver these outcomes.
Our vision - key characteristics

Integration of care

A modern model of integrated care will be achieved by systematically integrating both services and pathways, horizontally and vertically across organisational boundaries, providing tailored care for patients.

For horizontal integration this will mean a single team approach to care across health and social services so that duplication is reduced and care is coordinated in a more effective fashion.

For vertical integration this will mean primary, community and hospital services working together to ensure patient journeys are seamless across organisational boundaries.

Access to the highest quality of urgent and emergency care

By integrating care vertically this will ensure that the full spectrum of primary and secondary care services are mapped so that patients access appropriate unplanned care at the right time in the right environment.

For example by creating a variety of primary care and community centres to deal with lower end conditions this should ensure adequate capacity for major conditions that are required to be seen in a hospital setting.

For such services to work effectively all members of the health community need to ensure that users of the services are aware of the services that are available and the need to promote self-care.
Step change in the productivity of elective care

To ensure people are seen by the right person at the right time, by the right clinician in the most appropriate setting with appropriate referral. This will be supported using robust referral pathways which include triage/advice and minimises need for face to face consultation. It will also include access to specialist services only when appropriate and within the community where possible.

There will be a drive to reduce duplication and maximise efficiency by developing referral protocols and guidelines. We will seek to move all appropriate activity from a hospital setting into community hubs across Wirral.

Pathways will support education and up skilling and support the delivery of procedures and treatment interventions previously carried out by specialists in a secondary care setting.

Specialised services concentrated in centres of excellence

The CCG will work closely with commissioners of specialised services and neighbouring CCGs where there maybe potential for commissioning at scale; this might be in areas where there is low volume of activity in tandem with high cost per procedure and high degree of clinical specialism.

This will need to be in line with NICE Improving Outcomes guidance, sensitive to local need and citizen engagement.
Empowering patients and citizens

The CCG upholds the NHS 2012 white paper “No decision about me without me”. The CCG has recently produced a refreshed Experience, Engagement and Communication strategy which includes 7 objectives of how the CCG intends to engage with its local population. This includes a combination of specific engagement events with clinicians and residents as well as routine engagement via established patient groups.

In addition the CCG is developing its presence on social media to enable members of the public to interact and comment more rapidly on CCG business.

The CCG will be engaging with the public and local workforce throughout the development of Vision 2018 to ensure that the strategy is built upon the needs of our population.

A significant number of people with long term conditions want to remain as independent as possible and live as healthily as they can.

Their feedback suggested that they need more information, online and face-to-face. “PUFFELL” is a free, Internet-based portal which allows people to create a Personal Health Account and to track goals and engage with services where appropriate. This links with Wirral Well.org to direct people to existing services as they seek to self-support.

For those people not online VCAW offer a face to face and printable option. At every opportunity people are empowered to self-care and make responsible decisions regarding their lifestyle choices.

Our vision - key characteristics
The plan

Where we will focus our effort

Introduction

This section provides an overview of the key strategic challenges that we will seek to tackle. It describes the major components of the plan over the next 5 years.

1. An overall timing plan is provided as illustration.

2. The key outcomes we are planning to improve is described including

   • The 7 outcome ambitions; reducing health inequalities; parity of esteem
   • Improving health through prevention and self management

3. An overview of how the strategy seeks to tackle financial sustainability
High level programme plan

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve the programme in its totality.

Further detail on individual programmes is provided later in the Key Programmes of Change section.
Quality and Outcomes: 7 outcome ambitions

The 7 ambitions for improving outcomes

The National Outcomes Framework describes the five main categories of better outcomes to be delivered. These outcomes have been translated into seven specific, measurable ambitions, or critical indicators of success, against which the CCG will be measured over the 5 year planned period and year one and two as measures as progress:

1. Securing additional years of life for people with treatable mental and physical health conditions

   **PYLL (per 100,000 population)**

   **From 2237 (14/15) to 1931 (18/19)**

   This is a priority for the CCG, to drive improvement and reduce from baseline the potential for years of life lost from causes that can be supported by healthcare for all adults, children and young people.

   A clear focus will be on self-care and empowering people to take more control.

2. Improving health related quality of life for people with Long Term Conditions, including Mental Health

   **Average EQ-5D score for people reporting to have one or more LTC**

   **From 70.58 (14/15) to 74.90 (18/19)**

   This is a priority for the CCG, to improve health related quality of life for people with long term conditions and deliver
3. Reducing the amount of time people spend in hospital by having more integrated care in the community

E.A.4 Emergency admissions composite indicator

From 2588.7 (14/15) to 2316.2 (18/19)

This is again a priority for the CCG to ensure patients can share in the decision-making process about themselves and their care and support.

The interactions between community, residential and hospital services will be improved, with care delivered through integrated services 7 days a week that are joined up around the needs of patients.

This integrated care will be provided across the community, bringing specialised care and treatment (when appropriate) into community settings near patients’ homes, to enable the right care to be provided at the right time and the right place, with
Quality and Outcomes: 7 outcome ambitions

*patients supported to self-care as appropriate.* Health and social care professionals will work together, involving people in planning their own care and looking after their own wellbeing. People will have one key contact, who co-ordinates their GP, hospital, community and social care. More services will be available in the community ensuring shorter patient stays. The model of care will be co-developed with public and staff, to ensure it meets the needs of the Wirral population, with the right capacity and balance across the community, residential and hospital.

4. Increasing proportion of older people living at home independently following discharge from hospital

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

**From 87.0 (14/15) to 87.0 (18/19)**

Wirral’s current performance against this indicator is well above the average (80% in the North West) and this may be because services to support older people to live independently (for example reablement, intermediate care) have previously been fragmented across health and social care, therefore what could be monitored was limited in terms of which services were included in the analysis.

In addition because we are intending to move more care at discharge into step down care we expect that more complex patients will be included in the analysis which will also contribute to a slight reduction. However a performance of 87% is still well above the average for the North West of England and maintaining performance at this level would be a significant achievement.
5. Increasing the number of people with physical and Mental Health conditions who have a positive experience of hospital care

E.A.5 The proportion of people reporting poor patient experience of inpatient care

From 122.5 (14/15) to 112.5 (18/19)

Data demonstrates that scores have improved by 22% since the first report in April 2013. This broadly reflects good general levels of satisfaction by patients using acute inpatient experience care and A&E services as measured by the Friends and Family Test. However national measures to evidence patient/service user experience are currently under development for this area, with details due to be announced when available by NHS England.

We will use our quality systems to respond to complaints, and to react systemically to common themes / apply lessons learned.

6. Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community

The proportion of people reporting poor experience of General Practice and Out-of-Hours Services

From 4.0 (14/15) to 3.2 (18/19)

The CCG is performing well against this particular outcome measure and trajectories for the next 5 years reflect that holding the line will be a significant achievement given the significant challenges ahead.

The CCG will strive to achieve improvements based on the following improvements -

Relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes.

The opportunity for the patient to see the
same clinician should be available, if the patient chooses to do so. Younger fitter patients generally have less need of relationship continuity whereas older and more vulnerable patients need it more and they should be helped to achieve it.

- CCG will explore options for capturing routine data on patients' pattern of contact with professionals
- CCG will develop a practice toolkit that supports practices in methods of assessing and promoting relationship continuity
- CCG will consider incentives for practices to embed robust processes for maintaining relationship continuity

7. **Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.**

By looking at contributory factors such as rates of Clostridium Difficile (C-Diff) and MRSA: C-Diff still affects patients, plus new HCAI, e.g. norovirus and CPE (which are infections facing us in future years). Improvement plans are in place and our strategic commissioning will focus on eliminating this risk for our patients.

We will also focus attention upon medication errors into avoidable deaths and the need to record near misses and serious incidents

Through this, we will also seek assurance around the dissemination of learning and implementation of quality improvement plans.
Quality and outcomes: Health improvement and self care

Context

We have deliberately focused the attention of this vital work-stream on meeting chronic needs in different ways, but also recognise the value of the approach in responding proactively to episodic needs.

Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years (Department of Health 2011c).

People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days.

Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budgets in England (Department of Health 2011).

Around 70-80 per cent of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).

At the heart of chronic disease/ needs management is an informed patient who is empowered with access information and supported by local networks of treatment and care.

Approach

Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011).

We will work across the economy with Public Health and social care to align efforts across the spectrum from health treatment to wellness and prevention of ill health via the Prevention and Self Care Work stream of the Vision 2018 Programme. The scope of the CCGs efforts will focus largely upon enabling patients to
Quality and outcomes: Health improvement and self care

manage their care needs differently. Making this happen will require a comprehensive and joined up approach which will include providing and expanding:

Prevention elements -

- Focus on promotion of healthy starts for children and young people
- Immunisations, vaccinations and screening
- Continue to work with Public Health colleagues to increase uptake of Health Checks, focused on 40-74 age group
- Continue to work with Public Health on a range of measures related to prevention and early screening of cardiovascular

Health care enabling elements -

- Targeted risk stratification for over 60’s
- Use of technology including telehealth / telecare; assistive equipment
- Providing patients with access to their own records
- Patient and carer education programmes to advise on the best way to navigate towards support required
- Medicines advice and support in partnership with local pharmacy
- Progress work to develop community team resilience and capacity across health and social care
- Improved access to advice and support about lifestyle issues including diet and exercise; smoking and alcohol
- Low level psychological interventions such as counselling and coaching
- Access to advice and networks of support- eg pain management diabetes, info from charities etc
Quality and outcomes: Health improvement and self care

Existing schemes to build upon

Wirral already have many schemes in various stages of development and maturity. We will review these in the round and focus investment into the priorities which will yield the greatest potential improvement in outcomes.

Jointly commissioned current schemes include:

‘PUFFELL’
- Focused upon enabling people to find ways to improve their health, wellbeing and happiness by identifying goals and tracking progress

‘Breeze’ pilot
- Focused upon group based advice networks to provide information on diet, first aid, mental health awareness

Streaming and triage enhancements
- Focused upon helping staff consistently guide patients to the most appropriate setting of care for their needs

Promotion of advocacy and self advocacy;
- focussed on equipping people with the resources to cope, and the resilience to deal with the future, and a better understanding of their well being, through services such as Bounce Back

Expanding the scope of GP kiosks/ into A&E
- Focused upon providing intelligent health information tailored to the individual
Promotion of peer support;
- Focussed on empowering people to manage their conditions with the support of people who have similar experiences and are managing their own care, through services such as the Breeze patient peer mentoring programme

Promotion of volunteering;
- Focussed on befriending and helping people with everyday tasks when they are struggling to cope through services such as POPIN, Home from Hospital, and Age UK

Choose Well;
- Focused upon providing the help and advice needed to inform people’s choices

Provision of assistive technologies and equipment.
- Focused upon widening the use of assistive technologies and equipment to assist with self care that enables people to maintain their independence for as long as possible.

Health Trainers
- Focused upon providing one to one support, advice and guidance to people who want to improve their own health and wellbeing

‘Pharmacy First’
- Focused upon directing people to local pharmacies for appropriate health and treatment advice
Quality and outcomes: Health improvement and self care

Goals

The goals of this work-stream are focused upon enabling people within Wirral to live longer, healthier lives by being encouraged and enabled to take responsibility and make different choices in managing their own care needs.

Some of the key quality benefits we are seeking from investing in health improvement and self care include:

- Reducing health inequalities, eg those related to gender
- Improvement in patient experience through improved knowledge and responsibility
- Improve the quality of life of people living with health issues
- Improve the life years lost from disability

Target aspirations

In addition to quality improvements we plan to focus efforts on achieving contributions towards improved operational performance.

The precise targets will be developed by the Prevention and Self Care programme, with the following as a basis for scoping further:

1. Contribution to reducing inappropriate attendances and clinically inappropriate admissions to A&E

(Evidence nationally suggests that up to 30% of attendances and 25% of admissions to A&E could be dealt with in a lower clinical setting)

2. Reducing inappropriate GP appointments which could be managed in a different setting (e.g. pharmacy)

(A recent survey of GPs in Wirral indicated that a third of respondents felt that 30% of appointments could have been managed better in a more appropriate setting)
The programmes of change and improvement described in the following section will be developed further and refined to align with the 2018 programme structure outlined in the Commitment and Ownership section towards the end of this document.

The underlying logic underpinning our strategy is that of first managing and/or avoiding demand; appropriate demand needs to be then co-ordinated to the right clinical and cost setting; and those settings need to be as efficient as possible.

Approach to balancing system finances

The overall financial challenge was set out in the financial section of the case for change earlier in the document. The conclusions were that the CCG could face a gap up to £140m in 18/19 in its funding to keep up with cost and activity growth.

The CCG will work to align its own planning with that of the wider system Vision 2018 programme to ensure that efforts are consolidated into a single plan.

Examples of What other systems are basing their strategies upon

Managing Demand

- Prevention Integrated Care
- Referral Management

Right care – right setting

- Right setting
- LoS

Efficiency

- Improved pathway
- Workforce flexibility

Avoid \( \approx 10\% \) episodic demand

Prevent \( x\% \) LTC demand via self care

Transfer 20-40\% of planned care to community

15\% of episodic demand differently

Improve pathway efficiency by 15-20\%
The current assessment of resulting required reduction in CCG expenditure is circa £13.9m.

We are working with public health colleagues to retain a focus on early intervention and prevention and to ensure that a range of requirements are delivered through existing investments, for example supporting self-care, alcohol services and falls prevention.

We will continue work with health and social care partners as well greater involvement of the community and voluntary sectors to realise opportunities to impact on demand management, reduce duplication and improve outcomes for people needing care.

This plan has been supported by the evidence base from the JSNA and will link in with both CCG and Council commissioning plans for 2014/15 and 2015/16.

**Impact of Better Care Fund**

In 2015-16 financial year, circa £25m will be transferred from existing CCG allocations into a pooled budget arrangement for the Wirral Health & Social Care Economy enabled through the Better Care Fund.

The £25m will consist of a number of current CCG / NHS England budgets with the balancing fund to be made up of savings across existing health expenditure (in the form of a reduction of emergency activity / admissions into secondary care).

Current assessment of existing budgets to transfer into the pool is as follows:

- **Reablement** £2.116m
- **Carers** £0.7m
- **Joint Working** £8.252m

(currently £6.4m and held by NHS England)

**Total** £11.068m
NHS England has identified that any high quality, sustainable health and care system in England will be built upon six key characteristics which locally will be directly influenced by the CCG’s commissioning strategy over the next 5 years.

Wirral’s 5 Year Strategic Plan will be built upon the following approach and will include improvement in the following outcome indicators –

These work-streams are supported by the additional two characteristics of a high quality, care, and the CCG’s operational plan will be built around ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
Key programme: Modern integrated care

Introduction

Our overall strategy is centred on the development of Integrated Care to better meet the ongoing care needs of the people of Wirral. This section describes our plan for a person centred health and care system which will enable people to self care, to keep themselves well for longer and to reduce the level of unplanned care they receive.

This is different both in the nature of the care people receive and how the system is organised to deliver it. A whole systems approach means health and social care provider organisations forming new integrated care teams around the person - with co-ordinated team work to deliver care. This care will be directed by the people receiving it, where they define the outcomes they want and are empowered to achieve them. General practice will be at the centre of co-ordinating these teams which will make innovative preventative interventions, often social care based, to prevent unnecessary deterioration of people’s health and admission to hospital. Local authorities, CCGs and NHS England will pool budgets such that providers have collective responsibility for outcomes and for the budgets to deliver them. This collective responsibility will incentivise the integrated working of staff for the benefit of people, so they receive a seamless and efficient service. This new way of working will require major changes in cultures, behaviours and system structures to achieve change.

Goals

Over the next 5 years we are aiming to deliver a transformed service, focusing upon moving care from hospital to community based resources and supporting people in their own homes. Key goals include:

- Reducing the need for unplanned admissions to hospital for the over 75s
- Reducing the time spent in hospital to complete their care needs
- Reducing the need for long and short term residential care placements
Key programme: Modern integrated care

Approach

We have developed a number of scenarios using different peoples needs to describe how we see integrated care working in practice – eg

On Wirral, we will work to make this vision a reality by bringing together all of the public agencies that provide health and social care support, especially for older people, to better co-ordinate services such as health, social care and housing, to maximise individuals’ access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting - we will deliver this through developing 'integrated care coordination teams’.
Key programme: Modern integrated care

Delivery

Through movement of care to the community and supporting self-care, signposting and early intervention we will reduce demand on downstream services such as acute care and long term social care. We will also use risk stratification to target integrated support for patients who are potential high users of health and social care services.

We believe this transformation will require a different way of working across our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. This will be through providing:

• Seamless and timely response from integrated teams and other appropriate services
• Single gateway and streamlined pathways which are easier for people to navigate
• Encouraging self-care and self help
• Health and social care having joint responsibility for the patient pathway by pooling budgets to reduce duplication
• Implementation of shared electronic record to improve communication
• Coordinated care plans with patient led goal setting

We will continue to develop and improve the following schemes as examples:

• Self-care, self-help, information advice and support
• Early intervention and prevention (falls community equipment, early assessment)
• Integrated discharge team redesign and development of Integrated Care Coordination teams (ICCTs)
• Risk stratification and a more central role for primary care services
• Whole system model of care for adults with Learning Disabilities
• Mental health outreach and an integrated approach to dementia care e.g. improving access to psychological therapies
Key programme: Modern integrated care

Integration and Children’s services

In line with the Department of Health’s document on reducing hospitalisation for children and contributing to the future outcomes of integrated children’s services, NHS at Home, 2011, it is the intention of Wirral CCG to commission children’s services differently by developing a Community Nursing Service for the population of Wirral.

There are currently very few local Community Children’s Nursing (CCN) services able to meet the needs of all ill and disabled children and young people, the following are the group that have been identified as needing services:

• Children with acute and short-term conditions
• Children with long term conditions
• Children with disabilities and complex conditions, including those requiring continuing care and neonates
• Children/ young adults transitioning into adult care

Integration and Mental Health services

We will do all that we can to meet the Government’s mandate to put mental health on a par with physical health, and to close the gap in life expectancy between those with mental health problem and the wider population.

We will seek to address this through:

• Promotion of equal access to physical healthcare including prevention services
• Ensuring rapid response to crisis services
• Supporting partnering providers to take a multi disciplinary approach to mental illness at in patient/ out patient
• Improving case management of people who’s mental health is affecting physical health and vice versa by sharing case workers
Key programme: Modern integrated care

High level plan for Integrated Care

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

Wirral CCG: creating the Integrated Care Community

Needs and drivers for change
Increase in long term conditions
Increase in over 65s
Independent living
To be treated as a whole person
Risk stratification
Not enough joint-working between services
Not enough emphasis on patient education and self care
Community response

Priority plans for integrated care
Single gateway
Pooled budgets
Care coordination in the community
Redesign of children’s pathways
Electronic Shared care record for all
Support for learning disability
Single assessment and referral
Integrated care coordination teams in place
Shared care planning
Commissioning for Outcomes
Care closer to home
Personal budgets

System reconfiguration
Integrated care
Care coordination model
Single gateway for health and social care
Integrated community and primary care
GP practices working together, with care coordination teams.
Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission
Facilitated discharge

Enablers

Outcomes for integrated care
Reduced non elective admissions and care home placements
Reduction in length of stay and therefore hospital beds
Increased community capacity for integrated care services
Increase number of people managed in integrated service
Increase in coordinated care
Ensure a consistent high quality, safe and effective care
Key programme: Modern integrated care

Measurement

We will measure the agreed outcomes (both BCF and locally agreed) through a jointly developed performance reporting system which feeds into a monthly strategic joint commissioning group. This will cover the key overarching aim of reducing unplanned care admissions by 15% and elective care admissions by 20%, key BCF measures and other locally agreed measures. The key BCF measures are:

- Avoidable emergency admissions (composite measure)
- Percentage of care packages commenced within 24 hours of initial contact with agency

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population (average per month)
Introduction

The future model for Primary Care will be increasingly patient-centred, with GPs at the centre of organising and co-ordinating people’s care.

Primary Care has a unique role in enabling Wirral’s vision of future care delivery, through providing capacity to meet the demand for out of hospital care; and helping to drive integration by navigating and educating patients towards different sources of care – including increasing self management.

Goals

Over the next 5 years we are aiming to deliver a transformed Primary Care which is different in terms of: its role within managing urgent care demand; working in multi disciplinary teams; offering greater access; guiding patients to different choices. Key goals include:

• Reducing the demand on emergency admissions by 15%, and patients accessing A&E

• Reducing admissions to care homes by 10%

• Improve clinical outcomes for people who have one or more long term condition

• Improve recovery rates for Primary Care mental health.

• Increasing the uptake of NHS Health Checks and other prevention measures

Approach

We will achieve our vision through the implementation of wide variety of initiatives intended to grow the contribution of Primary Care within the overall system.

These include but are not limited to:

• Developing wider primary healthcare teams, working cohesively across groups of practices to deliver services such as community nursing, smoking cessation and flu vaccination clinics;

• Developing the roles of other primary care sources of capacity including pharmacists, opticians and dentists.
• Implementing integrated teams of physical health, mental health, and social care to work together to manage those people at most risk of a hospital admission.

• Ensuring that patients, particularly frail older people and those with long term conditions receive continuity of care from an appropriate team of health and social care professionals, with care delivered in an integrated and co-ordinated way, and with everybody aged over 75 having their care co-ordinated by an accountable clinician

• Managing demand for services, ensuring that referrals to specialists are only made where appropriate, to make the best use of our resources

• Using technology to enable our clinicians to work more closely together, undertaking diagnostic tests more quickly and easily, and in supporting patients to look after their own health

• Facilitating the opportunity for GP practices to work together to share skills and expertise and to realise efficiencies in the delivery of core general practice care

• Working with NHS England to ensure that the GP Practice estate is fit for purpose to deliver this vision and is future-proofed for the next generation of patient care
Key programme: Wider Primary Care

High level plan for wider primary care at scale

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

Wirral CCG: creating the Primary Care Community

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<th>Needs and drivers for change</th>
<th>Priority plans for primary care</th>
<th>System reconfiguration</th>
<th>Enablers</th>
<th>Outcomes for primary care</th>
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</thead>
<tbody>
<tr>
<td>Increase in long term conditions</td>
<td>Improving access to GP practice care</td>
<td>Acute care</td>
<td>Proactive co-ordination of care for complex patients and those with a Long Term Condition</td>
<td></td>
</tr>
<tr>
<td>Increase in over 65s</td>
<td>New local GP contract offer</td>
<td>Emergency, critical and specialist care that can only be delivered in an acute setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High prevalence of mental illness and substance misuse</td>
<td>New Primary Care Mental Health service in place</td>
<td>Integrated community and primary care</td>
<td>Address physical, mental health and social care needs holistically</td>
<td></td>
</tr>
<tr>
<td>Increase in emergency admissions</td>
<td>Transfer of planned care into community</td>
<td>GP practices working together, supported by primary care teams, to give advice, diagnose, treat, and support patients to look after themselves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced capacity in primary care</td>
<td>Review of primary care estate</td>
<td>Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not enough joint-working between services</td>
<td>Mapping of community services to inform primary care communities</td>
<td>Support patients and carers to manage their own health and wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not enough emphasis on patient education and self-care</td>
<td>Primary care communities fully formed</td>
<td>Ensure consistent high quality, safe and effective care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inequity in access to services</td>
<td>Training needs analysis of primary care staff, and up-skilling programme</td>
<td>IT - Estates - Staff - GP Contract - Patient education</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key programme: High quality urgent care

Introduction

Over the next 5 years there will be a large scale movement of care from the hospital setting to the community setting. Currently the ambulance service, A&E and acute care are the default settings for urgent care. It has been identified that there is growth in the number of patients being conveyed to hospital by 999 ambulance and in inappropriate 0 day length of stay admissions. These are the areas that we will target for movement of care activity to more appropriate settings – regarding inappropriate A&E use as failure of the overall system.

Goals

Over the next 5 years we are aiming to deliver a transformed urgent care response which is joined up and manages demand for treatment in a more manageable and sustainable way. Key goals include:

- Reducing the demand on emergency admissions by 15%
- Reducing unnecessary ambulance conveyance
- Significant reduction in patients being readmitted to hospital within 30 days
- Improved management of frequent attenders of A&E and people who are frequently admitted to hospital

Approach

We will achieve significant improvements for patients in urgent care by connecting urgent and emergency care services into a cohesive network so the overall system is more than just the sum of its parts.

A new model of care will be developed that centres around primary care (in the broadest sense) ensuring that patients in need of medical assessment can receive that assessment in their own home or in a community setting (for example in a community based hub).

These medical assessment services will need to include a range of medical interventions
Key programme: High quality urgent care

(such as IV fluids and antibiotics), diagnostic tests and access to specialist opinion (without the need for hospital admission or attendance) for example from a community geriatrician or an acute physician in the community hub.

We will continue to commission services that will support people with an acute exacerbation of their mental illness to receive fast and responsive care in the community, to ensure that inpatient beds are only ever used appropriately: this will include the use of home treatment teams for adults and older people. Where it is not possible to care for people safely within their own homes, we will continue to commission a small number of mental health crisis beds, but will seek to reduce the number of beds used year-on-year.

The history of systemic abuse at Winterbourne View has told us that too many people with a learning disability are placed in inpatient beds and out of area, and that more must be done within the community to prevent crisis and use of acute care facilities. As such, we will be working with our Local Authority partners to meet the requirements of the Winterbourne View Concordat, further reducing our use of learning disability and inpatient crisis beds, but ensuring that when somebody does require admission, that a multi-disciplinary team works with the patient and their carer immediately upon admission to plan for a safe discharge into the community, with steps put into place to prevent future crisis.

Emergency patients will be treated in the most appropriate centre with the expertise and facilities in order to maximise their chances of survival and a good recovery - only patients with acute healthcare needs are admitted to an acute hospital.

There will be a true Single Point of Access for health professionals, providing 24/7 access to physical, social and mental health services.

Patients are able to easily navigate the urgent and emergency care system to get the right advice in the right place, first time.

Care plans for known patients will be managed and kept up to date and available at all urgent
Key programme: High quality urgent care

and emergency care access points so that a patient's information is always available to those treating them.

**Implementation**

We will make a number of key changes to enable the shift in outcomes desired happen, these include:

- The development and implementation of ambulance pathfinder and community care plans to ensure that the patient is treated in the right place.
- The implementation of step up/step down system will ensure that patients have access to care that is appropriate to their needs.
- The development and bedding in of a range of admission prevention services and pathways which will promote self-care.
- Redesign of urgent mental health assessment pathway to ensure that needs are assessed and met without unnecessary delays.

- Redesign discharge pathways to ensure that patients are discharged safely and reduce the need for readmissions.
- Redesign of children’s pathways in urgent care and the community to prevent unnecessary hospital attendances.
Key programme: High quality urgent care

High level plan for high quality urgent care

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

Wirral CCG: creating the Unplanned Care Community

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<th>Needs and drivers for change</th>
<th>Priority plans for primary care</th>
<th>System reconfiguration</th>
<th>Enablers</th>
<th>Outcomes for unplanned care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in long term conditions</td>
<td>Single front door for urgent care on the APH site, including streaming patients back to primary care</td>
<td>Acute care</td>
<td>Reduced non elective admissions (long and short stay)</td>
<td></td>
</tr>
<tr>
<td>Increase in over 65s</td>
<td>Ambulance pathfinder and community care plans</td>
<td>Integrated community and primary care</td>
<td>Reduction in length of stay and therefore hospital beds</td>
<td></td>
</tr>
<tr>
<td>High prevalence of mental illness and substance misuse</td>
<td>Ensure successful transition and implementation of step up/step down system</td>
<td>Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in emergency admissions</td>
<td>Implement a new model of urgent care hubs in the community, including medical assessment</td>
<td>GP practices working together, supported by primary care teams, to give advice, diagnose, treat, and support patients to look after themselves.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced capacity in primary care</td>
<td>Develop a range of admission prevention services and pathways</td>
<td></td>
<td>Increased community capacity for urgent care services</td>
<td></td>
</tr>
<tr>
<td>Not enough joint-working between services</td>
<td>Implement NHS 111 and new GP out of hours service</td>
<td></td>
<td>Reduced conveyance to hospital by ambulance</td>
<td></td>
</tr>
<tr>
<td>Not enough emphasis on patient education and self-care</td>
<td>Redesign of urgent mental health assessment pathway</td>
<td></td>
<td>Reduced emergency readmissions</td>
<td></td>
</tr>
<tr>
<td>Poor performance against the A&amp;E 4 hour target</td>
<td>Redesign discharge pathways</td>
<td></td>
<td>Ensure consistent high quality, safe and effective care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Redesign of children’s pathways in urgent care and the community</td>
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</tbody>
</table>
Key programme: Elective care productivity

Introduction

The way elective (planned) care is currently organised has potential to improve in terms of productivity and outcomes for patients. There is variation in referral rates for outpatient consultations, and not every contact adds value to the patients treatment and recovery.

Elective services are largely delivered within the boundaries of acute hospitals, delivered by a traditional secondary care staffing model. Procedures can have longer lengths of stay than necessary.

A ‘traditional’ outpatient model of multiple face-to-face visits for diagnostics and consultations with no access to GP records is currently a barrier to more joined up care.

Goals

This programme of work has a number of important and quantifiable goals which we are seeking to achieve in the next 5 years, these include:

- A 20% improvement in the productivity of elective care
- An improvement in Patient Reported Outcome Measures across a range of conditions
- A greater proportion of elective treatment to be provided in community settings

Approach

Clinical resources across community / secondary would be utilised across traditional organisational boundaries through the community hubs to support improvements in patient outcomes by supporting self-care, prioritisation of resources and

Secondary care providers would therefore be responsible for the delivery of appropriate
Key programme: Elective care productivity

services including those patients who require procedures and investigations that can only be in a hospital setting.

A future model would be for the majority of appropriate outpatient activity to be delivered in the constituency community hubs across a number of specialties including respiratory, cardiology, dermatology, diabetes and endocrinology, Ear Nose and Throat (ENT), elderly medicine, haematology, therapies, gastroenterology, ophthalmology, rheumatology, orthopaedics, urology, vascular, general surgery etc.

Implementation

There are a number of key changes to the organisation and flow of elective care required. These include:

• Establishment of agreed referral protocols based on best practice to reduce unwarranted variation

• GPs supported to make the correct clinical judgement during consultations and use audit and feedback to reduce referrals that could have been managed in a different way

• An elective care system that is more ‘fluid’ encouraging consultants to discharge sooner, which would be supported by GPs as barriers to referring back are removed

• Safe, clean and modern facilities for elective care with services not confined to the traditional acute hospital setting i.e. outpatient appointments, diagnostics and minor elective procedures provided out of community ‘hubs’ by a flexible workforce and linked with integrated care teams.

• Enhanced recovery programmes linked into community teams resulting in reductions in overall LoS.

• Alternative types of outpatient clinic including technological solutions and one-stop shops with full access to GPs record.
Key programme: Elective care productivity

High level plan for step change in productivity of elective care

The plan below illustrates the key priorities for change, the outcomes being sought, and the key features and enablers required to achieve them.

Wirral CCG: creating the Planned Care Community

Needs and drivers for change

- Increase in long term conditions
- Increase in over 65s
- Right place right time right clinician
- Increase in planned elective care
- Develop community and primary care
- Not enough joint-working between services
- Not enough emphasis on patient education and self-care
- 18 week target

Priority plans for planned care

- 8am – 8pm weekday access to primary care (including weekends)
- Appropriate referral protocols
- Transfer of planned care into community
- Redesign of children’s pathways for planned care in the community
- Electronic Shared care record for all
- Appropriate referral pathways
- Community hubs
- 10 Integrated care co-ordination teams in place
- Re-design to include triage and advice
- Commissioning for Outcomes
- Care closer to home

System reconfiguration

- Planned care
  - Appropriately delivered hospital services.
  - Grow community care
- Integrated community and primary care
  - GP practices working together, supported by primary care teams, to give advice, diagnose, treat, and support patients to look after themselves.
  - Integrated care teams supporting the most complex, with rapid response to those at risk of hospital admission

Enablers

Service specification, procurement, joint commissioning

- Reduced elective admissions (excess bed days)
- Reduction in length of stay and therefore hospital beds
- Increased community capacity for planned care services
- Increase number of people managed in integrated service
- Protocols and managed referrals
- Ensure consistent high quality, safe and effective care

Outcomes for planned care

- Care closer to home
- Reduced elective admissions (excess bed days)
- Reduction in length of stay and therefore hospital beds
- Increased community capacity for planned care services
- Increase number of people managed in integrated service
- Protocols and managed referrals
- Ensure consistent high quality, safe and effective care
Enabling programmes

Introduction

As part of the refresh of Vision 2018 it has been recognised that to enable the key programmes of change to be successful, there are a number of important projects required to underpin the plan as a whole.

These are previewed as part of the Vision programme shown in the section later dealing with governance. For further detail please refer to Vision programme documentation.

This section provides a brief overview of the key enablers identified in the CCG’s planning, signalling that these will be aligned with Vision programmes as part of the process to bring these together.

Information Management Technology (IM&T)

The current disconnected nature of health and care information management systems is a significant barrier to achieving a new model of delivery which has integrated care at its heart, in order to achieve the required scale and pace of change the existing IM&T infrastructure will need to be addressed.

The CCG IM&T strategy sets out how we will utilise information and technology to support the our vision to improve health and reduce disease by working with patients, public and partners, tackling health inequalities and enable people take care of themselves.

Education and training

The delivery of significant change across Wirral will require a fundamental rethink about the size and shape of the future workforce – it will require a system wide workforce model underpinned by agreed principles for how the workforce will be redeployed as part of initiatives that look to drive changes in settings of care.

We will also help staff to adapt to new roles and ways of working through a joined up programme of skills development to support them through the changes.
Enabling programmes

Estates

Delivering a model of patient centred integrated care provides a real opportunity to radically transform the way the estate has historically been used in the Wirral. Central to this will be the idea that from a patient perspective there they are accessing NHS care without organisational boundaries.

Our strategy aims to review the use of estate right across the system to take advantage of existing scale and opportunities to join up care around the needs of patients.

Contracting and funding

In order to initiate service transformation, the CCG are looking at alternative contracting models which will overcome existing barriers to change. The CCG are looking to explore different contracting models eg Prime Provider/commissioner and alliance contractor as a way of improving the patient pathway.
Commitment and ownership

Working together to make it happen

Introduction

It is appreciated that there is significant change ahead and that organising and managing this will be a complex task. Recent work to bring leadership from across the system to strengthen the system Vision programme has highlighted the collective commitment that exists to work together and overcome obstacles.

We are committed to using this opportunity to bring stakeholders including organisations, clinicians and patients together to help shape and redesign how care is organised, located and delivered. We have therefore invested considerable effort in using their insights to direct this strategy, and will continue to do so as we develop the detail of proposed programmes.

As a CCG we recognise the importance of leadership and creating the right environment across the system where ideas and innovation can flourish, whilst at the same time being disciplined about delivery and collectively staying on track.
Clinical engagement

In developing this strategy, NHS Wirral CCG has engaged with its Member Practices through its consortia structure and through wider stakeholder engagement undertaken as part of Wirral CCG’s statutory obligations as outlined in the 2012 Health and Social Care Act and NHS England guidance: ‘A Call To Action,’ Everyone Counts Planning 2014/14 to 2018/19’ and ‘Transforming Participation in Health and Care 2013’. The Consortia continue to engage with their Member Practices on the development and implementation of the Vision programme, particularly in relation to the transformation of primary care.

The CCG has established a number of teams that comprise clinical and managerial representation from the CCG and a range of local providers, to drive the commissioning agenda in specific clinical areas. Feedback from clinicians, patients and Member Practices, as well as national and local evidence, drives the work of these QIPP (Quality Innovation Productivity Prevention) teams, and key themes and ideas emerging from these groups have supported the development of the CCG strategy.

There has been a wide number of staff and clinical engagement events including presentations at key meetings such as LMCs, Health and Wellbeing Boards, Families and Wellbeing Board, Staff Forums, Clinical Members Forums, Public Service Boards and Lectures.

An executive summary of the Vision 2018 programme and a survey has been sent to all staff across partner organisations in health and social care on Wirral. Staff were also given opportunity to input ideas in breakout development sessions at a workshop attend by 100 and Q&A sessions at the workshop and a separate lecture attended by 100 clinical staff. The qualitative and quantitative feedback and ideas captured from all this engagement will be analysed and used in workshops and work-streams when developing plans.
Citizen engagement

In the development of its 5 year plan, NHS Wirral CCG has employed a number of methods of engagement in order to encourage participation of local citizens. These have included public events, where, for example, local citizens attended a ‘Vision’ event to hear about, discuss and inform the CCG’s long term plans and the development of the Better Care Fund.

As well as taking part in active discussions, citizens and stakeholders were encouraged to record their thoughts and comments on the day and there is also a questionnaire available on the CCG website so people can continue to express their thoughts and opinions which will, in turn, inform the planning process. The insights gathered from the engagement events are recorded and provided in a ‘you said we did’ format on the CCG website to provide transparency.

Each of the commissioning Consortia has an active Patient Council that brings together representatives from Practice Patient Participation Groups and the wider population, who have driven the development of services that now play a key part in future CCG strategy. Each of the Consortia has also developed virtual means of engaging with its population, for instance via websites and virtual e-mail groups. The Consortia engagement structure will continue to play a significant role in the implementation of the strategy and Vision 2018 programme.

Wirral CCG has invested in an experience led commissioning programme to support our patient engagement processes. The process ensures patients, carers and staff are consulted at the earliest opportunity to allow patient feedback, thoughts and perspectives to be central to all service redesign projects. We have recently completed a Stroke Prevention project with an open question of how do we improve people’s experience of stroke.
In Wirral we are committed to expanding our attendance for focus groups to all patients to ensure authentic citizen participation. When designing and implementing CCG communication and engagement activities, the diversity of the population served, the need for equality and the potential barriers to communication and involvement some people face will be taken into account.

We advertise events through numerous mechanisms; these include CCG patient groups, GP Practice Patient Participation Groups, VCAW (Voluntary & Community Action Wirral), Healthwatch Wirral, GP practice TV screens, Wirral Multicultural society and subject specific voluntary organisations. For example, we recruited some patients for our stroke prevention project via the Stroke Association and AF Association and similarly recruited patients for an Ophthalmology event via Macular Disease Society.

For topics where focus group attendance may be difficult we have made a conscious effort to
The CCG works collaboratively with the Cheshire and Merseyside Clinical Network as part of a partnership working approach to plan and use best evidence for quality care and outcomes for patients. The learning and teaching from the Network informs the local operational delivery plan.

Communication and engagement for integration is key to driving greater transparency by working collaboratively with key stakeholders including provider organisations, Health watch and Community Action Wirral to deliver the desired outcomes. This engagement has been a key principle for the integration work stream here on Wirral.

A number of workshops have been held with both staff and public and regular meetings of the ‘Engagement with people’ sub group and their contribution has been used to shape the design of the Integrated Care Co-ordination Teams and the broader Vision 2018 programme.

Our aim is to consult with patients throughout a specific project ensuring patients are involved in the planning processes but also as projects progress it is important to keep patient views and priorities central to every project.

Friends and Family Test (FFT) data and complaints information are regularly discussed and monitored at the CCG’s Quality and Performance Committee. For FFT in particular, there is a regular Quality and Clinical Risk Meeting with the local acute provider where themes and issues are discussed and resolved. Any areas where there is a recurrent issue would inform both the contracting and planning processes.

travel to the patients we need to speak to. For example, during a project on children’s A&E, because our target audience was parents with young children, we attended Children’s A&E, playgroups, nurseries, and women’s groups including domestic violence groups and breastfeeding groups.
Stakeholder involvement

(ICCTs). This ensures that their valuable contribution has supported real decision making regarding the care coordinator model and the one number to contact that has been recommended by those engaging.

In addition the integration work stream encourages clinicians and professionals from the provider organisations to participate in design via the systems design group which combines service re-design and IT infrastructure to develop a shared record and care planning. This supports the overall aim to bring about transformation from a ‘bottom-up’, practical approach that reflects the views of all those involved in as transparent a way as possible to deliver our integration programme.

The CCG is using social media such as Facebook and Twitter to continue to encourage participation and an ongoing series of events is planned throughout the coming year around the broader strategic vision alongside Local Authority colleagues and local providers. This is alongside utilising communication and engagement channels such as Patient Councils, Patient Participation Groups to share messages and encourage feedback.

Finally, when undertaking service redesign initiatives, the CCG will continue to involve patients in the shaping of local services and ensure that, where appropriate, a formal consultation process is undertaken. This ensures that such developments are transparent in their development and embrace both citizen and clinical perspectives.

Staff engagement

The CCG also seeks to actively involve and inform its staff, alongside colleagues in partner organisations, in the ongoing development of the vision for Wirral.
Alignment of programmes with Vision 2018

Prior to submission of this strategy the CCG and its partners across health and social care have begun a process designed to strengthen planning and delivery of the Vision 2018 system plan by streamlining the structure of programmes and establishing tighter governance protocols. A key outcome from this approach is to harmonise the two strategies to arrive at a single plan for system sustainability.

Strategic leaders have agreed to focus improvement effort into three key thrusts –

- Planned (Elective) Care
- Unplanned (Non-Elective) Care
- Long Term Conditions and complex needs

These are underpinned by a range of enabling programmes as illustrated in the diagram to the right.
Governance

Governance arrangements have recently been refined as part of the refresh of the Vision programme.

A Strategic Leaders Group has been established to act as the forum for organisational leaders to define and agree the high level strategic direction required to achieve a sustainable system. This group reports to the Health and Wellbeing Board.

To organise and manage programme delivery an revised Implementation Group has been established which will be supported by a central Programme Office which will report on progress and help identify and manage interdependencies between initiatives.

Commitment and behaviours

Strategic leaders understand the need to create the right environment where they can meet the challenges ahead as a collective.

A set of principle and behaviours have been jointly agreed which leaders will observe, model and hold each other account to.
Contents

How the strategy was developed

Evaluation and research support

Ensuring quality and safety
How the strategy was developed

Approach

NHS planning has in the past been successful in supporting the delivery of annual incremental improvement. However due to the unprecedented challenges facing the NHS and Social Care, a longer term view of the planning of services to reflect the transformational change required is necessary.

NHS Wirral Clinical Commissioning Group’s strategy and plans have developed taking into account this level of challenge, together with a number of strands of work including:

Legacy Strategies

The NHS Wirral Clinical Commissioning Group 2013-2016 Strategic Plan

Currently available guidance and documents

- The NHS Constitution

- 2014/15 Planning Guidance: Everyone Counts
- CCG Assurance Framework
- A ‘Call to Action’ letters and guidance
- Better Care Fund guidance
- Commissioning for Value information
- Regional Directors of Finance Planning
- Assumptions
- Performance Reports
How the strategy was developed

Commissioning for prevention

NHS Wirral CCG’s commissioning approach is based upon the below methodology and in line with the 5 key steps

1. Analyse key health problems. The CCG evaluates and utilises local JSNA data and local intelligence combined with analysis and supported by benchmarking exercises

2. Understand and prioritise and set common goals. This is an integral part of the Strategic Plan focusing on the top health problems for Wirral and particularly those that cross cut across all provider pathways such as Long Term Conditions, elderly frail and this includes early detection particularly in primary care, through screening and enhanced services.

3. Identify high impact programmes. The CCG jointly commissions primary and secondary care initiatives with the Department of Adult Social Services, neighbouring CCGs as part of Better Care Fund initiatives and

Integration Programme

4. Plan resources. The CCG focuses on innovative use of resource and investment such as tele-health, tele-dermatology to support reduction in acute capacity

5. Measure and experiment. The CCG utilises expertise from John Moores University to evaluate and measure outcomes, such as the Integration Programme Evaluation

Outcome Based Commissioning

The CCG supports the shared purpose of all staff to deliver high quality compassionate care to achieve health and wellbeing outcomes for all. The focus is on 6 key action areas below. A key example is our Integration programme, which has a focus to deliver all action areas as we work collaboratively for better outcomes for all, to treat people as a whole person in a seamless way.

Action area one: Helping people to stay independent, maximise well-being and improving health outcomes
How the strategy was developed

well-being and improving health outcomes

Action area two:
Working with people to provide a positive experience of care

Action area three:
Delivering high quality care and measuring the impact

Action area four:
Building and strengthening leadership

Action area five:
Ensuring we have the right staff, with the right skills, in the right place

Action area six:
Supporting positive staff experience

Experience Led Commissioning

ELC is an innovative new commissioning operating model that puts people and participative co-design at the centre of commissioning process. ELC is a commissioning approach that has been independently evaluated and is helping Wirral CCG to achieve patient centric service design. This approach has been used to develop a stroke prevention strategy for Wirral.

It is a new way to undertake evidence based commissioning that transforms the process into a series of facilitated 'conversations' between people who use services, commissioners, and the front line caregivers and professionals who deliver them. These conversations employ co-design principles and build on evidence drawn from experience research. They are facilitated by accredited ELC Practitioners and underpinned by robust experience research that benchmarks local people’s experiences.

The process delivers both clinical and community engagement and ensures that clinical commissioners have a rigorous evidence base on which to base their decisions. ELC management processes are also evidence-based, which makes ELC is a unique, deeply evidence-based, person-centred commissioning management approach.
Evaluation and research support

Liverpool John Moore’s University Evaluation

The evaluation of the Integration Programme includes a review of the literature, evaluation of staff and patient perceptions, pre- and post-integrated care, using relevant research questions. A mixed methods approach of case studies, surveys, interviews, focus groups is utilised to gain insights and deliver conclusions. This also includes quantitative and economic assessment and appraisal and will collectively be invaluable to show the step change integration is delivering across Wirral.

Research & Innovation

The CCG has a robust commissioning and service design team who ensure that any planned changes are supported by latest evidence and research. In some cases, specific research and evaluation is commissioned by the CCG from academic institutions, such as the work commissioned from Liverpool John Moores University on the Integration Programme.

This included a review of the literature, evaluation of staff and patient perceptions pre and post integrated care using relevant research questions. In addition, a mixed methods approach of case studies, surveys, interviews, focus groups was utilised to gain insights and deliver conclusions. The CCG also works closely with academia on specific initiatives and approaches. This has included Experience Led Commissioning approach described above.

In addition, the CCG supports a bursary scheme which can include research projects as part of academic study.

The CCG also utilises knowledge from the National Institute of Clinical Excellence (NICE), Clinical Networks and other sources to both utilise latest evidence and benchmark best practice.

Also, membership of organisations such as AQUA ensure access to innovative approaches to improving quality in service developments.
The CCG has a responsibility to ensure that services that they commission consistently provide safe high quality and effective care for all—now and for future generations. There have been a number of reports into events within the NHS that have made it clear that a fundamental cultural change is needed to ensure that patients’ needs are paramount in the delivery of care. These principles have been embedded into the CCG’s commissioning activities.

Francis Report

The report on events at Mid Staffordshire Foundation Trust identified a series of systemic failings into patient care. The CCG has responded to this report by:

- Incorporating the recommendations from the Francis report into Provider contracts.
- Establishing a robust reporting mechanism within the CCG.

Ensuring quality and safety

- Incentivising providers to perform optimally against these standards (through CQUINs scheme)
- Holding providers to account with regard to quality.

Berwick Report

This has enhanced the Francis report by ensuring that the NHS hears the voice of patients and staff. The CCG is using this challenge to providers to enhance their data capture in regard to patient experience. With the data capture systems that are in place, themes and trends can be analysed to identify areas of concern.

Keogh report

This highlighted the importance of sharing intelligence on a larger scale between CCG’s and regulators. This has led to the establishment of Quality Surveillance Groups within Area Teams. Wirral CCG has played a full and active role in these meetings, and has identified areas of concerns that have been acted on by other CCGs and the AT.
Ensuring quality and safety

Winterbourne View

In response to the Winterbourne View report (December 2012), Wirral CCG is working in partnership with the Local Authority to develop a local model of integrated care for patients with a Learning Disability and one that favours a Multi-Disciplinary Approach with a team around the patient. There will be less reliance on inpatient beds for this client group as per the national guidance and more on community support and early intervention, as well as discharge planning involving the patient and their families and carers. The model will also include a step up and step down approach for people in the right place at the right time.

We are committed to maintaining/improving the experiences that patients and families have when accessing a CCG commissioned service. To this end we are promoting the use of the family and friends test in all settings including primary care in order to gain the views of our population in relation to the quality of care that is delivered locally.

Through our established patient and public feedback mechanisms, the CCG is aware of patient concerns in relation to safety and infection rates. The CCG plans to reduce the amount of C-difficile infections by the required 20% over the next year and will continue to secure through commissioning, best practice in responsible effective prescribing and reviewed practice at hospital clinical ward level to identify any areas for further training.

The CCG will ensure the local hospital continues to undertake mandatory reporting of Methicillin Resistant Staphylococcus aureus (MRSA) and Escherichia coli (Ecoli) cases.

We will work with the local hospital and other CCG’s to continually explore innovative solutions that help towards further reducing MRSA cases, for example;

- The role of the Consultant antimicrobial pharmacist.
- A campaign to support effective management of patients requiring
Ensuring quality and safety

antibiotic treatment. Consideration of a smart phone application to enable doctors to effectively and safely prescribe antimicrobials.

- Developing innovative practices for controlling and preventing healthcare acquired infections by collaborative working with the National Centre for Infection Prevention Management

The safety and welfare of children and vulnerable adults is of paramount importance to Wirral CCG. We work diligently to ensure that all of the services we commission ensure high quality safe effective care.

The following measures ensure that safeguarding and promoting the welfare of children and vulnerable adults is given priority and is discharged effectively across the whole local health community through commissioning arrangements:

- Executive level CCG membership of the Local Safeguarding Children Boards which ensures that safeguarding is at the forefront of service planning
- Senior CCG membership on the Health and Wellbeing Board
- Close collaboration with the Local Authority to assess and ensure the provision of coordinated integrated services to meet the needs of the local population, including specialist services for vulnerable groups
- Ensuring that safeguarding children and adult strategies and associated policies are in place
- Ensuring that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes
- Designated Nurses and Doctors in post to offer professional expertise and advice regarding safeguarding matters.
For children and young people the CCG is required to have regard to the need to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and to be active members of the Wirral Safeguarding Children’s Board. The draft Care and Support Bill sets out comparable requirements with respect to safeguarding vulnerable adults, including membership of Safeguarding Adults Boards.

The CCG has responsibilities to provide Looked After Children with healthcare assessments, on placement and annually/bi-annually review thereafter and provide for identified health care.

The systems that have been developed by the CCG are tested through a quarterly review process by the AT, to ensure that there are improvements in the quality of the services that they commission.
# Military Veteran Health – an update for Cheshire, Warrington and Wirral CCGs

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**Report to:** Governing Body  
**Lead Officer:** Margi Butler, Lead Commissioner (Cheshire, Warrington and Wirral) for Armed Forces Health and Offender Health (Community)

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- Link to Commissioning Strategy
- Link to current governing body

- **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

**Summary:** This report is to update Governing Body of the progress being made with the armed forces health agenda.

**Recommendation:** To Approve  
To Note: x

**Next Steps:**

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

**What are the implications for the following** (please state if not applicable):
The paper refers to the re-procurement of the military veteran IAPT service. This is currently funded by the CCG and additional investment is not being sought, however, the commissioning arrangements may change, subject to commissioner’s preference (cost per case v block). Improving GP awareness of veterans is a priority which could incur minimal costs - promoting within practices and training. Costs are not yet calculated.

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**Value For Money**
MVIAPT - this is a specialist service which Wirral veterans are accessing relatively well. With redundancies, access may increase. NHS Bury may propose cost-per-case as opposed to the current block arrangement.

**Risk**
Access to specialist psychological therapies is a recommendation within the Operating Framework and the Murrison Report.

Local IAPT services may not be able to deal with the complex issues that veterans may present with.

**Legal**
No issues identified

**Workforce**
No issues identified

**Equality & Human Rights**
The paper assures the Governing Body that Military Veterans are able to access healthcare services appropriately

**Patient and Public Involvement (PPI)**
This has been discussed at Wirral's Armed Forces Forum where members of the armed forces are present.

**Partnership Working**
In terms of MVIAPT, the specification, costings and activity have been shared with partners within Wirral CCG.

**Performance Indicators**
NHS Bury is developing Key Performance Indicators for the service.

Do you agree that this document can be published on the website? (If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

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

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Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

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

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

If you require any additional information please contact the Lead Director/Officer.
MILITARY VETERAN HEALTH
– AN UPDATE FOR CHESHIRE, WARRINGTON AND WIRRAL CCGS

Background

The NHS Operating Framework sets out requirements for how care is delivered and support offered to veterans and their families.

- Identify Veterans
- Referring for priority treatment
- Support staff who volunteer for reserve duties
- Supporting reservists having time off for training/ deployment
- Implementing Murrison Report
- Prosthetic needs
- Maintaining and developing Armed Forces Network

(A veteran is defined as someone who has served in the Armed Forces for one day – Ministry of Defence definition)

In addition, the Armed Forces Covenant\(^1\) outlines the moral obligation between the nation, the government and the armed forces. The aim of the community covenant is to encourage local communities to support the armed forces community in their area and promote understanding and awareness among the public of issues affecting the armed forces community.

Prevalence

The exact number of veterans across Cheshire, Warrington and Wirral (CWW), and indeed the country, is unknown. This is for a variety of reasons including veterans not identifying themselves as they either choose to quietly integrate into civilian life, or veterans not realising the benefits they may be entitled to due to their status of having served in the armed forces.

Commissioners are working closely with 42\(^\text{ND}\) NW Brigade, the army's headquarters for the North of England, to reinforce the importance of services understanding numbers and need against which services are commissioned.

The following table shows prevalence of veterans, based on information the Public Health team at Wirral PCT obtained in 2011.

\(^1\) Armed Forces Covenant, Ministry of Defence, 2011
Redundancy and Transition

The Armed Forces are undergoing a dramatic reduction in size and reorganisation. An Armed Forces Redundancy scheme is currently underway to achieve some of the reductions outlined in 2010 Strategic Defence and Security Review\(^2\). Additional reductions for the Army were announced in July 2011 after a ‘Three Month Review’. Altogether 33,000 personnel (19%) are to leave the services which are being achieved through a combination of redundancy, natural wastage and reduced intake. The bulk of the reduction is in the Army, which has a goal of reducing its regular force by nearly 20,000 personnel to 82,000 by 2020.

The Strategic Defence and Security Review suggest that by 2018, the army will number 82,000 regulars and 30,000 reservists.

This is of particular relevance as the reserve force may well include our NHS employees.

The identification of this group of people is a requirement of the Operating Framework along with the subsequent support of them as they return to work after returning from their military duties.

The Health of Military Veterans

There is much written about the health needs of military veterans with concerns for their mental health needs being cited as well as dependency on substances etc. Local armed forces colleagues are cautious about such claims, feeling that on the whole, this is a healthy, strong, well-adjusted population.

As ever, it is the minority that makes the headlines and causes most impact on services.

Locally, there are no bespoke chapters within the Joint Strategic Needs Assessments for veterans or their families. This could be due in part to the issue of identification of the client group.

A health needs assessment of veterans in custody\(^3\) (that is, in the six Cheshire/Mersey prisons) was commissioned in 2013. The report shows that the following were of some concern:

- Musculo-skeletal

\(^3\) Veterans in Custody in Cheshire & Merseyside – a Summary of Needs, J Pratt, 2013
There were wider health and social care needs relating to relationships and employment.

It should be noted that the sample size was small but very likely represented the health status of the majority of veterans ie relatively fit, well and healthy. The research did flag the concerns that veterans had for their wives and partners particularly mental health concerns due to the stresses of having serving partners who are away from home for lengthy periods of time.

**Progress of the Armed Forces Health Lead for CWW**

In September 2013 the Accountable Officers of the CWW CCGs agreed to jointly commission 0.2wte of a Senior Commissioner from Warrington CCG (hereafter known as the Lead), to lead on the armed forces health agenda. A description of the role was agreed.

The Lead is working as a conduit between the DoH, NW Armed Forces Network (NWAFN) and local CCGs in ensuring that CCGs are fit for purpose against the agenda and, responding in a timely way to directives that are coming out of the Centre or from the NWAFN. The Lead is working locally, sub-regionally, regionally and nationally; high-lights of each area are described below:

**National**

A single-management model has been developed by the post-holder and recently presented at a national conference, as it is recognised by the Armed Forces Lead at the Department of Health and the Ministry of Defence, as an exemplar of good practice.

**Regional**

The Lead is the CWW representative at the NW AFN. The Network is a requirement of the Operating Framework and is attended by multi-agency partners from the NHS, Ministry of Defence, Third Sector etc.

The Network exists to support CCG areas in implementing the Operating Framework and Community Covenant requirements. The Network functions at a strategic level in ensuring care continuity for armed forces across and between commissioned services, ensuring smooth transition from Defence Medical Services (MOD) to the NHS etc.

The Network is hosted by NHS Bury which is currently leading on the re-procurement of the Military Veteran IAPT service across the North West.

The Lead is sitting on the task group working on this re-procurement.
As a note, NHS North Yorkshire and Humber Area Team, who are the lead for armed forces health commissioning in the North, has recognised the innovative commissioning approach that CWW CCGs have adopted for armed forces health care and are using the model to support other CCGs in developing their response to this area of work.

**Sub-Regional**

i) The Lead has established key contacts in all of the local CCGs. This is to aid and assist in the dissemination of information and to establish routes into localities. Quarterly meetings with these contacts have been agreed and will commence in June 2014.

ii) The Lead represents all Cheshire CCGs at the Cheshire Community Covenant meeting. This meets bi-monthly at 75 Engineer Regiment HQ in Warrington to consider Covenant Grant applications and to informally performance manage progress against the Community Covenant pledges.

iii) The Lead has approached CCGs seeking support to roll out awareness raising training to GPs. This will improve the identification of veterans in Primary Care and thus enable them to be referred for priority treatment where appropriate. There is a cost attached to the training, agreement for which has yet to be universally agreed.

iv) The Lead has written to all CCGs (17.2.14) advising them to undertake an audit of the workforce to identify staff who are Reservists. This is an Operating Framework requirement.

v) The Lead is in the process of writing to all CCG Contract Leads advising them to refer to the priority status of veterans in their contracts.

vi) The Lead is advising on ways in which veterans may be identified in primary care including the use of electronic messaging in the waiting areas.

vii) The Lead is liaising with NHS Bury in trying to improve the offer that CWW veterans get in terms of access and outcomes to the MVIAPT service.

viii) The Lead is part of the Task Group that is re-specifying the MVIAPT service for 2015/16.

ix) Ad-hoc support is given when CCGs have issues with individual veterans who are seeking particular treatments etc.

x) The Lead represented the NHS in an event in October 2013 at which the Cheshire Community Covenant group presented an update to key colleagues including elected members.

xi) The Lead commissioned a health needs assessment of offenders across CWW4. One of the recommendations is to support veterans in custody. This is being driven via the 2015/16 work-plan for this project.

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4 Health Needs Assessment of Offenders in the Community, Cheshire East, Cheshire West & Chester, Warrington and Wirral, Michael Lloyd, 2013
Local

The Lead is supporting individual areas as they seek to set-up Armed Forces Networks (or indeed maintain them as in the case of Warrington and Wirral). A briefing has recently been shared with CCGs for insertion into Strategic Plans.

Future Work

- Embedding all the areas mentioned above including delivering the requirements of the Operating Framework
- Developing a response to NHSE’s 5 year plan for armed forces health including increasing veteran involvement (a main driver within the document).
- Improve understanding of the needs of families
- Re-procurement of the MVIAPT service
- Managing the NHS Constitution v Community Covenant!

Margi Butler
10th April 2014
Consortium Update Reports  
Governing Body July 2014

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<td>Lead Officer:</td>
<td>Iain Stewart, Chief Officer, Wirral Alliance Consortium</td>
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**Summary:**
Each Consortium has been asked to prepare a report on a quarterly basis detailing how it has contributed to key CCG priorities, including:
- patient engagement
- contribution to QIPP
- GP Practice education and training

This will demonstrate to patients, stakeholders and the public the range of innovative activities taking place at a Consortium level, and the contribution made to the overall CCG Strategic plan and priorities through the Consortia and their member practices.

This report describes activities undertaken by Wirral Alliance Commissioning Consortium during Quarter 4 (January to March 2014).

**Recommendation:**
To Approve

**Next Steps:**
The Consortia will prepare this report and submit to the Governing Body on a quarterly basis from this point.

*This section is an assessment of the impact of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*
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<tr>
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<td>The report highlights the way in which the Consortia have contributed towards the QIPP savings requirement.</td>
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<tr>
<td><strong>Value For Money</strong></td>
<td>When developing any scheme or investment plan, each Consortium will need to demonstrate value for money.</td>
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<tr>
<td><strong>Risk</strong></td>
<td>In addition to reports submitted to the Governing Body, the Consortia meet on a weekly basis regarding any engagement or service development activities, to reduce the risk of duplication, and to highlight any risks to the Consortia or organisation as early as possible.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>Each Consortium will work closely with the Commissioning Support Unit when developing any proposals to ensure that they are compliant with their legal obligations, for instance in relation to procurement, or decommissioning any service.</td>
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<tr>
<td><strong>Workforce</strong></td>
<td>The Consortia have described how they have supported the primary care workforce to deliver the CCG agenda through education and training.</td>
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<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
<td>Each Consortium will be expected to demonstrate that any commissioning and engagement work undertaken is in line with Equality and Human Rights requirements, and many of the projects undertaken by the Consortia aim specifically to target and reduce health inequalities.</td>
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<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td>The Consortia outline the patient and public engagement activities that they have undertaken.</td>
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<tr>
<td><strong>Partnership Working</strong></td>
<td>The service redesign and innovation projects undertaken by the Consortia are the produce of partnership working with a range of stakeholders, including primary and secondary care clinicians, and patients and public.</td>
</tr>
<tr>
<td><strong>Performance Indicators</strong></td>
<td>Performance Indicators will be developed by the Consortia in relation to specific schemes, so that their impact and merit in future investment may be evaluated.</td>
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(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)  
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</thead>
<tbody>
<tr>
<td>Consortium Report</td>
<td></td>
<td>Governing Body</td>
<td>October 2013</td>
<td>NA</td>
</tr>
<tr>
<td>Consortium Report</td>
<td></td>
<td>Governing Body</td>
<td>February 2014</td>
<td>NA</td>
</tr>
</tbody>
</table>

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).

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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 a x.

If you require any additional information please contact the Lead Director/Officer.
The Patient Engagement Group appears to have established as a core 5-6 people (including Chair and Secretary) who regularly attend monthly meetings. Consortium agreed to extend the development and administrative support from VCAW to the PEG until the end of June 2014 whilst the Group’s new Secretary settles into the role. Consortium Vice-Chair has not yet been able to attend monthly updates with Chair and Chief Officer due to other commitments. The patient leaflet on appropriate use of A&E services was deemed by the Executive board not to be value for money and will not be progressed. Consortium board members were very active in response to the proposed Primary Care Access Scheme, which was subsequently withdrawn by the CCG.

<table>
<thead>
<tr>
<th>Engagement Activity</th>
<th>Promoting Choice</th>
<th>Promoting innovation</th>
<th>Contribution to QIPP</th>
<th>Contribution to Strategic Plan</th>
<th>Quality in Primary Care</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>No feedback received during this quarter.</td>
<td>Business as usual in terms of demand management messages and encouragement to utilise the full range of services commissioned.</td>
<td>The Care Home Assessment &amp; Review Service (CHARS) monthly clinical assessment proforma has been recommended by Wirral Adult Social Services to Care Home providers on Wirral for inclusion into their contracts as a quality of care measure.</td>
<td>Upon completion of service reviews the consortium executive board determined the cessation of all service projects with effect from the end of March 2014. The professional development nurse service was continued for a further 12 months after extremely positive feedback from the consortium practice nurses. A patients/professionals video evaluation on the COPD PACE service was commissioned via the CSU Communications team. The final video production is expected in quarter 1. The consortium executive board noted the relatively low overspend following two consecutive successful years of generating budget efficiencies. The Consortium Executive Board agreed to a restructured approach for board and clinical engagement meetings to reflect the reduced running costs allowance.</td>
<td>The Consortium Executive board determined an approach to the use of non-recurring monies for 2014/15 to focus on increasing capacity within member practices during existing core in-hours service, in order to support improving demand management. A proposed scheme is to be developed for submission to the CCG Approvals Committee.</td>
<td>No specific activity during this quarter.</td>
<td>The professional development nursing service delivered the following training opportunities: chest examination skills (3 day course); Independent Nurse Prescribers Forum &amp; Medicines Management topics including CKD, Family Planning &amp; HRT, COPD; and Mental Health; CPR training; Foot Screening in Diabetes; Travel health study day.</td>
</tr>
<tr>
<td>Additional Comments and Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half of the consortium administrative resources are deployed to support CCG corporate affairs functions as part of a personal development initiative. The vacant Commissioning Manager role has been removed from the staffing complement for the consortium as part of the exercise to reduce running costs - this leaves a Band 4 administrative post for consortium support.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Integrated Performance and Finance Report

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>4.1</th>
<th>Reference:</th>
<th>GB 14 – 15/0022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report to:</td>
<td>Governing Body Meeting</td>
<td>Meeting Date:</td>
<td>1st July 2014.</td>
</tr>
<tr>
<td>Lead Officer:</td>
<td>Mark Bakewell, Lorna Quigley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors:</td>
<td>Finance and Business Intelligence teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance:</td>
<td>Link to Commissioning Strategy</td>
<td>Sound financial control is essential to the Clinical Commissioning Group (CCG) strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year. Ensuring that services that the CCG commission for the population comply with patient’s rights under the NHS constitution.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Link to current governing body Objectives</td>
<td>To achieve financial control total with sound financial management. To ensure that providers achieve strong performance against national targets.</td>
<td></td>
</tr>
<tr>
<td>Summary:</td>
<td>This report updates the Governing Body on: Activity Performance for Month 1 (April) Financial performance against budgeted allocation for 2014/15 as at Month 2 (May)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation:</td>
<td>To Approve</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To Note</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Next Steps:</td>
<td>Continuation of performance monitoring through the remainder of the financial year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

What are the implications for the following (please state if not applicable):

<table>
<thead>
<tr>
<th>Financial</th>
<th>The report sets out the financial performance within the CCG for 2014/15 financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value For Money</td>
<td>All expenditure plans are subject to an ongoing value for money review.</td>
</tr>
<tr>
<td>Risk</td>
<td>The report details the key risks and how these will be monitored in year as part of the reporting process</td>
</tr>
</tbody>
</table>
## Legal
Legal advice is sought on issues as and when required.

## Workforce
The financial plan includes budgeted “running costs” expenditure and is reflective of the respective workforce implications in these areas.

## Equality & Human Rights
Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure.

## Patient and Public Involvement (PPI)
Budgets include funding to ensure continued involvement of patients and public in CCG decisions. Patient choice is a right under the constitution in relation to referral for treatment.

## Partnership Working
The CCG works with a number of NHS Trusts and the Local Authority on a number of its commissioning budgets.

## Performance Indicators
The plan reflects the planned achievement of statutory financial duties and patient’s rights under the NHS constitution.

### 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)

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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If you require any additional information please contact the Lead Director/Officer.
Finance & Performance Update to Governing Body Meeting

1st July 2014
## Health Care Associated Infection (HCAI)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Preferred Outcome</th>
<th>April 2014</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of HCAI – MRSA number of trust associated cases</td>
<td>0 cases</td>
<td>Lower</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Incidence of HCAI – C diff number of trust associated cases</td>
<td>64</td>
<td>lower</td>
<td>14</td>
<td>*20% reduction this year</td>
</tr>
</tbody>
</table>

“Your partner in a healthier future for all”
# Delivering Same Sex Accommodation

<table>
<thead>
<tr>
<th>Category</th>
<th>Outline indicator</th>
<th>baseline</th>
<th>Preferred outcome</th>
<th>April 2014</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSA</td>
<td>All providers of NHS funded care are to eliminate mixed sex accommodation</td>
<td>0</td>
<td>Zero tolerance</td>
<td>1</td>
<td>Breach in CCU, due to clinical Reasons. Awaiting exception report.</td>
</tr>
</tbody>
</table>
## Friends and Family Test

<table>
<thead>
<tr>
<th>Area</th>
<th>Response rate (target 15%)</th>
<th>Net promoter score April 2014</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>22.9% 26.9%</td>
<td>64</td>
<td>Net promoter score for inpatients. Still below CWW average. Stretch target given via CQUIN</td>
</tr>
<tr>
<td>In patients</td>
<td>29.3% 21.2%</td>
<td>78</td>
<td>70</td>
</tr>
</tbody>
</table>
### Friends and Family Test

<table>
<thead>
<tr>
<th>Area (Maternity)</th>
<th>Response Rate (Target 15%)</th>
<th>Net Promoter Score February 2014</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante natal</td>
<td>16 %</td>
<td>12.7%</td>
<td>1</td>
</tr>
<tr>
<td>Birth</td>
<td>26%</td>
<td>30.5%</td>
<td>83</td>
</tr>
<tr>
<td>Post natal</td>
<td>24.2%</td>
<td>30.5%</td>
<td>1</td>
</tr>
</tbody>
</table>
## NHS Constitution

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome indicator</th>
<th>baseline</th>
<th>Preferred outcome</th>
<th>April 2014</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients seen within 4 hours of attending</td>
<td>Arrowe Park</td>
<td>95%</td>
<td>Higher</td>
<td>90.6%</td>
<td>As the WIC is on site this is a combined target</td>
</tr>
<tr>
<td></td>
<td>Arrowe Park Walk in Centre</td>
<td>95%</td>
<td>Higher</td>
<td>99.9%</td>
<td></td>
</tr>
<tr>
<td>Combined total</td>
<td>Combined total</td>
<td>95%</td>
<td>Higher</td>
<td>92.8%</td>
<td>This is a quarterly target. Improvement plan has been developed and is being monitored</td>
</tr>
<tr>
<td>Victoria Central Hospital walk in centre</td>
<td>Victoria Central Hospital walk in centre</td>
<td>95%</td>
<td>Higher</td>
<td>99.8%</td>
<td></td>
</tr>
<tr>
<td>Eastham walk in centre</td>
<td>Eastham walk in centre</td>
<td>95%</td>
<td>higher</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Outcome indicator</td>
<td>baseline</td>
<td>Preferred outcome</td>
<td>April 2014</td>
<td>Commentary</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ambulance handover and turnaround times</td>
<td>Cat A calls meeting the 8 minute standard</td>
<td>75%</td>
<td>Higher</td>
<td>75.8%</td>
<td></td>
</tr>
<tr>
<td>Ambulance handover and turnaround times</td>
<td>Ambulance handover times (15 mins)</td>
<td>100%</td>
<td>Zero tolerance</td>
<td>98.5%</td>
<td></td>
</tr>
<tr>
<td>Ambulance handover and turnaround times</td>
<td>Ambulance turn around times (30 mins)</td>
<td>95%</td>
<td>Higher</td>
<td>Data not available</td>
<td>Due to a change in reporting mechanisms, data not available this month.</td>
</tr>
<tr>
<td>Category</td>
<td>Outcome indicator</td>
<td>Baseline</td>
<td>Preferred outcome</td>
<td>April 2014</td>
<td>Commentary</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------</td>
<td>----------</td>
<td>-------------------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>RTT Admitted pathways</td>
<td>90%</td>
<td>Higher</td>
<td>92.0%</td>
<td>Pressure remain with the specialities of Urology, Upper GI surgery and pain services</td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>RTT non admitted pathways</td>
<td>95%</td>
<td>Higher</td>
<td>97.4%</td>
<td></td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>RTT Incomplete pathways</td>
<td>92%</td>
<td>Higher</td>
<td>94.9%</td>
<td></td>
</tr>
<tr>
<td>Referral to treatment</td>
<td>RTT 52+ week waiters (admitted pathways)</td>
<td>0</td>
<td>Zero tolerance</td>
<td>1</td>
<td>This is a patient waiting treatment at the neurological centre at the UH London. Treatment date 4/8/14</td>
</tr>
</tbody>
</table>
## NHS Constitution

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome indicator</th>
<th>Baseline</th>
<th>Preferred outcome</th>
<th>April 2014</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic tests</td>
<td>Patients should wait no longer than 6 weeks for a diagnostic test</td>
<td>99%</td>
<td>Higher</td>
<td>96.3%</td>
<td>This drop in performance is due to the increase in demand for Dexa scanning. A recovery plan is in place.</td>
</tr>
</tbody>
</table>

"Your partner in a healthier future for all"
Month 2 Financial Performance

- Limited data available for Month 2 reporting
- Planned Year to Date Surplus - £0.78m
- Current Year to Date Surplus - £0.65m
  - £0.13m variance from plan
- Planned Forecast Surplus - £4.682m as per plan
Month 2 Financial Performance

Performance Issues

• Joint Funded Packages of Care
• Some favourable non NHS variances
• Majority of NHS contracts reported breakeven due to insufficient data, this should be improved for Month 3 reporting

• QIPP target £5.4m
Glossary

BPCC - Better payment practice code
CCG – Clinical Commissioning Group
C. Diff - Clostridium Difficile
CHC – Continuing Health Care
CT Scan - Computed Tomography
CWW – Cheshire West and Warrington
HCAI – Healthcare Associated Infections
MRSA - Methicillin Resistant Staphylococcus Aureus
MSA – Mixed sex accommodation
*Over Performance – Over performing against the budget / plan by spending more than we assumed
PCT – Primary Care Trust
QIPP – Quality, Innovation, Productivity & Prevention
QPF – Quality, Performance & Finance Committee
RAG – Red Amber Green
RCA – Root Cause Analysis
RTT – Referral to treatment
TBC – To Be Confirmed
VCH – Victoria Central Hospital
WIC – Walk in Centre
YTD – Year To Date
WIRRAL GP COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Tuesday 13th May 2014, 6.30pm
Nightingale Room, Old Market House

Present:
Dr Navaid Alam (NA) GP Lead
Penny Angill (PA) Practice Manager Member
Christine Campbell (CC) Chief Officer
Dr Maria Earl (ME) GP Lead
Dr Andrew Lee (AL) GP Lead
Louise Morris (LM) Consortia Finance Lead
Dr John Oates (JO) Chair
Sam Saminaden (SS) Lay Representative

In attendance:
Carol Diamond (CD) Commissioning Support Manager
Anita Fletcher (AF) WGPCC Administrator
Paul McGovern (PM) Commissioning Support Manager
Jennifer Shaw (JS) Commissioning & Engagement Support Manager

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>WGPCC/EB/14-15/001</td>
<td>1.1 Apologies for absence</td>
</tr>
<tr>
<td></td>
<td>Apologies were received from Dr Akhtar Ali, Dr Simon Delaney, Dr Hannah McKay and Eddy Shallcross.</td>
</tr>
<tr>
<td></td>
<td>1.2 Declarations of interest</td>
</tr>
<tr>
<td></td>
<td>JO and ME declared interest in item 3.1 as their practices are involved in delivering this scheme. As such, JO would step down as Chair. Ordinarily one of the lay representatives would chair the meeting but, due to his ill health, it was agreed with SS that CC would chair this item when it was discussed.</td>
</tr>
<tr>
<td></td>
<td>1.3 Public Comments/Questions</td>
</tr>
<tr>
<td></td>
<td>There were no members of the public present.</td>
</tr>
<tr>
<td></td>
<td>1.4 Minutes and Action Points of the last meeting</td>
</tr>
<tr>
<td></td>
<td>An amendment to the first sentence of the penultimate paragraph in section 3.1 of the previous minutes was requested. The sentence should read “For the outcome figures, there has been a significant jump in the numbers of patients in January 2014 due to extra resources for winter pressures.”</td>
</tr>
<tr>
<td></td>
<td>Following this amendment, the minutes were agreed to be a true record of the meeting.</td>
</tr>
</tbody>
</table>

Matters Arising

Feedback on the Provision of Primary Care Mental Health (PCMH) – The Primary Care
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health Survey response was discussed. From verbal feedback at the Practice Members’ meeting on 1\textsuperscript{st} April 2014, it was felt that the eighteen responses received had been from practices rather than individuals; this was therefore a better response than originally thought. Jen Shaw is now taking forward the procurement of PCMH.</td>
</tr>
<tr>
<td></td>
<td><strong>WGPCC Executive Board meetings</strong> – JO explained that as these meetings now take place bi-monthly, a summary report will be produced by the Chair to be presented at the Governing Body meetings in the months in between minutes being available. This process will occur across the three Consortia.</td>
</tr>
<tr>
<td></td>
<td><strong>Action Points</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Matters Arsing: WGPCC representation on the CCG Governing Body Board</strong> – Action complete – Dr McKay and Dr Ali have been appointed as the Consortium representatives.</td>
</tr>
<tr>
<td></td>
<td><strong>Minutes for Noting</strong> – Action complete – The ratified Patient Council Executive Board minutes from the 10\textsuperscript{th} December 2013 have been included with the papers for this meeting.</td>
</tr>
<tr>
<td></td>
<td><strong>Feedback on the Future Provision of Primary Care Mental Health</strong> – Action complete – The online survey requesting views was reissuued.</td>
</tr>
<tr>
<td></td>
<td><strong>Minor Injury and Illness Service Evaluation 2013-14</strong> – Action complete – This is an agenda item at this meeting.</td>
</tr>
<tr>
<td></td>
<td><strong>Financial Budget 2013/14</strong> – Action complete – Month 10 financial information has been distributed to all WGPCC practices.</td>
</tr>
<tr>
<td></td>
<td><strong>1.5 Minutes for Noting</strong></td>
</tr>
<tr>
<td></td>
<td>The minutes from the Patient Council Executive Board meeting, held on the 10\textsuperscript{th} December 2013 and 6\textsuperscript{th} February 2014, were noted.</td>
</tr>
<tr>
<td></td>
<td>The minutes from the Governing Body meeting, held on 1\textsuperscript{st} April 2014, were noted.</td>
</tr>
<tr>
<td></td>
<td><strong>1.6 Complaints, Compliments and Patient Feedback</strong></td>
</tr>
<tr>
<td></td>
<td>Executive Board members were advised that a complaint from a patient regarding the Minor Injury Service delivered at Parkfield Medical Centre had been received through the CCG. As this matter had been dealt with and was now closed, it could be discussed at this meeting. The service did not quite meet the patient’s expectations regarding access to patients’ full record not being available at the Minor Injury and Illness service sites. The Nurse Lead has responded fully to the patient’s concerns. Going forward, patients will be made aware of this fact.</td>
</tr>
<tr>
<td>WGPCC/EB/14-15/002</td>
<td><strong>2.1 Cancer Audit</strong></td>
</tr>
<tr>
<td></td>
<td>Executive Board Members were advised that the report outlines the reasons for introducing a Cancer Quality Audit scheme, the elements practices needed to achieve and the learning outcomes.</td>
</tr>
<tr>
<td></td>
<td>Twelve practices signed up to the scheme, and received a one-off payment to enable clinicians to meet and discuss the current practice management of patients with cancer, review ten recent diagnoses of cancer and perform a significant event analysis on one patient diagnosis.</td>
</tr>
<tr>
<td></td>
<td>The report concludes that there is scope for further cancer audits to be made available across all Wirral GP practices, which will have the potential to increase early diagnosis of cancer and associated cost efficiencies.</td>
</tr>
</tbody>
</table>
|         | Findings from the audit are positive and show that over 80% of patients are referred after 1-2 consultations with the majority of patients being over 60 years of age. For the majority of
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>referrals, less than 70% are referred via a two week rule.</td>
</tr>
<tr>
<td></td>
<td>A number of difficulties were encountered with the audit and these are detailed within the report.</td>
</tr>
<tr>
<td></td>
<td>Key messages from the audit include:</td>
</tr>
<tr>
<td></td>
<td>• The importance of investigating vague persistent symptoms</td>
</tr>
<tr>
<td></td>
<td>• Negative tests should not reassure the patient or GP</td>
</tr>
<tr>
<td></td>
<td>• The need for a high index of suspicion in older patients</td>
</tr>
<tr>
<td></td>
<td>• Co-morbidity frequently clouds the picture</td>
</tr>
<tr>
<td></td>
<td>• The importance of continuity of care and good safety netting</td>
</tr>
<tr>
<td></td>
<td>Other reviews a practice may consider were highlighted and attention was drawn to reviewing all emergency admissions which resulted in a cancer diagnosis.</td>
</tr>
<tr>
<td></td>
<td>Members were informed that the report would be used for feedback at the Protected Learning Time event in July 2014.</td>
</tr>
<tr>
<td></td>
<td>Executive Board Members were advised that there are many powerful conclusions from the audit and sharing this at the PLT event in July is very positive.</td>
</tr>
<tr>
<td></td>
<td>Dr Earl and Carol Diamond were thanked for all their hard work in this.</td>
</tr>
</tbody>
</table>

### 2.2 WGPCC Care Homes Scheme

Executive Board Members were advised that the paper provides an evaluation on the care home scheme for the period from November 2013 to March 2014, which had been funded using non-recurrent resource in 2013/14. The scheme was in response to the higher rate of older people in nursing care compared to both the North West and England and the emergency admissions data for WGPCC practices.

Fifteen practices had participated in the scheme and an evaluation had been undertaken. Practices were asked to provide particular information in evaluating the scheme and were also asked to complete an evaluation report.

The findings of the scheme were divided as follows:

- Activity levels
- Improvements in communication and partnership working
- The utilisation of alternative community services
- What worked well and key outcomes achieved
- Any issues encountered
- Further comments

When practices were asked if there were any issues encountered in the scheme, the following were highlighted.

- The assessment and review was time-consuming
- Difficulties in discussing DNACPRs, particularly with family members.

Benefits of the scheme are reported as follows:

- Better and more proactive care co-ordination
- Improved communication and joint-working between the care home and practice
- Increased understanding and utilisation of community services
- Increased diagnosis of dementia
More time to discuss end of life issues with patient, family and care home
Greater relationship with patient, their family and carers.

Unfortunately the impact of the scheme on individual patients’ future hospital admission is not available due to the restrictions in access to patient identifiable information.

Members were advised that each Consortia had a different care home scheme in place and learning will be taken from each one.

The CCG, GPs from the Elderly Care QIPP team, and Local Authority will be working to develop options for improvement to elderly care, including how to better support care homes.

**Action:** JS to share the scheme evaluation with the Patient Council members.

### 2.3 Wirral CCG Draft Strategic Plan

Executive Board Members were advised that the final submission in draft format of the Strategic Plan is due to the Local Area Team on 20th June 2014. This document had been included to make Executive Board members aware of it; members were asked for any comments on this document to be sent to Christine Campbell.

Attention was drawn to pages 71 and 72 as this shows the drop in funding for this financial year. There will be a further 10% drop in funding for 2015/16; although finances are challenging now this will get worse.

### 3.1 Minor Injury and Illness Service 2013-14

Due to interest being declared by JO and ME, this item was chaired by CC.

Members were reminded that a decision on the service had been deferred at the last meeting as Members had requested further data. This data had been supplied electronically and further discussion had taken place at the Clinical Leads’ meeting on 8th April 2014. This further data has been included within the papers.

At the last meeting the clinical issues and service provision were discussed and so these would not be repeated here; at that meeting the Board had suggested that the future commissioning of these services should be considered by the CCG in line with the wider urgent care review; this meeting will look at future commissioning in line with the budget available to the Consortium, and the Consortium’s ability to make a decision regarding these services.

At the last meeting, some members were asked to leave the room due to a conflict of interest as there was a decision to be made. CC explained that, as members were being asked to support an item being referred to the Governing Body, rather than deciding on allocation of resources on behalf of the Consortium, JO and ME could remain in the room whilst the item was being discussed.

CC circulated a paper that provided a more up-to-date position on the Consortium’s available budget, due to information made available since papers were circulated. It was explained that the Minor Injury and Illness Services provided at Miriam MC and Parkfield MC were originally funded by the PCT as Invest to Save initiatives, and that the Consortium had been allocated £200,000 recurrently to fund these. As such, CC suggested that any decision regarding the future commissioning of these services should be one for the CCG, and not for the Consortium. Furthermore, members’ attention was drawn to page 71 from the CCG Constitution, and the Scheme of Delegation, which states that the Consortia can:
“Approve consortia commissioning proposals from within own delegated budgets up to an annual financial value of £500,000 (Matters where any proposal could have potential impact across wider economy would also require referral to Governing Body).”

Given that these services are open to the whole health economy, it was agreed that any decision regarding their future commissioning would potentially affect the wider economy, and therefore it would not be appropriate under the Constitution for the Consortium to make a decision regarding these services. CC highlighted further risks in decommissioning current services, including a request that had been received from the Chair of the Patient Council, requesting that no decisions are taken without full and robust patient engagement, and that contact had been received from a local MP, in support of the Minor Injury services, and advising that a Secretary of State visit was planned in the summer. A paper had been brought to the CCG Operational Team meeting in November regarding a strategy for provision of urgent care within the community (ie Walk in Centres and Minor Injury and Illness services, and a proposal on the future commissioning of these services is due to be considered by the CCG. As such, members agreed that it would not be appropriate to consider the future of these services in isolation to the other Wirral community urgent care provision.

Taking this and the risks into account, members agreed that the Consortium was not able constitutionally to discuss future commissioning of any of the three services, and that the future commissioning of these should be deferred to the Governing Body, to consider alongside the other Wirral community urgent care centres.

However, CC highlighted that the Consortium would need to fund at least £200,000 worth of the Minor Injury and Illness service at Miriam and Parkfield, given that we had received funding for this for 2014/15. However, looking at the total available for the Consortium, and the investment priorities agreed at the last meeting, there is already a shortfall of £50,000. It was explained that the budget has been cut by over £300k recurrently to fund the pressure in Physiotherapy AQP referrals (a service initiated by the Consortium), and contingency for Primary Care Mental Health, which is a budget and commissioning responsibility fully devolved to the Consortium. Members reviewed the expenditure plan for available resources and discussed where there may be scope to release the £50,000. It was agreed that the following would be considered in priority order:

- Part-fund the training budget through the clinical engagement budget if possible
- Consider if there is any slippage in the contingency set aside for Primary Care Mental Health (CC explained that whilst referrals had reduced, the complexity had increased, and the base contract value is still very unlikely to be enough to cover the cost of referrals in 13/14, and so it would be imprudent not to set aside a contingency, particularly given the additional resources required in 2013/14.)
- Stop the Consortium ECG service delivered through the Minor Injury sites in Birkenhead and Moreton (CC was asked to find data on usage of the service across practices).

Members discussed the value of the ECG service, and were reminded that it had been brought in to address waiting times. Several members raised that they have an ECG facility within their own practice and did not use the scheme, and so it was agreed to collect data on how widely the ECG service is used across practices to enable the Consortium to determine its future commissioning.

It was agreed that the Consortium was only able within its available resources to continue to fund the original PCT Minor Injury and Illness sites, and would only be able to do this by pulling back resources on areas already agreed as priority for investments. With no further Consortium funding, it would require reducing the weekday hours of these services by 10 hours, and closing on weekends and bank holidays. It would also include closing the site at Moreton Health Clinic. Given the risks highlighted – patients need to be consulted, political interest – the requirements of the Constitution with regards to proposals with a wider health impact, and the need to consider all community urgent care centres together, the Board agreed that the Consortium
could only fund all existing sites on their existing hours of service until the end of June, and would need to defer the decision about commissioning the services beyond June to the Governing Body.

Members were advised that the cost for the three centres to run from 1st April 2014 to 30th June 2014, at the existing level of service provision, would be £125,000, which the Board supported.

The Executive Board were happy with the recommendations to look at training, Mental Health and the ECG service in the first instance, to replace the £200k that has been allocated to the Consortium by the CCG.

**Action:** CC to explore ways to release £50k from existing financial priorities for the Consortium  
**Action:** CC to defer the decision regarding future commissioning of all three of the WGPCC Minor Injury and Illness sites to the Governing Body.

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### 4.1 Financial Budget 2013/14

LM presented the financial position for WGPCC as the end of March (Month 12) and advised that the year to date position for the Consortium is an over-spend of £1.6m, an adverse movement of £685k on the previous month, with over performance against commissioning expenditure of £1.77m offset by underperformance against running costs of £129k. Full detail is provided within the paper which is the final report of the year.

The final performance position in relation to NHS contracts at month 12 shows an overspend of £678k, previous month £71k overspend. Contract performance against the WUTH contract is an overspend of £1.06m as at March. The Wirral-wide position is £6.3m overspent at month 12).

At month 12, Non-NHS Contracts are overspent by £1.5m. An adverse movement in the month of £92k. Over performance in the main shows against Spire Murrayfield £549k, this is due to the increase in activity over anticipated levels. AQP services £1.1m. (Physio services £381k, Rheumatology £198k, plus other pressures against ENT, Dermatology and Audiology).

A request was made for activity data to be reported on for all providers, not just WUTH as it is felt the full picture is not being looked at. It proves difficult to have conversations with practices when only provider is shown.

With regards to non-recurrent investment, of the £1.64m non recurrent monies that were available to the Consortium, the year-end position is an underspend of £94k.

**Action:** LM to ensure activity data for all providers is included in future monthly reports.

The Executive Board noted the financial position for WGPCC as at the end of March 2014 and the final outturn position for 2013/14 financial year.

With regards to the Fair Shares arrangement, members were advised that this is a national formula and how CCGs set their budgets. It is widely recognised that a shift would occur in budgets. The CCG has not lost out but does evolve in a shift of indicative budgets; the budget for this Consortium is £4.3m down.

Physiotherapy AQP overspend was highlighted; CC explained that frequent requests had been made within the CCG for referral data across all practices and all providers, and that this was essential for tackling overperformance. It was suggested that the CCG may need to consider activity caps and referral criteria / thresholds for some of the AQP contracts / providers, in order
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<th>Ref No.</th>
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<tr>
<td>WGPCC/EB/14-15/005</td>
<td>5. Any Other Business</td>
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**4.2 Patient Council and Engagement Update**

Members were informed that the next meeting of the Wirral GPCC Patient Council is due to be held on 20th May 2014; items for the agenda include:

- WGPCC and Vision 2018 update
- Update on Primary Care Mental Health
- Final Draft of the Patient Council Terms of Reference
- Memory Clinic

CC reminded the group that the Patient Council chair had asked that issue of Minor Illness and Injury services is discussed by the Patient Council.

An Annual Report is currently being worked on showing all that has been undertaken following Patient Council meetings. This is a “you said, we did” document which, when completed, will be brought to the Patient Council Executive Board and the WGPCC Executive Board for information.

The main issues for discussion in the March meeting of the Patient Council included:

- Vision 2018 presentation which focused on:
  - Recap on National and Local Challenges
  - Recap on the meaning of Vision 2018
  - What the public have said so far
  - The next steps
- CSU Presentation on the Commissioning Policy Review and its consultation

**4.3 Practice Managers’ Update**

**Practice Managers’ Forum** – Executive Board members were advised that the Practice Managers’ Forum had taken place on Thursday 13th March 2014.

Phlebotomy had been a large discussion item at the meeting. Many practices have issues with domiciliary phlebotomy as appointments are not readily available. Comments made at the Practice Managers’ meeting had been noted and raised with the Community Trust. There was concern raised regarding potential clinical risk. Issues would be raised with the CCG at the next Operational meeting.

Executive Board members felt that this should be raised as a risk to the CCG. Phlebotomy would be added to the Consortium risk register and ask for it to be considered by the CCG.

**4.4 Items for Risk Register**

New items to be included on the risk register were phlebotomy issues and the future commissioning of the Minor Injuries and Illness Services.

that referrals may be managed within available budgets.

**Referrals** – The IT system used at Blackheath Medical Centre for managing referrals for patients was highlighted and it was suggested that this system could be adapted for other practices if they were interested in using this system.

A referral management paper is to be written by CC to look at strategies; the Blackheath Medical Centre system could be included in the paper.
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<tr>
<th>Ref No.</th>
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<tbody>
<tr>
<td>WGPCC/EB/14-15/006</td>
<td>6. <strong>Private Business</strong>  &lt;br&gt;There was no private business discussed.</td>
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<td></td>
<td>7. <strong>Date and Time of Next Meeting</strong>  &lt;br&gt;The date and time of the next meeting is Wednesday 11th June 2014, 6.30pm in the Nightingale Room, Old Market House, Birkenhead.  &lt;br&gt;Please send any apologies to Anita Fletcher on <a href="mailto:anitafletcher@nhs.net">anitafletcher@nhs.net</a></td>
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The meeting finished at 8.15pm
Present:

Dr M Green (MG)   St Hilary Brow (Chair)
Dr H Downs (HD)   Civic Medical Centre
Dr G Francis (GF)   Spital Surgery
Dr I Camphor (IC)   Heatherlands Medical Centre
Dr B Conlan (BC)   The Orchard Surgery
Iain Stewart (IS)   Chief Officer
Monika Doyle (MD)   Practice Manager Member
Debbie Marsden (DM)   Nurse Member
Wendy Sheen (WS)   PEG Representative (Chair)

In Attendance:

Allison Hayes   Executive Assistant
Karen Duckworth   Project Support Assistant
Louise Morris   Senior Accountant

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<th>Ref No.</th>
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<tbody>
<tr>
<td>WACC/EB/13-14/0049</td>
<td><strong>1.0 Preliminary Business</strong></td>
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<tr>
<td></td>
<td><strong>1.1 Apologies for absence</strong></td>
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<tr>
<td></td>
<td>Apologies were received from Dr Salahuddin, Paul Wormald, Matt Gilmore, Julie Webster, Sarah Quinn and Allan Stewart</td>
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<td><strong>1.2 Declarations of interest</strong></td>
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<td>There were no declarations of interest received.</td>
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<td><strong>1.3 Public comments/Questions</strong></td>
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<td>There were no members of the public present at the meeting.</td>
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<td><strong>1.4 Minutes and Action Points of Previous Meeting/Matters Arising</strong></td>
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<td></td>
<td>The previous meeting held on 18th February 2014 were agreed as a true record of the meeting. Grammatical errors were corrected.</td>
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<td><strong>Action Points</strong> – Please refer to the attached sheet.</td>
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**Matters Arising**

**1.5 Chair Report**
Chair gave an update around the following areas:

Chair gave an update regarding the Primary Care Access Scheme. There is an extraordinary CCG Governing Body meeting to be held on 20th March 2014 to discuss issues raised by Wirral general practices.
A letter from the WACC Chairman on behalf of the Executive Board in response to the Scheme has been submitted to the CCG and he reported that a number of Wallasey practices have also submitted a letter to the CCG.

The A&E streaming initiative has been queried by Wirral University Teaching Hospitals (WUTH) as to whether or not they are to receive separate funding, continuing from April 2014.

ABI and Stroke Neuropsychology contract, the CWP contract is due for renewal in October 2014. The CCG have recommended extending the contract until April 2015 to enable a specification review by the CCG.

Spa Medica and Community Ophthalmology contracts are due to end in June 2014 and both community ophthalmology contracts end in May 2014. A recommendation to extend both contracts to April 2015 whilst an assessment of demand increase is undertaken by the CCG.

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### 2.0 ITEMS FOR INFORMATION

#### 2.1 Quality, Performance and Finance

**Quality**

Apologies from the Strategic Analysts had been received; however a brief report was provided detailing the activity of Wirral Alliance as of Month 10.

Members noted the contents of the WACC WUTH Contract Monitoring Report Summary for April – December.

**Finance**

Senior Accountant provided the group with reports that set out the financial position for Wirral Alliance Commissioning Consortium and NHS Wirral Clinical Commissioning Group as at the end of January (month 10) within the 2013/14 financial year and the performance against the measures outlined in the CCG Assurance Framework for 2013/14

The Executive Board were asked to note:

- the financial position as at the end of January 2014 and the forecast outturn position
- the performance against indicators based on the information available
- the associated financial risks within the declared position.

Members of WACC Executive Board noted the finance report.

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### 3.0 ITEMS FOR DISCUSSION

#### 3.1 Board Governance

CO advised members of the governance considerations in relation to board attendance.

Members expressed how important practice representation is at board meetings and that a nominated deputy should be able to attend or be able to vote by proxy. Further discussions took
place in relation to quoracy.

Members voted for an increase of quoracy to 5 voting members, 3 being clinicians, one of which must be Chair or Vice-chair. All board members must attend where ever possible and have a vote, however they can send a representative member to observe but that representative will not have the right to vote. GP member for Heatherlands Medical Centre did not vote for the above proposal.

A review of the Terms of Reference (TORs) for each consortia has been recently completed after a request by the Audit Committee that consortia use consistent wording. The proposed amendment above will be incorporated into the reviewed terms of reference.

3.2 Better Care Fund

In the absence of Sarah Quinn, Programme Manager, IS updated members on the Better Care Fund.

Members discussed the proposed mention of seven day working in the document and discussions took place around national outcomes which need to be achieved. Members requested that the CCG is advised that their preference is for all references to 7 day working for general practices be removed from local plans as there is no national directive to support this assertion.

Members felt it important for an adequate consultation process to take place so that the outcome delivers improved patient care.

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<tr>
<td>WACC/EB/13-14/0052</td>
<td><strong>4.0 ITEMS FOR APPROVAL</strong></td>
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<td>WACC/EB/13-14/0053</td>
<td><strong>5.0 MINUTES FOR NOTING</strong></td>
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<tr>
<td><strong>5.1 Subgroups</strong></td>
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<td>The minutes from the following committees meetings were noted:</td>
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<tr>
<td></td>
<td>• WCCG Governing Body from 04.02.2014.</td>
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<td>• <strong>PEG Update</strong> – WS provided an update regarding the WACC Consortium PEG group which took place in February. Areas included:</td>
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<td>• Vision 2018 presentation</td>
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<td>• Attendance of members and speakers at future meetings</td>
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<td>• Public AGM meeting to be held on 15th April at 5pm at OMH</td>
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<tr>
<td></td>
<td>• Future meeting dates</td>
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<td></td>
<td>• Future Projects/proposals</td>
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<tr>
<td>WACC/EB/13-14/0054</td>
<td><strong>6.0 RISK REGISTER</strong></td>
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<td>Members noted the current risks. It was agreed to include the Primary Care Strategy to the risk list.</td>
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<tr>
<td>WACC/EB/13-14/0054</td>
<td><strong>7.0 Any other Business</strong></td>
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<td>There were no other items of discussion.</td>
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<td>Chair thanked members for their attendance and the meeting was closed at 14.45pm</td>
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**Private Business**

Private business minutes are recorded separately.

**8.0 Date and Time of Next Meeting**

As the next scheduled date is the day after a Bank Holiday and during school holidays, members asked for a different date to be considered by the management team – date to be advised.

Please send any apologies to Allison Hayes at allison.hayes@nhs.net

Board meeting ended at: 14.45pm.  Signed: Chair