### 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>GB14-15/0061</td>
<td>1</td>
<td>2.00pm</td>
<td>PRELIMINARY BUSINESS (Acting Chair – Dr P Naylor)</td>
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<td></td>
<td></td>
<td></td>
<td>1.1</td>
<td>Apologies for Absence</td>
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<td>1.2</td>
<td>Chair's Announcements</td>
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<td>1.3</td>
<td>Declarations of Interest</td>
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<td>1.4</td>
<td>Comments/questions from members of the public</td>
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<td>1.5</td>
<td>Minutes and Action Points of Last Meeting – held on 6th January 2015 (All)</td>
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<td>• Action Points</td>
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<td>1.6</td>
<td>Matters Arising</td>
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<td>1.7</td>
<td>Patient Story (Lorna Quigley)</td>
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<tr>
<td>GB 14-15/0062</td>
<td>2</td>
<td></td>
<td>ITEMS FOR APPROVAL</td>
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<td>2.2</td>
<td>CHC Joint Committee TORs (Iain Stewart)</td>
</tr>
<tr>
<td>GB 14-15/0063</td>
<td>3</td>
<td></td>
<td>ITEMS FOR DISCUSSION</td>
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<td>3.1</td>
<td>2015/16 Planning Update (Andrew Cooper)</td>
</tr>
<tr>
<td>GB 14-15/0064</td>
<td>4</td>
<td></td>
<td>ITEMS FOR INFORMATION</td>
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<td>4.1</td>
<td>Quality Performance and Finance- QPF (Lorna Quigley/Mark Bakewell)</td>
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<td>4.2</td>
<td>Direct Commissioning Report (Iain Stewart)</td>
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<td>4.3</td>
<td>PLCP (Sue Wells)</td>
</tr>
</tbody>
</table>
## ITEMS FOR NOTING

### 5.1 Subgroups (Ratified Minutes):
- Ratified Audit minutes of: 18.09.2014
- Ratified QPF minutes Dec 2014

## RISK REGISTER

Current Risk Register

## ANY OTHER BUSINESS

**7.1**

## DATE AND TIME OF NEXT MEETING

Tuesday 3rd March 2015
2pm – 4pm
Nightingale Room OMH

Please forward any apologies to Allison.hayes@nhs.net

****Papers require by Friday 20th February 2015****

### Wirral Clinical Commissioning Group – Future Meetings 2015

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>3rd March</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
</tr>
<tr>
<td>Tuesday</td>
<td>7th April</td>
<td>2pm – 5pm</td>
<td>Nightingale Room</td>
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</tbody>
</table>
WIRRAL CLINICAL COMMISSIONING GROUP  
GOVERNING BODY BOARD MEETING  
Minutes of Meeting – Public Session  
Tuesday 6th January 2015  
2pm  
Nightingale Room, Old Market House

Present:

John Wicks (JW)            Interim Chief Officer  
Dr P Naylor (PN)           Acting Chair WCCG  
Mark Bakewell (MB)         Chief Finance Officer  
Lorna Quigley (LQ)         Director of Quality and Patient Safety  
Dr H McKay (HM)            GP Executive  
Dr M Green (MG)            GP Executive  
Dr J Oates (JO)            GP Executive  
Paul Edwards (PE)          Director of Corporate Affairs  
Dr S Wells (SWe)           GP Executive  
Graham Hodkinson (GH)      Director of DASS  
Simon Wager (SW)           Lay member (Patient champion)  
James Kay (JK)             Lay Member (Audit & Governance)  
Fiona Jonhstone (SW)       Director of Public Health  
Iain Stewart (IS)          Head of Direct Commissioning  
Dr A Ali (AA)              GP Executive  
Christine Campbell (CC)    Head of Partnerships  
Andrew Smethurst (AS)      Secondary Care Doctor  

In Attendance:

Allison Hayes (AJH)        Board Support/Corporate Officer

Ref No. | Preliminary Business  
---|---  
GB14-15/0055  

1.1 Apologies for absence

Apologies were received from: Dr D Jones and Andrew Cooper. Karen Prior from Healthwatch also gave her apologies.

1.2 Chairs Announcements

Chair welcomed all members to the meeting. 3 members of the public attended the meeting. Chair briefed members around the current pressure on A&E departments both locally and nationally and informed members that the CCG was using a variety communications to ensure patients used the most appropriate services.

Chair introduced John Wicks, Interim Chief Officer to members.

1.3 Declarations of Interest

All GP members declared an interest in the item regarding Co Commissioning (item 2.2). Chair advised that as there is no decision making process is involved he will remain as Chair for the meeting.
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
</tr>
</thead>
</table>
| 1.4     | Comments/questions from members of the public  
There were no comments from members of the public. |
| 1.5     | Minutes from previous meeting held on 2\textsuperscript{nd} December 2014.  
The minutes of the previous meeting held on 2\textsuperscript{nd} December 2014 were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified. There were no matters arising. |
| 1.6     | Action Points – please refer to separate Action Sheet.  
Matters Arising  
There were no matters arising. |
| 1.7     | Patient Story  
LQ gave an overview of the patient story which looked at surviving sepsis.  
Members discussed the contents of the video and the processes and procedures in relation to dealing with Sepsis.  
Further discussions took place regarding community based services and how these service models work.  
The Governing Body noted the patient story. |
| 2.0     | Items for approval  
CQC Summary Reports  
LQ provided the Governing Body with details of a CQC Inspection report conducted at Wirral Community Trust and Wirral University Teaching Hospital (WUTH).  
The core services that where inspected in September 2014 within the Community Trust included:  
- Community health services for children, young people and families  
- Community health services for adults  
- End of life care  
- Urgent Care  
The report concluded that the Community Trust was judged to be compliant against all of the standards.  
The five standards that where inspected against at WUTH included:  
- Respecting and involving people who use services  
- Records  
- Care and welfare of people who use services  
- Staffing  
- Assessing and monitoring the quality of service provision  
Due to the concerns identified through the CQC inspection for WUTH process regarding the quality and safety of the service provided it is recommended that a single item quality summit is called to provide assurance to the CCG regarding the issues identified and support the mitigation
Members were asked to:
- Agree to the recommendation to implement a quality summit in conjunction with WUTH due to the concerns identified through the CQC inspection process regarding the quality and safety of the service provided at WUTH.

Members sought clarity around the Trust’s performance, clinical governances and assurance processes and it was agreed that this would be discussed at the quality and safety summit.

Members of the Governing Body noted the CQC inspection reports and supported the recommendation to implement a quality summit. The details of the summit are to be reported back to the Governing Body in February/March.

### 2.2 Constitution amendment re Continuing Health Care and Primary Care Co-commissioning

IS introduced a paper to members regarding CCG constitution amendments in relation to Continuing Health Care and Primary Care Co-commissioning.

PE outlined that the CCG has an opportunity to amend its constitution in January in line with the guidance entitled ‘Procedures for Clinical Commissioning Group Constitution Change, Merger or Dissolution’ (May 2013). These amendments will specifically allow the CCG to create the governance framework to manage the new Continuing Health Care arrangements presented at November Governing Body and to enable the CCG to undertake Primary Care Co-commissioning (Level 2) with NHS England. PE explained that the these amendments allowed the flexibility and ability to create joint committees with other CCGs and NHS England, but does not commit it to actually applying for Co-commissioning at this stage.

The Governing Body was asked to approve the contents of the proposed changes to the Constitution which are in line with ‘Model wording for amendments to CCG’s constitutions’ (NHSE, November 2014). Voting members supported these amendments, with the exception of one member (AA) who did not agree to the amendment to enable primary care co-commissioning.

Members went on to debate whether the CCG should submit an application to NHS England to undertake Primary Care Co-commissioning for the January submission date. IS informed members of a survey which was conducted with practices to establish if they supported progressing to Level 2 Co-commissioning and if this was the case, whether this was done in January or later in the year. The results showed that 80% of respondents supported progressing to Level 2, with a 50/50 split as to whether to apply in January or later in the year.

Further discussions took place in relation to the governance arrangements around co-commissioning, and IS stated that these arrangements would be developed and agreed with NHS England. JK expressed concerns that the governance arrangements were not sufficiently robust at this stage. Some members also stated that the CCG, given the recent Capability and Governance review and the need for a new Governing Body composition, was not yet ready to undertake new functions. PN asked voting members whether they supported submitting an application in January for level 2 co-commissioning. 5 members were in favour, 6 members against and 1 abstained. The Governing Body therefore decided to continue to work with practices, develop its structures, clarify governance arrangements and aim to submit its application later in the year.

**ACTION:** PE to submit constitutional changes to NHS England
3.1 Overview of the 5 Year Forward Look

In Andrew Copper’s absence, John Wicks presented a paper regarding the ‘5 Year Forward View’ and thanked AC for his work.

The ‘Five Year Forward View’, published by NHS England in October 2014, sets out a vision for improvement in the NHS over the next 5 years.

The paper acknowledges the significant achievements that the NHS has already made including its ranking as one of the highest performing health systems in the world, a decrease in waiting times, an increase in cancer survival, a reduction in early deaths from heart disease and so forth.

The Five Year Forward View’ document sets out a vision for the forthcoming 5 years to enable the NHS to continue to be a world-class health system that is able to meet the increasing health demands of the population whilst living within the constraints of an increasingly challenging financial climate. The paper identifies a number of models of care delivery that will need to be considered in the context of the specific challenges that the Wirral health and social care economy faces. In addition, the associated planning guidance for 2015/16 will also need to be implemented locally in line with the challenging timescales identified.

FJ highlighted the work being carried out in relation to inequalities and prevention and how work within the local communities can influence this.

JK highlighted the need to spend time reviewing the challenges and implications for Wirral.

The Governing Body noted the overview of the ‘Five Year Forward View’ document and noted the implications for Wirral including the summary of the 2015/16 planning guidance.

3.2 5 Year Forward Look GP Communications

IS stated that he would be working with existing consortia groups to discuss the 5 Year Forward Look.

3.3 ADASS AQuA quarterly performance report and benchmarking data

GH provided a report regarding the ADASS AQuA quarterly performance. The report provided data that it available quarterly across the North West. This enables the Board to compare Wirral’s performance in key areas of system performance against other areas.

The data is provided through AQuA. Comparing Wirral’s performance over time in relation to both high performing and low performing areas may help to inform future commissioning decisions.

Wirral performs relatively well in a number of areas. Delayed Transfers of Care remain as one of the best in Region with a relatively low number of delays. People who are subject to none elective admissions are discharged relatively quickly. The picture is mixed, however as Wirral remains an outlier in relation to 4 hour delays, none elective admissions remain relatively high rising through the final quarter, and the proportion of the Local Authority spend on residential/nursing care is very high. Set together these indicators reflect a system that is not effectively supporting people in their own homes when problems occur.

HM highlighted the need to review a patients length of stay within a hospital setting and if pre discharge is adequate.

The Governing Body noted the strong performing areas, areas where performance requires further improvement and gave consideration regarding strategic implications as appropriate.
4.0 Items for Information

4.1 Quality Performance and Finance Report

Quality Performance

LQ gave a presentation on the activity performance for month 7 (October) and highlighted the positive areas and the improvements in the challenges that were originally presented.

Areas included:

- Inpatient and A&E (minor components) Family and friends tests and response scores
- Maternity Friends and Family tests
- NWAS turnaround
- Delivering the same sex accommodation
- Diagnostic tests
- MRSA & Cdifficile
- Referral to treatment – NHS Constitution 4 hour target
- Health Care Associated Infection
- National Accident and Emergency targets

LQ went on to report the current A&E performance figures at WUTH and is to forward the details to members.

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

Finance Report

MB provided information of the Financial performance against budgeted allocation for 2014/15 as at month 8 (November).

- 1% Surplus - £4.68m
- 2.5% Headroom (non-recurrent resources) - £11.4m
- Minimum 0.5% Contingency
- CCG hold £3m vs £2.2m (0.5%) Better Payment Practice Code & Cash Management

Year to Date (Month 8) Financial Performance

Planned Year to Date Surplus - (£3.12m)
Current Year to Date Surplus - (£2.106m)

Key Issues

WUTH Contract Position – (£3.1m) under @ M7 vs ([£2.8m] @ M6 (£2.4m) @ M5]

- Other NHS Providers – Notably Royal Liverpool and Broadgreen (£0.65m) over and STHK (£0.25m over (51% over plan as at M* estimates))
- Commissioned Out of Hospital - £0.96m (CHC / Package costs)
- Prescribing £0.11m over performance (in month improvement £0.09m)
- QIPP Gap 8/12 - £4.2m

Forecast Outturn 2014/15

Forecast Assumptions
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Minute</th>
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|         | • Revised Forecast Surplus (M8 - £2.5m(0.53% of plan) – remains as per M7 revision  
  • YTD position reflect challenges of forecast delivery (slight deterioration in month but in line with forecast assumptions)  
  • Assumptions remain consistent with plan around main expenditure areas:  
   o WUTH  
   o Other Mersey Contracts (RLB, STHK, Aintree)  
   o Prescribing  
   o Commissioned Out of Hospital Care  
   o QIPP Gap |
|         | **Other Performance Indicators Cash Management**  
  – Balance as at the end of the November £292k |
|         | **Other Finance Updates**  
  • Uncertainty regarding CHC Restitution risk share arrangements  
  • Isle of Man Hosting arrangement  
  • Full month 9 accounts exercise |
|         | AS sought clarity regarding the parameters in relation to the QIPP plan and MB provided details around the current indicators. |
|         | The Governing Body noted the financial report as at month 8 (November). |
| GB14-15/0059 | **5.0 Items for Noting** |
|         | **5.1 Subgroups (ratified minutes for noting)**  
|         | HM sought clarity around the never events recorded in Jan and April and the concerns relating to as to when these events were reported. |
|         | The Governing Body noted the reports of the above subgroup. |
| GB14-15/0060 | **6.0 Risk Register** |
|         | PE gave an overview of the current risk register and all items were reviewed and noted today. Key areas of focus included:  
  • CHC transition  
  • CDif target  
  • Constitution amendments  
  • Financial Plan  
  • A&E 4 hour target |
|         | PE is to review all current risks recorded. |
|         | **7.0 Any other Business** |
|         | The Board meeting ended at 16:10pm. |
|         | **8.0 Date and Time of Next Meeting** |
|         | The date and time of the next meeting is **Tuesday 10th February 2015 in the Nightingale Room, OMH**  
  please contact Allison.hayes@nhs.net with any apologies or agenda items. |
Board meeting ended at: 16:10pm
Wirral Clinical Commissioning Group

Draft Action Points re Meeting of 6th January 2015 (Public Session)
Duncan Room, OMH
2pm

Outstanding Actions from: 2nd December 2014

<table>
<thead>
<tr>
<th>Topics Discussed</th>
<th>Minute</th>
<th>Action Points</th>
<th>Responsibility</th>
<th>Action Target date</th>
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New Actions from: 6th January 2015

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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>
<td>1.5</td>
<td>AJH/PE to rectify grammatical errors</td>
<td>AJH</td>
<td>10.02.2015</td>
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<tr>
<td>Constitution amendment re CHC &amp; Primary Care Co commissioning</td>
<td>2.2</td>
<td>PE to submit constitutional changes to NHS England</td>
<td>PE</td>
<td>ASAP</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 10th February 2015 at OMH, Nightingale Room. Agenda items and apologies are to be sent to: Allison.hayes@nhs.net
## Continuing Healthcare and Complex Care Services – Wirral, West Cheshire, South Cheshire, Vale Royal and Eastern Cheshire Clinical Commissioning Groups

<table>
<thead>
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<th>Agenda Item:</th>
<th>2.2</th>
<th>Reference</th>
<th>GB14-15/0062</th>
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<tbody>
<tr>
<td>Public / Private</td>
<td>Public</td>
<td>Meeting Date</td>
<td>10th February 2015</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Lorna Quigley, Director of Quality &amp; Patient Safety</td>
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<tr>
<td>Contributors</td>
<td>Fiona Field, Director of Partnerships South Cheshire CCG Iain Stewart, Head of Direct Commissioning, Wirral CCG</td>
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### Link to CCG Strategic System Plan
**Edit as applicable:**
1. Patient and primary care centric and based on high quality primary care, secondary and community services
2. Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes
3. Commissioned services which have a sound evidence base
4. Provides greater equality of access to all

### Link to current strategic objectives
**Edit as applicable:**
1. Prevent people from dying prematurely
2. Enhance the quality of life for people with long term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring people have a positive experience of care
5. Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm

### To approve
Yes

### To note

### Summary
1. That the formal transfer of CHC and Complex Care Services from NWCSU to SCCCG, VRCCG, Wirral CCG, West Cheshire CCG and Eastern Cheshire CCG is completed on 1st February 2015.
2. That the Joint Committee Terms of Reference are accepted by each CCG Governing Body.
3. That the Target Operating Model is accepted by each CCG Governing Body.
4. That South Cheshire CCG is the host organisation for all CHC and Complex Care Staff under TUPE agreements.
5. That on-going development of the services continues led by CCG’s and a further report on new service model is shared with 5 CCG’s through the Joint Committee in Spring 2015.

### Comments
This paper concludes the CCG involvement in Stage 2 of the transition project which transfers the service from North West Commissioning Support Unit to the 5 CCGs with effect from 1st February 2015.

### Next Steps
Proposals for service redesign to develop a best practice, consistent service across Cheshire and Wirral area footprint.
### What are the implications for the following (if not applicable please state why):

<table>
<thead>
<tr>
<th>Category</th>
<th>Question</th>
<th>Response</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
<td>Does the report consider the financial impact?</td>
<td><strong>NO</strong></td>
<td>The report details the work undertaken to-date to ensure the safe and stable transfer of the CHC &amp; Complex Care service from NWCSU to the Cheshire &amp; Wirral CCGs.</td>
</tr>
<tr>
<td><strong>Value For Money</strong></td>
<td>Does the report consider value for money?</td>
<td><strong>NO</strong></td>
<td>The report details the work undertaken to-date to ensure the safe and stable transfer of the CHC &amp; Complex Care service from NWCSU to the Cheshire &amp; Wirral CCGs.</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Is there a documented risk assessment?</td>
<td><strong>NO</strong></td>
<td>The report references a Due Diligence Review undertaken at the commencement of the transition project which has informed the progress of the service target operating model.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>Are there any legal implications and has legal advice been obtained?</td>
<td><strong>NO</strong></td>
<td>The agreed due process for transferring the service from NWCSU back to the 5 CCGs was adhered to (e.g. TUPE requirements; service notices; staff consultation).</td>
</tr>
<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</td>
<td><strong>NO</strong></td>
<td>The transfer at this stage is regarded as a “lift &amp; shift” of the current service with no changes to the patients’ service provision. Existing CCG Patient Councils were informed between October and December 2014.</td>
</tr>
<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
<td>Does the report provide evidence of whether there could be a positive or negative impact on protected groups (statutory duty for new / changes to services)</td>
<td><strong>NO</strong></td>
<td>The transfer at this stage is regarded as a “lift &amp; shift” of the current service with no changes to the patients’ service provision. Existing CCG Patient Councils were informed between October and December 2014.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff?</td>
<td><strong>NO</strong></td>
<td>The transfer at this stage is regarded as a “lift &amp; shift” of the current service with no changes to the patients’ service provision and no change to working approaches by staff. The agreed Target Operating Model defines the service to be delivered with effect from 1st February 2015 until a future time when full service redesign has been completed which will include full staff, patient and stakeholder consultation.</td>
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Partnership Working

Does the report evidence a partnership working in its development? **YES**

The paper describes a pan-Cheshire/Wirral project to enable the transition of the service with robust partnership working at senior level between the 5 CCGs.

Performance Indicators

Does the report indicate any relevant performance indicators for this item? **NO**

The transfer at this stage is regarded as a “lift & shift” of the current service with no changes to the service provision and performance indicators. The agreed Target Operating Model defines the service and continuing performance indicators to be delivered with effect from 1st February 2015 until a future time when full service redesign has been completed which will include an assessment of relevant key performance indicators.

Sustainability

Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)? **NO**

The transfer at this stage is regarded as a “lift & shift” of the current service with no changes to the service provision and therefore existing economic, social and environmental sustainability requirements should be maintained. The agreed Target Operating Model defines the service to be delivered with effect from 1st February 2015 until a future time when full service redesign has been completed which will include an impact assessment for economic, social and environmental sustainability.

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

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

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

<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>Verbal update</td>
<td>Minutes</td>
<td>Quality Performance &amp; Finance Committee</td>
<td>26th August 2014</td>
<td>Risk identified on financial spend and service performance matters</td>
</tr>
<tr>
<td>Paper</td>
<td>Minutes</td>
<td>Governing Body</td>
<td>7th October 2014</td>
<td>Update on current service issues; due diligence review and service transition proposal</td>
</tr>
<tr>
<td>Paper</td>
<td>Minutes</td>
<td>Governing Body</td>
<td>2nd December 2014</td>
<td>Update on transition project progress and agreed approach by the 5 CCGs</td>
</tr>
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</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). The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

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

1.1 Comprehensive work has taken place across 5 CCG’s to ensure a safe transfer of the current services from CSU management to the shared management arrangements as outlined in the Target Operating Model (TOM). All CCG’s have participated in the development of all the shared arrangements and the nominated leads (managerial and clinical) have actively taken on roles to ensure all elements of the transfer have been considered.

| Lead Officer | Fiona Field – South Cheshire and Vale Royal CCG |
| Clinical Lead | Judith Thorley – South Cheshire and Vale Royal CCG |
| Finance Lead | Andrew Whittingham – South Cheshire and Vale Royal CCG |

Lead Officer : Sarah Clein – West Cheshire CCG
Clinical Lead : Sheila Dilkes – West Cheshire CCG
Finance Lead : Gareth James - West Cheshire CCG

Lead Officer : Neil Evans – Eastern Cheshire CCG
Clinical Lead : Sally Rogers - Eastern Cheshire CCG
Finance Lead : Naill O’Gara – Eastern Cheshire CCG

Lead Officer : Iain Stewart & Christine Campbell – Wirral CCG
Clinical Lead : Lorna Quigley – Wirral CCG
Finance Lead : David Miles - Wirral CCG
All 5 CCG’s have also financially contributed to the additional resource of Integral Health Solutions (IHS) to programme manage the process, provide additional resource to driving forward the change management and assist focusing of workforce development and potential new models of service to increase efficiency and effectiveness.

IHS (Integral Health Solutions):
Hilary Heywood – Managing Director
Mick Dolan – Associate
Denise Edwards – Programme Support Manager

Additionally, we have sourced an “expert” in design of CHC from another area (Ros Howard) who is assisting our Clinical Leaders to base our new service model on best practice and clinical efficiency and good practice.

CSU staff have also supported CCGs in the work to ensure a safe “exit” from CSU and a safe “entry” into CCGs (the entry and exit shared plan) highlighting all actions needed by both parties, risks and mitigating actions.

Phil Meakin - HCO NWCSU
Lisa Kelly - HR Lead NWCSU
Yvonne Lochhead - Head of CHC & Complex Care NWCSU
(seconded by SC & VR since 18/12/14)

All CHC and Complex Care teams across the 5 CCGs have been closely involved and participating in engagement/development workshops and working groups with CCG Leads from November 2014 to present day.

2. KEY ISSUES / MESSAGES

2.1 Each CCG received a Due Diligence report on the CHC and Complex Care Services in Summer 2014. All CCGs had already made decisions that the services were not delivering to the required standards and that a different approach was needed to the one offered by the then Cheshire and Merseyside CSU. Despite efforts by all CCGs to invest in additional resources (staff members), the services continued to underperform and the situation was deteriorating.

2.2 Collectively, 4 Cheshire CCG’s agreed to jointly manage the services with staff hosted by South Cheshire CCG. Wirral CCG joined this project in September 2014.

2.3 NHS England were duly informed of this intention by the 5 CCGs based on the Due Diligence reports. NWCSU were formally notified of this intention based on service failure and lack of clinical leadership, by the respective CCGs between September and October 2014.
2.4 Since October 2014, the comprehensive task of transferring these services has been underway across Cheshire and Wirral utilising clinical leadership in CCGs, expertise of Lead Officers, IHS as programme managers and Lead Nurses from the services involved.

2.5 A joint Steering Group was established in October 2014 (all CCGs). This is to iterate into the formal Joint Committee from 1st February 2015. Terms of Reference are attached (Appendix 1); the Steering Group is currently chaired by East Cheshire CCG but a new Chair will be nominated at inaugural meeting on 11th February 2015.

2.6 A joint Operational (and Transitional) Group was established in December 2014. This will iterate into an Operational Group from 1st February 2015. All CCGs and NWCSU attend, (chaired by SC CCG).

2.7 A TUPE sub-group was established to ensure all HR and legal requirements for transfer of staff were completed. This included all staff engagement processes. NWCSU and host CCG at all events and meetings (chaired by SC CCG) - should cease after 1/2/15.

2.8 A clinical workforce redesign sub-group was established, CCG-led by all clinical leads, (chaired by EC CCG), Head of Service Locality Leads plus IHS to identify current service deficiencies and devise potential short term solutions - should cease during February 2015. Policies and procedures have been a priority in January 2015.

2.9 Financial sub-group established, (chaired by SC CCG) to consider current costs of running the service in NWCSU and the likely reduced costs of taking the services “in-house” and potential costs of the transfer including stranded costs. This will continue for a short time post transfer but should become subsumed into on-going Joint Committee and Operational Group.

2.10 Service redesign group established – to develop the new model of CHC and Complex Care for all CCGs, will continue post transfer into implementation of new ways of working. Clinically led by all CCGs, (chaired by EC CCG) Head of Service and Locality Leads.

2.11 TOM sub-group – (Target Operational Model) – led and (chaired by host CCG) and IHS, plus all CCG’s participating, NWCSU, and Head of Service to develop operating model for 1st February 2015 – ensures safe operating model and new governance arrangements for transferred services for all CCG’s. (Appendix 2).

- Weekly teleconferences through October and November (changed to working groups in November and December) hugely assisted the required joint working across all 5 CCG’s.

2.12 The purpose of the TOM is to describe the way in which the service will function from the 1st February and to create an interim Target Operating Model which will

- Galvanise the ‘Transition’ of Services from NWCSU to CCGs before the 31st January 2015
- Inform the development of ‘Efficiency Opportunities’ and initial ‘Workforce Re-Design’
- Ensure ‘Service Stabilisation’ prior to full scale service re-design in stage 3 of this transformation process
• Act as a focus for full scale ‘Service Improvement and the re-design of CHC & Complex Care Services’ once the services have transferred

• Enable CCGs to measure the success of the services that they have transferred and the CHC & Complex Care service as a whole.

2.13 Service Model Standards

• All CHC National Framework requirements will be met (and exceeded)

• Each patient in receipt of a CHC package of care, can be assured there is robust quality & safeguarding in place such that they are protected and provided with the optimum level of care possible.

• All providers should have a robust commercial contract underpinning the services commissioned for individual patients.

• All staff will receive and undertake all statutory and mandatory training deemed necessary and ensure effective CPD is regularly assessed.

• The costs of providing the CHC service across the footprint will be less than or equal to the existing cost of the NWCSU service provided.

• Clinical governance will be effectively deployed across the localities and robustly managed.

• To realise efficiencies and synergies through the locality-based model in the way we deliver CHC services. Savings made should be reinvested in the frontline services if at all possible.

The basic service components of a CHC and Complex Care Service (children's, mental health, learning disability and physical disability) consists of the 3 key service areas highlighted, underpinned by the 4 governance and control areas
The 4 additional service components that need to be factored into the operating model as key service components are listed at the top of the diagram.

3 IMPLICATIONS

3.1 Provision of CHC/Complex Care Services post February 2015

Cheshire and Wirral CCGs will collectively share the responsibility for CHC & Complex Care Services from 1st February 2015 via a Joint Committee of the CCGs. The Joint Committee will be accountable to individual CCGS for the performance and delivery of the service through the CHC management team transferred to CCGs as part of the new arrangements. It is expected that the accountability by the Joint Committee will support the stated ambition to manage the service as a collective with consistent policies, standards and protocols.

Different component parts of the end to end CHC & Complex Care commissioning support service will be provided:

- By a CHC & Complex Care Senior Management Team, including the transferring Head of Service, who will be directly accountable to the proposed CCG Joint Committee
- By the Host CCG (South Cheshire)
- At an Individual CCG locality level (East Cheshire, South Cheshire/ Vale Royal combined, West Cheshire and Wirral)
South Cheshire CCG, as the host of the service, will

- Employ all of the staff transferred to CCGs as part of the new service – including all of the statutory responsibilities expected as an employer e.g. contract management and payment of salaries, sickness absence, training and personal development, line management and supervision, health and safety. NB Currently SCCCG obtains HR support through NW CSU.

- Manage the transferring Head of CHC/ Complex Services who in turn will be responsible for the management of the Cheshire & Wirral, CHC and Complex Care Commissioning Support Service.

- Co-ordinating the co-production of performance/ management reports, new policies, internal/ external communication, etc., by the CCGs and NW CSU.

- Management of all assets - with explicit agreement of budget contributions from CCGs and risk share included in TOR for Joint Committee – as will be the case for all aspects of the hosting arrangements.

- The management of any (CCG) pooled budgets that will be required to operate the service model – the absolute minimum requirement will be for a pooled budget to cover staff costs and their HR management. Other pooled elements would depend on the final operating model and SCCCG’s finally defined role. The CHC Finance Leads Group will be responsible for determining the financial adjustments and pooled budget arrangements that will be required to support this decision.

- The Core Training & CPD for all transferred staff

- The management of a single SLA with NW CSU. – rather than x4 separate SLAs held by the individual CCGs

The local, CCG based CHC team will be managed by the management team which reports to the Joint Committee. The team will work to consistent policies, standards and protocols to provide the following component parts of the service,

- Administration of referrals
- CHC/ Led Case Management & MDT
- Co-ordination of CHC/ FNC Panel & Decision on Eligibility
- Commissioning of Care for Individual Patients
- PHB: Devise Care Plan & Budget
- PHB: Brokerage of Care Via CCIL SLA
- Clinical Review of Continued Eligibility for Care
- Accounting & Financial Control
GOVERNING BODY BOARD REPORT

- Management of key stakeholders in order to establish common ways of working with respective colleagues in a separate locality who may have the same or similar interfaces – in order to achieve consistency in approach.

It is that NWCSU will be commissioned to provide

- Commercial Contract Management
- Data Systems - Broadcare
- Pre 1/4/2013 PUPoC Case Management
- For West CCG only until service is transferred out, Complaints and Dispute resolution

It has been agreed that the additional services in the TUPE transfer arrangements that support CHC and Complex Care as:

- Quality and safeguarding – to be ‘divided’ to reflect CCG boundaries and Local Authority area. Wirral will take 0.25 of a whole-time vacancy. West Cheshire and Vale Royal CCGs will share one whole-time individual, Eastern Cheshire and South Cheshire CCGs will share part of the other whole-time post. The remainder of the post will also support West Cheshire CCG.
  This is a temporary arrangement until service redesign is completed. The redesign will link into current CCG quality teams and arrangements with local authorities for safeguarding and will be based on “fair shares”.

- Complaints and Disputes Resolution – ECCCG, SCCCG, VRCCG already provide their own in-house complaints services. WCCCG and WCCG are in the process of moving these services in-house. The two complaints and resolution posts are to TUPE will continue to directly support the CHC and Complex Care teams - the processes are challenging and require focused, clinical expertise.

- 1 post for SCCCG, VRCCG and ECCCG and 1 post for WCCCG and WCCG

Complex Care Teams will be provided across the footprint (pan-Cheshire and Wirral) and the siting of the various disciplines (Mental Health, L&D, PD, Children’s) will be based in different sites depending on the highest volume/demanding locality area for each area of specialism. Numbers and contact points will be communicated across the footprint for any referrals (both in and out of area) for a specific area of complex specialism.

4 CONCLUSION

- The transfer of both CHC and Complex Care Services will happen on 1st February 2015. The new shared management arrangements are in place from this date to take forward the services “in-house”. This will be done on a pan-Cheshire and Wirral footprint to ensure consistency, high clinical standards and application of national protocols and practices.

- The hosting CCG will not manage service development but will provide the hosting for employment for the staff providing the service.
• All 5 CCGs will need to develop their skills in co-managing a joint service through the new governance arrangements in place.

• NWCSU will continue to provide the management of the supporting information system (Broadcare) and produce performance data so all CCGs can monitor progress in performance.

• KPIs have already been agreed in the TOM.

• Integrated financial data will become part of the management of the service rather than a separate reporting system. This should improve assurance to all CCGs as the service becomes more closely managed and developed during 2015.

• A formal SLA with NWCSU is being negotiated for 2015/16 for Broadcare and performance data, contract management, case management of PUPOCs (pre 2013 legacy cases of CHC restitution) for 1st April 2015

5 APPENDICES (Must be copied below or available on request – do not embed)

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Cheshire & Wirral CCGs

Joint Committee for Continuing Health Care, Funded Nursing Care & Complex Care

Final Terms of Reference

Agreed by Cheshire & Wirral CCGs CHC, FNC & Complex Care Steering Group on 23 January 2015

Version 1.3
Introduction

1. Due to the passing of a Legislative Reform Order (2014/2436) (“LRO”), by parliament (1/10/14), CCGs can now form a Joint Committee with one or more CCGs - see (www.england.nhs.uk/wp-content/uploads/2014/09/lett-on-lro.pdf).

2. The National Health Service Act 2006 (as amended) (“NHS Act”) provides, at section 14Z9, that a CCG’s functions may be exercised jointly with other CCGs, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of the CCGs concerned. Section 14Z9 of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between the CCGs involved in the Joint Committee.

3. The following CCG Governing Bodies have amended their Constitutions to allow the formation of a Joint Committee to cover their commissioning arrangements for Continuing Health Care (CHC), Funded Nursing Care (FNC) & Complex Health.
   - Eastern Cheshire CCG
   - South Cheshire CCG
   - Vale Royal CCG
   - West Cheshire CCG
   - Wirral CCG.

4. The liability of each CCG to carry out its functions will not be affected where they enter the joint commissioning arrangements described above. The Joint Committee will be responsible for overseeing the management of the Cheshire & Wirral CHC, FNC & Complex Care Commissioning Service Function. It will not be responsible for setting or managing individual CCG allocations/ budgets for these service areas.

5. The Terms of Reference and scheme of delegation described in this document are based on NHS England guidance (November 2014) to CCGs on the establishment of primary care co-commissioning arrangements (www.england.nhs.uk/commissioning/pc-co-comms/), which included standard template documents for the implementation of Joint Committees, developed in conjunction with NHS England Lawyers - Capsticks Solicitors.

Role & Function of the Cheshire & Wirral CCGs Joint Committee for CHC, FNC & Complex Care

6. The role of the CCG Joint Committee shall be to carry out the functions relating to the commissioning of Continuing Health Care, Funded Nursing Care and Complex Health Care identified in the National Health Service Act 2006 (as amended) under the Legislative Reform Order (2014/2436) passed by parliament and in line with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2012)\(^1\).

7. This includes the following activities for CHC, FNC and Complex Care (Children’s, Mental Health, Learning Disability and Physical Disability):
   - Referral Management, Clinical Assessment, Eligibility for Care and Case Management including review of packages of care previously commissioned by the service
   - Individual Patient Commissioning including Personal Health Budgets (PHBs)
   - Provider Contract Management.

---

\(^1\) Delayed discharges directions added 1/11/2013 and Equality Analysis document added 12/4/13
8. Four governance and control functions support the full service:

- Clinical Governance including Quality Assurance, Safeguarding and Provider Monitoring
- Data Assurance and Data System Management
- Performance Management, Professional Development and Reporting
- Accounting and financial control.

9. In addition, three discrete activities – ‘Disputes on Eligibility Decisions’, ‘Previously Unassessed Period of Care’ (PUPoC - post 1/4/13) and ‘Complaints’ have been factored into the Target Operating Model that details the key components of this service.

10. In performing its role the CCG Joint Committee will exercise its management of all the service components identified in paragraphs 13, 14 and 15 in accordance with the Target Operating Model, which will sit alongside these terms of reference. The functions of the Joint Committee will therefore include the following elements:

- Agreeing the planning assumptions that will be used to underpin the management of the service including quality, financial, workforce, training, supervision, scope of activity and operating model considerations
- Agreeing and reviewing operating policies and procedures
- Reviewing and updating how the parties will work together in the operating model to carry out the commissioning of these services including:
  - The duties and responsibilities of the parties
  - How risk (clinical, financial, reputational) will be managed and apportioned between the parties
  - Financial arrangements, including, payments towards the pooled fund\(^2\) that will be used to support this service and management of that fund
  - Contributions from the CCG parties, including details around assets, employees and equipment to be used under the joint working arrangements
- Carrying out needs assessments relating to the commissioning of CHC, FNC and Complex Care Services for the geographical area in question
- Undertaking service reviews and re-design as appropriate
- Co-ordinating a common approach to the commissioning of CHC, FNC and Complex Care across the geographical area in question as appropriate
- Managing the CCG Pooled Budget for this service
- Determining the Future Model for the Commissioning of CHC, FNC and Complex Care services in Cheshire & Wirral, for implementation in the summer of 2015. Agreeing Future Model plans and overseeing their implementation.
- Making decisions to satisfy any legal requirements associated with the commissioning of CHC, FNC and Complex Care Services and ensuring that Cheshire & Wirral CCGs are meeting the statutory requirements of the National framework for NHS Continuing Healthcare and NHS Funded Nursing Care (2012)\(^3\).

\(^2\) The CCGs are establishing a pooled fund made up of contributions from the participating CCGs. This pooled fund will be used to make payments towards expenditure incurred in the administration and management of this service.

Geographical Coverage

11. The Joint Committee will comprise the following CCGs:

- Eastern Cheshire CCG
- South Cheshire CCG
- Vale Royal CCG
- West Cheshire CCG
- Wirral CCG.

12. In effect it will jointly undertake NHS CCG functions for the commissioning of Continuing Health Care, Funded Nursing Care and Complex Care services across Cheshire & Wirral.

Membership

13. The voting members of the Joint Committee shall comprise two Governing Body representatives from each of the participating CCGs. For the avoidance of doubt the Joint Committee shall consist of voting representatives as follows:

- X2 Representatives (with at least one clinician) from Eastern Cheshire CCG Governing Body
- X2 Representatives (with at least one clinician) from South Cheshire CCG Governing Body;
- X2 Representatives (with at least one clinician) from Vale Royal CCG Governing Body
- X2 Representatives (with at least one clinician) from West Cheshire CCG Governing Body
- X2 Representatives (with at least one clinician) from Wirral CCG Governing Body.

14. The membership as set out above will meet the requirements of each member CCG’s constitution.

15. Any other individual may depute for any Joint Committee Member provided that the relevant CCG has sent a completed authorisation form to the Chair of the Committee in respect of such individual’s attendance to arrive no later than the day before the relevant meeting. Any individual so authorised must be a member of the CCGs Governing Body.

16. The Chair of the Joint Committee shall be a member of one of the Joint committee of CCGs. This role will be rotated annually between CCGs to reflect the collaborative approach of the CCGs on the Joint Committee. The Joint Committee will select a Chair and Vice-Chair at the first formal meeting of the Joint Committee scheduled to take place on 11 February 2015. Due to their responsibilities as ‘Host CCG’ (see Target Operating Model), the Chair of the Joint Committee will not be a member of South Cheshire CCG.

17. Membership of the Joint Committee will combine both Voting and Non-Voting members. Non-Voting members of the Joint Committee represent other functions/parties/organisations or stakeholders who are involved in the CHC, FNC & Complex Care service and will provide support and advice to the Voting members on any proposals. Initially the Joint Committee shall also consist of Non-Voting representatives as follows:

- Head of the Cheshire & Wirral CHC, FNC & Complex Care Service
- Two Locality Manager Wirral CHC, FNC & Complex Care Service
- A representative from the Cheshire, FNC & Wirral CHC & Complex Care Finance Leads Group.

18. A standing (Non-Voting) single invitation per organisation will be available to the three Local Authorities providing Social Services in the Cheshire & Wirral area – with invitations to be facilitated by the geographically relevant CCG organisation.

19. A standing (Non-Voting) single invitation will also be available for each of the three local Healthwatch organisations – with invitations to be facilitated by the geographically relevant CCG organisation.
20. Each CCG will consult their Local Authority, local Healthwatch organisation and providers on relevant matters relating to the operation of the CHC, FNC & Complex Care Services commissioning support service overseen by the Joint Committee.

21. The membership as set out above will meet the requirements of all of the CCG’s constitutions.

Meetings & Voting

22. The Joint Committee shall adopt the Standing Orders of South Cheshire CCG, as the ‘Host’ CCG as defined in the Target Operating Model, insofar as they relate to the:

- Notice of meetings
- Handling of meetings
- Agendas
- Circulation of papers; and
- Approach to Conflicts of Interest (in line with national guidance issued by NHS England).

23. The Joint Committee will make decisions within the bounds of its remit. The following decisions of the Joint Committee shall be Category 1 Decisions:

- To endorse the Business Case for the Future Model Cheshire & Wirral CHC, FNC & Complex Care Commissioning Support Service, planned for implementation during the summer of 2015;

- To reach a decision, following engagement with CCG Governing Boards and local stakeholders, on the preferred option.

24. All other decisions of the Joint Committee shall be Category 2 Decisions, unless the Joint Committee specifically and unanimously agrees that another issue should be considered as a Category 1 Decision.

25. Each member of the CCG Joint Committee shall have one vote. The CCG Joint Committee shall reach decisions by (a simple majority of members present, but with the Chair having a second and deciding vote, if necessary). The decisions of the Joint Committee shall be binding on all CCGs and will be published by the CCGs in accordance with their local protocols and policies.

26. The quorum for a meeting of the Joint Committee shall be:

- For a meeting at which a Category 1 Decision will be made, all of the voting members of the Joint Committee must be in attendance or able to participate virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

- For a meeting at which no Category 1 decisions will be made, as close to 75 % (in terms of whole numbers) of the voting members of the Joint Committee (therefore 8 out of 10) are required to be in attendance or able to participate virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

27. In the first month following the transition of the service from NW CSU (February 2015) two meetings of the CCG Joint Committee will be held, thereafter they will be scheduled to take place on a monthly basis. Whilst this is the case the Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the Joint Committee. Meetings will be scheduled by the secretariat to ensure that they do not conflict with respective CCG Boards.
28. Meetings of the Joint Committee shall not be open to the public unless the Joint Committee considers that it would be in the public interest to permit members of the public to attend a meeting or part of a meeting.

29. Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

30. The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

31. Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders of South Cheshire CCG, referred to above, unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

32. In line with the Target Operating Model, South Cheshire CCG will be responsible for providing administrative support to the Joint Committee. As such the secretariat to the Joint Committee will:

- Co-ordinate the preparation of papers for each meeting which will be sent to Joint Committee members no later than one week prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.
- Circulate the minutes and action notes of the committee with 5 working days of the meeting to all members.
- Co-ordinate the production of a monthly CHC, FNC & Complex Care Executive Summary Report which will be circulated to each CCG’s Governance & Audit Committee for information. This should include Clinical Quality information and as such should also be received by Quality & Performance Committees at each CCG.
- Co-ordinate the production of a CHC, FNC & Complex Care Annual Report for formal presentation to each CCG’s Governing Board.

33. These terms of reference will be formally reviewed by the Joint committee after the first six months of its operation and thereafter on an annual basis -from time to time they may also be amended by mutual agreement to reflect the experience of the Joint Committee in fulfilling its functions and the wider experience CCGs in the commissioning of CHC, FNC and Complex Care services.

[Signature provisions – to be inserted for formal signing at 1st meeting of the CCG Joint Committee, scheduled for 11 February 2015]
CHC, FNC and Complex Care Interim Target Operating Model (TOM)

FINAL

Agreed by Cheshire & Wirral CCGs CHC, FNC & Complex Care Steering Group on 23 January 2015

Full Framework Version 3.2
Contents

1. Introduction
2. Part 1: Setting the Future Vision
3. Part 2: Designing the Target Operating Model
4. Part 3: Working up the Detail of the Operating Model
5. Part 4: Assurance Check against the Due Diligence Report (September 2014)
Introduction
Introduction

This page summarises how Cheshire and Wirral CCGs have used the Target Operating Model concept to drive a change in the provision of their CHC, FNC and Complex Care commissioning services.

Cheshire & Wirral CCGs are using the concept of a Target Operating Model’ (TOM) to drive a change in the provision of their CHC, FNC and Complex Care commissioning services, which starts with the transition of these services from NW CSU to CCGs on 01 February 2015.

A Target Operating Model is a conceptual representation of reality, in this case designed to help the CCGs and their partners understand, interpret and share a desired future.

The TOM described in this report has been developed to ‘stay in the heads’ of the CCG’s people and is shown diagrammatically as well as in words. In this regard the detail of the TOM is described in Parts 2 and 3 of this report, summarised in the illustrations included on pages 28, 30, 32 and 34 - 37.

Part 1 sets the strategic framework for the TOM and Part 4 provides a check-list to ensure that CCGs are addressing the areas of concern and key risks identified in the Due Diligence Report produced by IHS in September 2014.

The transfer of core CHC, FNC and Complex Care Commissioning Services to CCGs on 01 February 2015 is the first stage of a transformation process that will include:

- Workforce Re-design (01 February – March 2015)
- Implementation of a New Operating Model based on national best practice (Summer 2015).

As such the Target Operating Model described in this document is an Interim TOM in lieu of the changes in the operating model that will result from the above, further, stages in the transition process. As these changes are introduced the TOM will need to be updated.

In this instance the Operating Model is being used to describe the way the Cheshire & Wirral CCGs CHC, FNC and Complex care commissioning service will function on 01 February 2015, and to create an interim ‘Target Operating Model’ (TOM) which will:

- Galvanise the ‘Transition’ of Services from NW CSU to CCGs before the 31st January 2015
- Inform the development of ‘Efficiency Opportunities’ and initial ‘Workforce Re-Design’
- Ensure ‘Service Stabilisation’ prior to full scale service re-design in stage 3 of this transformation process
- Act as a focus for full scale ‘Service Improvement and the re-design of CHC, FNC and Complex Care Services’ once the services have transferred
- Enable CCGs to measure the success of the services that they have transferred and the CHC, FNC and Complex Care service as a whole.
Part 1: Setting the Future Vision

Strategic Vision & Aspirations for the CHC, FNC and Complex Care Service
The Target Operating Model – Framework Overview

All components need to be aligned to provide consistency, integrated delivery and direction towards a shared vision and performance objectives.

The Target Operating Model (TOM):

- Sets the strategic framework underpinning how the service will operate & perform
- Defines what work will be done, how the work links together, key patient interface points, system dependencies
- Who does what and where - accountabilities, performance measures, day to day governance and control.

The Framework for the TOM used in this report is illustrated on this page.
Developing a Vision as Context for the TOM

**Option 1:**

*To deliver a clinically-led CHC, FNC and Complex Care service which is locally-based, patient-focused and provides value for money through quality assured packages of care*

**Option 2:**

*To meet and respond to the CHC, FNC and Complex Care needs of patients within our footprint offering appropriate packages of care or provision of individual funds, which are clinically robust, quality assured and financially controlled*

**Option 3:**

*To deliver a responsive and timely CHC, FNC and Complex Care service to patients within our footprint, which meets their clinical needs, provides financial value for money and satisfies the rigour of quality controls and safeguarding requirements*
The set of aspirations described in this page has been drawn from stakeholder contributions to the Due Diligence Report.

Developing a set of aspirations for the future is the responsibility of the Clinical Quality & Future Model Group.

This proxy set of aspirations can be challenged as follows:

- Are they aspirational enough?
- Are they motivational for staff?
- Will they drive service improvements?
- Do we want to be ‘average’ or do we want to be ‘leading edge’ and ‘innovative’ in the way we deliver CHC/Complex Care?

Developing a Set of Future Aspirations as Context for the TOM

- Proactive interventions in care – identifying trends, raising risks, seeking improvements and delivering against a longer term plan.
- Concentrated and deep level of involvement of staff providing the CHC, FNC and Complex Care service across the full range of activities required – rather than a few individuals covering a wide spectrum of localities with limited capacity to become deeply involved in any aspect of the service.
- Accurate forecasting of future activity levels, budgets & spend, trend analysis and linkage to future resource requirements.
- Adopting a strategic view across the service as well as operational delivery through the development of a strategic plan, opportunities to realise efficiencies, manage high cost cases and establish alternative solutions delivering better value for both the CCG and patients – and delivering against this.
- Ensuring an Integrated approach across clinical, contracts and finance specialists – to propose optimum solutions for patients and the CCG.
- Integrated approach and strong alignment with existing strategies, policies and plans within each CCG (and across CCGs) area.
- Strong partnerships and integrated approach to the delivery of services across a footprint, i.e. LA, Acute, Community, GP, Specialist care (In area/Out of area), Local Providers – working together to deliver effective care to patients.
- Data integrity visibly demonstrated: data is accurate, reliable & complete.
- Efficient utilisation of resources in the way they work, how they work, and where they work. The right people are doing the right job in the right place.
- Clinical governance, training, peer reviews, professional development is established.
- Immediate reaction and resolution to emergency events and areas of high risk.
- Transparent and visible activities with robust reporting which drive informed decisions in a timely fashion.
- Engagement and involvement of staff in service improvements.
Developing a Set of Service Principles as Context for the TOM

- The CHC, FNC and Complex Care services provided are responsive, timely and meet (and exceed) all CHC, FNC and Complex Care National Framework requirements.
- The service is locality-based, meeting the needs of all CHC, FNC and Complex Care patients within our footprint.
- Clinically-led, and professional trained nurses provide the core service, focusing on delivering and excelling at providing appropriate packages of care which meet individual patient needs.
- Patient data is secure, and all data is accurate, reliable and complete.
- Proactive interventions in the service are initiated to continuously seek to improve the CHC, FNC and Complex Care service and levels of care offered.
- Robust governance is established which provides control, clinical management and the rapid escalation and cascade of decisions and direction.
- The CHC, FNC and Complex Care service will be supported by quality assurance and safeguarding arrangements that protect patients enabling them to live free from harm, abuse and neglect.
- All providers will be regularly monitored, underpinned by robust commercial contracts and provide value for money services.
- Clarity in accountabilities, and the roles and responsibilities of all CHC teams will be effectively communicated and maintained.
- All statutory and mandatory training needs of staff will be met and monitored, and future aspirations will be actively encouraged and facilitated.
In setting strategic direction, there is the need to set out the vision for the service.

This needs to be underpinned by key objectives which, by definition, if achieved, should enable the service to achieve the strategic vision over a defined timeframe.

In measuring progress towards the vision, the objectives need to have performance measures and targets which are ‘SMART’ quantified, and regularly measured and from which, the service can be effectively performance managed.

This page illustrates the relationship between strategic direction, vision and key underpinning service objectives – all required as important context for the development of the TOM.

Performance measures and targets across the service, for a locality, each team and down to individual level with regular performance updates will build strong ‘ENGAGEMENT’ and ownership in delivering the vision.

There should be clear and visible ‘ALIGNMENT’ of objectives with the strategic vision, enabling strong communication to all parties involved in the service delivery.

The temptation to capture and measure every piece of data will be a distraction. The service needs to identify the ‘CRITICAL FEW’ objectives and performance measures that will make a distinct and tangible difference to achieving the vision – and are the best indicators about the performance of the service on a quarterly basis.
Developing CHC, FNC and Complex Care Key Objectives

For all elements of the CHC, FNC & Complex Care Service a set of key objectives should be identified to drive the development of performance standards and KPIs.

Ideally from these objectives, specific measures and targets would then be set at each of the following levels:

- The Pan-Cheshire & Wirral footprint
- Locality-specific
- Team specific.

At an individual level, there would be direct alignment of individual objectives to the objectives for their team, their locality and across the footprint, so every individual can see the contribution they make towards achieving the vision.

The objectives illustrated in this page, have been developed from the IHS Due Diligence Report (Sept 2014). As such they are being adopted for use in the TOM until further developed by the Clinical Quality & Future Model Group.

<table>
<thead>
<tr>
<th>Key Objectives for the CHC, FNC and Complex Care Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 All CHC National Framework requirements will be met (and exceeded).</td>
</tr>
<tr>
<td>2 Each patient in receipt of a CHC package of care, can be assured there is robust quality and safeguarding in place such that they are protected and provided with the optimum level of care possible.</td>
</tr>
<tr>
<td>3 All providers will have a robust commercial contract underpinning the services commissioned.</td>
</tr>
<tr>
<td>4 All staff will receive and undertake all statutory and mandatory training deemed necessary and ensure effective CPD is regularly assessed.</td>
</tr>
<tr>
<td>5 At the date of transition (01/02/15) from NW CSU, the costs of providing the Cheshire &amp; Wirral CHC, FNC and Complex Care Commissioning Service will not exceed the existing (2014/15) costs of the service.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
  Note: Future costs to Cheshire & Wirral CCGs will depend on the outcomes of planned service reviews. |
| 6 A Clinical Governance system will be in place to ensure that Service Managers are accountable for continuously improving the quality of the CHC, FNC & Complex Care services and safeguarding high standards creating an environment in which excellence in clinical care will flourish. |
  |
  This system will integrate with local CCG processes and include: risk management; clinical audit; education, training and continuing professional development; evidence-based care and effectiveness; patient and carer experience and involvement; efficient and effective staff management. |
| 7 The Senior Management Team will seek to continuously improve productivity and efficiency of the service through ongoing initiatives whilst maintaining a locality focus for services. |
Alignment of Objectives to Performance Indicators & Targets

CHC, FNC & Complex Care

From the agreed key objectives, there should be a clear and visible linkage to the key performance indicators and how, through their achievement, this delivers benefits for the service overall.

This page is designed to illustrate what this might look like for the overall CHC service at a strategic level.

Each KPI will need to be designed to be mindful of the linkage required to achieve the strategic vision.

Note: specific objectives will need to reflect the variations between CHC, FNC and Complex Care services.

The development of key Objectives and Performance Indicators will allow stakeholders to measure the successful transition of the service to the TOM and is further developed in Part 3 of this document.

<table>
<thead>
<tr>
<th>Key Objectives</th>
<th>Key Performance Indicators (Selected Areas for Illustration Only)</th>
<th>Delivering Benefit - Area for Consideration (For Illustration Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CHC National Framework requirements will be met (and exceeded).</td>
<td>Eligibility decisions reached within 28 days of receipt of the Checklist.</td>
<td>What will be the benefits derived from the service? At individual patient level, locality level, CCG level, pan-Cheshire level?</td>
</tr>
<tr>
<td>Each patient in receipt of a CHC package of care, can be assured there is robust quality &amp; safeguarding in place such that they are protected and provided with the optimum level of care possible.</td>
<td>Fast Track patients with provision in place within 48 hours of a completed Fast Track Tool.</td>
<td></td>
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<tr>
<td>All providers will have a robust commercial contract underpinning the services commissioned.</td>
<td>Patients in receipt of service provision with a completed 3 month review after eligibility decision.</td>
<td></td>
</tr>
<tr>
<td>All staff will receive and undertake all statutory and mandatory training deemed necessary and ensure effective CPD is regularly assessed.</td>
<td>Patients in receipt of service provision with a completed 12 month review.</td>
<td></td>
</tr>
<tr>
<td>At the date of transition (01/02/15) from NW CSU, the costs of providing the Cheshire &amp; Wirral CHC, FNC and Complex Care Commissioning Service will not exceed the existing (2014/15) costs of the service.</td>
<td>Proportion of Fast Track patients still in receipt of provision at 3 months.</td>
<td>Other non-service specific consideration might include:</td>
</tr>
<tr>
<td>Note: Future costs to Cheshire &amp; Wirral CCGs will depend on the outcomes of planned service reviews.</td>
<td>Number of patients in receipt of Personal Health Budgets.</td>
<td>- The Opportunities to be realised from integrating the service with other strategic initiatives and policies</td>
</tr>
<tr>
<td>A Clinical Governance system will be in place to ensure that Service Managers are accountable for continuously improving the quality of the CHC, FNC &amp; Complex Care services and safeguarding high standards creating an environment in which excellence in clinical care will flourish.</td>
<td>All members of staff have completed statutory and mandatory training.</td>
<td>- The use of third sector to deliver packages of care</td>
</tr>
<tr>
<td>This system will integrate with local CCG processes and include: risk management; clinical audit; education, training and continuing professional development; evidence-based care and effectiveness; patient and carer experience and involvement; efficient and effective staff management.</td>
<td>Provision of activity reports in accordance with agreed schedules.</td>
<td>- Using joint funding with LAs to generate improved efficiencies in the delivery and financing of care</td>
</tr>
<tr>
<td>To continuously improve productivity and efficiency of the service through ongoing initiatives whilst maintaining a locality focus for services.</td>
<td>Information requests relating to complaints allocated and acknowledged to appropriate lead within two working days of receipt (48 hours)</td>
<td>- The potential to build strong relationships with local community-based providers and mental health trusts.</td>
</tr>
</tbody>
</table>
Part 2: Designing the Target Operating Model (TOM)

Designing the Target Operating Model and the CHC, FNC and Complex Care Service Components to Deliver the Strategic Vision
What is a Target Operating Model (TOM) & How Will it be Used Here?

Cheshire & Wirral CCGs are using the concept of a new ‘operating model’ to drive a change in the provision of their CHC/Complex Care commissioning services. A Target Operating Model (TOM) should be driven by the case for change, whilst also considering the internal and external forces acting on the enterprise.

The IHS Due Diligence report that was signed off by the CCGs in September 2014 is the starting point for this workstream. The case for change articulated in that report focuses on performance improvement, increasing quality and safety and the need to re-design the Cheshire & Wirral CHC, FNC and Complex Care commissioning service.

The TOM approach adopted here considers the core elements of the organisation (People, Process, Technology and Governance) to understand the current service and define a future operating model which will enable the CCGs in Cheshire & Wirral move towards their strategic goals.

In this instance the Operating Model is being used to describe the desired way the Cheshire & Wirral CCGs CHC, FNC and Complex care commissioning service will function from 01 February 2015, and to create an interim ‘Target Operating Model’ (TOM) which will:

- Galvanise the ‘Transition’ of Services from NW CSU to CCGs before the 31st January 2015
- Inform the development of ‘Efficiency Opportunities’ and initial ‘Workforce Re-Design’
- Ensure ‘Service Stabilisation’ prior to full scale service re-design in stage 3 of this transformation process
- Act as a focus for full scale ‘Service Improvement and the re-design of CHC, FNC and Complex Care Services’ once the services have transferred
- Enable CCGs to measure the success of the services that they have transferred and the CHC, FNC and Complex Care service as a whole.

All Target Operating Models should enable the service provider to simply represent ‘how they do business / provide the services’. In the Due Diligence report that was signed off by the CCGs in September 2014 IHS described the need to answer the following questions. These questions are being answered within this work stream:

- What work transfers?
- Where will the work be done?
- Who will do the work?
- How will the work get done?
- What are the dependencies and risks and how will these be managed?
What are the Features of a TOM and What Will It Look Like?

Every TOM is different. There is no standard template. However it must be:

- Memorable
- Visual
- Simple.

This page describes the parameters that the Target Model Task & Finish Group have adopted to develop the key products that were required as part of this workstream.

There is no single accepted definition of a Target Operating Model. It is used in many different ways depending on the organisation and the change scenario. Every TOM is different. There is no standard template, however, it must be: memorable; visual and simple, with enough detail to understand how the different components of the service work together.

On this basis it should be noted that:

- The TOM is not a detailed Operational Policy for the CHC Service describing the day to day management of services.
- The TOM is not a detailed documentation of processes, operational decision making, information flows, people’s roles and job descriptions, the application of technology and information systems, the use of tools or protocols or detailed operational metrics and feedback loops. However, a High Level RACI (Responsibilities, Accountabilities, Consulted and Involved) analysis has been developed to support its implementation.
- The TOM is not a strategy or a detailed plan for implementing the new arrangements (this is being completed in other work streams).
- The TOM is not the vision for the service – this will be developed and consulted on by the ‘Clinical Quality & Future Model Task & Finish Group’. The ‘working vision’ used to inform the development of the TOM has been extracted from the Due Diligence report.

Likewise the governance arrangements described in this report are presented diagrammatically to show the high level governance and decision making structure, differentiating between the Cheshire & Wirral CCGs Joint Committee (see page 32) which will be accountable for the service, the host CCG which will employ all CCG based staff and the partner CCGs involved.

It has not at this stage been developed to include the detailed terms of reference and membership of the committees, groups, etc. that make up the governance and decision making arrangements.

The actual **Target Operating Model** itself is a conceptual representation of reality in this case designed to help the CCGs and their partners understand, interpret and share a desired future. To this end, the TOM has been developed to be small enough to stay in the heads of your people, a single concept which can be described and shown diagrammatically rather described in words (pages 28, 30, 32 and 34 -37).
As part of the Due Diligence report, produced by IHS in September 2014, a basic operating model was developed to describe the component parts of the CHC, FNC and Complex Care commissioning service operated by NW CSU (formerly C&M CSU).

An illustration of that original model is used here as a reference point for the development of the TOM required for implementation on 01February 2015.

All aspects of CHC, FNC & Complex Care (Children’s, Mental Health, Learning Disability and Physical Disability) consist of the following three core activities:

- Clinical Assessment, Eligibility & Case Management
- Individual Patient Commissioning
- Provider Management.

Note. There is a larger scale of complexity within complex care commissioning that needs to be reflected in the development of the TOM from this point forward.

Four governance and control areas underpin the full service:

- Clinical Governance
- Data Assurance
- Performance Reporting
- Financial management and control.

In addition, 4 discrete activities – ‘Personal Health Budgets’ (PHBs), ‘Disputes on eligibility decisions’, ‘Previously Unassessed Period of Care’ (PUPoC - pre and post 1/4/13]) and ‘Complaints’ – need to be factored into the operating model as key service components.
Whilst the Target Operating Model will consist of a variety of components it is also necessary to define, at a high level:

- how the service works from a patient perspective
- how the component parts fit together
- Organisational level accountability and responsibilities
- Further definition of the Host CCG Role and the Service Components Provided at a Local Level.

Pages 18 – 24 are used to illustrate the considerations that the Target Model Task & Finish Group needed to make in order to develop the TOM represented in this report.

This page provides a strategic view of service delivery.

The focus of the service is the delivery of the three core CHC services (which applies equally across CHC, FNC and Complex Care). The vision and direction for the service is realised through the delivery of the three core components of the service and underpinned with robust governance and performance management arrangements. Supporting activities such as data and information management, stakeholder management, staff, resources, financials and commercial management are enablers which need to be integrated with the core service.
The Assumed Roles of the Host CCG, Individual CCGs and NWCSU?

Stakeholders in the Provision of the CHC/ Complex Care Commissioning Service

From the 01 February 2015 it is the intention of Cheshire & Wirral CCGs to jointly manage their CHC and Complex Care Commissioning Services through a Joint Committee of the CCGs to be formally established during February 2015, with South Cheshire CCG as the host CCG.

Different component parts of the end to end CHC, FNC and Complex Care commissioning service will be provided:
• By a CHC, FNC and Complex Care Senior Management Team directly accountable to the proposed CCG Joint Committee
• By the Host CCG (South Cheshire)
• At an Individual CCG locality level (Eastern Cheshire, South Cheshire/ Vale Royal combined, West Cheshire and Wirral)
• By NW CSU.

What is the Role of the HOST CCG?

Whilst South Cheshire has agreed to act as the HOST CCG in the new service that will operate from 01 February 2015 this role needed to be defined in more detail. The TOM Task & Finish Group identified this as an urgent task because of the significant impact on the development of the Target Operating Model and the associated governance arrangements.

At the start of this process it was understood by all parties that SCCCG will:
• Employ all of the staff transferred to CCGs as part of the new service – including all of the statutory responsibilities expected as an employer e.g. contract management and payment of salaries, sickness absence, training and personal development, line management and supervision, health and safety. NB Currently SCCCG obtains HR support through NW CSU.
• Manage the transferring Head of CHC, FNC and Complex Services who in turn will be responsible for the management of the Cheshire & Wirral, CHC and Complex Care Commissioning Service.

Service Components to be Provided Within Local Teams

At the start of this process it was also understood by all parties that Local, CCG based teams, will provide the following component parts of the CHC/ FNC Commissioning Service:
• Administration of referrals
• CHC/ Led Case Management & MDT
• Co-ordination of CHC/ FNC Panel & Decision on Eligibility
• Commissioning of Care for Individual Patients
• PHB: Devise Care Plan & Budget
• PHB: Brokerage of Care Via CCIL SLA
• Clinical Review of Continued Eligibility for Care
• Accounting & Financial Control.

Service Components Provided by NW CSU

It had previously been confirmed by the CCGs that NW CSU will provide via an SLA(s) “Commercial Contract Management’, ‘Data Systems’ & ‘Pre 1/4/2013 PUPoC Case Management’.
Further Definition of the Host CCG & Joint Committee Roles, the Service Components to be Provided at a Local Level & Individual CCG Responsibilities

Further Definition Required of the Host CCG Lead Role

On the basis of the agreements already reached it was (reasonably) assumed that South Cheshire would also be responsible for:

- The Joint Governance arrangements and as such to take responsibility for the administration of the CCG Joint Committee which will be needed to support these arrangements.
- Co-ordinating the co-production of performance/management reports, new policies, internal/external communication, etc., by the CCGs and NW CSU.
- The management of any (CCG) pooled budgets that will be required to operate the service model – the absolute minimum requirement will be for a pooled budget to cover staff costs and their HR management. Other pooled elements would depend on the final operating model and SCCCG’s finally defined role.

Additionally it was proposed that the role of South Cheshire could be extended still to include the following elements subject to further discussion with the CHC Steering Group:

- The Core Training & CPD for all transferred staff?
- The management of a single SLA with NW CSU – rather than x4 separate SLAs held by the individual CCGs?

Potential Further Extension to Local CHC Service Provision

Currently the ‘Clinical Assessment, Eligibility, Individual Patient Commissioning, Case Management and Review’ components of the CHC service are managed by x2 Locality Leads for ‘Wirral & West Cheshire’ and ‘South Cheshire, Vale Royal and Eastern Cheshire’. Whilst these elements of the service are delivered by local teams based in the localities, it was assumed that CCGs wanted to see more emphasis on the local model and integration with the CCGs themselves. How can this be achieved?

Currently the following elements of the Service are provided at scale across several localities. Was there a view that they could be provided at a local level and integrated with other local work streams?

- Quality & Safeguarding- support currently provided to ‘Wirral & Mid Mersey’ and ‘Cheshire’ CCGs, with line management that is provided across C&M.
- Complaints and Dispute Resolution. South Cheshire CCG already provides its own complaints service through core CCG teams. Vale Royal and Wirral CCGs will provide their own complaints service from 01 February 2015. Eastern Cheshire CCG is planning to transfer complaints from NW CSU to the CCG during March 2015. A date has as yet not been finalised for the transfer of the service from NW CSU to West Cheshire CCG. How will core CCG complaints services integrate with the CHC Team managing disputes and complaints?

Complex Care

Due to the efficiencies and expertise required all components of the complex care commissioning Service are provided at scale across the Cheshire & Wirral population. How should this be organised on 01 February 2015. Can individual CCGs play a more significant part in the management of this service? Do they want to?
<table>
<thead>
<tr>
<th>KEY ISSUE/ QUESTION</th>
<th>Agreement Reached</th>
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</thead>
<tbody>
<tr>
<td>1. Where will organisational responsibility sit for the CHC, FNC and Complex Commissioning Service?</td>
<td>Cheshire &amp; Wirral CCGs will collectively share responsibility for CHC, FNC and Complex Services from 01 February 2015 – via a Joint Committee of the CCGs. Based on the above the transferring Head of Service will be accountable to the Joint Committee of CCGs for the delivery of the CHC, FNC and Complex Care commissioning services not provided by individual CCGs or by NW CSU. Note A. Due to the passing of a Legislative Reform Order (LRO) by parliament (1/10/14), CCGs can now form a joint committee with one or more CCGs and NHS England see <a href="http://www.england.nhs.uk/wp-content/uploads/2014/09/letter-on-lro.pdf">http://www.england.nhs.uk/wp-content/uploads/2014/09/letter-on-lro.pdf</a>. Advice on the establishment of Joint CCG Committees was recently included in NHSE guidance to CCGs on the establishment of primary care co-commissioning arrangements <a href="https://www.england.nhs.uk/commissioning/pc-comms/">https://www.england.nhs.uk/commissioning/pc-comms/</a>. IHS believe that this formal, legal arrangement between NHS Commissioning organisations as part of the amended NHS Act may obviate the need for commercial contracts between the CCGs involved in this arrangement. Note B. A Joint CCG Committee will oversee the provision of CHC, FNC and Complex Care Commissioning Services in Cheshire &amp; the Wirral and will have responsibility for ensuring that the provision of CHC and Complex Care Commissioning Services in Cheshire &amp; Wirral has appropriate arrangements in place to exercise its functions to a high quality, safely, effectively, efficiently and economically in accordance with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised) and other appropriate guidance. Note C. Where an individual CCG makes arrangements with another CCG in a Joint Committee as described above, the CCGs will need to develop an agreement setting out the arrangements for joint working, including details of: how the parties will work together to carry out their commissioning functions; the duties and responsibilities of the parties; how risk will be managed between the parties; financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund; contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements. The liability of each CCG to carry out its functions will not be affected where they enter the joint commissioning arrangements described above.</td>
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## KEY ISSUE/ QUESTION

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<tr>
<td>(Confirmed at Target Model Group on 12/1/15 and Steering Group on 14/1/15 )</td>
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</table>

### 2. How will the CHC/ FNC ‘Clinical Assessment’, ‘Eligibility’, ‘Case Management’, ‘Commissioning of Care (including Personal Health Budgets)’ and the ‘Review of Agreed Packages of Care’ components be managed? In two Locality Teams as is the case within the NW CSU or in four Locality Teams one for each CCG, with SC/VR sharing a team?

- It was agreed that from 01 February 2015 these service components should be based in and work from four locality teams as follows:
  - SCCG & VRCCG
  - ECCCG
  - WCCG
  - WCCCG.

- Whilst this is the case, the four teams will be managed at a global level by the management team which reports to the Joint Committee where accountability for the performance and delivery of the service collectively sits. As such the two transferring Locality Managers will manage x2 Locality Teams each.

### 3. For CHC/ FNC – Where will accountability sit for the Clinical Assessment’, ‘Eligibility’, ‘Case Management’, ‘Commissioning of Care (including Personal Health Budgets)’ and the ‘Review of Agreed Packages of Care’ components of the commissioning Service?

- Colleagues were asked to think about: who is responsible for ensuring KPIs are met?; if there were staff capacity issues e.g. Long Term sickness, who would manage the gap?; where would clinical leadership be provided from?; How would operational issues be managed?

- It was agreed that accountability at CCG level would cut across the stated ambition to manage the service as a collective with consistent policies, standards and protocols. As such the Joint Committee of CCGs will be accountable to the individual CCGs for the delivery of the service through the CHC Management Team transferred to CCGs as part of the new arrangements. The joint committee of CCGs will ensure that a fair and appropriate level of service is delivered to each CCG. AS such CCG contributions to the pooled budget set up to support the service would be based on a population or caseload basis to be determined by a CHC Finance Leads Group.
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<td>(Confirmed at Target Model Group on 12/1/15 and Steering Group on 14/1/15 )</td>
</tr>
<tr>
<td>4. For CHC, FNC &amp; Complex Care – Who will be responsible for managing:</td>
<td>Currently the NW CSU provided CHC, FNC &amp; Complex Care commissioning service includes x2 teams which support the management and processing of CHC/FNC related ‘disputes and complaints on eligibility decisions’ and ‘PUPoC case management’. These teams are in addition to each CCG’s arrangements for the ‘overall management of complaints for their commissioned services’.</td>
</tr>
<tr>
<td>- Complaints</td>
<td>CCGs were understandably keen to ensure maximum integration of CHC administration in this area with their locality arrangements. However, it was agreed that as at 01 February 14 it was important to ensure stability in this area. As such ‘CHC/FNC related ‘disputes and complaints on eligibility decisions’ and ‘PUPoC case management’ would continue to be supported by two teams – one supporting Wirral and West Cheshire; one supporting Vale Royal, South Cheshire and Eastern Cheshire.</td>
</tr>
<tr>
<td>- Disputes on eligibility decisions</td>
<td>Each CCG will be responsible for the integration of its complaints management process with the work of these teams- meetings to agree responsibilities and accountabilities within the CHC disputes/ complaints management process would be co-ordinated by the CHC, FNC and Complex Care Head of Service (January 2015). Whilst each CCG had signalled an intention to manage its own complaints process, at the point of transition only South Cheshire, Vale Royal and Wirral will have transferred the service from NW CSU to CCG ownership. Eastern Cheshire will provide its own complaints service from March 2015. West Cheshire plans to manage its own complaints service but a date has as yet not been finalised for the transfer of the service from NW CSU.</td>
</tr>
<tr>
<td>- PUPoC Case Management post 1/4/13?</td>
<td>The CCGs felt strongly that this component of the CHC and complex service should be managed at a local level and integrated with core CCG Quality Assurance, Safeguarding and Provider Performance functions.</td>
</tr>
<tr>
<td>Where will the accountability for delivery sit?</td>
<td>It was therefore agreed that from 01 February each CCG should provide its own commissioning service in these areas. As such discussions with TUPE transferring staff will need to be undertaken to determine, by agreement, which CCG they will support from 01 February 2015 (see section 3). Each CCG will be responsible for reviewing the capacity of their existing teams, recruiting additional capacity where required. All CCGs acknowledge that there may be a need to increase capacity in what is considered to be an under resourced area.</td>
</tr>
<tr>
<td>5. For CHC, FNC and Complex Care – Who will be responsible for the ‘Quality Assurance, Safeguarding and Provider Performance’ component related to these services?</td>
<td>It was agreed that the CHC Finance Leads Group will be responsible for determining the financial adjustments and pooled budget arrangements that will be required to support this decision.</td>
</tr>
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</table>
### Further Definition of the Host CCG & Joint Committee Roles, the Service Components to be Provided at a Local Level and Individual CCG Responsibilities (5)

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<tbody>
<tr>
<td>6. For Complex Care – Who will be responsible for each complex care service e.g. MH, LD, children’s and Adult. Where will the accountability for delivery sit?</td>
<td>It was agreed that all complex care commissioning services should be provided at a pan Cheshire &amp; Wirral level. From 01 February 2015 complex care will be the responsibility of the CHC/Complex Care Senior Management Team who will report to the CCG Joint Committee. As such the Joint Committee will be accountable to the individual CCGs for performance in this area. The x2 CHC/Complex Care Locality Managers transferring to CCGs will continue to manage x2 Complex Care Teams each. Originally the view of CCGs was that where possible each CCG will host, provide accommodation, for a complex care service. However, to support the transition process it was agreed, at this stage, for the services to remain as currently located.</td>
</tr>
<tr>
<td>7. Do you agree that the host CCG has responsibility for: management of Head of Service; employment of all CCG CHC staff; management of any pooled budgets; coordinating the co-production of performance/management reports and the administration of the CCG Joint Committee?</td>
<td>It was agreed by all partners that SCCCG would be responsible for the provision of the identified services from 01 February 2015. As such SCCCG will report to the Joint Committee for the delivery of the areas identified, where accountability will sit.</td>
</tr>
<tr>
<td>KEY ISSUE/ QUESTION</td>
<td>Agreement Reached</td>
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<tr>
<td>8. Who will be responsible/accountable for the receipt, holding and management of all assets e.g. equipment, telephones, cars, computers, etc.,?</td>
<td>It was agreed that SCCCG will be responsible for the management of all assets – with explicit agreement of budget contributions from CCGs and risk share included in TOR for Joint Committee, when agreements have been reached in these areas.</td>
</tr>
<tr>
<td>9. Who will be responsible/accountable for core training, personal development, appraisal &amp; CPD?</td>
<td>All parties agreed that as the employer SCCCG will be responsible for the core training, in line with legislation, personal development and appraisal of all staff. It was also agreed that the CHC/Complex Care Senior Management team will be responsible to the CCG Joint Committee for staff CPD. As such the Joint Committee will be accountable to the individual CCGs for these supporting elements of the CHC/Commissioning service.</td>
</tr>
<tr>
<td>10. Do you agree that the NW CSU has responsibility for: Broadcare; Commercial Contracts with Provider organisations and the case management of all PUPoCs pre 1/4/2013, and Retrospective Cases? Should the Host CCG manage the SLA with NW CSU?</td>
<td>It was agreed by all partners that NW CSU would be responsible for the provision of the identified services from 01 February 2015. It was also agreed that SCCCG, as the host CCG, should manage a single contract with NW CSU for all of the CHC/Complex Care services provided by NW CSU to Cheshire &amp; Wirral CCGs. As such SCCCG will be accountable to the CCG Joint Committee for the management of this services. It was agreed that the CHC Finance Leads Group will be responsible for determining the financial adjustments and pooled budget arrangements that will be required to support this decision.</td>
</tr>
</tbody>
</table>
Additional Assumptions & Next Steps

This page summarises a number of further considerations that have arisen in between the 2nd and 3rd meetings of the Target Model T&F Group.

In order to draft the Target Operating Model represented in pages 28, 30, 32 and 34 -37, assumptions have been made that will need to be signed off by the group at its next meeting.

Additional Assumptions

The Development of interim Target Operating Model is a dynamic process that requires continued refinement, before it is signed off by the Cheshire & Wirral CHC, FNC and Complex Care Steering group on 16 January 2015.

Assumptions about the following additional considerations have been made to inform the draft TOM represented on pages 28, 30, 32 and 34 -37 of this report.

a) Patients will interface directly with the CHC/ FNC service through the specific locality teams for their area. They will contact the locality team through either:
   - A specific named contact OR
   - A locally communicated CHC number/email address for the team.

b) General queries will be directed through the locality team as appropriate.

c) Complaints and disputes will be received directly by the CCG core team and dealt with as appropriate by the CHC/Complex Care specific teams working for ‘Wirral and West Cheshire’ and ‘Vale Royal, South Cheshire and Eastern Cheshire’

d) NW CSU will manage Broadcare the Broadcare system. SCCCG as the Host CCG will ensure appropriate IT resources and equipment are provided to all CHC staff and access to the system/data is available when required through an SLA with NW CSU (see page 73).

e) There will be 4 locality teams, with 2 Locality Leads taking responsibility for the CHC service across 2 CCG’s each.

f) Complex Care teams will be provided across the footprint (pan-Cheshire) and the siting of the various disciplines (Mental Health, L&D, PD, Children’s) will remain as is.

f) Each locality team will manage key stakeholders as required (e.g. Local Authorities, Acute Hospital and Community Providers) and seek to establish common ways of working with respective colleagues in a separate locality who may have the same or similar interfaces – in order to achieve consistency in approach.

g) Each Locality CHC Team will be required to work to consistent policies, standards and protocols.

h) Multi-disciplinary panels will be convened as appropriate by each locality team.

Part 1: Setting the Future Vision

Part 2: Designing the Operating Model

Part 3: Working up the Detail

Part 4: Assurance Check
Part 2 : Designing the Target Operating Model (TOM) (Continued)

The next section outlines the Target Operating Model at a high-level, from each of the following perspectives:

• A Patient Perspective
• Integrated Service Components : end to end service delivery
• Governance Framework
• Staffing Structure and Location
A High Level Patient Perspective TOM
CHC/ Complex Care TOM - A High Level Patient Perspective

Patient interface - telephone, direct home visit, acute visit, mail – through each of the 4 specific locality teams

Designed as a locality-based model but centrally coordinated and managed, with support from specialist roles and teams brought in to support localities as appropriate depending on each patient need and case

**Complex Care – the same principles will apply with each area of complex specialism. It will be centrally coordinated whilst based out of specific locality offices (for delivery across the footprint)

INTEGRATED SYSTEM, TECHNOLOGY, DATA & INFORMATION MANAGEMENT

CLINICAL LEADERSHIP

Referrals, Clinical Assessment, Eligibility, Panels and Case Management

Individual Patient Commissioning (Including PHBs) & Reviews

Management of Disputes, IRPs & PUPoC Case Management (post 1/4/13)

Specialist Teams from CSU
- Commercial Contracts & Procurement
- Pre 1/4/13 PUPoCs
- ‘Broadcare’ System Management

Specialist Teams from CCG
- Finance
- Quality & Safeguarding
- Non Eligibility Related Complaints

Specialist Teams from Third Parties / Providers / Local Authorities
- Multi-disciplinary panels
- Out of area specialists
A TOM Showing The Integration of Service Components

Key:

**Green** Shapes – Individual CCG Responsibility

**Orange** Shape – CCG Joint Committee Responsibility

**Light Blue** Shape – Host CCG (SCCCG) Responsibility

**Dark Blue** Shape – NW CSU
The TOM as a Governance Model

Key:

Green Shape – Individual CCG Responsibility
Orange Box – Joint CCG Committee Responsibility
Light Blue Shape – Host CCG (SCCCG) Responsibility
Dark Blue Box – NW CSU Responsibility

Brown Triangle – Joint Operational Group

A box with a dotted border indicates provision of the commissioning service. A box with a solid border indicates a commissioning function.

The direction of arrows indicates accountability.
Commercial (SLA) Contracts between NW CSU and Host CCG for the provision of: Commercial and Technical Contract Management, Data Systems (Broadcare) & Case Mgt of pre 1/4/13 PUPoC

Individual CCG Governing Boards – Legally Accountable for the Commissioning of CHC, FNC and Complex Care

Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

C&W Finance Leads Group

X5 Financial & Budget Mgt Arrangements

X4 CCG Clinical Governance Assurance Committees

X5 Individual CCG Governing Boards – Legally Accountable for the Commissioning of CHC, FNC and Complex Care

HOST CCG

SCCCG as the host organisation is responsible for the Line Management and Supervision of the CHC Complex Care Senior Management Team, the employment of all CCG based CHC/Complex Care staff and the associated responsibilities of an employer, Core Training, PD & CPD, management of any (CCG) pooled budgets, co-ordinating the co-production of performance/management reports, the administration of the CCG Joint Committee and management of all CCG based CHC Assets.

Pan Cheshire & Wirral CHC/Complex Care Senior Management Team

The Senior Management Team, which is line managed by SCCCG as the Host CCG, is responsible for the management of the service at a pan Cheshire & Wirral level. The Senior Management team consists of a Head of Service and x2 Locality/ Specialist Lead Managers.

All complex care is managed at a pan-Cheshire & Wirral level along with Disputes, complaints and post 1/4/13 PUPoC cases

LOCALLY BASED CHC COMMISSIONING SERVICE

The provision of X4 Locality CHC Teams
WCCG, SC/VR CCG, WCCCG & ECCCG.

X4 CCG QA, Safeguarding & Provider Monitoring Embedded services

x3 Locally Based Accounting & Financial Control Teams

GOVERNANCE MODEL #1

LEGISLATION & NATIONAL GUIDANCE

Joint Ops Group

X4 CCG Clinical Governance Assurance Committees

LOCALLY BASED CHC COMMISSIONING SERVICE

The provision of X4 Locality CHC Teams
WCCG, SC/VR CCG, WCCCG & ECCCG.

Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

X5 Individual CCG Governing Boards – Legally Accountable for the Commissioning of CHC, FNC and Complex Care

Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

C&W Finance Leads Group

X5 Financial & Budget Mgt Arrangements

X4 CCG Clinical Governance Assurance Committees

X5 Individual CCG Governing Boards – Legally Accountable for the Commissioning of CHC, FNC and Complex Care

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LEGISLATION & NATIONAL GUIDANCE

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X4 CCG Clinical Governance Assurance Committees

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The provision of X4 Locality CHC Teams
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Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

C&W Finance Leads Group

X5 Financial & Budget Mgt Arrangements

X4 CCG Clinical Governance Assurance Committees

X5 Individual CCG Governing Boards – Legally Accountable for the Commissioning of CHC, FNC and Complex Care

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All complex care is managed at a pan-Cheshire & Wirral level along with Disputes, complaints and post 1/4/13 PUPoC cases

LOCALLY BASED CHC COMMISSIONING SERVICE

The provision of X4 Locality CHC Teams
WCCG, SC/VR CCG, WCCCG & ECCCG.

X4 CCG QA, Safeguarding & Provider Monitoring Embedded services

x3 Locally Based Accounting & Financial Control Teams

GOVERNANCE MODEL #1

LEGISLATION & NATIONAL GUIDANCE

Joint Ops Group

X4 CCG Clinical Governance Assurance Committees

LOCALLY BASED CHC COMMISSIONING SERVICE

The provision of X4 Locality CHC Teams
WCCG, SC/VR CCG, WCCCG & ECCCG.
A TOM Showing Staffing Structure & Locations

Key:

- **Light Blue** shaded Area – Indicates Staff located in base of CCG Area represented
- **Orange** Box – Indicates accountability to Joint Committee through C&W CHC/Complex Care Management Structure
- **Dark Blue** Box – Indicates Provision of Components by NW CSU
- **Green** Box indicates Provision of Components by CCG
- Arrowed Boxes – Indicates Specialist Complex Care Commissioning Service to CCG from teams located in other CCGs

Part 1: Setting the Future Vision

Part 2: Designing the Operating Model

Part 3: Working up the Detail

Part 4: Assurance Check
*NOTE: Also the Locality Lead for Eastern Cheshire

**NOTE: SC CCG & VR CCG have appointed an additional ICN who will start in Jan 2015. It is assumed that his/her contract will be issued from SC CCG.

CSU Services provided via LA:
- Commercial Contract Management
- Broadcare systems Management
- PUPoCs (pre1/4/13)

CGG Core Services
- Quality Assurance, Safeguarding & Provider Monitoring
- Complaints Process Management
- Accounting & Financial Control

Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

C&W Head of CHC, FNC and Complex Care

Locality & MH Complex Care Lead *

SC/ VR CCG CHC Operational Lead

SC/ VR CCG A Individual Commissioning Nurse Team**

C&W MH Manager

Specialist Nurse MH Cheshire & Wirral

SC/ VR CCG CHC Team Admin

LD, Children’s & Adults Complex Care Lead

Children’s Complex Care based in West Cheshire

LD’s Complex Care based in Wirral

Adult Complex Care based in West Cheshire

Complex Care Admin based in West Cheshire

GENERAL NOTE: Staff working across a wider footprint than their base locality will be required to hot desk in the other localities they support so they maintain a local presence.
**STAFF STRUCTURE & LOCATION**

**WEST CHESHIRE PERSPECTIVE**

**CCG Core Services**
- Quality Assurance, Safeguarding & Provider Monitoring
- Complaints Process Management
- Accounting & Financial Control

**Joint Committee of Cheshire & Wirral CCGs**
- CHC, FNC and Complex Care

**C&W Head of CHC, FNC and Complex Care (Based in SC CCG)**

**Locality & LD, Adults & Children’s Complex Care Lead***

**MH Complex Care Lead**

**C&W Children’s Manager**

**Adult Complex Care Specialist Nurse**

**WCCCg CHC Operational Lead**

**WCCCg Individual Commissioning Nurse Team**

**WCCCg CHC Team Admin**

**Complex Care Admin**

**LD’s Complex Care based in Wirral**

**MH Complex Care based in South Cheshire**

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**CSU Services provided via LA:**
- Commercial Contract Management
- Broadcare systems Management
- PUPoCs (pre1/4/13)

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**GENERAL NOTE:** Staff working across a wider footprint than their base locality will be required to hot desk in the other localities they support so they maintain a local presence.

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*NOTE: Also the Locality Lead for Wirral*
Joint Committee of Cheshire & Wirral CCGs
CHC, FNC and Complex Care

CCG Core Services
Quality Assurance, Safeguarding & Provider Monitoring
Complaints Process Management
Accounting & Financial Control

C&W Head of
CHC, FNC and
Complex Care
(Based in SC CCG)

LD, Children’s & Adults
Complex Care Lead
(Based in WC CCG)

Locality & MH Complex
Care Lead*
(Based in SC CCG)

EC CCG CHC
Operational Lead

EC CCG Individual
Commissioning
Nurse Team

EC CCG CHC
Team
Admin

MH Complex
Care
based in South
Cheshire

LD’s Complex
Care
based in Wirral

Adult Complex
Care
based in West
Cheshire

Children’s Complex
Care
based in West
Cheshire

CHC Disputes & PUPoCs (Post 1/4/13)
X2 Teams Based in Chester & Nantwich
(NB: provides service across C&W)

CSU Services
provided via LA:
- Commercial
  Contract Management
- Broadcare
  systems Management
- PUPoCs
  (pre1/4/13)

*CROSS SITE SERVICES

*NOTE: Also the Locality
Lead for South Cheshire
and Vale Royal

GENERAL NOTE: Staff
working across a wider
footprint than their
base locality will be
required to hot desk in
the other localities
they support so they
maintain a local
presence.

*NOTE: Also the Locality
Lead for South Cheshire
and Vale Royal
**NOTE: Also the Locality Lead for West Cheshire**

**NOTE: SC CCG, VR CCG and EC CCG have funded a Specialist LD Nurse to support work in their geographies starting after the 01 Feb 2015.**

GENERAL NOTE: Staff working across a wider footprint than their base locality will be required to hot desk in the other localities they support so they maintain a local presence.
Part 3: Working up the Detail of the Operating Model

Although the Target Operating Model is not a detailed Operational Policy it is important to capture sufficient detail to inform stakeholders how the service will operate at a tactical level including:

a) Processes (How work gets done)

b) People (Who does the work, organisation structure & role accountabilities)

c) Service Standards & Performance Reporting (including KPIs)

d) Systems, Data, Information (Ensuring it is accurate, reliable & complete)
Part 3: Working up the Detail of the Operating Model

a) Processes (How work gets done)
This page provides a high level illustration of the processes currently operated by NW CSU to provide CHC, FNC & Complex Care Commissioning Service, including:

- Referral
- Case Management
- MDT Assessment
- Panel & Eligibility Decisions
- Commissioning of Care (including PHBs)
- Clinical Review of Eligibility.

These process maps are provided here as a simple illustration of how the work will be done as at 01 February 2015 – subject to review by the Workforce Redesign Group.

Work is currently taking place in the Workforce Redesign Group to review these processes and how they are operated by the workforce to improve service quality and outcomes.

It is the intention of this group to identify a set of ‘quick wins’ that can be implemented at or soon after service transition. These proposals will be incorporated into future versions of this report.

**Part 1: Setting the Future Vision**

- Referral
- Assessment
- Authorisation
- Individual Package Procurement
- Case Management
- Review
- Discharge
- Financial Administration

**Continuing Healthcare (CHC)**

- Referral
- Assessment
- Decision
- Authorisation
- Individual Package Procurement
- Case Management
- Review
- Patient discharged
- Financial Administration
- Dispute process
- Discharge

**Complex Care (Children & Adults)**

- Referral
- Assessment
- Authorisation
- Individual Package Procurement
- Case Management
- Review
- Discharge
- Financial Administration

**Funded Nursing Care (FNC)**

- Referral
- CHC Process
- Assessment/Review
- Financial schedule
- Patient discharged

**Part 2: Designing the Operating Model**

**Part 3: Working up the Detail**

**Part 4: Assurance Check**
How the Work Will Be Done - Process Maps Operated by NW CSU (2)

This page provides a high level illustration of the processes currently operated by NW CSU including:

- Dispute Resolution,
- PUPoC Reviews (post 1/3/14)
- Complaints Support (under revision –see note)
- Commercial Contract Management
- Finance Administration

These process maps are provided here as a simple illustration of how the work will be done as at 01 February 2015.

These process maps will need to be reviewed and potentially revised in future versions of this document.

- Process maps need to be developed for:
  - QA, Safeguarding & Provider Monitoring
  - Data Systems & Management
  - Performance Management & Reporting.

Note: As at 22/1/15, this process map is being revised to reflect the decisions reached by a small task and finish group which met on 20/1/15. The group led by the Head of CHC, FNC & Complex Care included CCG Leads and members of the CHC Complaints and Disputes Team. The Head of Service will be responsible for communicating and implementing the changes made to this process and the TOM will need to be updated in due course.
How The Work Will Be Done - Statutory Process to Determine CHC Eligibility

This page illustrates the statutory process required to determine and review eligibility for CHC services. In effect all CHC services are required to operate this process and flow chart – including the Target Operating Model operated from 01 February 2015.
How the Work Will Be Done - Referral, Assessment, Eligibility Decision, Case Management, Review & Commissioning of Care

Across the footprint, each CHC/Complex Care Service will:

- Accept and screen referrals, including:
  - Fast Track, for consideration of Continuing Healthcare/Funded Nursing Care eligibility
  - Timely identification of correct responsible commissioner using NHS England guidance appropriately
  - Meeting all national standards for the effective management and assessment of referrals.

- Conduct specialised clinical assessments and/or co-ordinate a multidisciplinary meeting and completion of the decision support tool (DST) in accordance with the National Framework for NHS Continuing Healthcare and Funded Nursing Care.

- Make a recommendation regarding eligibility to the authorising body. The CHC team can authorise packages of care below £1000 – above this threshold sign off is required by individual CCG budget holders.

- Procure an appropriate package of care for CHC eligible clients, including consideration of the Personal Health Budget option, where appropriate.

- For fast-track patients, packages of care will be implemented within 48 hours (unless for valid and unavoidable reasons).

- Case management including responsibility for 3 and 12 month reviews will be confirmed as part of Workforce Re-design workstream.

- A clinical commissioning review involves an assessment of an individual’s needs and if they have changed, completion of a full decision support tool to establish eligibility for CHC and potentially a revised care plan and care package.

- Individual Commissioning Nurses who lead the eligibility assessments for each individual, will define the specific package of care that will add most value to each individual patient at the optimum cost. As they are often working in partnership with individual patients and/or their representatives, a detailed knowledge and understanding of the provider landscape and specific anomalies within each locality is paramount. Of equal importance is the need for ICNs to take into account each individual patient’s needs and requirements.

- Locality admin teams will support the ICN in the procurement of the appropriate packages of care – which can range in complexity from Tier 1 and 2 packages (for CHC) to highly specialist and complex packages of care for those with complex health needs. Integration with Complex Care Commissioning Managers and Clinicians is critical to the efficient functioning of the CHC service.

- High cost cases will be overseen by an identified Lead Director/ Budget Holder in each CCG working with their Director of Finance as necessary (for further information on financial authorisation (see pages 47 and 48).

- All active cases will be reviewed after an initial 3 month period, and then on an annual basis thereafter (as a minimum) – led by the ICN in the Locality-based team.
How the Work Will Be Done - Quality Assurance, Safeguarding & Provider Management (1)

The setting of provider (commercial) contracts, procurement and all contractual and commercial activities associated with Providers will be led by the NWCSU Contract Management team. This service will be commissioned by South Cheshire CCG (via an SLA with NW CSU) on behalf of all of all Cheshire & Wirral CCGs

Individual CCG’s, will be responsible for the Quality Assurance, Safeguarding and Provider Monitoring component of the CHC service for the services commissioned in their area. As such this function will be embedded within CCG Teams.

NB: The development of the New Service Model, to be implemented during the Summer of 2015, should include a detailed operational manual which maps processes and responsibilities.

CCG Responsibilities

CCG Quality & Safeguarding Teams will be responsible for assessing providers within their geographies. CCG teams will monitor local providers on behalf of all the CCGs in the Cheshire & Wirral partnership. Through their embedded services each CCG will be responsible for the following areas of work.

Nursing Home and ‘Provider Quality and Performance’ Monitoring and Reporting

- Continuously monitor provider performance against key quality indicators as agreed with CCGs and local stakeholders e.g. LAs.
- Highlight any exceptions/quality concerns/risks to CCGs via a monthly exception report/early warning dashboard or more frequently if required.

Note: NW CSU will continue to provide the quarterly Quality and Performance Reports to CCGs (including safety thermometer, CQUIN data and dashboards), as part of a Data Systems SLA managed by South Cheshire on behalf of Cheshire & Wirral CCGs. These reports will include commentary/intelligence from CCG Quality Teams who will be supported (where agreed) by staff TUPE transferring from NW CSU as part of the transition process (see page 45).

Quality Assurance and Performance Management

- Undertake formal performance and quality meetings with nursing homes and providers where there are quality concerns as identified through performance monitoring, follow up actions agreed and any matters arising on behalf of CCGs.
- Raise performance and quality issues with providers, seeking to resolve issues and enable continuous service improvements.
- Advise NW CSU to apply appropriate contract mechanisms i.e. contract query and trigger processes, withholding of payments, breach-notices, etc., until CCGs are assured performance issues have been addressed.
- New providers (inc. OOA) will be notified to NW CSU Broadcare Team who will be responsible for maintaining list of providers.

NB (Where safeguarding incidents are reported the relevant CCG Safeguarding Lead would take the lead for health).

Commercial Contract Management

Ultimately, NW CSU via the SLA with SC CCG, will be responsible for the agreement, management and administration of commercial contracts with providers in line with NHS guidelines. NW CSU will be directed in this regard by the CHC, FNC and Complex Care Joint Operations Group. NB this component will include procurement of Framework Agreements with providers, as directed by the Cheshire & Wirral CCG Joint Committee.

Escalation & Sharing of Information

Escalation of critical issues will be through ‘Locality Meetings’ involving CCG Quality & Safeguarding Teams, CQC, LA and (where there are contracts NW CSU) – forming part of regular dialogue between key partners. An Area Team, Cheshire & Wirral Quality & Safeguarding Group will support the development of a consistent approach across the geography, communicate key issues and arrange joint action where necessary.
How the Work Will Be Done - Quality Assurance, Safeguarding & Provider Management (2)

The setting of provider (commercial) contracts, procurement and all contractual and commercial activities associated with Providers will be led by the NWCSU Contract Management team. This service will be commissioned by South Cheshire CCG (via an SLA with NW CSU) on behalf of all of all Cheshire & Wirral CCGs.

Individual CCG’s, will be responsible for the Quality Assurance, Safeguarding and Provider Monitoring component of the CHC service for the services commissioned in their area. As such this function will be embedded within CCG Teams. This page describes how the TUPE transferring staff will support CCG teams.

Resourcing Local Teams

CCGs agree that this area of the service is under resourced. Each CCG will be required to review the resourcing of its core teams to ensure there is sufficient capacity in place to take on this workload from 01 February 2015.

Two members of staff will be TUPE’d over to Cheshire & Wirral CCGs as part of the transition process.

- 1.00 WTE, Band 8b – Quality, Safeguarding and Provider Lead (currently on a phased return from sick leave as at 21/1/15)
- 1.00 WTE, Band 7 – Quality, Safeguarding and Provider Coordinator (on sick leave as at 21/1/15).

An additional 0.25WTE Band 7 vacancy also exists in the current NW CSU structure (allocated to support the Wirral).

CCG leads have agreed that the transferring posts will be allocated as follows to support CCG Quality Teams.

- Band 7 post will support West Cheshire and Vale Royal CCGs
- Band 8b – 50% supporting Band 7 in West Cheshire & Vale Royal – 50% supporting strategic development of this function including liaison with other CCG teams.
- Wirral CCG will use the 0.25 WTE vacancy (Band 7) to increase the capacity of its local team.
- Eastern Cheshire and South Cheshire CCGs will receive no allocation of staff, relying on their existing quality teams to undertake their responsibilities.

Note 1: These arrangements are considered to represent an ‘interim’ arrangement subject to the development of a new model for Cheshire CCGs which will be developed by a short term task and finish group made up of CCG leads.

Note 2: At the date of transfer, 01 February 2015, due to sickness absence, the Band 8 post, supported by the Head of CHC, FNC and Complex Care Service, will deal with West Cheshire & Vale Royal priorities.

Note 3: The CHC Finance Leads Group will need to make any necessary financial adjustment and reflect them in the contributions to the pooled budget managed by SC CCG on behalf of the CCG Joint Committee.

TUPE Transferring staff will not have an explicit safeguarding role – this is fulfilled by CCG Safeguarding Leads. However all clinicians working to support the commissioning of CHC, FNC and Complex Care will continue to have a responsibility to report any safeguarding concerns through the agreed channels. Currently CHC, FNC and Complex Care clinical staff do not have access to the Datix system to directly report concerns. This anomaly will be resolved, post transition, by the task and finish group referred to earlier on this page.
From 01 February two CHC Complaints and Disputes Teams will work with CCG complaints services to manage disputes and complaints relating to CHC services

In addition the central team will also co-ordinate the case management of retrospective claims for CHC funding (post 1/4/13).

This CHC Team will work across the Cheshire & Wirral CHC, FNC and Complex Care Service and will be based in x2 locations; WC CCGs 1829 Building, Chester. And SC/ VR CCGs, Barony Building, Nantwich.

All CHC and Complex Care complaints that are not related to decisions on eligibility or funding will be managed by the core CCG complaints teams.

Note: The development of the New Service Model to be implemented during 2015 should include a detailed operational manual which maps processes and responsibilities.

CHC, FNC & Complex Care Related Complaints & Disputes

From 01 February two CHC Complaints and Disputes Teams will work with CCG complaints services to manage disputes and complaints relating to CHC services (see process map on page 41).

As such the teams will liaise directly with the appropriate locality-based team / complex care manager to manage the resolution process for all CHC eligibility disputes raised by individuals in accordance with the National Framework for Continuing Healthcare and NHS Funded Nursing Care (2012). This will include:

- (Referral) - Receipt, administration and processing of referral, liaison with claimant all in accordance with timescales
- Stage 1 - Initial investigation, liaison with claimant, initial meeting
- Stage 2 - Completion of individual needs portrayal, arrangements and presentation to a local independent review panel, liaison with claimant
- IRP - Administration associated with and presentation to Independent review panel held by NCB.

Where a dispute cannot be resolved locally and NHS England decide that an Independent Review Panel is appropriate, the CHC teams will liaise closely with NHS England providing all necessary documentation and attend the IRP meeting, if required.

If an IRP finds a local eligibility decision unsound, the CHC service will formally review the recommendations and report to the CCG any lessons learned and changes in practice and policy required.

If a case is referred to the Ombudsman, the CHC Service will provide all documentation and assistance required to reach a final resolution.

This also includes management of disputes with other CCGs over ‘who funds’ in accordance with DH ‘responsible commissioner’ guidance and disputes with Local Authorities with regard to jointly funded packages.

PUPoC Case Management

The central CHC, FNC and Complex Care team will also co-ordinate the case management of retrospective claims for CHC funding (post 1/4/2013). As such the team will liaise directly with the appropriate locality-based team to manage the case, this will include:

- Receipt, administration and processing of referral, liaison with claimant within timescales
- Administrative and clinical checks to determine progression, completion of checklist, liaison with claimant
- Completion of needs portrayal and liaison with claimant
- Management of the clinical decision making process.
A Cheshire & Wirral CHC Finance Leads Sub Group has been established to confirm the Target Operating Models financial arrangements for the CHC, FNC and Complex Care service transitioned to CCGs on 01 February 2015. The first full meeting of this group took place on 18/12/2014. This page describes the scope of this group’s work.

From 01 February, the SCCCG financial team (as host CCG) will oversee and manage a pooled budget on behalf of the partnership. The pooled budget will be created to manage the shared CHC, FNC and Complex Care commissioning service. Individual CCGs will be responsible for the accounting and budget management processes related to their individual spends on CHC, FNC and complex care services commissioned for patients.

Note: The development of the New Service Model to be implemented during 2015 should include a detailed operational manual which maps processes, responsibilities and levels of authorisation.

As Cheshire & Wirral CCGs are committed to the development of a shared CHC, FNC and Complex Care commissioning service – with a consistent operational model, processes, policies and standards – the Finance Leads group has been asked to develop consistent protocols and procedures and levels of authorisation for commissioning packages of care. The Target Model Task & Finish Group has also requested the Finance Leads to review how CCG financial teams can support commissioners of care during the authorisation process to ensure consistency of approach, the application of financial controls and accuracy of reporting against budgets.

Mapping CCG Accounting & Financial Control

The finance leads group will need to review process maps for each CCG’s ‘CHC/Complex Care Accounting & Financial Control’ component so that it is understood by all relevant parties within the process, including:

- financial authorisation;
- the processing of invoices, their validation, queries and corrections and payment.

With knowledge of the TOM, the finance group will review new and existing process maps for each CCG and identify the responsible and accountable roles both within the commissioning team (for authorisation of packages of care) and within each CCG, including CCG budget holders.

Given that Wirral CCG and West Cheshire CCG will ‘be taking Accounting & Financial Control’ back into their organisations from the NW CSU, the rigour through which this is deployed and the process, and roles and responsibilities will need to be well-defined and clearly articulated across all parties.

NB: Wirral & West Cheshire have agreed to jointly manage this function/set of activities from the 01 April 2015. Vale Royal/South Cheshire and Eastern Cheshire already manage this component in the CHC process for themselves.
A Cheshire & Wirral CHC Finance Leads Sub Group has been established to confirm the Target Operating Models financial arrangements for the CHC, FNC and Complex Care service transitioned to CCGs on 01 February 2015. The first full meeting of this group took place on 18/12/2014. This page describes the scope of this groups work.

From 01 February, the SCCCG financial team (as host CCG) will oversee and manage a pooled budget on behalf of the partnership. The pooled budget will be created to manage the shared CHC, FNC and Complex Care commissioning service.

**Management of CCG Budgets**

There will be no change in the management of expenditure on CHC, FNC & Complex Care commissioned services. Each CCG will continue to set its own budgets, agree and put into place its own budget management arrangements, monitor and report current year financial position and forecast spend. The Finance Leads group will be required wherever possible to agree consistent policy in line with the shared arrangements, stipulating where this is the case, and identify budget holders in each CCG.

**Pooled Budget & SLA with NW CSU**

It has been agreed that SC CCG will act as the host CCG for the transitioned service. As such it has also been agreed that SC CCG:

- Will host all CCG staff contracts and the activities related to the management of these contracts
- Provide line management for the CHC, FNC and Complex Care Senior Management Team
- Manage and co-ordinate the CCG Joint Committee that will be set up to manage CHC, FNC and Complex Care commissioning services.
- Manage all CHC, FNC and Complex Care assets transitioned to CCGs as part of the new arrangements
- Manage a single SLA with NW CSU for the components of the CHC, FNC and Complex Care commissioning service that they will continue to provide

- Manage the pooled CCG budget required to deliver the CHC, FNC and Complex Care commissioning service.

As such the Finance Leads group will be responsible for:

- Determining the pooled budget* required to support the above agreements e.g. costs to support; salaries of CCG based staff; equipment; IT Network costs, website and domain costs; Cars; phones; overpayments, petty cash, management payments to host CCG, NW CSU SLA Costs, IT & new Technology Fund, etc.,
- Agreeing individual contributions from CCGs
- Finalising the level of payments to the host CCG.
- Determining the costs of the elements/ components of the service remaining in NW CSU and agreeing the level of stranded costs currently under discussion.
- With Neil Evans as lead from the CHC, FNC and Complex Care Steering Group, negotiating an SLA, on behalf of all CCGs, with NW CSU for implementation on 01/02/2015.

SC CCG will be accountable to the Joint Committee of CCGs for the management of the pooled budget.

Note: In principle it was agreed that costs relating to service elements provided across the Cheshire & Wirral geography, and not specific to individual CCGs, would be apportioned to ensure a fair split of costs between the partner CCGs (either by capitation or weighted population). The apportionment of costs will be agreed through the Cheshire & Wirral CHC, FNC and Complex Care Finance Leads Group, with support from their respective Directors of Finance. This agreement will include a simple process to determine how any future additional service pressures are to be funded.

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**Part 1: Setting the Future Vision**
**Part 2: Designing the Operating Model**
**Part 3: Working up the Detail**
**Part 4: Assurance Check**
Part 3: Working up the Detail of the Operating Model

b) People (Who does the work, organisation structure & role accountabilities

Staffing Structure & Location
(As At 13/1/15)
Clarity on the roles and responsibilities across the service from the point of transition, and the locations these roles will be based in is captured on the following pages.

This covers immediate ‘known’ intentions from 1 February 2015 through either TUPE transfers of staff, or the direct recruitment of additional skills and capabilities which is already underway. It does not factor in the required workforce re-design component which is critical to transforming the service which will take place post-transition.

The following pages outline the key roles required to deliver the CHC services across the footprint and within each locality.

The Operating Model is largely locality based, with a senior management team who will be responsible for operational delivery of the service to the CCG Joint Committee. Specialist skills will be brought in from the CSU, CCG & other providers depending on specific patient cases and needs.

The majority of resources will be transferred under TUPE from the CSU as at 1 February 2015, however, there will be key roles which will require direct recruitment by SCCG to supplement and enhance the current skills and capabilities of the CHC service.

In addition, there are a small minority of roles which are currently being recruited to directly by CCG’s and/or plans agreed to commence recruitment. These roles have also been identified on the following pages.
Locality-based Organisation Structure - Vale Royal & South Cheshire

Based on the TUPE list of staff transferring from NW CSU to CCGs on 01 February 2015, the CHC, FNC and Complex Care roles based in VR & South Cheshire (The Barony Buildings, Nantwich) will be:

- VR & South Cheshire Locality-based CHC team identified for transferring from the CSU
- All roles identified on this page will be based at The Barony, Nantwich
- CHC/FNC team has a total of 8.0 WTE
- The specialist Mental Health complex team will be based at The Barony – the Specialist Manager role has still to be agreed for transferring from CSU

*NOTE: SC CCG & VR CCG have appointed an additional ICN who will start in Jan 2015. It is assumed that his/her contract will be issued from SC CCG. The headcount above has been increased to reflect this.

- C&W Head of CHC, FNC and Complex Care (Band 8d; 1.0 WTE)
- Locality & MH Complex Care Lead (Band 8b; 1.0 WTE) – shared with Eastern Cheshire
- Locality Operational Lead (Band 8a; 1.0 WTE)
- ICN * (Band 6; 5.4 WTE)
- Clinical admin team (Band 3; 0.59 WTE)
- C&W MH Specialist Manager (Band 8a; 1.0 WTE)
- C&W Specialist MH Nurse (Band 7; 1.0 WTE)

NB: This nurse will report to LD Complex Care Lead based in Wirral

LD Specialist Nurse (Assumed band 7 1.0 WTE) (Currently being recruited)

Part 1: Setting the Future
Part 2: Designing the Operating Model
Part 3: Working up the Detail
Part 4: Assurance Check
Locality-based Organisation Structure - Eastern Cheshire

Based on the TUPE list of staff transferring from NW CSU to CCGs on 01 February 2015, the CHC, FNC and Complex Care roles based in Eastern Cheshire (Alderley House, Macclesfield) will be:

- Eastern Cheshire Locality-based CHC team identified for transferring from the CSU.
- CHC/FNC team has a total of 6.27 WTE.
- All roles identified on this page will be based at New Alderley House, Macclesfield.
- All specialist complex care support will be provided by roles based elsewhere across Cheshire & Wirral to meet Eastern Cheshire needs.

- Local Operating Lead (Band 8a; 1.0 WTE)
- ICN (Band 6; 4.0 WTE)
- Clinical admin team (Band 3; 1.0 WTE, Band 1; 0.27 WTE)
Locality-based Organisation Structure - West Cheshire

Based on the TUPE list of staff transferring from NW CSU to CCGs on 01 February 2015, the CHC, FNC and Complex Care roles based in West Cheshire (1829 Building, Chester) will be:

- West Cheshire Locality-based CHC team identified for transferring from the CSU, and will be based at 1829 Building.
- CHC/FNC team has a total of 7.0 WTE.
- Whilst specialist nurses for both Adults and Children’s complex care transfer, there will be the need to recruit for a Specialist Manager in both roles, plus a complex care admin team.
- There will also be an additional 4.6 WTE staff transferring for Restitution, Complaints and Disputes specific to CHC across Cheshire & Wirral – based in West Cheshire.

Part 1: Setting the Future
Vision

Part 2: Designing the Operating Model

Part 3: Working up the Detail

Part 4: Assurance Check
Locality-based Organisation Structure - Wirral

Based on the TUPE list of staff transferring from NW CSU to CCGs on 01 February 2015, the CHC, FNC and Complex Care roles based in the Wirral (Old Market House, Birkenhead) will be:

- Wirral Locality-based CHC team identified for transferring from the CSU.
- All roles identified on this page will be based at Old Market House, Birkenhead.
- CHC/FNC team has a total of 6.5 WTE.
- The L&D Specialist Manager will be based in the Wirral but provide support across the Cheshire & Wirral footprint. However, the 2 complex resources supporting this role are specific to the Wirral locality ONLY.
- An additional specialist LD nurse will be recruited to support SC, VR & EC CCG’s from 1 February 2015.

*NOTE: SC CCG, VR CCG and EC CCG have funded a Specialist LD Nurse to support work in their geographies starting after the 01 Feb 2015 this post holder will be based in the Barony Building Nantwich. This post be based.

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Part 1: Setting the Future
Vision

Part 2: Designing the
Operating Model

Part 3: Working up the
Detail

Part 4: Assurance Check
Locality-based Organisation Structure - Quality & Safeguarding

Based on the TUPE list of staff transferring, there will be 1 Band 8B, 1.0 WTE and 1 Band 7, 1.0 WTE role for Quality & Safeguarding

Two members of staff will be TUPE’d over to Cheshire & Wirral CCGs as part of the transition process

- 1.00 WTE, Band 8b – Quality, Safeguarding and Provider Lead (currently on a phased return from sick leave as at 21/1/15 )
- 1.00 WTE, Band 7 – Quality, Safeguarding and Provider Coordinator (on sick leave as at 21/1/15).

An additional 0.25WTE Band 7 vacancy also exists in the current NW CSU structure (allocated to support the Wirral).

CCG leads have agreed that the transferring posts will be allocated as follows to support CCG Quality Teams.

- Band 7 post will support West Cheshire and Vale Royal CCGs
- Band 8b – 50% supporting Band 7 in West Cheshire & Vale Royal – 50% supporting strategic development of this function including liaison with other CCG teams.
- Wirral CCG will use the 0.25 WTE vacancy (Band 7) to increase the capacity of its local team.
- Eastern Cheshire and South Cheshire CCGs will receive no allocation of staff, relying on their existing quality teams to undertake their responsibilities.

Note 1: These arrangements are considered to represent an ‘interim’ arrangement subject to the development of a new model for Cheshire CCGs which will be developed by a short term task and finish group made up of CCG leads.

Note 2: At the date of transfer, 01 February 2015, due to sickness absence, the Band 8 post, supported by the Head of CHC, FNC and Complex Care Service, will deal with West Cheshire & Vale Royal priorities.

Note 3: The CHC Finance Leads Group will need to make any necessary financial adjustment and reflect them in the contributions to the pooled budget managed by SC CCG on behalf of the CCG Joint Committee.
Part 3: Working up the Detail of the Operating Model

c) Target Operating Model Service Standards & Reporting
Setting Strategic Direction:
Context for Successful Achievement of the Vision

In setting strategic direction, there is the need to set out and specify the vision for the service.

This needs to be underpinned by key objectives which, by definition, if achieved, should enable the service to achieve the strategic vision over a defined timeframe.

In measuring progress towards the vision, the objectives need to have performance measures and targets which are ‘SMART’ quantified, and regularly measured and from which, the service can be effectively performance managed.

This page illustrates the relationship between strategic direction, vision and key underpinning service objectives – all required as important context for the development of the TOM.

Performance measures and targets across the service, for a locality, each team and down to individual level with regular performance updates will build strong ‘ENGAGEMENT’ and ownership in delivering the vision.

There should be clear and visible ‘ALIGNMENT’ of objectives with the strategic vision, enabling strong communication to all parties involved in the service delivery.

‘CRITICAL FEW’ CONCEPT

The temptation to capture and measure every piece of data will be a distraction. The service needs to identify the ‘CRITICAL FEW’ objectives and performance measures that will make a distinct and tangible difference to achieving the vision – and are the best indicators about the performance of the service on a quarterly basis.
### Developing CHC & Complex Care Key Objectives

For all elements of the CHC, FNC & Complex Care Service, a set of key objectives should be identified to drive the development of performance standards and KPIs.

Ideally from these objectives, specific measures and targets would then be set at each of the following levels:

- The Pan-Cheshire & Wirral footprint
- Locality-specific
- Team specific

At an individual level, there would be direct alignment of individual objectives to the objectives for their team, their locality and across the footprint, so every individual can see the contribution they make towards achieving the vision.

The objectives illustrated in this page have been developed from the IHS Due Diligence Report (Sept 2014). As such they are being adopted for use in the TOM until further developed by the Clinical Quality & Future Model Group.

<table>
<thead>
<tr>
<th>Key Objectives for the CHC &amp; Complex Care Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> All CHC National Framework requirements will be met (and exceeded).</td>
</tr>
<tr>
<td><strong>2</strong> Each patient in receipt of a CHC package of care, can be assured there is robust quality &amp; safeguarding in place such that they are protected and provided with the optimum level of care possible.</td>
</tr>
<tr>
<td><strong>3</strong> All providers will have a robust commercial contract underpinning the services commissioned.</td>
</tr>
<tr>
<td><strong>4</strong> All staff will receive and undertake all statutory and mandatory training deemed necessary and ensure effective CPD is regularly assessed.</td>
</tr>
</tbody>
</table>
| **5** At the date of transition (01/02/15) from NW CSU, the costs of providing the CHC, FNC and Complex Care Commissioning Service will be less than or equal to the existing (2014/15) cost of the service to Cheshire & Wirral CCGs. Future costs will be dependent on:
  - The outcome of Workforce Re-design reviews (planned for post 01/02/15)
  - A new re-designed Future Model (planned for implementation summer 2015)
  - Future demand for CHC, FNC and Complex Care. |
| **6** A Clinical Governance system will be in place to ensure that Service Managers are accountable for continuously improving the quality of the CHC, FNC & Complex Care services and safeguarding high standards creating an environment in which excellence in clinical care will flourish.

This system will integrate with local CCG processes and include: risk management; clinical audit; education, training and continuing professional development; evidence-based care and effectiveness; patient and carer experience and involvement; efficient and effective staff management. |

| **7** The Senior Management Team will seek to continuously improve productivity and efficiency of the service through ongoing initiatives whilst maintaining a locality focus for services. |
Performance scorecards will need to be established from 01 February 2015 to enable effective management of the service and decision-making in a timely manner.

When the Future Model (Summer 2015) is implemented, there should be 3 levels of focus:
- Strategic
- Tactical
- Operational.

The table in this page describes what should be covered in the levels above and the scope of services that they should cover.

However, at the point of Service Transition from the NW CSU to CCGs, it will be important not to overload the new system with too many KPIs to manage.

It is proposed the ‘CRITICAL FEW” are used, at the strategic and tactical levels only, to provide visibility on service performance and the implementation of the new arrangements.

<table>
<thead>
<tr>
<th>Scorecard Focus</th>
<th>Pan-Cheshire &amp; Wirral</th>
<th>Locality-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALL CHC Services (CHC, FNC &amp; Complex Care)</strong></td>
<td><strong>Strategic</strong> level objectives, measures and targets across all services and footprint-wide (aligned to the Vision)</td>
<td><strong>Strategic</strong> level objectives for locality CHC services (aligned to the Vision and meeting any individual CCG Commissioning Intentions)</td>
</tr>
<tr>
<td><strong>CHC &amp; FNC</strong></td>
<td><strong>Tactical</strong> scorecard for the management of CHC &amp; FNC services across the footprint</td>
<td><strong>Operational-level</strong> scorecard for the management of CHC &amp; FNC services specific to a locality</td>
</tr>
<tr>
<td><strong>Complex Care</strong></td>
<td><strong>Tactical</strong> scorecard showing the breakdown of individual specialist complex care services (MH, PD, LD &amp; Children’s) across the footprint</td>
<td><strong>Operational-level</strong> scorecard for the management of specialist complex care services specific to a locality</td>
</tr>
<tr>
<td><strong>NW CSU Performance</strong></td>
<td><strong>Tactical</strong> scorecard showing the performance NW CSU against for the service components provided</td>
<td><strong>Operational-level</strong> scorecard showing (where relevant) Locality specific performance of NW CSU provided services.</td>
</tr>
</tbody>
</table>
On 01 February it is proposed that performance scorecards are managed at a pan-Cheshire & Wirral and CHC Locality-specific level.

Six potential categories have been identified to hold the ‘CRITICAL FEW’ performance measures and targets that will be used to measure performance.

The table on this page identifies the performance categories and the range of consideration for potential KPIs.

A long list of potential measures, in each of the categories identified, has been produced for consideration and is captured on pages 61-66.

Pages 68–71 set out the Scorecards that are recommended to the Target Model T&F Group for inclusion in the TOM from 01 February 2015.

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KPI</strong></td>
<td><strong>Measure</strong></td>
</tr>
<tr>
<td>a) CHC Service</td>
<td>Day to day operational service requirements</td>
</tr>
<tr>
<td>b) Patient Satisfaction</td>
<td>Complaints, disputes, commendations, speed of response to queries</td>
</tr>
<tr>
<td>c) Staff Engagement</td>
<td>Includes training, CPD, staff absenteeism, productivity, engagement, accidents</td>
</tr>
<tr>
<td>d) Finance &amp; Commercials</td>
<td>Budget, Projected LBE, High spend cases</td>
</tr>
<tr>
<td>e) Provider Management</td>
<td>Q&amp;S measures with regards to providers, commercial contracts at risk</td>
</tr>
<tr>
<td>f) Wider Stakeholders</td>
<td>Acutes, Local Authorities, NHS England, Third-Sector Parties</td>
</tr>
</tbody>
</table>
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

### CHC, FNC and Complex Care Service

<table>
<thead>
<tr>
<th>CHC ACTIVITY</th>
<th>MEASURE</th>
</tr>
</thead>
</table>
| **CLINICAL ASSESSMENT, ELIGIBILITY & CASE MANAGEMENT** | • % eligibility decisions reached within 28 days of receipt of checklist  
• Notification of non-eligibility within x days of eligibility assessment  
• % fast-track patients with provision in place within 48 hours of completed FT Tool  
• % patients in receipt of service provision with a completed 3 month review after eligibility decision  
• Notification to Finance of complex cases or potentially large cost cases arising within 48 hours of eligibility assessment  
• No of patients in receipt of a PHB out of total patients eligible  
• % Appeals upheld  
• % checklist completed within 14 days of request  
• No of incomplete referrals awaiting completion of a Checklist  
• % completed MDT referrals carried out jointly by health & social care professionals  
• No of pre-1 April 2013 retrospective applications with an outcome reached out of the total outstanding  
• No of post-1 April 2013 retrospective applications with an outcome reached out of the total outstanding |

| **INDIVIDUAL PATIENT COMMISSIONING** | • Time taken between panel decision & POC procurement  
• Tier 1 packages in place (Tran Admin)  
• Complex packages (Spec Admin)  
• Reviews scheduled against plan  
• % patients in receipt of service provision with a completed 12 month review  
• % spot purchased placements as a proportion of all current placements  
• % Current spot (NCA) placements out of area  
• % fast-track patients still in receipt of provision at 3 months |

| **PROVIDER MANAGEMENT** | • Safeguarding issues raised  
• % provider payments made  
• Number of queries raised to resolve provider payments  
• Number of queries resolved within agreed timescale |
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

**Patient Satisfaction**

<table>
<thead>
<tr>
<th>CHC ACTIVITY</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLAINTS</td>
<td>• Number of complaints raised this month</td>
</tr>
<tr>
<td></td>
<td>• Number of complaints resolved</td>
</tr>
<tr>
<td></td>
<td>• Number of complaints outstanding</td>
</tr>
<tr>
<td></td>
<td>• Complaints escalated to next level</td>
</tr>
<tr>
<td>DISPUTES</td>
<td>• Number of Disputes raised</td>
</tr>
<tr>
<td></td>
<td>• Number of disputes with regards to the process</td>
</tr>
<tr>
<td></td>
<td>• Number of eligibility disputes</td>
</tr>
<tr>
<td></td>
<td>• Number of disputes addressed and closed</td>
</tr>
<tr>
<td>COMMENDATIONS</td>
<td>• Number of commendations received</td>
</tr>
<tr>
<td>TIMELINESS OF RESPONSE</td>
<td>• Response time to resolve complaints</td>
</tr>
</tbody>
</table>
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

<table>
<thead>
<tr>
<th>CHC ACTIVITY</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENGAGEMENT</strong></td>
<td>• % staff engagement</td>
</tr>
<tr>
<td></td>
<td>• Number of grievances raised</td>
</tr>
<tr>
<td></td>
<td>• % staff absenteeism</td>
</tr>
<tr>
<td></td>
<td>• Staff turnover rate</td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>• % statutory &amp; mandatory completed</td>
</tr>
<tr>
<td></td>
<td>• Number of days stat &amp; man training taken to complete (&lt; 120 days?)</td>
</tr>
<tr>
<td></td>
<td>• % staff completed CPD</td>
</tr>
<tr>
<td></td>
<td>• % staff with CPD plans agreed</td>
</tr>
<tr>
<td></td>
<td>• % individual performance assessments completed</td>
</tr>
<tr>
<td><strong>HEALTH &amp; SAFETY</strong></td>
<td>Number of H&amp;S accidents at work</td>
</tr>
<tr>
<td><strong>PRODUCTIVITY</strong></td>
<td>• % roles unfilled</td>
</tr>
<tr>
<td></td>
<td>• % staff utilisation</td>
</tr>
</tbody>
</table>
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

<table>
<thead>
<tr>
<th>Financial Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHC ACTIVITY</strong></td>
</tr>
</tbody>
</table>
| **FINANCE** | • % high cost cases spend against CHC overall spend  
  • Complex care spend (YTD, Budget, LBE)  
  • CHC & FNC spend (YTD, Budget, LBE)  
  • OOA vs IA spend  
  • Joint-funded cases overall spend  
  • Locality specific spend  
  • Benchmarking spend against North of England CCG’s  
  • CSU level of spend  
  • Provider spend (YTD, Budget, LBE) |
| **COMMERCIAL** | • Provider payment days (No of days for payments to be made)  
  • % providers on contracts/frameworks  
  • Outside framework spend |
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

### Provider Management

<table>
<thead>
<tr>
<th>CHC ACTIVITY</th>
<th>MEASURE</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALITY</td>
<td>• % quality assessments against plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of CQC concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of safeguarding issues raised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of failure notices issued</td>
<td></td>
</tr>
<tr>
<td>COMMERCIAL</td>
<td>• Provider payment days (No of days for payments to be made)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % providers completing returns by target date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % providers on existing commercial contracts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outside framework spend</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of providers with payments withheld</td>
<td></td>
</tr>
<tr>
<td>FINANCE</td>
<td>• % provider spend against plan</td>
<td></td>
</tr>
</tbody>
</table>
This table summarises potential KPIs based on:

- The Vision & Key Objectives for the CHC & Complex Care Service described earlier in this document
- The existing SLA with NW CSU
- An internet based research of other CHC/Complex Care Services.

Together with the other tables on pages 61 – 66 it has been used to develop a set of recommended KPIs (pages 68 – 71) for inclusion in the TOM from 01 February 2015.

### Wider Stakeholders

<table>
<thead>
<tr>
<th>CHC ACTIVITY</th>
<th>MEASURE</th>
<th>TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTES</strong></td>
<td>• Number of referrals from Acutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of areas of concern raised by Acutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Relationship measure of CHC service with Acute</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNITY BASED TRUSTS</strong></td>
<td>• Number of referrals from Community Trusts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of areas of concern raised by Community Trusts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Relationship measure of CHC service with Community Trusts</td>
<td></td>
</tr>
<tr>
<td><strong>LOCAL AUTHORITIES</strong></td>
<td>• Number of joint-referrals from LA’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of areas of concern raised by LA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Relationship measure of CHC service with LA</td>
<td></td>
</tr>
<tr>
<td><strong>THIRD SECTOR PROVIDERS</strong></td>
<td>• Number of third sector providers actively supporting interventions in CHC</td>
<td></td>
</tr>
</tbody>
</table>
Target Operating Model

Proposed KPIs

At the point of Service Transition, from the NW CSU to CCGs, it will be important not to overload the new system with too many KPIs to manage.

Pages 68 – 71 set out the Scorecards and Monitoring Reports, containing the ‘Critical Few’ KPIs and Service Demand Measures, that were recommended and agreed by the Target Model T&F Group for inclusion in the TOM from 01 February 2015.

The proposed KPIs are at the strategic and tactical levels only, identifying targets for adoption across the Cheshire & Wirral geography to provide visibility on service performance and the implementation of the new arrangements. Operational, locally specific targets (where they are deemed appropriate by the future Joint Committee), will need to be developed as part of the Future Model of CHC, FNC & Complex Care commissioning.

Scorecards for ‘Financial Management’ and ‘Quality Assurance & Safeguarding’ service components are not included here. These components of the service will be the responsibility of individual CCGs and should be developed at that level post transition. It is recommended that discussions in these areas are informed by Cheshire & Wirral CHC & Complex Care ‘Finance Leads’ and local Quality & Safeguarding Leads and that the Joint Committee is required to endorse the KPIs in these areas to ensure a reasonable level of consistency.
## Tactical KPIs – Cheshire & Wirral Footprint

*KPIs highlighted in yellow below feature in the current Interim SLA with NW CSU – note the targets are revisited to reflect best practice service.*

<table>
<thead>
<tr>
<th>Scorecard Category</th>
<th>KPI Measure/ Definition</th>
<th>Target</th>
<th>Actuals &amp; Forecast</th>
<th>Trend &amp; Benchmark Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>YTD</td>
<td>Quarter</td>
</tr>
<tr>
<td>CHC &amp; FNC Service Performance</td>
<td>Eligibility decisions reached within 28 days of receipt of the Checklist.</td>
<td>90% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fast Track patients with provision in place within 48 hours of completed Fast Track Tool.</td>
<td>90% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients in receipt of service provision with a completed 3 month review after eligibility decision (Separate Lines for CHC &amp; FNC)</td>
<td>80% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients in receipt of service provision with a completed 12 month review. (Separate Lines for CHC &amp; FNC)</td>
<td>80% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information requests relating to complaints allocated and acknowledged to appropriate lead within 48 hrs of receipt</td>
<td>90% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The proportion of enquiries from service users, families and carers or professionals that were acknowledged within five working days</td>
<td>100% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of outstanding post 01/04/2013 PUPoC applications</td>
<td>Decreasing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of IRP Panel Appeals upheld</td>
<td>90% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Care Service Performance</td>
<td>Patients in receipt of complex care packages (where more than 50% health) with a completed 12 month review.</td>
<td>80% Achieved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Measure To Monitor Demand – Cheshire & Wirral Footprint

Reported to CCG Joint Committee and Joint Operations Group Reported At ‘Cheshire & Wirral’ & ‘Locality Levels’

**Frequency** – Quarterly, one month after the Quarters End.

First Report Produced for Q3 2014/15

## Scorecard Category

| CHC & FNC Service Demand |

## KPI Measure/ Definition

*KPIs highlighted in yellow below feature in Quarterly CHC & FNC returns to HSCIC required by NHS England.*

## Target

- **CHC patients newly eligible in the quarter, per 50k weighted**
  - N/A

- **CHC patients eligible at the quarter end, per 50k weighted population**
  - N/A

- **FNC patients newly eligible in the quarter, per 50k weighted**
  - N/A

- **FNC patients eligible at the quarter end, per 50k**
  - N/A

- **Proportion of Fast Track patients that were still in receipt of a package of CHC care at 3 months.**
  - N/A

## Actuals & Forecast

<table>
<thead>
<tr>
<th>YTD</th>
<th>Quarter</th>
<th>Rolling 4-Quarter Average</th>
<th>Q2 2014/15 (Pre Transition)</th>
<th>Previous Quarter</th>
<th>National/ Region/ Other Comparative CCGs</th>
</tr>
</thead>
</table>

## Trend & Benchmark Comparison

- **YTD**
- **Quarter**
- **Rolling 4-Quarter Average**
- **Q2 2014/15 (Pre Transition)**
- **Previous Quarter**
- **National/ Region/ Other Comparative CCGs**
### Tactical KPIs – Cheshire & Wirral Footprint

Reported to CCG Joint Committee and Joint Operations Group

Reported At ‘Cheshire & Wirral’ & ‘Locality Levels’

Frequency – Quarterly, one month after the Quarters End. First Report Produced for Q3 2014/15

<table>
<thead>
<tr>
<th>Scorecard Category</th>
<th>KPI Measure/ Definition</th>
<th>Target</th>
<th>Actuals &amp; Forecast</th>
<th>Trend &amp; Benchmark Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YTD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quarter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rolling 4-Quarter Average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2 2014/15 (Pre Transition)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Previous Quarter</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National/ Region/ Other Comparative CCGs</td>
</tr>
<tr>
<td><strong>Commercial Provider</strong></td>
<td>Proportion of providers from whom a care package was commissioned that were on existing commercial contracts</td>
<td>70% Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td>(Analysed by: Nursing Homes &amp; Domiciliary Care Cheshire &amp; Wirral, Each Locality and OOA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of spot purchased placements as a proportion of all current placements</td>
<td>Decreasing [TBI]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of Current spot placements out of area</td>
<td>Decreasing [TBI]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td>Number of Outstanding (Eligibility &amp; Funding) Disputes</td>
<td>Decreasing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Tactical KPIs – Cheshire & Wirral Footprint

**Part 1: Setting the Future Vision**  
**Part 2: Designing the Operating Model**  
**Part 3: Working up the Detail**  
**Part 4: Assurance Check**

Reported to CCG Joint Committee and Joint Operations Group  
Reported At ‘Cheshire & Wirral’ & ‘CHC Locality Teams’  
Frequency – Quarterly, one month after the Quarters End.  
First Report Produced for Q3 2014/15

<table>
<thead>
<tr>
<th>Scorecard Category</th>
<th>KPI Measure/ Definition</th>
<th>Target</th>
<th>Actuals &amp; Forecast</th>
<th>Trend &amp; Benchmark Comparison</th>
</tr>
</thead>
</table>
| **Staff Management** | **Proportion of staff that have completed mandatory training**  
*Note: Considered in the context of long term sickness and other significant absences e.g. maternity leave.* | 100% Achieved | N/A | N/A |
| | **Proportion of staff days lost due to sickness absence** | Decreasing | N/A | N/A |
| | **Proportion of staff with up to date CPD Plans Agreed** | 100% Achieved | N/A | N/A |
| | **Staff Turnover Rate**  
Labour turnover is equal to the number of employees leaving, divided by the average total number of employees, multiplied by 100 (in order to give a percentage value). The number of employees leaving and the total number of employees are measured over one calendar year.  
\{NELD} \{(NEBY + NEEY)/2 \right \} \times 100  
Where: NELD = Number of Employees who Left During the Yr; NEBY = Number of Employees at the Beginning of the Yr; NEEY = Number of Employees at the End of the Yr | Decreasing | N/A | N/A | 12 Month period as at 31 Dec 2014 | N/A |

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Part 3: Working up the Detail of the Operating Model

d) Systems, Data, Information

*(Ensuring it is accurate, reliable & complete)*
How the Broadcare Data & Information System Fits Into the Operating Model

Cheshire & Wirral CCGs will continue to use ‘Broadcare’, a specialist data management system that supports every part of the NHS Continuing Healthcare, Funded Nursing Care and Complex Care commissioning process. All performance and intelligence reporting will be through this tool also. It will be used to:

- Store all Patient/Client Data on every CHC, FNC & Complex Care patient that has been referred, assessed and where eligible has a package of care commissioned for them, including Personal Health Budgets
- Generate template letters ensuring each communication is recorded against each client, ensuring a fully auditable document trail
- To produce standard reports customised by the Cheshire & Wirral CCG CHC, FNC and Complex Care Service for performance management and audit purposes at an operational and strategic level
- To produce Department of Health quarterly figures
- Financial information to support payments, reconciliation and monitoring of spend at each CCG level.

The Broadcare system will be commissioned, managed and maintained by NW CSU on behalf of the Cheshire & Wirral CCGs. As such NW CSU will also be commissioned to:

- Monitor the overall health of the Broadcare application
- Audit compliance (e.g. input to mandatory fields) and consistency of data input across Cheshire & Wirral CCG CHC FNC and Complex Care Teams – making recommendations where corrective action is required
- Provide technical assistance to support the development of reports and template communications
- Ensure the Broadcare provider guarantees Cheshire & Wirral CCG data through re-configuration, patching, upgrades, backup and restore, database cloning, test management, and data clean-up routines
- Ensure the Broadcare provider backs-up data as contractually required
- Supports increased data quality through the development (if not already in place) and continued use and application of shared data policies, models and methods.
- Ensure the privacy, security and integrity of your data
- Training new staff in its use (additional training requirements would be negotiated separately to the SLA discussed below)

The above requirements will be included in an SLA for NW CSU CHC, FNC and Complex Care related service components to be negotiated by Neil Evans (EC CCG on behalf of the Cheshire & Wirral Partnership) and signed with SC CCG (as host CCG). Contractual arrangements for all NW CSU service components will need to be in place before the 31/1/15.

The CHC, FNC and Complex Care Senior Management Team, reporting to the Joint Committee of CCGs as accountable body, will be responsible for all data input to the system.

As part of developing the future model of care CCGs will need to consider how they use the Broadcare system (or any alternatives) to drive improvements in the quality and efficiency of the CHC, FNC and Complex Care commissioning service – and where they buy in their advice and support for this system management tool.
Roles & Responsibilities

The Cheshire & Wirral CCG CHC, FNC and Complex Care Joint Committee will from 01 February 2015 set the direction for IT & the use of new innovative technology within the CHC, FNC and Complex Care Commissioning Services.

The CHC, FNC and Complex Care Senior Management Team and the Joint Operational Group (including NW CSU membership) will ensure that solutions and adopted technology are designed around optimal clinical workflows, enabling health and care professionals to do their jobs more effectively.

South Cheshire CCG, as the owner of all CHC, FNC and Complex Care assets, will on behalf of the CCG collaborative be responsible for the procurement and maintenance of all equipment.

Key Deliverables

Based on the IHS Due Diligence Report (September 2014) the priorities for CCGs during the early part of the transition process will be to develop the following technology enabled capabilities to enhance service capacity.

- Mobile access to digital care records across the geography through use of laptop and smart phones, using dongles and VPNs – freeing up practitioners freed from having to return to base to access/update digital care and assessment records.
- Digital capture of clinical data at point-of-care – reducing effort in recording data, avoiding duplicate data entry, reducing time in making data available to others and increased quality of data entry.
- Remote face-to-face interaction e.g. practitioner advice during the assessment and review process, discussions with providers, saving travel.
- Smart workforce deployment - support for allocating visits/cases, training and development management, E-learning reducing travel effort and expense.

Interim TOM Priority During Transition

At the TOM Workshop held on 22 December 2014 the primary focus was on mobile access to the Broadcare digital care and assessment records for ICNs and Specialist Complex Care Nurses. The CHC, FNC and Complex Care Senior Management Team will during January 2015 work with clinical, administration, Broadcare system (NW CSU) and IT (SC CCG) leads to identify what is required to create an agile workforce and to maximise productivity.

Recommendations will need to be produced for consideration by the Operations & Transition Group (pre transition) and the Joint CCG Committee and Operating Groups (post transition). As well as Value for Money considerations proposals will need to consider: and align with:

- Technology, and Architecture Standards – e.g. NHS Number
- Open Application Programming Interfaces (APIs)
- Interoperability standards,
- Information Governance and Open Source Solutions.

IT & Technology Fund

The CHC, FNC and Complex Care Finance Leads group will need to agree the size of and contributions to an IT & Technology Fund as part of pooled budget arrangements.
Part 4: Assurance Check

The transfer of core CHC, FNC and Complex Care Commissioning Services to CCGs on 01 February 2015 is the first stage of a transformation process that will include:

- Workforce Re-design (01 February – March 2015)
- Implementation of a New Operating Model based on national best practice (Summer 2015).

Throughout this programme of work, as they design and move towards the future state, it is important that Cheshire & Wirral CCGs ensure that they are continually addressing the areas of concern and key risks identified in the Due Diligence Report produced by IHS in September 2014.
To ensure a thorough current state diagnostic IHS adopted a risk management approach.

The following areas were assessed:

- Organisational capability
- Performance against the SLA and concerns expressed by CCG leads
- The individual service components of the CHC service.

IHS subsequently used the risk assessment to identify the priorities for action and to inform its recommendations for future action by Cheshire & Wirral CCGs.

This page provides an illustration of how the outcomes from this process were presented.

Pages 77 – 81 illustrate the risk assessment in each of the three areas considered.
IHS evaluated each area of the organisational capability diagnostic in terms of the level of risk currently experienced by CCG’s with regards to the CHC service provider. Each diagnostic area had 2 criteria:

- The significance or impact of each risk from a clinical, financial, CCG reputation or patient perspective
- The likelihood of each risk occurring.

<table>
<thead>
<tr>
<th>Diagnostic Area</th>
<th>Level of Significance / Impact (Low, Medium, High)</th>
<th>Likelihood of Risk (Low, Medium, High)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical</td>
<td>Financial</td>
</tr>
<tr>
<td>Clinical Leadership &amp; Direction</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Capability &amp; Capacity</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Roles &amp; Accountabilities</td>
<td>M</td>
<td>L</td>
</tr>
<tr>
<td>CHC Service Performance</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Financial Management</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Integrated Partnerships</td>
<td>L</td>
<td>M</td>
</tr>
<tr>
<td>Governance &amp; Assurance</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Contract Management</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Quality &amp; Safeguarding</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Performance Management</td>
<td>H</td>
<td>H</td>
</tr>
</tbody>
</table>
In summary, the key diagnostic areas which were of most concern were:

- Clinical Leadership & Direction
- Capability & Capacity
- Financial Management.
### Key Findings – IHS Due Diligence Report – Areas of Concern Raised by CCGs (1)

Each of the key areas of concern raised by CCG’s during the 1:1 interviews were evaluated against the level of risk experienced by CCG’s with regards to the CHC service.

Each diagnostic area had 2 criteria:
- The significance or impact of each risk from a clinical, financial, CCG reputation or patient perspective
- The likelihood of each risk occurring.

<table>
<thead>
<tr>
<th>CCG Areas of Concern</th>
<th>Level of Significance / Impact (Low, Medium, High)</th>
<th>Likelihood of Risk (Low, Medium, High)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical</td>
<td>Financial</td>
</tr>
<tr>
<td>Capacity</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Capability</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Value for Money</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Clinical Control &amp; Leadership</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Provider Contract Management</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Transparency &amp; Visibility</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Governance &amp; Assurance</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Proactive &amp; actively managing issues</td>
<td>L</td>
<td>M</td>
</tr>
<tr>
<td>Backlog of Reviews</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Integration with existing CCG programmes</td>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>

Part 1: Setting the Future Vision
Part 2: Designing the Operating Model
Part 3: Working up the Detail
Part 4: Assurance Check
Key Findings – IHS Due Diligence Report – Areas of Concern Raised by CCGs (2)

In summary, the key diagnostic areas which were of most concern were:

- Capacity
- Clinical Control & Leadership
- Governance & Assurance
- Capability
- Backlog of Reviews.

Positions are relative to each other in relation to risk and its severity.

RISK LIKELIHOOD

IMPACT (Clinical, Financial, Reputational, Patient)

Part 1: Setting the Future Vision
Part 2: Designing the Operating Model
Part 3: Working up the Detail
Part 4: Assurance Check
For simplicity, the CHC service was distilled down to a number of core components to make the risk assessment more meaningful and manageable.

Specific areas of highest risk are as follows:

- Backlogs of reviews as part of case management
- Patient Commissioning & integration of clinical, finance & contracts to secure value for money & best outcomes for patients
- Visible Clinical governance across the footprint.

<table>
<thead>
<tr>
<th>CCG Areas of Concern</th>
<th>Level of Significance / Impact (Low, Medium, High)</th>
<th>Likelihood of Risk (Low, Medium, High)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical</td>
<td>Financial</td>
</tr>
<tr>
<td>Capacity</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Capability</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Value for Money</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Clinical Control &amp; Leadership</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Provider Contract Management</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Transparency &amp; Visibility</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Governance &amp; Assurance</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>Proactive &amp; actively managing issues</td>
<td>L</td>
<td>M</td>
</tr>
<tr>
<td>Backlog of Reviews</td>
<td>H</td>
<td>M</td>
</tr>
<tr>
<td>Integration with existing CCG programmes</td>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>

Part 1: Setting the Future Vision
Part 2: Designing the Operating Model
Part 3: Working up the Detail
Part 4: Assurance Check
Following the assessment of the CHC service components there were 2 distinct groupings which emerged as high risk areas:

- Clinical Governance & Assurance
- Individual Patient Commissioning
- Clinical Assessment & Review (the issue being the large number of backlogs in reviews.)
Workshop Objectives

The objectives for the workshop (including 21 participants; CHC, FNC and Complex Care staff; CCG clinical, managerial and finance leads; and representatives from NW CSU) were as follows:

- To brief all attendees on the intended CHC Target Operating Model from the point of transition (01/02/15).
- To ‘strength-test’ the TOM by considering five areas of perceived high risk, describing how the operating model will work and developing solutions to mitigate these risks.
- Using group work on the high risk areas to produce a RACI for all key CHC / Complex Care roles such that there is common understanding of who will be responsible, accountable, consulted and informed during the delivery of services.
- To capture key observations on what works well, what needs further improvement, and what needs to change – prior to transition.
- To agree the key outputs and next steps required to address outstanding risks.

Following advice from the Target Model Task & Finish Group IHS produced a synopsis of the high risk areas highlighted in their original due diligence work. (See Pages 84 and 85).

The view of the Target Model Group was that this synopsis would help to identify the risk areas that should be considered by the participants at this workshop with a view to:

- Further defining or amending the draft TOM before signoff by the Cheshire & Wirral CCG CHC Steering Group on 23 January 2015
- Identifying additional actions required to support transition.
- Mitigation of the risks that needed to be addressed in the transfer of the service to CCGs, in advance of workforce re-design and the identification of a future state model for the provision of commissioning support services in this area.

The following ‘high risk’ areas were signed off by the Target Model Group Chair for consideration during the group work at the workshop.

- Clinical Leadership & Direction
- Capability & Capacity
- Quality & Safeguarding
- CHC Service Performance
- Governance & Assurance.

The workshop participants were divided into five groups with each group asked to work on one risk area, addressing the following questions:

- How will the operating model work to mitigate this risk/issue? Where, how, who, when? What would success look like?
- How will progress be monitored, captured and reported?
- If a problem arose, how would this be dealt with and escalated for a decision? Will it be fast and effective?
- Where does accountability sit within the governance and operational arrangements of the new service?
- Who will be responsible?
- Who and which organisations will be involved?
- Is there common understanding and application across all groups and attendees?
- Where there are differences - is further work to clarify the TOM required?
- Are there areas of confusion and how can these be resolved?
The following ‘high risk’ areas were signed off by the Target Model Group Chair for consideration during the group work at the workshop.

- Clinical Leadership & Direction
- Capability & Capacity
- Quality & Safeguarding
- CHC Service Performance
- Governance & Assurance

### Area of Risk/Concern

<table>
<thead>
<tr>
<th>Area of Risk/Concern</th>
<th>Synopsis of September 2014 - Due Diligence Report</th>
</tr>
</thead>
</table>
| Clinical Leadership & Direction | Clinical leadership at Board level is critical to provide the strategic direction on the development and improvement of the CHC/FNC & Complex Care Service.  

There needs to be evidence of problem solving and the resolution of key issues by the leadership at this level other than simply seeking solutions for operational issues at an individual locality CCG level.  

The failure to deliver a comprehensive service (and to manage pressures) cannot be presented for individual CCGs to resolve at a locality level with separate requests for additional funding and prioritisation often requiring specialist clinical expertise and knowledge. This approach equates to a lack of proactivity and strategic leadership. The leadership cannot absolve responsibility/accountability for locality specific service improvement plans without CCGs losing their confidence in the assurance and governance arrangements.  

Criteria for success include: Strategic direction, proactive management and robust clinical assurance processes in place. |
| Capability & Capacity | This is widely acknowledged and recognised as a critical issue. Identified in 2013/14 but to date still no resolution across the Cheshire & Wirral footprint. Even where local CCG support provided (people and funding), an unacceptable level of service issues remain. Concerns include:  

- Lack of capacity in locality teams to meet all contracted obligations and to achieve basic KPIs based on productivity, level of administrative burden on nurses and allocation of resources across localities based on population.  
- Lack of capacity in complex/specialist areas leading to limited service provision (i.e. individuals ‘spread too thin’).  
- Capacity and capability of centralised admin teams.  

Criteria for success include:  

- Clarity of core skills required  
- Service appropriately resourced to meet demand  
- Robust staff development & peer reviews in place  
- Behaviors reflecting organisational aspirations. |
| Quality & Safeguarding | Small team which has had to be supported by individuals brought from CCGs to supplement activities. Capacity of CSU team is not enough to meet the requirements/demands of each CCG. More a reactive operational service than a proactive service. Lack of clinical assurance across all service providers regarding standards of care.  

Criteria for success include:  

- Clinical assurance across all providers and their standards of care  
- Immediate reactive response for emergency and/or critical events  
- Proactive plan to assure the quality & safeguarding of patients  
- Integrated approach across MDTs agencies and providers in a footprint (both in and out of area). |
The following ‘high risk’ areas were signed off by the Target Model Group Chair for consideration during the group work at the workshop.

- Clinical Leadership & Direction
- Capability & Capacity
- Quality & Safeguarding
- CHC Service Performance
- Governance & Assurance.

<table>
<thead>
<tr>
<th>Area of Risk/Concern</th>
<th>Extract from September 2014 Due Diligence Report</th>
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<tbody>
<tr>
<td>CHC Service Performance</td>
<td>Levels of performance in key areas do not meet basic KPIs. CCGs cannot be confident that an efficient, effective and fit for purpose CHC service is being delivered.</td>
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<td>Performance measures are not consistently reported and are not used to drive service improvement plan. Inconsistent approaches and ways of working across teams/geographic areas. No agreed – service wide - operational plan.</td>
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<td>Criteria for success include:</td>
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<td>- Aligned key measures and targets.</td>
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<td>- Clearly articulated service offers aligned to CCG requirements</td>
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<td>- End to end delivery is efficient, effective and fit for purpose</td>
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<td>- Consistency in service delivery across all teams and areas</td>
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<td>- Performance measures clearly articulated &amp; used to drive service improvements.</td>
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<tr>
<td>Governance &amp; Assurance</td>
<td>CCG’s feel exposed to areas of perceived clinical, safety and financial risk where reporting is not robust and where there is no credible data/information. No clear decision making and consistent governance arrangements are in place across the CHC service. In particular clinical assurance needs to be more visible and robust.</td>
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<td>Requirement is for a robust assurance and governance framework that provides effective decision making in a timely and efficient manner</td>
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Workshop Outputs

The outputs from the workshop are described in a set of tables (pages 87 - 94) that provide a high level summary of:

- Key issues discussed by each group
- A basic RACI for each Key Issue
- Action required following the workshop.

This summary has been used to produce this Target Operating Model which was considered by the Cheshire & Wirral CHC & Complex Care Steering Group on 23 January 2015.
<table>
<thead>
<tr>
<th>Group</th>
<th>Issues</th>
<th>Comment</th>
<th>Accountability</th>
<th>Responsibility</th>
<th>Consulted (Involved)</th>
<th>Informed</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>CHC Service Performance</td>
<td>Broadcare Training for New Staff</td>
<td>Data which is accurate, reliable and complete is an essential component of the CHC &amp; Complex Care Commissioning Support Service.</td>
<td>SC CCG (as host CCG) will be accountable to the Cheshire &amp; Wirral CHC &amp; Complex Care Joint CCG Committee* for the SLA agreed with NW CSU.</td>
<td>As such the NW CSU will be responsible for delivering training through an SLA with SC CCG.</td>
<td>The CHC &amp; Complex Care Senior Management Team will need to ensure that that staff are available to attend training requirements.</td>
<td>CHC &amp; Complex Care Staff including locality and specialist teams</td>
<td>To be reflected in Target Operating Model for implementation on 01 February 2015.</td>
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<td>The CCGs will continue to use ‘Broadcare’, a specialist data management system that supports every part of the NHS Continuing Healthcare, Funded Nursing Care and Complex Care commissioning process.</td>
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<td>SLA (for implementation before 01 February 2015) to include core training provision by NW CSU.</td>
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<td>The Broadcare system will be commissioned, managed and maintained by NW CSU via an SLA with SC CCG (as host CCG).</td>
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<tr>
<td>CHC Service Performance</td>
<td>Broadcare Quality Assurance</td>
<td>As above.</td>
<td>Cheshire &amp; Wirral CHC &amp; Complex Care Joint Operations Group reporting to CCG Joint Committee</td>
<td>NW CSU via the SLA with SC CCG will be responsible for auditing compliance (e.g. input to mandatory fields) and consistency of data input across Cheshire &amp; Wirral CCG CHC &amp; Complex Care Teams – making recommendations where corrective action is required.</td>
<td>Implementing action to ensure high quality data will be the responsibility of the CHC &amp; Complex Care Senior Management Team</td>
<td>CHC &amp; Complex Care Staff including locality and specialist teams</td>
<td>To be reflected in Target Operating Model for implementation on 01 February 2015.</td>
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<td></td>
<td>NW CSU will be required to provide Quality Assurance Reports to Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group to be managed by SC CCG on behalf of the partnership.</td>
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<td></td>
<td>Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group to be established before 01 February 2015.</td>
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</table>

*NB: Referred to as Joint CCG Committee from this point forward.
## Workshop Outputs (2)

<p>| Group                     | Issues                                      | Comment                                                                                                                                                                                                 | Accountability                                                                                      | Responsibility                                                                                       | Consulted (Involved)                                                                 | Informed                                                                 | Action                                                                                           |
|---------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <strong>CHC Service Performance</strong> | Data Input to Broadcare System               | Data which is accurate, reliable and complete is an essential component of the CHC &amp; Complex Care Commissioning Support Service. The CCGs will continue to use ‘Broadcare’, a specialist data management system that supports every part of the NHS Continuing Healthcare, Funded Nursing Care and Complex Care commissioning process. The Broadcare system will be commissioned, managed and maintained by NW CSU via and SLA with SC CCG (as host CCG). | Cheshire &amp; Wirral CHC &amp; Complex Care Joint Operations Group reporting to CCG Joint Committee         | The CHC &amp; Complex Care Senior Management Team, reporting to the Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group will be responsible for all data input to the system. | All CHC &amp; Complex Care Staff. CCG Quality Assurance &amp; Safeguarding Teams            | All CHC &amp; Complex Care Staff. CCG Quality Assurance &amp; Safeguarding Teams                | To be reflected in Target Operating Model for implementation on 01 February 2015. |
| <strong>CHC Service Performance</strong> | Broadcare Management &amp; Administration       | As above.                                                                                                                                                                                                | SC CCG will manage an SLA with NW CSU for the provision of Broadcare related services. SC CCG will subsequently report to the Joint Committee of CCGs. | NW CSU will be responsible for the management and administration of the Broadcare system through an SLA with SC CCG. | CHC &amp; Complex Care Senior Management Team for advice on some aspects of SLA requirements. CCG Joint Committee Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group. |                                                                                         | To be reflected in Target Operating Model for implementation on 01 February 2015. |
|                           |                                             |                                                                                                                                                                                                           |                                                                                                     |                                                                                                     | SLA (for implementation before 01 February 2015) to include management and maintenance of the Broadcare system by NW CSU. |                                                                                         |                                                                                         |</p>
<table>
<thead>
<tr>
<th>Group</th>
<th>Issues</th>
<th>Comment</th>
<th>Accountability</th>
<th>Responsibility</th>
<th>Consulted (Involved)</th>
<th>Informed</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>CHC Service Performance</td>
<td>Development and Management of Interim &amp; Future KPIs</td>
<td>Performance scorecards will need to be established from 01 February 2015 to enable clear visibility of performance for the effective management of the service, and decision-making in a timely manner.</td>
<td>Pre Transition – Cheshire &amp; Wirral CHC &amp; Complex Care Steering Group</td>
<td>Development Pre Transition - Target Model Task &amp; Finish Group.</td>
<td>All staff will be involved in the achievement and delivery of KPIs.</td>
<td>All staff will be involved in the achievement and delivery of KPIs.</td>
<td>The ‘Critical Few’ KPIs to be drafted and developed by the Target Model Task &amp; Finish Group, for sign off by the Steering Group on 14/01/15.</td>
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<td></td>
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<td>It was agreed at the workshop that there should be a culture of accountability using performance measurement to drive service improvement.</td>
<td>Post Transition - Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group reporting to CCG Joint Committee</td>
<td>Management Post Transition by the CHC &amp; Complex Care Senior Management Team</td>
<td>Both the Joint Committee of CCGs and the Joint Operations Group will be involved in ensuring support for their achievement and delivery.</td>
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<td>Workshop participants agreed that there should be a small (interim) basket of the ‘CRITICAL FEW’ performance measures and targets for monitoring success post 01 February 2015. The following KPIs were identified as being important in group discussions at the workshop:</td>
<td></td>
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<td>Development Pre Transition – will be the responsibility of the Target Model Task &amp; Finish Group reporting to CHC &amp; Complex Care Steering Group.</td>
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<td>Reduction/eradication of backlog reviews Less Disputes Increased staff satisfaction Reduced sickness absence Improved staff retention Increased opportunity for CPD Decrease in Safeguarding Incidents Patient Satisfaction</td>
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<tr>
<td>CHC Service Performance</td>
<td>Communication</td>
<td>It is important to ensure that there is communication between all working groups both pre and post transition. As part of this process the implications of implementing the Target Operating Model will be addressed.</td>
<td>Pre transition - CHC &amp; Complex Care Steering Group</td>
<td>All working Group Chairs.</td>
<td>All working groups members - CCG Leads, IHS, CHC &amp; Complex Care Senior Management Team -</td>
<td>Staff via formal consultation and regular team meetings.</td>
<td>Critical TOM implications and actions to be identified for each working group by IHS (5/1/15).</td>
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</table>
### Workshop Outputs (4)

<table>
<thead>
<tr>
<th>Group</th>
<th>Issues</th>
<th>Comment</th>
<th>Accountability</th>
<th>Responsibility</th>
<th>Consulted (Involved)</th>
<th>Informed</th>
<th>Action</th>
</tr>
</thead>
</table>
| Capacity & Capability | IT & Technology Solutions to provide increased capacity. | Restricted capacity is a widely acknowledged and recognised as a critical issue (See description of risk - slide 5). Further points for consideration highlighted by this group included:  
- The complexity of individual cases and patients’ needs  
- NHS wide financial pressures  
- Increased family expectations  
- The size of the geographical area that needs to be served  
- The additional pressure that reviews when addressed may put on the existing service. To mitigate these risks short term action was highlighted for consideration in the following areas:  
- Mobile working and technology  
- Skill mix review and revised structures that tackle administration and caseload issues relating to overlapping roles and the need for greater productivity. The group identified a wide range of success factors and potential KPIs (which are reflected in other Parts). | Pre-transition – CHC & Complex Care Steering Group and Operations & Transition Group.  
Post Transition - Cheshire & Wirral CHC & Complex Care Operations Group reporting to CCG Joint Committee | *Pre Transition – Workforce Re-design Group, Operations & Transition Group and CHC & Complex Care Senior Management Team.  
*Post Transition CHC & Complex Care Senior Management Team and Cheshire & Wirral CHC & Complex Care Operations Group | All staff need to be consulted and involved in delivering change in this area. All staff need to be consulted and involved in delivering change in this area. | CHC & Complex Care Senior Management Team to arrange an immediate meeting between key staff* and IT Lead. Note: IT Lead in SC CCG (host) needs to be identified.  
Early insight on ‘direction of travel’ from Workforce Re-Design Group to be shared with CHC & Complex Care Senior Management Team. This is to be followed with early meeting of key staff** to think through how to free up capacity through re-design considering structure, roles, skill mix and capability. CHC & Complex Care Finance Leads group will need to agree the size of and contributions to an IT & Technology Fund as part of pooled budget arrangements. Update TOM to reflect short term need to invest in technology solutions required to support more agile working e.g. mobile internet dongles, VPNs voice recognition etc.,. |
### Workshop Outputs (5)

<table>
<thead>
<tr>
<th>Group</th>
<th>Issues</th>
<th>Comment</th>
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<th>Responsibility</th>
<th>Consulted (Involved)</th>
<th>Informed</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Quality &amp; Safeguarding</td>
<td>Data Input to Broadcare System.</td>
<td>This group considered the critical success factors required to ameliorate Quality &amp; Safeguarding risk, including:</td>
<td>Cheshire &amp; Wirral CHC &amp; Complex Care Operations Group reporting to CCG Joint Committee</td>
<td>CQC and CCG Quality &amp; Safeguarding Teams will be responsible for assessing providers within their geographies. CCG teams will monitor local providers on behalf of all the CCGs in the Cheshire &amp; Wirral partnership.</td>
<td>CHC &amp; Complex Care Staff and Senior Management Team Providers LAs CCG Quality &amp; Safeguarding Teams NW CSU</td>
<td>CHC &amp; Complex Care Staff and Senior Management Team Providers LAs CCG Quality &amp; Safeguarding Teams NW CSU</td>
<td>To be reflected in Target Operating Model for implementation on 01 February 2015. SLA (for implementation before 01 February 2015) to include requirements for maintaining provider list by NW CSU.</td>
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<tr>
<td>Quality &amp; Safeguarding</td>
<td>Contracts for all Providers</td>
<td>As above.</td>
<td>NW CSU reporting to Joint Operations Group.</td>
<td>Ultimately, NW CSU via the SLA with SC CCG will be responsible for the agreement, management and administration of commercial contracts with providers of CHC, FNC (greater than a 50% NHS contribution) &amp; Complex Health Care. NW CSU will be directed in this regard by the CHC &amp; Complex Care Joint Operations Group</td>
<td>Pre Transition - Joint Operations &amp; Transition Group. Pre &amp; Post Transition – Quality &amp; Future Models Group + NW CSU Post Transition - Joint CCG Committee and Joint operations Group</td>
<td>CHC &amp; Complex Care Senior Management Team CCG Quality &amp; Safeguarding Teams CHC &amp; Complex Care Nurse Assessors Providers LAs NW CSU</td>
<td>A workshop will be held early in the transition process to develop work programme leading to the agreement of contracts with all providers. The workshop will be responsibility of Quality &amp; Future Model and Operations &amp; Transition Groups. Prior to the above placements and contracts will need to be mapped.</td>
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<td>Group</td>
<td>Issues</td>
<td>Comment</td>
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| Quality & Safeguarding & Integrated approach across MDTs agencies and providers in a footprint (both in and out of area). | Escalation of critical issues/ risks. | This group considered the critical success factors required to ameliorate Quality & Safeguarding Risk, including:  
   - Clinical assurance of all providers and their standards of care  
   - Immediate reactive response for emergency and/or critical events  
   - Alerts and early intervention to avoid crisis in care of patients  
   - Proactive plans and approach to ensure the quality & safeguarding of patients  
   - Improved sharing of intelligence across CCGs/ LA and CQC  
   - Particular needs to ensure the quality of domiciliary care for patients. | Individual CCGs will have accountability for Quality Assurance, Provider Monitoring & Safeguarding for the providers in their geographies.  
The Cheshire & Wirral Quality & Safeguarding Group will report through to the Joint Committee of CCGs | Escalation of critical issues will be through ‘Locality Meetings’ involving CCG Quality & Safeguarding Teams, CQC, LA and (where there are contracts NW CSU) – forming part of regular dialogue between key partners.  
A Cheshire & Wirral Quality & Safeguarding Group will support the development of a consistent approach across the geography, communicate key issues and arrange joint action where necessary. | CCG Quality & safeguarding Teams  
LA safeguarding teams  
CQC  
NW CSU (follow-up through contract management) | All CHC & Complex Care Nursing Staff.  
CCG Quality Assurance & Safeguarding Teams | To be reflected in Target Operating Model for implementation on 01 February 2015.  
SLA (for implementation before 01 February 2015) to include NW CSU involvement in Locality and Cheshire & Wirral wide Quality & Safeguarding meetings + requirement to follow up contract related actions as part of contract management function.  
Consideration will be given to developing a Cheshire & Wirral Quality & Safeguarding Group should NHS England Area Team arrangements be dissolved. This new group should be established by the Quality & Future Model Group during transition. |
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<tbody>
<tr>
<td>Governance &amp; Assurance</td>
<td>The Role of the CCG Joint Committee.</td>
<td>CCG’s feel exposed to areas of perceived clinical, safety and financial risk where reporting is not robust and where there is no credible data/information. No clear decision making and consistent governance arrangements are in place across the CHC service. In particular clinical assurance needs to be more visible and robust.</td>
<td>Individual CCGs will remain legally accountable for CHC &amp; Complex Care Commissioning. A CCG Joint Committee will oversee the management of the CHC and Complex Care Service on behalf of Cheshire &amp; Wirral CCGs. The CCG Joint Committee will report to individual CCG Boards and appropriate sub-committees in their individual governance arrangements.</td>
<td>South Cheshire CCG, as the host CCG, will be responsible for the organisation, administration and management of the CCG Joint Committee. The CHC &amp; Complex Care Senior Management Team will manage the service on behalf of CCGs and report to the CCG Joint Committee. Various sub groups will report to the CCG Joint Committee. To ensure visibility of financial issues a Cheshire &amp; Wirral Finance Leads Group will also report to the CCG Joint Committee.</td>
<td>Cheshire &amp; Wirral CCG Governing Bodies CHC &amp; Complex Care Senior Management Team CCG Joint Committee</td>
<td>All CHC &amp; Complex Care Staff. HWBs &amp; LAs Key providers</td>
<td>To be reflected in Target Operating Model for implementation on 01 February 2015. Steering Group to agree arrangements for Finance Leads Group to be established at Transition.</td>
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<tr>
<td>A requirement to establish a Cheshire &amp; Wirral wide Finance Leads Group</td>
<td>This group highlighted:</td>
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<td>• the need for a Finance Leads group reporting to the CCG Joint Committee</td>
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<td>• the CCG Joint Committee to ensure the consistent follow-up of key issues across the Cheshire &amp; Wirral system for the CCG Joint Committee to provide strategic direction for the CHC &amp; Complex Care Service at a clinical, managerial and financial level</td>
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<td>• for the CCG Joint Committee to ensure consistency in the definition and treatment of ‘Specialist Services’, the commissioning of OOA placements, the commissioning of MH/LD packages of care and Health Care Funding.</td>
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<tr>
<td>Group</td>
<td>Issues</td>
<td>Comment</td>
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</table>
| Clinical Leadership | The Role of the CCG Joint Committee.  
A requirement to establish a Cheshire & Wirral wide Finance Leads Group | Clinical leadership at Board level is critical to provide the strategic direction on the development and improvement of the CHC/ FNC & Complex Care Service. There needs to be evidence of problem solving and the resolution of key issues by the leadership at this level other than simply seeking solutions for operational issues at an individual locality CCG level. This group emphasised the following points.  
- The CCG Joint committee should bring a consistent approach, in line with national framework, across the CCGs, improve communication and improve understanding of the service at a strategic level. Building links with wider CHC networks & NHSE will need to be a feature of clinical leadership at this level.  
- Clinical leadership at this level should support integration and ensure professional support to both experts and generalists.  
- The CCG Joint Committee should be a clinically led group and together with new local QA & Safeguarding roles in CCGs should ensure there is a robust challenge into the system as and when required.  
- Strategic Clinical Leadership should ensure succession planning and a motivated workforce are priorities for senior management.  
- Every clinician working in the service should understand their contribution to CHC & Complex Care service development and be supported to deliver this contribution including support to patients as part of managing PHBs. | Individual practitioners will be accountable for the management of cases assigned to them.  
The CHC & Complex Care Senior Management Team will be accountable for providing individual practitioners with the support and training they require to deliver the service.  
The CCG Joint Committee will provide strategic leadership and clinical challenge to inform the management of the service by the Senior Management Team.  
The CHC & Complex Care Senior Management Team will manage the service on behalf of CCGs and report to the CCG Joint Committee.  
To ensure visibility of clinical quality issues. Each CCG will be required to identify a Clinical Lead from their Governing Body to attend Joint Committee meetings. | The CCG Joint Committee will provide strategic leadership and clinical challenge to inform the management of the service by the Senior Management Team. | CHC & Complex Care Senior Management Team | All CHC & Complex Care Staff. | Relevant Clinical Professional bodies and groups. | To be reflected in Target Operating Model for implementation on 01 February 2015. |
## 2015/16 Planning – Governing Body Update

**Agenda Item:**
3.1

**Reference**
GB14-15/0063

**Public / Private Meeting Date**
10/02/15

**Lead Officer**
Andrew Cooper, Head of Strategic Planning and Outcomes

### Contributors

**Link to CCG Strategic System Plan**
1. Patient and primary care centric and based on high quality primary care, secondary and community services  
2. Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes  
3. Commissioned services which have a sound evidence base  
4. Provides greater equality of access to all

**Link to current strategic objectives**
1. Prevent people from dying prematurely  
2. Enhance the quality of life for people with long term conditions  
3. Helping people to recover from episodes of ill health or following injury  
4. Ensuring people have a positive experience of care  
5. Ensuring people are treated and cared for in a safe environment and protected from avoidable harm

### To approve
Yes (requests a mandate for formal engagement on Vision 2018 emerging models)

### To note
Yes (in relation to progress to date with 2015/16 planning)

### Summary
The purpose of the paper is to update Wirral CCG Governing Body on progress to date with planning for commissioning of services in 2015/16.

However, it is acknowledged that progress in relation to the Wirral Vision 2018 transformation programme will be integral to planning for 15/16 and beyond; the paper therefore also provides detail relating to the emerging Vision 2018 models and seeks a mandate to formally engage with all stakeholders, including patients and the public, to further develop and implement the model.

### Comments
No additional comments

### Next Steps
The paper concludes by suggesting that formal engagement with all stakeholders is now required in order to seek opinion to further enhance the emerging Vision 2018 models and ensure that the CCG meets its duty in terms of public sector equality. This paper therefore requests a mandate from the Wirral CCG Governing Body to undertake this formal engagement on the proposed models.

In addition, the Governing Body is also asked to note the progress made to date with planning for the 2015/16 financial year as described in paragraphs 2.1 and 2.2 of the paper.
<table>
<thead>
<tr>
<th>What are the implications for the following (if not applicable please state why):</th>
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<tbody>
<tr>
<td>Financial</td>
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<td>Financial</td>
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<td>Value For Money</td>
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<td>Value For Money</td>
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<td>Risk</td>
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<td>Risk</td>
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<td>Legal</td>
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<td>Legal</td>
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<td>Patient and Public Involvement (PPI)</td>
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<td>Equality &amp; Human Rights</td>
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<td>Partnership Working</td>
</tr>
<tr>
<td>Partnership Working</td>
</tr>
</tbody>
</table>
Performance Indicators

Does the report indicate any relevant performance indicators for this item? NO
Report does not describe a service

Sustainability

Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)? YES
The emphasis of the report is to note progress with planning for sustainable services in both the short to medium term and take forward formal engagement on emerging models with a view to delivering sustainable services in the long term.

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)

\(\checkmark\)

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

<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>Five Year Forward View Summary</td>
<td>Wirral CCG Governing Body</td>
<td>06/01/15</td>
<td>Content noted with request for update at Governing Body in February 2015</td>
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</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). The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

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

1.1 The purpose of this document is to update Wirral CCG Governing Body on progress to date with planning for commissioning of services in 2015/16.

1.2 However, it is acknowledged that progress in relation to the Wirral Vision 2018 transformation programme will be integral to planning for 15/16 and beyond; the paper therefore also provides detail relating to the emerging Vision 2018 models and seeks a mandate to formally engage with all stakeholders, including patients and the public, to further develop and implement the model.

2. KEY ISSUES / MESSAGES

2.1 As identified in the paper submitted to the Wirral CCG Governing Body in January 2015, there are challenging timescales associated with submission of plans for 2015/16 commissioning. In terms of milestones, since the last Governing Body meeting, the CCG was required to submit initial headline data plans for a number of areas. These areas include anticipated activity and performance for Refer to Treatment Times (RTT) for consultant-led elective services, anticipated A&E activity and performance against the 4 hour treatment standard along with initial headline activity and predicted performance for cancer services.

2.2 Trend analysis was undertaken by the CCG Business Intelligence team to predict likely activity levels for 2015/16. This information was then reviewed along with projections for demographic growth and consideration of anticipated service developments in 2015/16 to agree the ‘first cut’ of data for the activity and performance submission. The required information was submitted to NHS England within the agreed timescales. Further, more detailed submissions are due by 20th February 2015.

2.3 In order to plan for beyond 2015/16, the Wirral health and social care economy has embarked on a programme of transformational change known as Wirral Vision 2018. The Wirral CCG Strategic Plan acknowledges the significant challenges faced locally in terms of demographics and socio-economic inequality that lead to disparity in health outcomes and identifies Vision 2018 as the vehicle to affect the necessary change.

2.4 In terms of the magnitude of the local issues, the Index of Multiple Deprivation (2010), ranked Wirral as being amongst the most deprived 20% of areas nationally. There are
significant inequalities - not only between Wirral and the rest of England, but also within Wirral. For example, the gap in life expectancy between the most and least affluent areas within Wirral was 12.4 years for men and 10 years for women (Marmot indicators 2014). In addition, the peninsula has a relatively high population of older people combined with a relatively low proportion of people in their twenties and thirties compared to England and Wales; the population over 85 is projected to increase by 29.9% by 2021. This ageing of the population is likely to result in increasing demand for services and, when considered against a backdrop of significant financial pressure on all public services, it is essential that more effective ways of making public money deliver better outcomes are identified.

2.5 In order to ensure a continued focus on the transformational change required, the Vision programme has identified a number of strategic objectives (Appendix 1). These have been developed through local prioritisation based on outputs from the Joint Strategic Needs Assessment (JSNA), the CCG Strategic Plan and stakeholder collaboration; the objectives have also been referenced against partner organisation strategic plans and objectives to ensure alignment across the economy. It is anticipated that these objectives will be delivered via the already established Vision 2018 workstreams which include the lead programme areas of unplanned care, planned care and long-term conditions and complex needs.

2.6 Latterly, the evolving principles and objectives of the Vision 2018 programme have begun to consolidate into 2 emerging models that not only identify that care must be provided in a more integrated way across primary, community and acute health sectors but must also recognise that integration with social care and connections into the voluntary, third sector and community assets are essential.

2.7 The focus of the emerging ‘Health and Wellbeing Model’ (see Figure 1 below) is person-centred and describes the health and social care provision for ‘Mrs Smith’ and her family. It considers self-care and independence as a foundation to wellbeing with access to public sector services in a timely and rapid manner, only when necessary. The model describes a care navigation approach to support access to layers of provision as appropriate to individual need, which in turn supports people to live healthier for longer.
2.8 Figure 2 below, the ‘Delivery Model’ (also known colloquially as the ‘Flower Model’), describes how the strategic view of health and wellbeing identified in Figure 1 could be delivered. It is based on a geographic structure, linked to the Integrated Care Coordination Teams (ICCTs) which are currently being implemented to provide integrated care across acute, mental health, community and social care sectors. However, it goes further than a focus purely on provision of statutory services and identifies the importance of reach into community assets to support self-care.
Figure 2 – Draft ‘Delivery Model’
2.9 Figure 3 below provides some tangible examples of how support and care could be provided within each of the strata of the 'petal'.

Figure 3 – Examples of Support and Care Provision
2.10 Through the Vision 2018 programme, these emerging models have undergone some initial 'market testing' with a number of groups as follows:

<table>
<thead>
<tr>
<th>Group</th>
<th>Attendees</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Stream Analysis (VSA) event</td>
<td>Multi-professionals</td>
<td>9th-11th December 2014</td>
</tr>
<tr>
<td>Vision 2018 Strategic Leadership Group, Implementation Group, Programme Managers</td>
<td>Multi-professionals</td>
<td>23rd Dec, 17th Dec, 5th Jan 2015</td>
</tr>
<tr>
<td>Integration Adults</td>
<td>Multi-professionals</td>
<td>8th January 2015</td>
</tr>
<tr>
<td>Diabetes</td>
<td>QIPP (Multi-professionals /specialist clinicians)</td>
<td>13th January 2015</td>
</tr>
<tr>
<td>End of Life</td>
<td>QIPP (Multi-professionals /specialist clinicians)</td>
<td>14th January 2015</td>
</tr>
<tr>
<td>Culture and Workforce</td>
<td>HR leads</td>
<td>14th January 2015</td>
</tr>
<tr>
<td>Full Time Officers</td>
<td>Full Time Officers</td>
<td>15th January 2015</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>QIPP (Multi-professionals /specialist clinicians)</td>
<td>16th January 2015</td>
</tr>
<tr>
<td>Engagement with People</td>
<td>Patients, public, voluntary sector</td>
<td>19th January 2015</td>
</tr>
<tr>
<td>Systems Resilience</td>
<td>QIPP (Multi-professionals /specialist clinicians)</td>
<td>19th January 2015</td>
</tr>
<tr>
<td>GP Members Forum (WGPCC)</td>
<td>GPs</td>
<td>19th January 2015</td>
</tr>
<tr>
<td>Wirral CCG Operational Group</td>
<td>CCG GPs and Managers</td>
<td>28th January 2015</td>
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<tr>
<td>GP Members Forum (WHCC)</td>
<td>GPs</td>
<td>29th January 2015</td>
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</table>

2.11 The feedback has been generally very positive with requests from some groups for additional clarification and further explanation of the terms and concepts referred to within the models. Whilst clarification has been provided to individual groups, it is suggested that structured, consistent and coherent engagement with all stakeholders is now required.
3. IMPLICATIONS AND CONCLUSION

3.1 In order to plan effectively for the future commissioning of services that are sustainable in terms of meeting the increasingly challenging needs of the local population within the constraints of public finance, it is essential that a shared vision for the future state is articulated and agreed.

3.2 It is proposed that the ‘Health and Wellbeing Model’ described above in Figure 1, along with the practicalities of the ‘Delivery Model’ described in Figures 2 and 3 begins to articulate this vision in a relatively straightforward and coherent manner. However, it is also acknowledged that feedback to date has been relatively informal.

3.3 It is therefore suggested that formal engagement with all stakeholders is now required in order to seek opinion to further enhance the model and ensure that the CCG meets its duty in terms of public sector equality. This paper therefore requests a mandate from the Wirral CCG Governing Body to undertake this formal engagement on the proposed models.

3.4 In addition, the Governing Body is also asked to note the progress made to date with planning for the 2015/16 financial year as described in paragraphs 2.1 and 2.2 above.
4. APPENDICES (Must be copied below or available on request – do not embed)

<table>
<thead>
<tr>
<th>No.</th>
<th>Title of Appendix</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Vision Strategic Objectives</td>
</tr>
</tbody>
</table>

Appendix 1

Vision Objectives

1. We deliver the right care in the right place at the right time. First time & every time.
2. We deliver an improved health & wellbeing experience to all patients, service users and carers, in all health, community and social care settings.
3. We reduce the frequency and necessity for emergency admissions and for care in hospital, residential and nursing home settings.
4. We enable more people to access appropriate and effective services closer to home.
5. We improve health & social care outcomes in early years to improve school readiness.
6. We enable more people to live independently at home for longer.
7. We improve the health and social care related quality of life for people with more than one long term condition, physiological and/or psychological.
8. We increase collaboration and effective joint working between health and social care partners.
9. We improve the satisfaction levels for our workforce colleagues across all health, community and social care settings.
10. We improve the end of life experience for individuals and their carers.
11. We are better able to prevent ill health and diagnose conditions quickly thereby reducing the burden on treatment facilities.
12. We enable people to live longer, healthier lives.
13. We reduce the cost of health & social care while maintaining balance of quality and value.
14. We ensure equal and fair access to clinically appropriate services for everyone on the Wirral.
15. We will reduce health inequalities so that all Wirral’s residents can expect and receive the same health & wellbeing opportunities.
## Integrated Performance and Finance Report

### Agenda Item:

4.1

### Reference

GB14-15/0064

### Public / Private

Public

### Meeting Date

10th February 2015

### Lead Officer

Mark Bakewell - Chief Financial Officer  
Lorna Quigley - Director of Quality and Patient Safety

### Contributors

CCG Finance and Business Intelligence teams

### Link to CCG Strategic System Plan

1. Patient and primary care centric and based on high quality primary care, secondary and community services  
2. Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes  
3. Commissioned services which have a sound evidence base  
4. Provides greater equality of access to all

### Link to current strategic objectives

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

### To approve

X

### Summary

The Governing Body is asked to:  
1. Note the financial position for Month 9 (December) and performance against the NHS constitution for month 8 (November)  
2. To support the actions that are being taken to mitigate against risks and under/over performance within the report.

### Comments

Next Steps

Continuation of performance monitoring through the remainder of the financial year

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

<table>
<thead>
<tr>
<th>Financial</th>
<th>Does the report consider the financial impact?</th>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>The report sets out the financial performance within the CCG for 2014/15 financial year</td>
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<thead>
<tr>
<th>Value For Money</th>
<th>Does the report consider value for money?</th>
<th>YES</th>
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<tr>
<td></td>
<td>All expenditure plans are subject to an ongoing value for money review.</td>
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<tr>
<th>Risk</th>
<th>Is there a documented risk assessment?</th>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>The report details the key risks and how these will be monitored in year as part of the reporting process</td>
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<thead>
<tr>
<th>Legal</th>
<th>Are there any legal implications and has legal advice been obtained?</th>
<th>YES</th>
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</table>
Legal advice is sought on issues as and when required.

<table>
<thead>
<tr>
<th>Patient and Public Involvement (PPI)</th>
<th>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</th>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>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.</td>
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</table>

<table>
<thead>
<tr>
<th>Equality &amp; Human Rights</th>
<th>Does the report provide evidence whether there could be a positive or negative impact on protected groups <em>statutory duty for new / changes to services</em>?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff?</th>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>The financial plan includes budgeted “running costs” expenditure and is reflective of the respective workforce implications in these areas</td>
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</table>

<table>
<thead>
<tr>
<th>Partnership Working</th>
<th>Does the report evidence a partnership working in its development?</th>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>The CCG works with a number of NHS Trusts and the Local Authority on a number of its commissioning budgets.</td>
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<table>
<thead>
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<th>Performance Indicators</th>
<th>Does the report indicate any relevant performance indicators for this item?</th>
<th>YES</th>
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<tbody>
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<th>Sustainability</th>
<th>Does the report address economic, social and environmental sustainability <em>should be addressed for new / change projects</em>?</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not applicable to this report.</td>
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**Do you agree that this document can be published on the website?**
(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

☑

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

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

10th February 2015
Performance Update Month 8
### NHS Wirral CCG
#### CCG Dashboard 2014/15

#### Health Outcomes Framework/Every one Counts

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<th>May</th>
<th>Jun</th>
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### NHS Constitution

#### RTT

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#### Cancer - 2 week

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#### Cancer - 31 day

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#### Cancer - 62 day

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#### Mixed Sex

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<th>Jul</th>
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#### Mental Health

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<th>Sep</th>
<th>Oct</th>
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<td>CPA follow up within 7 days</td>
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### Other - Activity & Efficiency

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<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
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<th>Dec</th>
<th>Jan</th>
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<th>Mar</th>
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<tr>
<td>- Total elective (YTD)</td>
<td>4,067</td>
<td>8,138</td>
<td>12,424</td>
<td>16,856</td>
<td>20,773</td>
<td>25,100</td>
<td>29,556</td>
<td>33,689</td>
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<tr>
<td>- Total elective plan (YTD)</td>
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<td>8,454</td>
<td>12,481</td>
<td>16,900</td>
<td>20,940</td>
<td>25,158</td>
<td>29,575</td>
<td>33,412</td>
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<td>- Non-elective (YTD)</td>
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<td>8,115</td>
<td>12,026</td>
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<td>20,295</td>
<td>24,398</td>
<td>28,361</td>
<td>32,329</td>
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<td>- Outpatients (YTD)</td>
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<td>22,751</td>
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<tr>
<td>- GP referrals (YTD)</td>
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<td>15,517</td>
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<tr>
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"Your partner in a healthier future for all"
## NHS Constitution - 4 hour A&E

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<th>Baseline</th>
<th>Preferred Outcome</th>
<th>Oct 2014</th>
<th>Nov 2014</th>
<th>Comment</th>
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<td>95%</td>
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<td>90.9%</td>
<td>86.7%</td>
<td>As the WIC is on site this is a combined target</td>
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<tr>
<td></td>
<td>Combined total</td>
<td>95%</td>
<td>Higher</td>
<td>95.9%</td>
<td>89.9%</td>
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<tr>
<td></td>
<td>Victoria Central Hospital walk in Centre</td>
<td>95%</td>
<td>Higher</td>
<td>98.8%</td>
<td>99.6%</td>
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<td></td>
<td>Eastham Walk in Centre</td>
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<td>Higher</td>
<td>99.7%</td>
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“Your partner in a healthier future for all”
Inpatient and A&E Friends and Family Tests

### Inpatients Friends and Family test

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<thead>
<tr>
<th>Acute Trust</th>
<th>% who recommend</th>
<th>% who don't recommend</th>
<th>Response rate</th>
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<tbody>
<tr>
<td>Wirral University Teaching Hospital NHS FT</td>
<td>84.5%</td>
<td>86.3%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Mid Cheshire Hospitals NHS FT</td>
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<td>97.1%</td>
<td>97.4%</td>
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<tr>
<td>The Clatterbridge Cancer Centre NHS FT</td>
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<td>96.8%</td>
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### Accident and Emergency: Friends and Family test

<table>
<thead>
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<th>Acute Trust</th>
<th>% who recommend</th>
<th>% who don't recommend</th>
<th>Response rate</th>
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<tbody>
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### Maternity: Friends and Family Test Question 1

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<th>% who recommend Dec-14</th>
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<th>% who don't recommend Oct-14</th>
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<td>Warrington &amp; Halton Hospitals NHS FT</td>
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### Maternity: Friends and Family Test Question 2

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<th>% who don't recommend Oct-14</th>
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### Maternity: Friends and Family Test Question 3

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<th>% who recommend Dec-14</th>
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<th>% who don't recommend Oct-14</th>
<th>% who don't recommend Nov-14</th>
<th>% who don't recommend Dec-14</th>
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<th>Dec-14</th>
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### Maternity: Friends and Family Test Question 4

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<th>% who don't recommend Oct-14</th>
<th>% who don't recommend Nov-14</th>
<th>% who don't recommend Dec-14</th>
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<th>Dec-14</th>
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<td>1.8%</td>
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Finance Update Month 9
2014/15 Key Planning Requirements

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

• Better Payment Practice Code
• Cash Management
Month 9 Update

- WUTH Position held on trajectory - £3.1m (M7) - £3.4m (M8) forecast held at £3.7m - circa £218m
- Deterioration of performance at Royal Liverpool, Countess, Non-Contracted Activity (0.7m YTD, £0.8m FOT)
- Increase in Spire (Murrayfield) activity (£77k YTD, FOT £208k)
- Increase in Prescribing Over Performance (£220k YTD, £204k FOT (forecast included pricing impact estimate)
- CHC / Packages position held but YTD broadly equal to FOT position at £1.1m - minimal risk coverage
- Residual Balance of Outturn QIPP Gap £6.3m and Contingency (£3.0m) remains

- Circa £1.1m adverse movement in YTD and Forecast Outturn based on Month 9 Update
- Potential 2nd revision required of 2014/15 forecast outturn position £2.5m surplus to £1.4m surplus
- However CCG notified of return of resource regarding CHC retrospective top slice £1.1m
2014/15 Continuing Healthcare Risk Pool

• CCGs contributed to a £250m risk pool for 2014/15 based on their overall allocation size. £250m was the initial estimate of likely settlements in 2014/15 against the overall CHC provision at the end of 2013/14 of £732m – Wirral Share £1.7m

• There is forecast underutilisation against the pool of £155.6m in 2014/15 which will be returned to CCGs in the same proportions as their contribution to the £250m pool – Wirral Share £1.1m

• The return of the funding to CCGs was provided on the basis that they will show at Month 9 an improvement in their financial forecast for 2014/15 which is equivalent to the reduction in their CHC risk pool contribution.

• CCG’s invited to ‘discuss’ with NHS England should return not result in improvement

Impact on 2015/16

• Possible Clawback of returned resource

• Any subsequent under- or overspend against the revised CHC risk pool of £94.4m will be returned or collected in 2015/16 alongside the 15/16 contributions (15/16 Wirral estimate 1.7m).
Month 9 -
December

**Wirral Clinical Commissioning Group**

<table>
<thead>
<tr>
<th></th>
<th>Planned Surplus (M9)</th>
<th>Forecast Outturn Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£4.68m</td>
<td>(£4.68m) - Planned</td>
</tr>
<tr>
<td>Year to Date (M9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(£3.5m)</td>
<td></td>
</tr>
<tr>
<td>Revised Pro-Rata @ £2.5m -</td>
<td>(£1.9m)</td>
<td></td>
</tr>
<tr>
<td>Current ytd Surplus</td>
<td>(£1.5m)</td>
<td>(£2.5m) – Reported M7 Onwards</td>
</tr>
<tr>
<td>Operational Position</td>
<td>£2.0m</td>
<td>(£2.18m) Movement from Planned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>M9 YTD</th>
<th>M8 YTD</th>
<th>Movement</th>
<th>Forecast Outturn M9</th>
<th>Forecast Outturn M8</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>WUTH</td>
<td>(£3.8m)</td>
<td>(£3.4m)</td>
<td>(£0.4m)</td>
<td>(£3.7m)</td>
<td>(£3.7m)</td>
<td>£0m</td>
</tr>
<tr>
<td>Other NHS</td>
<td>£1.9m</td>
<td>£1.2m</td>
<td>£0.7m</td>
<td>£2.4m</td>
<td>£1.6m</td>
<td>£0.8m</td>
</tr>
<tr>
<td>Non NHS</td>
<td>£0.5m</td>
<td>£0.3m</td>
<td>£0.2m</td>
<td>£0.6m</td>
<td>£0.5m</td>
<td>£0.1m</td>
</tr>
<tr>
<td>Prescribing</td>
<td>£0.3m</td>
<td>£0.1m</td>
<td>£0.2m</td>
<td>£0.5m</td>
<td>£0.3m</td>
<td>£0.2m</td>
</tr>
<tr>
<td>CHC</td>
<td>£1.1m</td>
<td>£1.0m</td>
<td>£0.1m</td>
<td>£1.1m</td>
<td>£1.1m</td>
<td>£0.1m</td>
</tr>
<tr>
<td>Other &amp; Identified Slippage</td>
<td>(£0.4m)</td>
<td>(£0.4m)</td>
<td>(£0.4m)</td>
<td>(£2.0m)</td>
<td>(£1.0m)</td>
<td>(£1.1m)*</td>
</tr>
<tr>
<td>QIPP</td>
<td>£4.7m</td>
<td>£4.3m</td>
<td>£0.4m</td>
<td>£6.3m</td>
<td>£6.4m</td>
<td>(£0.1m)</td>
</tr>
<tr>
<td>Contingency</td>
<td>(£2.3m)</td>
<td>(£2.0m)</td>
<td>(£0.3m)</td>
<td>(£3.0m)</td>
<td>(£3.0m)</td>
<td>£0m</td>
</tr>
<tr>
<td></td>
<td>£2.0m</td>
<td>£1.0m</td>
<td>£1.0m</td>
<td>£2.6m</td>
<td>(£0.4m)</td>
<td>£1.0m</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td></td>
<td></td>
<td></td>
<td>(£4.7m)</td>
<td>(£4.7m)</td>
<td>£0m</td>
</tr>
<tr>
<td>Revised Surplus</td>
<td></td>
<td></td>
<td></td>
<td>(£2.5m)</td>
<td>(£2.5m)</td>
<td>£0m</td>
</tr>
</tbody>
</table>

“Your partner in a healthier future for all”
Forecast Outturn 2014/15

Forecast Assumptions

• Forecast Surplus (M9 - £2.5m (0.53% of plan) – remains as per M7 revision.

• YTD position reflect challenges of forecast delivery (deterioration in month but in line with forecast assumptions)

• Drivers remain consistent with plan around main expenditure areas
  – WUTH
  – Other Mersey Contracts (RLB, STHK, Aintree)
  – Prescribing,
  – Commissioned Out of Hospital Care,
  – QIPP Gap
# Self Assessment at Month 9 (December) 2014/15

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

Cash Management

- The CCG cash balance at the end of December was £46k. This is in line with current NHSE guidance that CCGs aim towards 1.25% month end

<table>
<thead>
<tr>
<th>Month</th>
<th>Period</th>
<th>Financial Paid Year</th>
<th>Total Number of Invoices Paid</th>
<th>Total Paid Within Target No.</th>
<th>%age</th>
<th>Total Value of Invoices Paid £</th>
<th>Value paid within Target £</th>
<th>%age</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRIL</td>
<td>01</td>
<td>14/15</td>
<td>859</td>
<td>851</td>
<td>99.07%</td>
<td>35,541,975.01</td>
<td>35,531,503.78</td>
<td>99.97%</td>
</tr>
<tr>
<td>MAY</td>
<td>02</td>
<td>14/15</td>
<td>1181</td>
<td>1173</td>
<td>99.32%</td>
<td>35,967,941.11</td>
<td>35,934,439.00</td>
<td>99.91%</td>
</tr>
<tr>
<td>JUNE</td>
<td>03</td>
<td>14/15</td>
<td>1034</td>
<td>1016</td>
<td>98.26%</td>
<td>34,361,056.48</td>
<td>34,341,056.80</td>
<td>99.94%</td>
</tr>
<tr>
<td>JULY</td>
<td>04</td>
<td>14/15</td>
<td>1294</td>
<td>1288</td>
<td>99.54%</td>
<td>36,872,841.93</td>
<td>36,862,171.57</td>
<td>99.97%</td>
</tr>
<tr>
<td>AUGUST</td>
<td>05</td>
<td>14/15</td>
<td>1082</td>
<td>1075</td>
<td>99.35%</td>
<td>35,004,849.52</td>
<td>34,990,681.87</td>
<td>99.96%</td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>06</td>
<td>14/15</td>
<td>1107</td>
<td>1081</td>
<td>97.65%</td>
<td>35,907,284.46</td>
<td>35,831,259.72</td>
<td>99.79%</td>
</tr>
<tr>
<td>OCTOBER</td>
<td>07</td>
<td>14/15</td>
<td>985</td>
<td>966</td>
<td>98.07%</td>
<td>35,315,488.67</td>
<td>35,277,394.25</td>
<td>99.89%</td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>08</td>
<td>14/15</td>
<td>1208</td>
<td>1186</td>
<td>98.18%</td>
<td>34,048,782.93</td>
<td>33,938,407.61</td>
<td>99.68%</td>
</tr>
<tr>
<td>DECEMBER</td>
<td>09</td>
<td>14/15</td>
<td>1039</td>
<td>1031</td>
<td>99.23%</td>
<td>34,799,099.14</td>
<td>34,734,998.49</td>
<td>99.82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9789</td>
<td>9667</td>
<td>98.75%</td>
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</table>

“Your partner in a healthier future for all”
## PRIMARY CARE REPORT

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>4.3</th>
<th>Reference</th>
<th>GB14-15/0064</th>
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<tr>
<td>Public / Private</td>
<td>Public</td>
<td><strong>Meeting Date</strong></td>
<td>10th February 2015</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Iain Stewart, Head of Direct Commissioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors</td>
<td>Barbara Dunton, Commissioning Support Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to CCG Strategic System Plan</td>
<td><strong>Edit as applicable:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Patient and primary care centric and based on high quality primary care, secondary and community services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Commissioned services which have a sound evidence base</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Provides greater equality of access to all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to current strategic objectives</td>
<td><strong>Edit as applicable:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Prevent people from dying prematurely</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Enhance the quality of life for people with long term conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Helping people to recover from episodes of ill health or following injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Ensuring people have a positive experience of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### To approve

Yes

### Summary

This report is the first update for the newly formed Direct Commissioning Team and provides summary detail of the range of activities undertaken within the five reporting domains. Key items from a primary care performance dashboard will be included in due course to further enhance the information reported to Governing Body.

### Comments

Direct Commissioning function is awaiting outcome of vacancy control submission to re-establish full staff complement.

### Next Steps

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

<table>
<thead>
<tr>
<th>Financial</th>
<th><strong>Does the report consider the financial impact?</strong> NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value For Money</th>
<th><strong>Does the report consider value for money?</strong> NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report provides summary detail on general activities undertaken across five</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Domain</th>
<th>Question</th>
<th>Answer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Is there a documented risk assessment?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
<tr>
<td>Legal</td>
<td>Are there any legal implications and has legal advice been obtained?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
<tr>
<td>Patient and Public Involvement (PPI)</td>
<td>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</td>
<td>YES</td>
<td>Based upon the initial engagement with the various patient contacts, there is a strong sense of patients wishing to be more involved in the commissioning process and subsequent decisions taken by the CCG for local health services.</td>
</tr>
<tr>
<td>Equality &amp; Human Rights</td>
<td>Does the report provide evidence of whether there could be a positive or negative impact on protected groups (statutory duty for new / changes to services)</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
<tr>
<td>Workforce</td>
<td>Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
<tr>
<td>Partnership Working</td>
<td>Does the report evidence a partnership working in its development?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
<tr>
<td>Performance Indicators</td>
<td>Does the report indicate any relevant performance indicators for this item?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains. However, there is agreement to develop a primary care dashboard that will report to the Quality, Performance &amp; Finance Committee.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)?</td>
<td>NO</td>
<td>Report provides summary detail on general activities undertaken across five domains.</td>
</tr>
</tbody>
</table>
Do you agree that this document can be published on the website?  
(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)

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

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

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

If you require any additional information please contact the Lead Officer.
<table>
<thead>
<tr>
<th></th>
<th>Primary Care Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Routine contract monitoring carried out by NHS England</td>
</tr>
<tr>
<td></td>
<td>• Enhanced Services monitoring carried out by Wirral CCG</td>
</tr>
<tr>
<td></td>
<td>• GP practice visits carried out by Head of DC and GP lead to four member practices noted to have below average rates for both unplanned admissions and referrals and negative variance for both – learning to be shared with all Wirral practices via primary care communications includes strong inter-GP communication about referral decisions; high awareness of the range of services available in the community; duty doctor system in place.</td>
</tr>
<tr>
<td></td>
<td>• Constant monitoring for quality of communications to Primary Care, both internal/external.</td>
</tr>
<tr>
<td></td>
<td>• Datix pilot about to commence in 4 practices to be used to report concerns raised regarding providers and significant events occurring in practice to look for themes. Will be rolled out to all practices when pilot phase complete.</td>
</tr>
<tr>
<td></td>
<td>• Bespoke Wirral risk stratification tool being piloted in 4 practices.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Member Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>• Attendance at WHCC &amp; GPCC existing GP Forums – discussed 5 Year Forward View; Co-Commissioning; new drug and alcohol service</td>
</tr>
<tr>
<td></td>
<td>• Invite extended to all 7 Alliance practices to join the WHCC GP Forum since December 2014</td>
</tr>
<tr>
<td></td>
<td>• Primary Care Communications email account firmly established as “funnel” for all communications, very positive feedback from members</td>
</tr>
<tr>
<td></td>
<td>• Practice Managers consultation/engagement event held Thursday 15th January 2015 to establish views of PMs and how they wish to be engaged with. Outcomes shared with all Practices Managers and future format agreed.</td>
</tr>
<tr>
<td>3</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>---</td>
<td>-------------------</td>
</tr>
<tr>
<td>• Practice Nurse Senate commenced, Direct Commissioning team want to meet with Practice Nurse colleagues in a similar consultation event to capture views on how they would like to engage/be engaged with going forward. Plan to meet mid-February.</td>
<td></td>
</tr>
<tr>
<td>• Member Practices’ event on 10th December 2014 to start engagement on Co-commissioning of primary care followed up with survey monkey questionnaire to gauge support and interest</td>
<td></td>
</tr>
<tr>
<td>• Members section to be created on CCG website to further enhance communications</td>
<td></td>
</tr>
<tr>
<td>• Head of Direct Commissioning (DC) attended GPCC Patient Forum to provide an update on organisational change.</td>
<td></td>
</tr>
<tr>
<td>• Head of DC met with Chairs of separate patient council groups to discuss changes and invite views on engagement going forward in the new structure</td>
<td></td>
</tr>
<tr>
<td>• Future meeting set for end February 2015 to establish a way forward with a patient engagement model</td>
<td></td>
</tr>
<tr>
<td>• Head of DC attending individual Patient Participation Groups by invite, to update patients on CCG and opportunities/ideas for future engagement.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DC Commissioning Support Manager attending launch of Directly Bookable Service (DBS), the replacement for Choose &amp; Book, this will offer patients the choice already offered under Choose &amp; Book, along with choice of appointment times, enabling patients when referred, can leave the surgery with an appointment time for the chosen clinic. Due to launch in spring 2015.</td>
<td></td>
</tr>
<tr>
<td>• WCCG continue to support providers with updating Choose &amp; Book to offer additional options for patients. E.g.: One to One midwifery to be available on Choose &amp; Book</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Development of a Wirral wide education programme is underway</td>
<td></td>
</tr>
<tr>
<td>• Envisaged quarterly Protected Learning Time events for three Primary Care staff groups, GPs, Practice Nurses, non-clinicians (Practice Managers and admin staff). These will be rotated monthly between the three groups,</td>
<td></td>
</tr>
</tbody>
</table>
meaning there will be one education event per month, but quarterly for each group.

- DC Team will be developing a Training Forum to organise, plan and evaluate PLT events. This will consist of a GP, Practice Nurse, Practice Manager, Practice staff member, DC Commissioning Support Manager and DC Executive Assistant.
- Initial Wirral wide Protected Learning event is scheduled for 25th February 2015 on “Cancer care”, currently in development.
- Professional Development resources for primary care nursing currently being discussed to determine quality and effectiveness for future model.
## Final Version of Commissioning Policies

<table>
<thead>
<tr>
<th>Agenda Item:</th>
<th>4.4</th>
<th>Reference</th>
<th>GB14-15/0064</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public / Private</td>
<td>Public</td>
<td>Meeting Date</td>
<td>10.02.2015</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Sue Wells – GP Lead Wirral CCG</td>
<td></td>
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</tr>
<tr>
<td>Contributors</td>
<td>Clare Grainger – Programme Support Manager</td>
<td></td>
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</tbody>
</table>

### Link to CCG

<table>
<thead>
<tr>
<th>Strategic System Plan</th>
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</thead>
<tbody>
<tr>
<td>• Rigorously developed and agreed care pathways working together with patients to secure their help, understanding, ownership and support of the needed changes</td>
</tr>
<tr>
<td>• Commissioned services which have a sound evidence base</td>
</tr>
<tr>
<td>• Provides greater equality of access to all</td>
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</tbody>
</table>

### Link to current strategic objectives

<p>| |</p>
<table>
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<tbody>
<tr>
<td>• Enhance the quality of life for people with long term conditions</td>
</tr>
<tr>
<td>• Helping people to recover from episodes of ill health or following injury</td>
</tr>
<tr>
<td>• Ensuring people have a positive experience of care</td>
</tr>
</tbody>
</table>

### To approve

### To note

### Summary

A paper was brought to Governing Body in October 2014 entitled ‘Report on proposed changes to commissioning policies’. This paper provided an overview of the process undertaken to update the commissioning policies and presented the final policy for approval.

Governing Body approved the paper with any variations recorded in the minutes that were then presented at the Governing body in November 2014.

The enclosed document is the final version of the commissioning policy incorporating the variations previously noted at Governing Body.

### Comments

### Next Steps

The document enclosed will become adopted as Wirral CCGs commissioning policies.

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

<table>
<thead>
<tr>
<th>Financial</th>
<th>Does the report consider the financial impact?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial impact figures were detailed in the paper presented at the Governing Body meeting in October.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value For Money</th>
<th>Does the report consider value for money?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through applying latest clinical evidence to procedures it will enable new treatments to be available with higher success rates and replace those offering reduced clinical benefit. New procedures will also reduce unnecessary delays in authorizing treatment which can happen when a treatment is subject to an 'individual funding request' (IFR). The revised policy would enable clinicians to clearly identify when this is necessary. There will be no decrease in other areas to pay for the policy changes.</td>
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</table>

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<thead>
<tr>
<th>Risk</th>
<th>Is there a documented risk assessment?</th>
<th>YES</th>
</tr>
</thead>
</table>
The report presented at October Governing Body highlighted risks related to expectancy being set by this policy for any future reviews.

**Legal**

**Are there any legal implications and has legal advice been obtained?**  YES  
The Commissioning Support Unit (CSU) was commissioned to take legal advice and ensure any risks or legal implications were negligible.

**Patient and Public Involvement (PPI)**

**Does the report provide evidence whether there could be a positive or negative impact on patients and public?**  YES  
Patients and public have been engaged and consulted as part of the NICE guideline development and as part of the formal engagement and consultation that has informed the report. Full details are available within the report presented at the Governing Body meeting in October 2014.

**Equality & Human Rights**

**Does the report provide evidence of whether there could be a positive or negative impact on protected groups (statutory duty for new / changes to services)**  YES  
A full equality analysis report was detailed in the report presented the Governing Body in October 2014.

**Workforce**

**Does the report provide evidence of whether there could be a positive or negative impact on the CCG or other NHS staff?**  YES  
As described in the paper presented in October 2014 to the Governing Body there is expected to be negligible impact on workforce.

**Partnership Working**

**Does the report evidence a partnership working in its development?**  YES  
As described in the report of October 2014 there is evidence of partnership and collaborative working across the Cheshire and Merseyside CCG's to try to align the process with the assistance of the CSU. Wirral CCG were particularly pro-active in pushing to achieve an alignment and agreement on the proposals.

**Performance Indicators**

**Does the report indicate any relevant performance indicators for this item?**  NO  
The new policy does not introduce any new contracts therefore currently commissioned services will continue to be monitored with standard procedures already established. There is no performance indicator related to this work.

**Sustainability**

**Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)**  NO  
The policy is not expected to have an impact on sustainability.

---

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

*(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions)*
This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path i.e. other papers that are directly related to the current paper under discussion.

### Report History/Development Path

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Reference</th>
<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
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</thead>
<tbody>
<tr>
<td>Procedures of Low Clinical Priority</td>
<td>Item no. 2.6</td>
<td>Clinical Strategy Group (CSG)</td>
<td>12.11.13</td>
<td>Briefing and discussion</td>
</tr>
<tr>
<td>Commissioning Policy Review</td>
<td>Item no. 2.5</td>
<td>Operational Team Meeting</td>
<td>28.1.14</td>
<td>CSU presentation</td>
</tr>
<tr>
<td>Procedures of Low Clinical Priority Commissioning Policy Review</td>
<td>Item no. 2.1</td>
<td>Extraordinary Clinical Strategy Group</td>
<td>23.1.14</td>
<td>Briefing and discussion highlighting consultation</td>
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<tr>
<td>AOB</td>
<td></td>
<td>Clinical Strategy Group</td>
<td>11.2.14</td>
<td>Highlighting consultation had started</td>
</tr>
<tr>
<td>Public Engagement &amp; Consultation Activity – Commissioning Policies Review</td>
<td>Item no. 55</td>
<td>Families and Wellbeing Policy and Performance Committee</td>
<td>8.4.14</td>
<td>The Chair indicated to Members that if they had any further comments to add to the review, they could do so online. RESOLVED: That (1) the report be noted; and (2) Ms Curtis from CSU be thanked for her informative presentation.</td>
</tr>
<tr>
<td>PLCV</td>
<td>Item no. 2.3</td>
<td>Extraordinary Clinical Strategy Group</td>
<td>8.7.14</td>
<td>Members voted to agree recommended position but escalated to Operational team meeting for clarification on some areas</td>
</tr>
<tr>
<td>Procedures of Low Clinical Priority – contentious issues</td>
<td>Item no. 4.1</td>
<td>Operational Team Meeting</td>
<td>15.7.14</td>
<td>Members agreed to CSG recommendations</td>
</tr>
<tr>
<td>Report on Proposed changes to commissioning policies PLCP</td>
<td>Item no. 2.1</td>
<td>Governing Body meeting</td>
<td>07.10.2014</td>
<td>Approved</td>
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</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). The definition of "prejudicial" is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

If you require any additional information please contact the Lead Officer.
CHESHIRE & MERSEYSIDE
Commissioning Policy
Wirral Variation

CRITERIA
2014/15
Introduction

The Cheshire and Merseyside CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available in Cheshire and Merseyside. This document is intended to be a statement of such arrangements made by the Cheshire and Merseyside CCGs and act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which Cheshire and Merseyside CCGs will commission the service, either via existing contracts or on an individual basis. It gives guidance to referrers on the policies of the CCGs in relation to the commissioning of procedures of low clinical priority, thresholds for certain treatment and those procedures requiring individual approval.

In making these arrangements, the Cheshire and Merseyside CCGs have had regard to relevant law and guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012 and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012; the Joint Strategic Needs Assessment; and relevant guidance issued by NHS England.

The Cheshire and Merseyside CCGs have a duty to secure continuous improvement in the quality of services and patient outcomes, but are also under a duty to exercise their functions effectively, efficiently and economically. Therefore, health benefits must be maximised from the resources available. As new services become available, demand increases and procedures that give maximum health gain must be prioritised. This means that certain procedures will not be commissioned by CCGs unless exceptional clinical grounds can be demonstrated. The success of the scheme will depend upon commitment by GPs and other clinicians to restrict referrals falling outside this protocol.

The NHS standard contract specifies that the Co-ordinating Commissioner will agree with the Provider the circumstances where the Provider will need to seek prior approval (PA) to confirm the appropriateness of a proposed intervention or course of treatment. It is expected that such schemes focus on procedures of limited/low clinical effectiveness, or infrequent high cost and/or complex procedures. In designing and implementing PA schemes, individual patient needs must remain paramount. (Reference Guidance on the Standard NHS contract for Acute Hospital Services, community and Mental Health & Learning Disabilities.

Ideally the Co-ordinating Commissioner will agree a single set of PA requirements with which each Provider is expected to comply. However, there may be exceptional circumstances in which an Associate CCG needs to specify its own PA requirements. Agreeing a Cheshire and Merseyside Prior Approval Policy will improve equity of access to services, value for money and clinical effectiveness across the network.

CCGs will not pay for activity unless it meets the criteria set out in the document or individual approval has been given and the Referral and Approval Process as set out has been followed. This prior approval scheme will be incorporated into all NHS standard NHS contracts agreed by CCGs. Compliance with this policy will be monitored via regular benchmarking reports and case note audits.

To support this approach a set of Core Clinical Eligibility Criteria have been developed and are set out below, patients may be referred in accordance with the referral process if they meet these criteria. In some limited circumstances, a ‘Procedure of Lower Clinical Priority’ (PLCP) may be the most clinically appropriate
intervention for a patient. In these circumstances, agreed eligibility criteria have been established and these are explained, in the later sections of the document, if the criteria are met the procedure will be commissioned by the CCG.

Core Clinical Eligibility

Patients may be referred in accordance with the referral process where they meet any of the following Core Clinical Eligibility criteria:

- All NICE Technology Appraisals will be implemented.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- Reconstructive surgery post cancer or trauma, including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. Leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- Any patient who needs urgent treatment will always be treated.
- No treatment is completely ruled out if an individual patient’s circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patients responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 2.
- Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

Referral & Approval Process

Interventions specified in this document are not commissioned unless clinical criteria are met, except in exceptional circumstances. Where clinical criteria are met treatment identified will form part of the normal contract activity.

If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfill the eligibility criteria for a Procedure of Lower Clinical Priority, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. If in doubt over the local process, the referring clinician should contact the General Practitioner. Failure to comply with the local process may delay a decision being made. The referral letter should include specific information regarding the patient’s potential eligibility.

Diagnostic procedures to be performed with the sole purpose of determining whether or not a Procedure of Lower Clinical Priority is feasible should not be carried out unless the eligibility criteria are met or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG), or as agreed by the CCG as an exceptional case.
The referral process to secondary care will be determined by the responsible CCGs. Referrals will either:

- Have been prior approved by the CCG.
- OR
- Clearly state how the patient meets the criteria.
- OR
- Be for a clinical opinion to obtain further information to assess the patient’s eligibility.

GPs should not refer unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. In cases where there may be an element of doubt the GP should discuss the case with the IFR Team in the first instance.

If the referral letter does not clearly outline how the patient meets the criteria then the letter should be returned to the referrer for more information and the CCG notified. Where a GP requests only an opinion, the patient should not be placed on a waiting list or treated, but the opinion given to the GP and the patient returned to the GP’s care, in order for the GP to make a decision on future treatment.

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not and may request additional information before seeing the patient. Patients who fulfills the criteria may then be placed on a waiting list according to their clinical need. The patient’s notes should clearly reflect exactly how the criteria were fulfilled, to allow for case note audit to support contract management. Should the patient not meet the eligibility criteria this should be recorded in the patient’s notes and the consultant should return the referral back to the GP with a copy to the CCG, explaining why the patient is not eligible for treatment.

Should a patient not fulfill the clinical criteria but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Team for assessment contact details for the IFR team can be found in Appendix 2.

**Exceptionality**

In dealing with exceptional case requests for an intervention that is considered to be a poor use of NHS resources, the Cheshire & Merseyside CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

*The patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.*

Further details on exceptionality can be found at this link:

http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20managing%20individual%20funding%20requests.pdf
The Cheshire & Merseyside CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS namely, that people with equal need should be treated equally. Therefore non-clinical factors will not be considered except where this policy explicitly indicates otherwise.

In essence, exceptionality is a question of equity. The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

**Psychological Distress**

Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly indicates otherwise. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as route into aesthetic surgery.

Unless specifically stated otherwise in the policy any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS mental health professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient’s psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

**Personal Data (including Photographs)**

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

- Clearly label the envelope to a named individual i.e. first name & surname, and job title.
- Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.
- Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

**Information in Payment:** Costs incurred for photographic evidence will be the responsibility of the referrer. Photographic evidence is often required in cases which are being considered on exceptionality. They are reviewed by clinical member/s of the IFR team only.
Medicines Management

Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

- Any new PbR excluded drug where the drug has not yet been approved / prioritised for use in agreement with the local CCG.
- Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication.
- Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1.
- Any drug used out with NICE GUIDANCE (where guidance is in existence).
- Any proposed new drug / new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG.
- Any medicines that are classed by the CCG as being of limited clinical value.
- Any medicines that will be supplied via a homecare company agreement.

The Clinical Commissioning Group does not expect to provide funding for patients to continue treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have on-going access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

NOTE: funding for all solid and haematological cancers are now the responsibility of NHS England.

Conditions & Interventions

The conditions & interventions have been broken down into speciality groups.

GPs should only refer if the patient meets the criteria set out or individual approval has been given by the CCG, as set out in the CCGs process as explained above. Requests for purely cosmetic surgery will not be considered except where this policy explicitly provides otherwise. Patients meeting the core clinical eligibility criteria set out above can be referred, all other referrals should be made in accordance with the specified criteria and referral process. The CCG may request photographic evidence to support a request for treatment.

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.
Evidence

At the time of publication the evidence presented was the last currently available. Where reference is made to publications over five years old, this still represents the most up to date view.

<table>
<thead>
<tr>
<th>Treatment/Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1. Complementary Therapies |                                         | Wirral will continue to commissioning homeopathy as at present but this service will be subject to review. All other complementary therapies are not routinely commissioned unless recommended by NICE guidance. | **Complementary and alternative medicine** – NHS Choices 2012.  
| 2. Dermatology       |                                         | Will only be commissioned in the following circumstances:  
**Severe** scarring following:  
- acne once the active disease is controlled  
- chicken pox or  
Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT.  
[www.evidence.nhs.uk](http://www.evidence.nhs.uk)  
[NHS England interim protocol](http://www.nhs.uk)  
NHS England (2013) |
| 2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels) |                                         | Procedures will only be performed on the head and neck area.  
Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavor to work in partnership with the CCG. |  

<table>
<thead>
<tr>
<th><strong>Treatment/Procedure</strong></th>
<th><strong>Exceptionality - Prior Approval - Criteria</strong></th>
<th><strong>Evidence</strong></th>
<th><strong>Comments</strong></th>
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</thead>
</table>
| 2.2 Surgical or Laser Therapy Treatments for Minor Skin Lesions e.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, corn/callous dermatofibromas, comedones, molluscum contagiosum chalazion | Will be commissioned in any of the following circumstances:  
- Symptomatic e.g. ongoing pain or functional impairment.  
- Risk of infection.  
- Significant facial disfigurement.  
- All vascular lesions on the face except benign, acquired vascular lesions such as thread veins. | Proceedings of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. | Uncomplicated benign skin lesions should NOT be referred.  
Send suspected malignancy on appropriate pathway.  
Consider if benefit outweighs risk associated with surgery.  
Consider Primary Care or community service.  
Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which have also shown rapid growth and are painful should be referred to an appropriate clinic. |
| 2.3 Surgical Treatment for Removal of Lipoma in Secondary Care. | Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position.  
Lipomas that are under 5cms should be observed only unless the above applies. | Modernisation Agency’s Action on Plastic Surgery 2005. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service  
| 2.3 NEW Treatments for Skin Pigment Disorders. | NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross.* | No guidance found.  
http://www.changingfaces.org.uk/Skin-Camouflage | Initially the recommended NHS suitable treatment for |
<table>
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<tr>
<th>Treatment/Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
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</thead>
</table>
| Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 | Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | Interim Gender Dysphoria Protocol & Service Guidelines 2013/14  
NHS England interim protocol  
NHS England (2013)  
Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. | hypo – pigmentation is biopsy of suspicious lesions only.  
Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.  
* Access available for Wirral patients via Dermatology Department. |
| Surgical Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers. | Will be commissioned in any of the following circumstances:  
- Severe Pain substantially interfering with functional abilities.  
- Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.  
- Extensive warts (particularly in the immune-suppressed patient).  
- Facial warts.  
Patients with the above exceptional symptoms may | Modernisation Agency’s Action on Plastic Surgery 2005.  
Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.  
patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae | Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years.  
There are numerous OTC preparations available. Community |
<table>
<thead>
<tr>
<th>Treatment/Procedure</th>
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<th>Evidence</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatologist.</td>
<td>need specialist assessment, usually by a dermatologist.</td>
<td></td>
<td>treatments such as cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.</td>
</tr>
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</table>

### 3. Diabetes

**3.1 NEW Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus.**

Commissioned if **ALL** the following criteria are met:

- Type 1 Diabetes
- AND currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151
- HBA1c >69mmol/mol
- OR experiencing severe hypoglycemic episodes which require intervention by a caser
- AND selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARID) value
- AND managed by a recognized centre of excellence in Diabetes currently using a minimum of 20 continuous infusion pumps per annum.

- Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012.
- Glycaemic control in type 1 diabetes during real-time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805.
<table>
<thead>
<tr>
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<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Freckmann G, Pleus S, Link M, Zschorneck E, Klotzer HM.</td>
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<tr>
<td>Treatment/Procedure</td>
<td>Exceptionality - Prior Approval - Criteria</td>
<td>Evidence</td>
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<td>Langeland LBL, Salvesen O, Selle H, Carlsen SM, Fougner</td>
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<tr>
<td>Treatment/Procedure</td>
<td>Exceptionality - Prior Approval - Criteria</td>
<td>Evidence</td>
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<td>**Effect of sensor-augmented insulin pump therapy and automated insulin suspension vs standard insulin pump therapy on hypoglycemia in patients with type 1 diabetes: a randomized clinical trial. <em>JAMA</em> 2013; 310(12):1240-1247.</td>
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<td>Choudhary P, Lonnen K, Emery CJ, Freeman JV, McLeod KM, Heller SR. Relationship between interstitial and blood</td>
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<tr>
<td>Treatment/Procedure</td>
<td>Exceptionality - Prior Approval - Criteria</td>
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<tr>
<td>Formosa N, Matyka K. Continuous glucose monitoring in children and adolescents with type 1 diabetes mellitus: A literature review. <em>Archives of Disease in Childhood</em> 2012; <strong>97</strong>.</td>
<td></td>
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<tr>
<td>Yeh HC, Brown TT, Maruthur N. Comparative effectiveness and safety methods of insulin delivery and glucose monitoring for diabetes mellitus: A systematic review and</td>
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<tr>
<td>Treatment/Procedure</td>
<td>Exceptionality - Prior Approval - Criteria</td>
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4. **ENT**
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<th>Treatment/ Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
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</table>
| 4.1 NEW Adenoidectomy | Commissioned only in either of the following clinical situations.  
  In Children  
  For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy.  
  In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 4.3  
  Adenoidectomy for recurrent or chronic nasal symptoms in children  
  The Cochrane Library 2010.  
  Adenoidectomy for otitis media in children  
  The Cochrane Library 2010.  
  Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract)  
  Centre for Reviews and Dissemination 2013.  
  NICE “Do not do” recommendation:  
  “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.”  
  Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ. Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis. Health Technology Assessment 2014;18(5) |
<table>
<thead>
<tr>
<th>Treatment/Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
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</table>
| 4.2 Pinnaplasty – for Correction of Prominent Ears | May be commissioned in the following circumstances:  
For surgical "correction" of prominent ear(s) only when all of the following criteria are met:  
1. Referral only for children aged 5 to 18 years at the time of referral  
AND  
2. With very significant ear deformity or asymmetry  
Patients not meeting these criteria should not be routinely referred for surgery.  
Incisionless otoplasty is not commissioned. | Pinnaplasty  
Department of Health (2007).  
Local PCT consensus - review conducted 2007.  
IPG 422: Incisionless otoplasty  
NICE 2012.  
[http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty)  
Royal College of Surgeons (2013). | Children under the age of five are usually oblivious and referrals may reflect concerns expressed by the parents rather than the child. |
4.3 Insertion of Grommets for Glue Ear (otitis media with effusion)

**a. Children**

The CCG will commission treatment with grommets / Myringotomy for children with otitis media with effusion (OME) where:

- There is also a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year.

- OR

- There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon).

- AND

  - OME persists after three months AND
  - the child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse confirmed over 3 months.

- OR

- Persistent bilateral OME with hearing loss

  - Less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child’s developmental, social or educational status.

**Children with Downs Syndrome** are normally fitted with Hearing Aids.

Management of children with cleft palate is under specialist supervision.

Do Not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 4.1 Adenoidectomy.

**b. Adults**

will fund grommets in adults with OME only in the following circumstances:

- Significant negative middle ear pressure measured on two sequential appointments AND significant ongoing associated pain.

- OR

- Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.

http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome
Royal College of Surgeons (2013).

NICE Pathway – Surgical management of Otitis Media with effusion in children (2012).

CG60 Surgical management of children with otitis media with effusion (OME) (February 2008).

The advice in the NICE guideline covers:

- the surgical management of OME in children younger than 12 years.

- guidance for managing OME in children with Down’s syndrome and in children with all types of cleft palate.

- It does not specifically look at the management of OME in:

  - children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease).

  - children with multiple complex needs.

Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children - Cochrane Ear, Nose and Throat Disorders Group 2010.

treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions
| 4.4 | Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children | Tonsillectomy will only be commissioned where:  
- Seven or more well documented clinically significant adequately treated sore throats in the preceding year; or  
- Five or more such episodes in each of the previous two years; or  
- Three or more such episodes in each of the preceding three years.  

Is commissioned if appropriate following peri-tonsillar abscess.  
Tonsillectomy is not commissioned for tonsil stones or halitosis.  
Tonsillectomy may be appropriate for significant hypertrophy causing OSA (Obstructive Sleep Apnea).  
Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis – Cochrane Ear, Nose and Throat Disorders Group (2008).  
Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009.  
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy  
Royal College of Surgeons (2013)  
Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats. |
|---|---|---|---|
| 4.5 | Surgical Remodelling of External Ear Lobe. | This is not routinely commissioned. | Modernisation Agency’s Action on Plastic Surgery 2005.  
Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. |
| 4.6 | NEW Use of Sinus X-ray | X-rays of sinuses are not routinely commissioned. | BSACI guidelines for the management of rhinosinusitis and nasal polyposis  
Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007.  
NHS Choices Sinusitis  
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitis  
Royal College of Surgeons (2013). |
| 4.7 | Rhinoplasty - Surgery to Reshape the Nose. | This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: - Objective nasal deformity caused by trauma. - Problems caused by obstruction of nasal airway. - Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment. |}
| 5. Equipment | 5.1 NEW Use of Lycra Suits | Lycra Suits are not normally commissioned for postural management of cerebral palsy. Further consultation will take place with the patient group and further information, if available, will be considered. Currently this will only be available by IFR. | What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. Blackmore AM, Garbellini SA, Buttigieg P & Wells J. (2006) Any application for exceptional funding should include a comprehensive |
A systematic review of the effects of soft splinting on upper limb function in people with cerebral palsy. An AACPDM Evidence Report


Elliott CM, Reid SL, Alderson JA & Elliott BC. (2011) Lycra arm splints in conjunction with goal-directed training can improve movement in children with cerebral palsy. NeuroRehabilitation. vol.28/1(47-54), 1053-8135;1878-6448


Health Improvement Scotland (2013). What is the clinical and cost effectiveness of dynamic elastomeric fabric

Public Health Recommendations:

Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.

Lycra suit orthoses for cerebral palsy should be assigned low priority.


*Do lycra garments improve function and movement in cerebral palsy?*
<table>
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<tr>
<th>6.</th>
<th>Fertility</th>
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children with cerebral palsy?
BestBets, 2010
<table>
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<tr>
<th>6.1</th>
<th>Fertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation</th>
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</table>
|     | Fertility services are commissioned in line with NICE guidelines. In summary A woman of reproductive age who has not conceived after 1 year of regular unprotected sexual intercourse (or 6 cycles of artificial insemination with either partner or donor sperm) in the absence of a known cause should be offered further clinical assessment. Offer earlier assessment by a specialist consultant if there is a known cause or age >36.
|     | Couples failing to conceive after 2 years regular unprotected sexual intercourse (or 12 cycles of artificial insemination) are eligible for IVF as follows: -
|     | Women age < 40 offer 3 full cycles IVF with or without ICSI. If the woman reaches 40, complete the current cycle but offer no further. Women age 40-42 offer 1 full cycle with or without ICSI provided: -
|     | • They have never had previous IVF
|     | • There is no evidence of low ovarian reserve
|     | • There have been discussions regarding the additional implications of IVF and pregnancy at this age. (for further detail see NICE guidance)
|     | All couples should be given appropriate lifestyle advice. Treatment is only funded at NHS centres arranged by Wirral CCG. Couples must have no living children from the current or previous relationship (to include adopted children).
|     | Fertility services are not commissioned following male or female sterilisation or failed reversal of sterilisation. Surrogacy is not commissioned. |

| 7. | **General Surgery** |


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<th>7.1</th>
<th>Haemorrhoidectomy - Rectal Surgery: &amp; Removal of Haemorrhoidal Skin Tags</th>
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<tr>
<td></td>
<td>Surgery commissioned for symptomatic:</td>
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<tr>
<td></td>
<td>- Grade III and IV haemorrhoids.</td>
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<td></td>
<td>- Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments –</td>
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<td>- Diet modification to relieve constipation.</td>
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<td>- Topical applications.</td>
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<td>- Stool softeners and laxatives.</td>
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<td>- Rubber band ligation.</td>
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<td>- Sclerosant injections.</td>
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<td>- Infrared coagulation.</td>
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<td>Surgical treatment options include:</td>
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<td>- Surgical excision (haemorrhoidectomy).</td>
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<td>- Stapled haemorrhoidopexy.</td>
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<td></td>
<td>- Haemorrhoidal artery ligation.</td>
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<tr>
<td></td>
<td>Removal of Skin tags is not routinely commissioned.</td>
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<tr>
<td></td>
<td>Haemorrhoidal artery ligation NICE 2010.</td>
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<td></td>
<td>Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008.</td>
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<td></td>
<td>Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US.</td>
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<td></td>
<td>Haemorrhoids NICE Clinical Knowledge Summaries 2012 <a href="http://cks.nice.org.uk/#azTab">http://cks.nice.org.uk/#azTab</a></td>
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</tbody>
</table>

There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure. Short term efficacy and cost effectiveness is similar.
| 7.2 | Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias. | Surgery: not commissioned if no symptoms, easily reducible (i.e. can be ‘pushed back in’) and not at significant risk of complications. | [Commissioning Policy for Procedures of Limited Clinical Value](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding)  
Royal College of Surgeons (2013).  
[NHS Derby City and NHS Derbyshire County (December 2012).](http://www.derbyshire.nhs.uk/pathways/PLCV-Doc-Dec-2012.pdf)  
[A systematic review on the outcomes of correction of diastasis of the recti](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding)  
Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al. | Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect. |
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<tr>
<td>Surgical correction of Diastasis of the Recti</td>
<td>Surgical repair is not routinely commissioned.</td>
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| 7.3 | Surgery for Asymptomatic Gallstones | This procedure is not routinely commissioned. | [Commissioning Policy for Procedures of Limited Clinical Value](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones)  
Royal College of Surgeons (2013). | This procedure is considered a Low clinical priority for asymptomatic gallstones.  
Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for some unrelated reasons. Lithotripsy rarely performed as rate recurrence high. |
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<td>Lithotripsy for Gallstones</td>
<td>Lithotripsy not routinely commissioned.</td>
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### 8. Gynaecology

**8.1 Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding**

| Hysterectomy | Hysterectomy not commissioned unless all of the following requirements have been met:  
|              | • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this treatment.  
|              | • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance.  
|              | - Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives.  
|              | - Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens.  
|              | - Endometrial ablation has been tried (unless patient has fibroids >3cm). | CG44 Heavy menstrual bleeding: full guideline  
|              | NICE 2007.  
|              | QS47 Heavy Menstrual Bleeding  
|              | NICE 2013.  
| D&C (dilatation and curettage) | Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure. |  

### 9. Mental Health

**9.1 NEW**

| In patient Care for Treatment of Chronic Fatigue Syndrome (CFS). | In patient care for Chronic Fatigue Syndrome is not routinely commissioned. |  
| In patient Care for Treatment of Chronic Fatigue Syndrome (CFS). |  
| Adaptive pacing, cognitive behaviour therapy.  
| Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states:  
| “Most people with CFS will not need hospital admission. However, there may be circumstances when a planned
| 9.2 | Treatment of Gender Dysphoria | Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at either Charring Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non-core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis. | NHS England interim protocol

Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. | admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital”. |

| 9.3 NEW | Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services) | This is not routinely commissioned. | Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007)


Alcohol-use disorders: diagnosis, assessment and |
| 9.4 NEW | Private Mental Health (MH) Care - Non-NHS Commissioned Services including psychotherapy adult eating disorders general in-patient care post-traumatic stress adolescent mental health | This will not normally be funded.

Most Mental health conditions can be managed in the community with input from Community Mental Health Teams.

NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD.

There is also a specialist NHS MH service provided for affective disorders.

A request for private MH care should be initiated by a consultant psychiatrist and give full explanation as to why NHS care is inappropriate or unavailable. |
| --- | --- | --- |

Veterans’ post traumatic stress disorder programme (Adult) Service Specification


Post –traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care


Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification

NHS England Specialised Commissioning (2013)


Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013. |
| 10.1 NEW | Bobath Therapy | Bobath Therapy is not routinely commissioned by the NHS.  
Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme  
Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial  
| 10.3 NEW | Functional Electrical Stimulation (FES) | Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities Exclusion Criteria • Fixed contractures of joints associated with muscles to be stimulated Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g. pin and plate. • Ataxic and polio patients are generally poor responders although there are exceptions. |
## 11. Ophthalmology

### 11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid.

Only commissioned in the following circumstances:
- Eyelid function interferes with visual field.

**Eyelid Surgery**


Excess skin in the upper eyelids can accumulate due to the ageing process and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.

### 11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.

Only commissioned in any of the following circumstances:
- Correction of ectropion or entropion which threatens the health of the affected eye.
- Removal of lesions of eyelid skin or lid margin.
- Rehabilitative surgery for patients with thyroid eye disease.

**Eyelid Surgery**


Excessive skin in the lower lid may cause “eye bags” but does not affect function of the eyelid or vision and therefore does not need correction.

### 11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids).

Only commissioned for:
Larger legions which satisfy all of the following:
1. Not responded to treatment for underlying familial lipoprotein lipase deficiency
2. Failed topical treatment
3. Causing significant disfigurement

Topical treatments may be available in a Primary care or Community setting.

**Local PCT consensus – review conducted 2007.**


The following treatments should be considered for patients with xanthelasma:

Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or
Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.

Investigation for underlying lipid abnormalities should be undertaken in the first instance.

Lesions are harmless.

Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or cryotherapy.

<p>| 11.4 NEW | Surgery or Laser Treatment for Short Sightedness (myopia) or Long sightedness | Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned. |</p>
<table>
<thead>
<tr>
<th>Sightedness (hypermetropia)</th>
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<tr>
<td><strong>11.5 NEW</strong> Cataract Surgery</td>
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<tr>
<td>See appendix 1 for details of Referral Guidance template.</td>
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<tr>
<td>Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights.</td>
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<tr>
<td>There is good evidence that bilateral cataract replacement is beneficial.</td>
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</tbody>
</table>

**Thresholds for cataract surgery** – Shropshire and Telford Hospital NHS Trust, 2012.

Shropshire CCG POLICY ON LOW PRIORITY TREATMENTS Version 13 – June 2013
Based on OPCS 4.6 and ICD 10
8.2 Cataract surgery pg38.

Hull CCG, 2012.

NHS Atlas of Variation, (cataract spend, cataract admissions)

Don’t turn back the clock: Cataract surgery - the need for patient centred care.
RNIB / Royal College of Ophthalmologists (2011).

Cataract surgery guidelines
The Royal College of Ophthalmologists (RCOpth) 2010.

Action on cataracts good practice guidance Department of Health (2000).

Cataract care pathway
Map of Medicine (2013).

NHS UK - http://www.nhs.uk/conditions/Cataracts-age-related/Pages/Introduction.aspx
T et al. Surgical interventions for age-related cataract (Review). Cochrane Database of Systematic Reviews [ 2006

(Fedorowicz Z, Lawrence D, Gutierrez P. Day care versus in-patient surgery for age-related cataract (Review). Cochrane Database of Systematic Reviews [ 2005


Brown GC, Brown MM, Menezes A, Bushbee BG. Cataract


Ma QJ, Escobar A, Bilbao A, IRYSS-Appropriateness Cataract Group. Explicit criteria for prioritization of cataract surgery. *BMC health services research* 2006; **6**.


Cataracts:Management and Referral. NHS Clinical Knowledge Summaries [ 2010 [cited 2010 Dec. 7];


Las HC, Gonzalez N, Aguirre U, Blasco JA, Elizalde B, Perea E et al. Can an appropriateness evaluation tool be used to prioritize patients on a waiting list for cataract extraction? *Health Policy* 2010; **95**(2-3):194-203.


Roman R, Comas M, Mar J, Bernal E, Jimenez-Puente A, Gutierrez-Moreno S et al. Geographical variations in the benefit of applying a prioritization system for cataract surgery in different regions of Spain. *BMC health services research* 2008; **8**.

Conner-Spady BL, Sanmugasunderam S, Courtright P,
| 11.6 NEW | Coloured (irlens) Filters for Treatment of Dyslexia | There is insufficient evidence of efficacy of this treatment. It is not routinely commissioned until such time when there is robust evidence. | Coloured filters for reading disability: A systematic review WMHTAC 2008 |
| 11.7 NEW | Intra Ocular Telescope for Advanced Age-Related Macular Degeneration | This is not routinely commissioned as there is limited published evidence of effectiveness. | Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012). |
| 11.8 | Surgical Removal of Chalazion or Meibomian Cysts | Referral to secondary care will only be considered when all of the following are met:  
- Present for six months or more.  
- Conservative treatment has failed.  
- Sited on upper eyelid. AND  
Causes blurring or interference with vision. OR  
Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk. | Guidance for the management of referrals for Meibomian Cysts  
NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013).  
NHS Cornwall & Isles of Scilly, Devon, Plymouth and Torbay |

**12. Oral Surgery**

| 12.1 Surgical Replacement | Only commissioned in the following circumstances: | Surgical Replacement of the Temporo-mandibular Joint: Discussions ongoing |
Any or a combination of the following symptoms are present:
- Restricted mouth opening (<35mm).
- Dietary score of< 5/10 (liquid scores 0, full diet scores 10).
- Occlusal collapse (anterior open bite or retrusion).
- Excessive condylar resorption and loss of height of vertical ramus.
- Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms).
- Other significant quality of life issues.

AND

Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.

**13. Pediatrics**

| 13.1 NEW | Cranial Banding for Positional Plagiocephaly | Not routinely commissioned. | Nonsurgical treatment of deformedational plagiocephaly: a systematic review  
What is the role of helmet therapy in positional plagiocephaly?  
BestBETS 2008. | This treatment is considered low priority.  
Most children's head shapes will improve naturally in their own time. |

**Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.**

**Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009**

<table>
<thead>
<tr>
<th>14.1</th>
<th>Plastic &amp; Cosmetic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction Mammaplasty - Female Breast Reduction</td>
<td>Commissioned only if all of the following circumstances are met:</td>
</tr>
<tr>
<td></td>
<td>Musculo-skeletal symptoms are not due to other causes.</td>
</tr>
<tr>
<td></td>
<td>AND</td>
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<tr>
<td></td>
<td>There is at least a two year history of attending the GP with the problem.</td>
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<tr>
<td></td>
<td>AND</td>
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<td></td>
<td>Other approaches such as analgesia and physiotherapy have been tried.</td>
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<td></td>
<td>AND</td>
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<td></td>
<td>The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache).</td>
</tr>
<tr>
<td></td>
<td>AND</td>
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<tr>
<td></td>
<td>The wearing of a professionally fitted brassiere has not helped.</td>
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<td></td>
<td>AND</td>
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<tr>
<td></td>
<td>Patients BMI is &lt;25 and stable for at least twelve months.</td>
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<tr>
<td></td>
<td>AND</td>
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<tr>
<td></td>
<td>The patients breast is a cup size H or larger</td>
</tr>
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<td>AND</td>
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</tbody>
</table>


An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010).


Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

Best not performed on young teenagers and delayed until any planned family is complete.

Unilateral reduction is preferable to unilateral augmentation.
<p>| There is a proposed reduction of at least a three cup size reduction AND Aged over 18 years old AND It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist. Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. |</p>
<table>
<thead>
<tr>
<th>14.2</th>
<th>Augmentation Mammoplasty - Breast Enlargement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Only commissioned in the following circumstance:</strong> In all cases:</td>
<td></td>
</tr>
<tr>
<td>There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. OR</td>
<td>Freitas, R, et al, 2007, <em>Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases</em>, Aesthet Plast Surg, 31, 140-46.</td>
</tr>
<tr>
<td>Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. All non-surgical options must have been explored e.g. padded bra.</td>
<td>Heimberg, D, et al, 1996, <em>The tuberous breast deformity: classification and treatment</em>, Br J Plast Surg, 49, 339-45.</td>
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<tr>
<td>14.3</td>
<td>Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation</td>
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<td>--------------------------------------------------------------------------------</td>
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<td></td>
<td>Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision. Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14</td>
</tr>
</tbody>
</table>

- **Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base** - London Health Observatory 2010.
- **Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service**
- **NHS England interim protocol**

- Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

<p>| | | |</p>
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<tbody>
<tr>
<td></td>
<td>Vale of Glamorgan Local Health Board, 2006, Policy on the commissioning of procedures of low priority or limited clinical effectiveness not normally funded, Annex A, 3.36.</td>
<td>Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.</td>
</tr>
<tr>
<td></td>
<td><strong>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base</strong> - London Health Observatory 2010.</td>
<td>Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.</td>
</tr>
<tr>
<td></td>
<td><strong>Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service</strong></td>
<td></td>
</tr>
</tbody>
</table>
| | **NHS England interim protocol**
| | | |
| | Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group
  Department of Health (June 2012). | |

1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future
<table>
<thead>
<tr>
<th>Page</th>
<th>Mastopexy - Breast Lift</th>
</tr>
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<tbody>
<tr>
<td>14.4</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td></td>
<td>May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.</td>
</tr>
<tr>
<td></td>
<td>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
</tr>
</tbody>
</table>

Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.


NHS England interim protocol

Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

Policy may differ from current policy.

Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

NHS England interim protocol

Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.


NHS England interim protocol
| 14.5 | Surgical Correction of Nipple Inversion | This is not routinely commissioned.  
Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.  
NHS England interim protocol | Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule.  
This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months. |

| 14.6 | Male Breast Reduction Surgery for Gynaecomastia. | Not routinely commissioned except on an exceptional basis where all of the following criteria are met:  
True gynaecomastia not just adipose tissue.  
AND  
Underlying endocrine or liver abnormality excluded.  
AND  
Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this.  
AND  
Not due to prescribed drug use.  
NHS England interim protocol | Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer. |
Has not responded to medical management for at least three months e.g. tamoxifen.

AND

Post pubertal.

AND

BMI <25kg/m² and stable for at least 12 months.

AND

Patient experiences persistent pain.

AND

Experiences significant functional impairment.

AND

In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution.


Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

| 14.7 | Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism – | Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; | Epidemiology, Diagnosis and Management of Hirsutism: A Consensus Statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70). | Hirsutism - NICE: Clinical Knowledge Summaries 2010. | The method of depilation (hair removal) considered will be the most appropriate form usually diathermy. |
- Abnormally located hair-bearing skin following reconstructive surgery located on face and neck.
- There is an existing endocrine medical condition and severe facial hirsutism.

1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated.
2. Medical treatments have been tried for at least one year and failed.
3. Patients with a BMI of >30 should be in a weight reduction programme and should have lost at least 5% body weight.

All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist).

Photographs will also be required to allow the IFR team to visibly assess the severity equitably.

Funded for 6 treatments only at an NHS commissioned premises.

Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14
Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

<table>
<thead>
<tr>
<th>14.8 NEW</th>
<th>Surgical Treatment for Pigeon Chest</th>
<th>This procedure is not routinely commissioned by the NHS on cosmetic grounds.</th>
<th><strong>JP310 Minimally invasive placement of pectus bar:</strong> guidance NICE (2009).</th>
</tr>
</thead>
</table>

Laser and photoepilation for unwanted hair growth – Cochrane Library 2009.
Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
NHS England interim protocol
| 14.9 | Surgical Revision of Scars. | Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.  
Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service.  
Interim Gender Dysphoria Protocol & Service Guidelines 2013/14  
NHS England interim protocol. |
| 14.10 | Laser Tattoo Removal | Only commissioned in any of the following circumstances:  
- Tattoo is result of trauma inflicted against the patient’s will.  
- The patient was a child and not responsible for his/her actions at the time of tattooing.  
- Inflicted under duress.  
- During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). An individual funding request will be required.  
Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.  
| 14.11 | Apronectomy or Abdominoplasty (Tummy Tuck). | Not routinely commissioned other than if all of the following criteria are met:  
The flap hangs at or below the level of the symphysis pubis.  
Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).  
Bariatric surgery (if performed) was performed at least 3 years previously.  
Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.  
A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44). | Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced.  
Poor level of evidence of positive outcomes. |
AND any of the following:
Causes significant problems with activities of daily life (e.g. ambulatory restrictions).

Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.

Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made)

IFR information must contain the following information;
- Date of bariatric surgery (where relevant).
- Pre-operative or original weight and BMI with dates.
- Series of weight and BMI readings demonstrating weight loss and stability achieved.
- Date stable weight and BMI achieved.
- Current weight BMI.
- Patient compliance with continuing nutritional supervision and management (if applicable).
- Details of functional problems.
- Details of associated medical problems.

| 14.12 | Other Skin Excisions/Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty) | Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months. | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service
http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring
Royal College of Surgeons (2013). The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is |
(Some allowance may be made for redundant tissue not amenable to further weight reduction).

Bariatric surgery (if performed) was performed at least 3 years previously.

AND any of the following:

Causes significant problems with activities of daily life (e.g. ambulatory restrictions).

Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.

IFR information **must** contain the following information;

- Date of bariatric surgery (where relevant).
- Pre-operative or original weight and BMI with dates.
- Series of weight and BMI readings demonstrating weight loss and stability achieved.
- Date stable weight and BMI achieved.
- Current weight BMI.
- Patient compliance with continuing nutritional supervision and management(if applicable).
- Details of functional problems.
- Details of associated medical problems.


[Interim Gender Dysphoria Protocol & Service Guidelines 2013/14](#)

[NHS England interim protocol](#)

less likely to be indicated except for appearance. Therefore it will not be available on the NHS.
| 14.13 | Treatments to Correct Hair Loss for Alopecia. | Only commissioned in either of the following circumstances:  
- Result of previous surgery  
- Result of trauma, including burns  

Hair Intralace System is not commissioned. Dermatography is not commissioned.  

NHS wigs will be available according to NHS policy.  


Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavor to work in partnership with the CCG. | British Association of Dermatologists’ guidelines for the management of alopecia areata 2012  
Interventions for alopecia areata – Cochrane Library  
Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment.  
No evidence of effective treatments for alopecia – Cochrane Pearls 2008.  
Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010  
(further evidence provided within this document by Islington PCT to support funding).  
<table>
<thead>
<tr>
<th>Section</th>
<th>Procedure</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.14</td>
<td>Hair Transplantation</td>
<td>Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
</tr>
<tr>
<td>14.15</td>
<td>Treatments to Correct Male Pattern Baldness</td>
<td>This is not routinely commissioned. Modernisation Agency’s Action on Plastic Surgery 2005.</td>
</tr>
</tbody>
</table>
| 14.17 | Liposuction | Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophias or non-excisable clinical significant lipomata. An individual funding request will be required. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | Reviews and Dissemination 2013. 
Hymenoplasty and Labial Surgery (RCOG Statement 6). 
http://www.britspag.org/sites/default/files/downloads/Labiapllapc14.18 | Rhytidectomy - Face or Brow Lift | This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: 
- Congenital facial abnormalities. 
- Facial palsy. 
- Treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis. | Modernisation Agency’s Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol | Changes to the face and brow result due to normal ageing; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore |
Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14
Where the provision of “non-core” surgeries is appropriate, the GIC (Gender Identity Clinic) should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the
appearance and function.

### 15. Respiratory

| 15.1 | Treatments for Snoring.  
| | Soft Palate Implants and Radiofrequency Ablation of the Soft Palate  
| | Sodium Tetradecyl Sulfate (STS) Injection or ‘snoreplasty’  
| | Uvulopalatoplasty and Uvulopalatopharyngoplasty | Not Routinely Commissioned.  
| |  | Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005).  
| |  | Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36.  
| |  | The British Snoring & Sleep Apnoea Association  
| |  | NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient’s subsequent ability to use nasal CPAP.  

### 16. Trauma & Orthopedics

<table>
<thead>
<tr>
<th>NEW</th>
<th>Diagnostic, Interventions and Treatments for Early Management of Back Pain</th>
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<tbody>
<tr>
<td></td>
<td>Persistent non-specific low back pain of duration 6 weeks to 12 months.</td>
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<td></td>
<td>Excluding spinal pathology, radiculopathy, and children.</td>
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</tbody>
</table>

|     | X Rays and MRI scans should not routinely be offered unless in a context of referral for surgery. Management should consist of a structured exercise programme, manual therapy or acupuncture. |

|     | The following treatments should not be offered for the early management of persistent non-specific low back pain. |
|     | • Selective serotonin re-uptake inhibitors (SSRIs) for treating pain. |
|     | • Injections of therapeutic substances into the back. |
|     | • Laser therapy. |
|     | • Interferential therapy. |
|     | • Therapeutic ultrasound. |
|     | • Transcutaneous electrical nerve stimulation (TENS). |
|     | • Lumbar supports. |
|     | • Traction. |

Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as ‘Snoreplasty’ is not well recognised in the UK as an effective method of treating snoring.

**CG88 Low back pain: full guideline**
NICE 2009.

**Review of Clinical Guideline (CG88) – Low back pain: early management of persistent non-specific low back pain**
NICE 2012.

**IPG 319: Percutaneous intradiscal electrothermal therapy**
| Radiofrequency Facet Joint Denervation | The following referrals should not be offered for the early management of persistent non-specific low back pain.  
- Radiofrequency facet joint denervation  
- Intra Discal Electro Thermal Annuloplasty (IDET)  
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), |
| Intra Discal Electro Thermal Annuloplasty (IDET) percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), | Not routinely commissioned. There is limited data on effectiveness and no data on superiority over other treatments. |
| TAMARS (technology assisted micromobilisation and reflex stimulation) Fusion | Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme.  
AND  
- Still has severe non-specific low back pain for which they would consider surgery. |
| 16.2 Facet Joint - Non Specific Back Pain Over 12 Months including radio | Non Specific back pain over 12 months – Not routinely commissioned.  
May have a role as a diagnostic procedure when |

for low back pain  
NICE 2009.  
IPG83: [Percutaneous intradiscal radiofrequency thermocoagulation](http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf)  
Final_TAMARS_report[1].pdf  
RCS commissioning guidance on LBP due out November.  
Gives guidance and tools.  
Will also give guidance on facet joints.

http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf
<table>
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<tr>
<th>16.3</th>
<th>Endoscopic Laser Foraminoplasty</th>
<th>This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances.</th>
<th>IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011.</th>
<th>Current evidence of the safety and efficacy of endoscopic laser foraminoplasty does not appear adequate to support the use of this procedure without special arrangements for consent and for audit or research.</th>
</tr>
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<tbody>
<tr>
<td>16.4 NEW</td>
<td>Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain</td>
<td>This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances.</td>
<td>IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.</td>
<td>Current evidence on the efficacy of peripheral nerve-field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device.</td>
</tr>
</tbody>
</table>

Epidural Injection

- Considering Radio frequency ablation. This would require an individual funding request.
- Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc & spinal stenosis where surgery is not desirable.
- ‘Non Specific Back Pain – Not routinely commissioned.’

[http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf](http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf)
| 16.5 NEW | Endoscopic Lumbar Decompression | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG300: **Percutaneous endoscopic laser lumbar discectomy**  
NICE, 2009 | Current evidence on the safety and efficacy of percutaneous endoscopic laser lumbar discectomy is inadequate in quantity and quality. |
| 16.6 NEW | Percutaneous Disc Decompression using Coblation for Lower Back Pain. | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 173: **Percutaneous disc decompression using coblation for lower back pain.**  
NICE 2006 | Current evidence suggests that there are no major safety concerns associated with the use of percutaneous disc decompression using coblation for lower back pain. There is some evidence of short-term efficacy; however, this is not sufficient to support the use of this procedure without special arrangements for consent and for audit or research. |
| 16.7 NEW | Non-Rigid Stabilisation Techniques | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 366: [Non-rigid stabilisation techniques](https://www.nice.org.uk/guidance/ipg366) NICE 2010 | Current evidence on the efficacy of non-rigid stabilisation techniques for the treatment of low back pain shows that these procedures are efficacious for a proportion of patients with intractable back pain. |
| 16.8 NEW | Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 321: Lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. NICE 2009. | Current evidence on the safety and efficacy of lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research. |
| 16.9 NEW | Percutaneous Intradiscal Laser Ablation in the Lumbar Spine | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010. | Current evidence on the safety and efficacy of percutaneous intradiscal laser ablation in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit. |
| 16.10 NEW | Transaxial Interbody Lumbosacral Fusion | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 387: [Transaxial interbody lumbosacral fusion](https://www.nice.org.uk/guidance/IPG387) NICE 2011. | Current evidence on the efficacy of transaxial interbody lumbosacral fusion is limited in quantity but shows symptom relief in the short term in some patients. Evidence on safety shows that there is a risk of rectal perforation. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research. |
| 16.11 NEW | **Therapeutic Endoscopic Division of Epidural Adhesions** | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 333: [Therapeutic endoscopic division of epidural adhesions](https://www.nice.org.uk/guidance/ipg333) NICE 2010 | Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research. |
| 16.12 NEW | Automated Percutaneous Mechanical Lumbar Discectomy. | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005. | Current evidence suggests that there are no major safety concerns associated with automated percutaneous mechanical lumbar discectomy. There is limited evidence of efficacy based on uncontrolled case series of heterogeneous groups of patients, but evidence from small randomised controlled trials shows conflicting results. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and for audit or research. |
| 16.13 NEW | Prosthetic Intervertebral Disc Replacement in the Lumbar Spine | This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. | IPG 306: [Prosthetic intervertebral disc replacement in the lumbar spine](https://www.nice.org.uk/clinicians/clinical-guidance/ipp306) NICE 2009.  
Total disc replacement for chronic back pain in the presence of disc degeneration  
The Cochrane Database of Systematic Reviews, Issue 9 (2012). | As effective as discectomy in the short term 2-3 yrs. but after that outcomes are similar. Long term follow-up data on efficacy and safety is lacking. Current evidence on the safety and efficacy of prosthetic intervertebral disc replacement in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit. |
<table>
<thead>
<tr>
<th>16.16 NEW</th>
<th>Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain</th>
<th>Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection.</th>
<th><a href="http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English">http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English</a></th>
</tr>
</thead>
</table>
| 16.17 NEW | Palmar Fasciectomy/Needle Faciotomy for Dupuytren’s Disease. | Requests for treatment will be considered when:  
• Metacarpophalangeal joint contracture of 30o or more, (inability to place hand flat on table OR  
• Any degree of proximal interphalangeal joint contracture, OR  
• Patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 100 or more.  
There should be significant functional impairment. | [IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004.](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[Dupuytrens disease](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[NICE Clinical Knowledge Summaries (2010).](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[British society hand surgeons](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[New guidelines awaited.](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[NHS North West London commissioning policy – Dupuytren's Disease April 2013.](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[Common Hand Conditions](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[NHS Dorset Clinical Commissioning Group (2011).](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[IPG368: Radiation therapy for early Dupuytren's disease NICE 2010.](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English) |
| 16.18 | Hip and Knee Replacement Surgery & Hip Resurfacing | Referral is based on local referral pathways.  
**Funding for total or partial knee replacement** | [NHS North West London commissioning policy – Hip Replacement (Total) April 2013.](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English)  
[A hip and knee score threshold can form part of a demand management](http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English) |
surgery is available if the following criteria are met:

1. Patients with BMI <40

AND

2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

AND

3. Has radiological features of severe disease;

OR

4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.

AND

5. Comply with guidance on Wirral Hip and Knee replacement referral form

Patients not meeting the above criteria can be referred via the IFR route where there are exceptional circumstances present.

**Referral criteria for Total Hip Replacements (THR)**

should be based on the level of pain and functional impairment suffered by the patient. NHS Wirral CCG will fund THR for patients who:

1. Patient complains of severe joint pain AND functional limitation, despite the use of non-surgical treatments such as adequate doses

NHS North West London commissioning policy – Knee Replacement (Total)

April 2013.

**Clinical thresholds knee replacement**

York & Humber Health Intelligence (2011).

Commissioning Guide: *Painful osteoarthritis of the hip*

Royal College of Surgeons (2013).

http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English

Relevant NICE Guidance (TA44) as referred to above

http://publications.nice.org.uk/guidance-on-the-use-of-metal-on-metal-hip-resurfacing-arthroplasty-ta44

1. Appraisal Committee’s preliminary recommendations.

1.1 Total hip replacement and resurfacing arthroplasty prostheses are recommended as treatment options for people with end-stage arthritis of the hip only if the prosthesis has a rate (or projected rate) of revision of less than 5% at 10 years.

1.2 If more than one type of prosthesis meeting the above criteria is suitable for a patient, the prosthesis with the lowest acquisition costs should be chosen.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>of NSAID analgesia, weight control treatments and physical therapies.</td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>2. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.</td>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>3. Comply with guidance on the Wirral Hip and Knee referral replacement form.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44)
### 16.19 Diagnostic Arthroscopy for Arthritis of the Knee

Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate.

However it is not routinely commissioned for any of the following indications:
- Investigation of knee pain.
- Treatment of Osteo-Arthritis including Arthroscopic washout.
- If there is diagnostic uncertainty despite a competent examination or if there are “red flag” symptoms then a Magnetic resonance imaging (MRI) scan may be indicated.

If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.

### Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee

Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies).

### Patient Specific Unicompartmental Knee Replacement

This is not commissioned.

### Patient Specific Total Knee Replacement

This is not commissioned.

---

**Commissioning Guide: Painful osteoarthritis of the knee**
Royal College of Surgeons (2013).

[http://guidance.nice.org.uk/CG177](http://guidance.nice.org.uk/CG177)
CG177Osteoarthritis (NICE 2014)

**IPG317 Individually magnetic resonance imaging-designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance**
NICE, 2009

**EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates**
ECRI Institute (2012)

**IPG 345: Mini-incision surgery for total knee replacement**
NICE 2010

Referral should be made to specialist centres only.
<table>
<thead>
<tr>
<th>16.20</th>
<th><strong>Surgical Treatment for Carpal Tunnel Syndrome</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| • Patients have not responded to 3 months of conservative treatments, including:  
  ➢ >6 weeks of night-time use of wrist splints.  
  ➢ Corticosteroid injection in appropriate patients.  
  ➢ Conservative treatments contraindicated. |
| **Severe cases:** |
| Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment. |
| The following treatments are not commissioned for carpal tunnel syndrome: |
| • Diuretics.  
  • NSAIDS.  
  • Vitamin B6.  
  • Activity modification.  
  • Heat treatment.  
  • Botulinum toxin. |
| **Local corticosteroid injection for carpal tunnel syndrome** |
| Cochrane Database of Systematic Reviews, 2007. |
| **Clinical practice guideline on treatment of Carpal Tunnel Syndrome** |
| **Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome** |
| NHS Oxfordshire, 2009. |
| **Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome** - Cochrane Database of Systematic Reviews 2002. |
| **Surgical treatment options for carpal tunnel syndrome** |
| Cochrane Database of Systematic Reviews 2007. |
| **Surgical versus non-surgical treatment for carpal tunnel syndrome** |
| Cochrane Database of Systematic Reviews 2008. |
| **Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review** |
| **Median Nerve Lesions and Carpal Tunnel Syndrome** |
| Patient.co.uk. |
| **Commissioning Guide: Painful tingling fingers** |
| Royal College of Surgeons (2013). |
| **Mild cases often resolve spontaneously after 6 months.** |
### Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)

<table>
<thead>
<tr>
<th>Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of conservative treatments including watchful waiting.</td>
</tr>
<tr>
<td>AND any of the following</td>
</tr>
<tr>
<td>• Nail growth disturbed</td>
</tr>
<tr>
<td>• Discharging, ulcerated or infected.</td>
</tr>
<tr>
<td>• Size interferes with normal hand function.</td>
</tr>
</tbody>
</table>

**Overview of condition** – Medscape.

**Digital Mucous Cyst**

Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned. Reassurance that no treatment is required should be given to the patient.


**Berkshire PCT, 2009**

**Hip Arthroscopy for Femoro–Acetabular Impingement**

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCGs routinely commissions hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria:</td>
</tr>
<tr>
<td>A definite diagnosis of hip impingement syndrome / femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.</td>
</tr>
<tr>
<td>An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal</td>
</tr>
</tbody>
</table>


**NHS Hull Clinical Commissioning Group 2012.**


Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Removal of Bunions/Surgery for Lesser Toe Deformity</td>
<td>Requests for the removal of bunions will only be considered where; conservative methods of management* have failed. AND the patient suffers significant functional impairment** as a result of the bunions. AND radiographic evidence of joint damage (at point of referral).</td>
<td>*Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate. **Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living. Treatment will not be commissioned for cosmetic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.</td>
</tr>
</tbody>
</table>

IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011

Bunions
NICE Clinical Knowledge Summaries (2012)
IPG 332: *Surgical correction of hallux valgus using minimal access techniques* NICE (2010)
Commissioning Guide: *Painful deformed great toe in adults* Royal College of Surgeons (2013)
| 16.24 NEW | Surgical Treatment of Morton’s Neuroma | Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway.  
1. The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads.  
2. Been referred to an orthotist or podiatrist for an assessment.  
Morton’s neuroma  
NICE Clinical Knowledge Summaries (2010). |
| 16.25 NEW | Surgical Treatment of Plantar Fasciitis | Surgical Treatment is not routinely commissioned unless the following pathway has been followed:  
1. patient has documented evidence that they are not responding to conservative treatments  
2. patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following  
3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss.  
4. Been referred to a podiatrist or physiotherapist.  
Plantar fasciitis  
NICE Clinical Knowledge Summaries (2009).  
Plantar fasciitis  
BMJ 2012;345:e6603. |
| 16.26 NEW | Treatment of Tendinopathies | These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow. | IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis  
NICE 2009. |
|----------------------------------|-------------------------------------------------|

### 17. Urology

#### 17.1 NEW Circumcision

- Indicated for the following condition:
  - balanitis xerotica obliterans.
  - traumatic foreskin injury/scarring where it cannot be salvaged.
  - 3 or more episodes of balanitis/balanoposthitis.
  - Pathological phimosis.
  - Irreducible paraphimosis.
  - Recurrent proven Urinary Tract Infections (UTIs) with an abnormal urinary tract.

- Wirral CCG currently commission circumcision for cultural or religious reasons.
- This will be subject to review.


- [Balanitis](https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions) NICE Clinical Knowledge Summaries 2009.

- [I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56.](https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions)

- [Balanitis](https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions) Patient.co.uk.

**Penile Implant: A Surgical Procedure to Implant a Device into the Penis.**

Penile prostheses for erectile dysfunction are commissioned for men who have failed to respond to the British Society for Sexual Medicine Guidelines first and second treatments and who have one of the following conditions:

- Peyronie’s disease
- Post-priapism
- Malformation of the penis

For all other circumstances an IFR should be submitted if considered exceptional.

<table>
<thead>
<tr>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. REFERENCES</td>
</tr>
<tr>
<td>15. Song WD, Yuan YM, Cui WS, Wu AK. Penile prosthesis implantation in Chinese patients with severe erectile dysfunction: 10 year experience. Asian Journal of Requests for inflatable devices are received occasionally from various CCG areas.</td>
</tr>
<tr>
<td>There is good evidence of high efficacy 80-100% low failure rate &lt; 5 % after five yrs and low infection rate 2-3%.</td>
</tr>
<tr>
<td>All guidelines put devices third line behind PG5 inhibitors and mechanical devices/injections etc</td>
</tr>
<tr>
<td>NICE considered penile implants but did not think them high priority for review.</td>
</tr>
<tr>
<td>Public Health Recommendations:</td>
</tr>
<tr>
<td>1. Penile prostheses for erectile dysfunction should be assigned low priority.</td>
</tr>
</tbody>
</table>
| 2. In rare circumstances, funding will be available for men who have failed to respond to the
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Description</th>
<th>Reference(s)</th>
<th>Additional Notes</th>
</tr>
</thead>
</table>

**British Society for Sexual Medicine guidelines first and second line recommended treatments and who have one of the following conditions:**
- Peyronie's disease.
- Post – priapism.
- Malformation of the penis.

---

**Evidence Briefing Penile Prosthesis.doc**

17.3 Reversal of Male Sterilisation

The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child. Cross reference to fertility policy.

17.4 ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome

This is not commissioned as there is limited clinical evidence of effectiveness. [Guidelines on chronic pelvic pain](https://www.european-association-of-urology.org/)

European Association of Urology (2012).

17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome

This is not commissioned as there is limited evidence of effectiveness. [Guidelines on chronic pelvic pain](https://www.european-association-of-urology.org/)

European Association of Urology (2012).

17.6 Surgery for Prostatism

Only commissioned where there are sound clinical [CG97: Lower urinary tract symptoms: The management of](https://www.nice.org.uk/guidance/cg97)

No references to
<table>
<thead>
<tr>
<th>NEW</th>
<th>18. Vascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.1 NEW</td>
<td>Surgery for Extreme Sweating</td>
</tr>
<tr>
<td>Hyperhidrosis – all areas</td>
<td>Treatment of hyperhidrosis with surgery is not routinely commissioned.</td>
</tr>
<tr>
<td>Surgical resection thoracic sympathectomy</td>
<td>Risk of compensatory hyperhidrosis elsewhere is very high.</td>
</tr>
<tr>
<td>18.2 NEW</td>
<td>Chelation Therapy for Vascular Occlusions</td>
</tr>
<tr>
<td>18.3</td>
<td>Intervventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery for varicose veins.</td>
</tr>
<tr>
<td></td>
<td>Referral for consideration of surgical treatment only for symptomatic varicose veins</td>
</tr>
<tr>
<td></td>
<td>Refer to vascular surgeons</td>
</tr>
<tr>
<td></td>
<td>• Ulcers/history of ulcers /lower limb</td>
</tr>
</tbody>
</table>

Reasons and after failure of conservative treatments and in any of the following circumstances:

- International prostate symptom score >7;
- Dysuria;
- Post voided residual volume >150ml;
- Recurrent proven Urinary Tract Infections (UTI);
- Deranged renal function;
- Prostate-specific antigen (PSA) > age adjusted normal values.

Lower urinary tract symptoms in men
NICE 2010.

LUTS in men, age-related (prostatism)
NICE Clinical Knowledge Summaries (2010).

[http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts)
Royal College of Surgeons (2013).

A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.

Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006.

Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial


Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base

CG168: Varicose Veins in the legs
NICE 2013.
Skin changes secondary to superficial venous disease.

- Symptomatic varicose veins despite explanation and a period of following lifestyle advice.
- AND willing and suitable for a surgical procedure.

Treatment of varicose veins is **NOT** commissioned for cosmetic purposes.

- A systematic review and meta-analysis of treatments for varicose veins – Centre for Reviews and Dissemination 2011

- Ultrasound-guided foam sclerotherapy for varicose veins – NICE IPG 440 2013

- A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein – Centre for Review and Dissemination 2013

CG 168: Varicose veins
NICE 2013

http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins

---

19. Other

19.1 Botulinum Toxin A & B

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

The use of botulinum toxin type A is commissioned in the following indications:

- Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections.
- Blepharospasm and hemifacial spasm.
- Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/G8
- Focal dystonia, where other measures are inappropriate or ineffective.
- Focal spasticity in patients with upper motor

NICE TA260 June 2012 –Migraine (chronic) botulinum toxin type A  http://guidance.nice.org.uk/TA260

Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women  http://guidance.nice.org.uk/C171 and only one course of injections.

**Diagnosis and management of hyperhidrosis** British Medical Journal
neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective.

- Idiopathic cervical dystonia (spasmodic torticollis).
- Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260).
- Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women)
  [http://guidance.nice.org.uk/CG171](http://guidance.nice.org.uk/CG171) and Clinical Guideline 97 (men)
  [http://guidance.nice.org.uk/CG97](http://guidance.nice.org.uk/CG97) where conservative therapy and conventional drug treatment has failed to control symptoms.
- Sialorrhoea (excessive salivary drooling), when all other treatments have failed.

Botulinum toxin type A is not routinely commissioned in the following indications:

- Canthal lines (crow's feet) and glabellar (frown) lines.
- Hyperhidrosis.
- Any other indication that is not listed above:

The use of botulinum type B is not routinely commissioned.

Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing
authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications.

For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG’s defined processes.

If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.
Appendix 1: Cataract Referral Guidance
Referrals for cataract should only be made in the following context:

1) ASSESSMENT OF VISION AND QUALITY OF LIFE

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1. How well can patient see objects in the distance?</td>
<td>without difficulty</td>
</tr>
<tr>
<td>2. How well can patient read writing on the TV and/or road signs?</td>
<td>without difficulty</td>
</tr>
<tr>
<td>3. How well can patient recognise people on the street?</td>
<td>without difficulty</td>
</tr>
<tr>
<td>4. How well can patient read from newspapers/books?</td>
<td>without difficulty</td>
</tr>
<tr>
<td>5. How often does patient suffer from glare at night?</td>
<td>without difficulty</td>
</tr>
</tbody>
</table>

Interpretation

If answer to question 4 is b or c, this is often an indication of macular problems rather than cataract. If this is the only problem, referral for cataract surgery is inappropriate. However, referral for an opinion on maculopathy might be required.

If answers to questions 1 to 3 are mainly (c), this is probably cataract-related and referral may be appropriate.

If glare is the ONLY problem (question 5), the referrer (after discussion with the patient) will need to make a judgment as to the potential impact of cataract removal before deciding whether surgery is appropriate.
3) RISKS AND CONSENT
Has the potential to benefit been explained?
Have details of the procedure and risks been explained to patient?
Is patient still willing to proceed?

The referrer should be satisfied that the criteria outlined in (1) to (3) have all been met before refer
Appendix 2 IFR Process

Identification of need
1

Identification of Commissioner CCG v NHS England
3

Decision made
4

NHS England commissioned services
5

NHS England IFR proforma completed
7

NHS England decision process followed
9

CCG commissioned services
6

Local IFR proforma completed
8

Local decision process followed
10

Decision communicated
11
Cheshire & Merseyside
NHS Funded Treatment for Subfertility
Policy
Wirral Variation
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1. INTRODUCTION

1.1 This policy describes circumstances in which the Clinical Commissioning Group (CCG) will fund treatment for subfertility as defined in section 3.

1.2 The objective of treatment for subfertility is to achieve a successful pregnancy quickly and safely with the least intervention required and the delivery of a healthy child.

1.3 The criteria set out in this policy apply irrespective of where the residents of the CCG have their treatment (local NHS hospitals, tertiary care centres or independent sector providers). A patient is defined as someone registered with a GP practice within the CCG boundary.

This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) published in February 2013.


http://guidance.nice.org.uk/CG156 (summary guidance)


2. GENERAL PRINCIPLES

2.1 The CCG has had regard to the NICE guidance in the formulation of this policy.

2.2 The eligibility criteria set out below does not apply to clinical investigations for subfertility which are available to anyone with a fertility problem.

2.3 The eligibility criteria does not apply to the use of assisted conception techniques for reasons other than subfertility, for example in families with serious inherited diseases where in-vitro fertilization (IVF) is used to screen out embryos carrying the disease (see section 19), or to preserve fertility, for example for patients about to undergo chemotherapy, radiotherapy or other invasive treatments.

2.4 The CCG respects the right of patients to be treated according to the obligations set out in the NHS Constitution and the Human Rights Act specifically with regard to age and sex discrimination.

3. DEFINITION OF SUBFERTILITY, TIMING OF ACCESS TO TREATMENT AND AGE RANGE

3.1 Fertility problems are common in the UK and it is estimated that they affect one in seven couples. 84% of couples in the general population will conceive within one year if they do not use contraception and have regular sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause can not be identified.
3.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. In the following circumstances an earlier assessment should be considered:

- If the woman is aged 36 or over then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less.
- If there is a known clinical cause of infertility or a history of predisposing factors for infertility.

3.3 Women should be offered access to investigations if they have subfertility of at least 1 year duration (6 months for women aged 36 and over) and offered IVF if they have subfertility of at least 2 years duration (12 months for women aged 36 and over). Additional criteria apply for IVF in women aged 40 – 42 (See paragraph 12.4).

3.4 If, as a result of investigations, a cause for the infertility is found, the patient should be referred for appropriate treatment without further delay.

The CCG will offer access to intra-uterine insemination (IUI) or donor insemination (DI) services where appropriate after subfertility of at least 12 months duration. See NICE guidance recommendations 117 – 119.


This policy adopts the NICE guidance that access to high level treatments including IVF should be offered to women between the ages of 23 - 42. First treatment cycles must be commenced before the woman’s 42nd birthday (See section 12.4 for further details).

Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156 section 6.3 guidance recommendations.


OTHER ELIGIBILITY CRITERIA

4. DEFINITION OF CHILDLESSNESS
4.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if previous living child from current or previous relationship then excluded from sub fertility treatment.

4.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child.

4.3 Once a patient is accepted for sub fertility treatment they will no longer be eligible for further treatment if a pregnancy leading to a live birth occurs or the patient adopts a child.

5. SAME SEX COUPLES AND SINGLE WOMEN
5.1 This policy is intended, as per NICE guidance, for people who have a possible pathological problem (physical or psychological) to explain their infertility. The CCG will fund sub
fertility treatment for same sex couples and single women provided there is evidence of proven subfertility, defined as no live birth following artificial insemination (AI) of up to 6 cycles or proven by clinical investigation as per NICE guidance. AI must be undertaken in a clinical setting with an initial clinical assessment and appropriate investigations.

5.2 Eligibility Criteria. The CCG will not fund the AI cycles referred to in 5.1 but will fund access to a clinical consultation to discuss options for attempting conception, further assessment and appropriate treatment.

6. SURROGACY

6.1 The CCG will not commission any form of fertility treatment to those in surrogacy arrangements (i.e. the use of a third party to bear a child for another couple). This is due to the numerous legal and ethical issues involved.

7. REVERSAL OF STERILISATION AND TREATMENT FOLLOWING REVERSAL

7.1 Subfertility treatment will not normally be provided where this is the result of a sterilisation procedure in either partner.

7.2 The surgical reversal of either male or female sterilisation will not normally be funded.

7.3 Where subfertility remains after a reversal of sterilisation, treatment will not normally be funded.

8. FEMALE BODY MASS INDEX (BMI)

8.1 Women will be required to achieve a BMI of 19-29.9 before subfertility treatment begins. Women outside this range can still undergo investigations and be added to the ‘watchful-waiting’ list but subfertility treatment will not commence until their BMI is within this range.

9. SMOKING

9.1 Patients should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment.

10. DRUGS AND ALCOHOL

10.1 Patients will be asked to give an assurance that their alcohol intake is within Department of Health guidelines and they are not using recreational drugs. Any evidence to the contrary will result in the cessation of treatment.


TREATMENT OPTIONS
11. INTRA – UTERINE INSEMINATION (IUI) / DONOR INSEMINATION (DI)

11.1 Consider unstimulated intrauterine insemination as a treatment option in the following groups as an alternative to vaginal sexual intercourse:

- people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm;
- people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive);
- people in same-sex relationships.

For those people who have not conceived after six (6) cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, offer a further six (6) cycles of un-stimulated intrauterine insemination before IVF is considered.

11.2 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total period of time as per section 3.3 before IVF will be considered.

11.3 Donor insemination (with IUI) will be funded where clinically indicated.

11.4 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility.

11.5 Patients who are receiving IUI who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered.

11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF.

12. IVF DEFINITION AND NUMBER OF CYCLES

12.1 A cycle is the process whereby one course of IVF (or ICSI) commences with ovarian stimulation and is deemed to be complete when all viable fresh and frozen embryos resulting from that stimulation have been replaced.

12.2 For women aged 23-39 the Wirral CCG offers 3 full cycles.

12.3 All cycles must be commenced before 40th birthday.

12.4 For women aged 40 and up to 42 the CCG offers 1 full cycle provided: They have never previously had IVF (including privately);
There is no evidence of low ovarian reserve; (see section 3.7 or NICE Guidance section 6.3). There has been a discussion about the implications of IVF at this age. The cycle must be commenced before the woman's 42nd birthday.

12.5 Access to additional cycles is not an automatic right – the outcome of any previous cycle will be taken into account.

12.6 The number of IVF cycles commissioned is unrelated to the number of IUI/DI cycles commissioned.

12.7 As IVF success rates decline significantly after 3 cycles the CCG will take into account the number of cycles received irrespective as to whether they were funded by the NHS or privately.

12.7.1 If patients have funded 3 or more IVF cycles privately they will not be entitled to any NHS funded cycles.

12.7.2 If patients have funded 2 cycles privately they will be entitled to 1 NHS cycle.

12.7.3 If patients have funded 1 cycle privately they will be entitled to 2 NHS cycles.

13. NUMBER OF TRANSFERRED EMBRYOS

13.1 In keeping with the Human Fertilisation and Embryology Authority’s (HFEA) multiple birth reduction strategy patients will be counselled about the risks associated with multiple pregnancies and advised that they will receive a single embryo transfer (whether fresh or frozen) unless there is a clear clinical justification for not doing so (e.g. a single top quality embryo is not available). In any event a maximum of 2 embryos will be transferred per procedure (either fresh or frozen).

13.2 Patients with a good prognosis should be advised that a single embryo transfer, involving fresh followed by frozen single embryo transfers, can virtually abolish the risk of a multiple pregnancy while maintaining a live birth rate which is the same as that achieved by transferring 2 fresh or frozen embryos.

13.3 The CCG will only contract with providers who make a public commitment to comply with the HFEA single embryo transfer policy and can demonstrate significant progress towards achieving the annual target set by the HFEA with performance that is not significantly above the target.

13.4 Further information is available via the HFEA’s ‘One at a Time’ website -
http://www.oneatatime.org.uk.

13.5 Provider multiple-pregnancy data is available via the HFEA’s website -
http://www.hfea.gov.uk/6195.html
14. CANCELLED AND ABANDONED CYCLES
14.1 A cancelled cycle is defined by NICE as ‘egg collection not undertaken’. This would not count as a cycle when considering eligible number of cycles.

14.2 An abandoned cycle is not defined by NICE but is defined by this policy as including IVF treatment leading to a failed embryo transfer. This would count as a cycle when considering eligible number of cycles.

15. HANDLING OF EXISTING FROZEN EMBRYOS FROM PREVIOUSLY FUNDED CYCLES
15.1 All stored and viable embryos should be replaced before a new cycle commences. This includes embryos stored by private providers.

16. SPERM RETREIVAL
16.1 Sperm retrieval for the management of male related fertility problems is a separate clinical procedure and will be charged at Payment by Results rates to the CCG.

16.2 Sperm retrieval for the management of male related fertility problems will be provided for men who, with their partner, will be eligible for NHS funded IVF treatment.

16.3 Couples will have to self-fund sperm retrieval for vasectomised men even if the female partner also requires subfertility treatment.

17. OVUM / EMBRYO DONATION
17.1 Ovum/Embryo donation and sub fertility treatment will be available for women with the following conditions; premature ovarian failure, defined as amenenorrhea of at least 12 months duration with an hormonal profile in the menopausal range, under the age of 40. The cause may be spontaneous, or as a result of other morbidity, or congenital abnormality or iatrogenic.

17.2 NHS funding would not normally be available for women outside these groups who do not respond to follicular stimulation.

18. EGG SHARING/DONATION AND SPERM DONATION
18.1 Egg sharing/donation and sperm donation will be available for couples requiring donated eggs/sperm.

18.2 Egg sharing/ donation for any ‘commercial’ consideration (i.e purchase of additional entitlements) will not be approved.

18.3 Egg and sperm donations will be sourced by providers and charged separately.

19. EMBRYO, EGG AND SPERM STORAGE
19.1 Embryo, egg and sperm storage will be funded for patients who are undergoing NHS subfertility treatment in line with The Human Fertilisation and Embryology Authority guidance. The storage standard period for sperm, egg and embryo storage is normally ten years.
20. PRE – IMPLANTATION GENETIC DIAGNOSIS
20.1 This is subject to a separate NHS England policy.

20.2 All applications must be made to the NHS England for approval and must be for conditions listed by the Human Fertilisation and Embryology Authority.

21. ANTI – VIRAL TRANSMISSION (e.g. HIV and HepC)
21.1 This is subject to separate guidance issued by the Greater Manchester Sexual Health Network. The policy can be accessed at the following site; https://www.liv.ac.uk/hiv/HIV_Infertility_guidelines_(inc._access_to_SW)_v.28_21.02..pdf

22. CRYO – PRESERVATION
22.1 Cryo-presevation services in line with the principles outlined in NICE IPG 156 section 1.16 will be offered to:
   women with premature ovarian failure/ under the age of 40 (see previous definition- see section 17)
   men and women with cancer or other illnesses which may impact on fertility may access tertiary care services to discuss fertility preservation (egg, embryo or sperm storage).

   Other illnesses are not defined in the policy but will be considered on an individual basis via an IFR

   Storage will be in-line with section 19.

22.2 The eligibility criteria set out in this policy do not apply to cryo-preservation but do apply to the use of the stored material.

22.3 Storage of ovarian tissue will not be funded.
# Audit Committee Meeting

**Thursday 18th September 2014**  
10.00am – 12.00pm, Room 539, Old Market House

## Present:

- James Kay (JK)  
  Audit Committee Chair
- Mark Bakewell (MB)  
  Chief Financial Officer
- Liz Temple-Murray (LTM)  
  Manager - Grant Thornton
- Sylvia Cheater (SC)  
  Audit Lay Member
- Tracey Fisher (TF)  
  Audit Lay Member
- Simon Wagener (SW)  
  Lay Member
- Laura Wentworth (LW)  
  Corporate Support Officer
- Bernard Halley (BH)  
  Audit Lay Member
- Anne-Marie Harrop (AMH)  
  Assistant Director
- Paul Edwards (PE)  
  Head of Corporate Affairs
- Joy Hammond (JH)  
  Head of Fraud & Probity Service

## In Attendance:

- Chelsea Worthington (CW)  
  Administrative Assistant (minute taker)
- Andrew Cooper (AC)  
  Chief Officer WHCC
- Keith Bowman (KB)  
  Associate Director MIAA

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Agenda Items</th>
<th>Action</th>
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<tbody>
<tr>
<td>AC14-15/03</td>
<td><strong>PRELIMINARY BUSINESS</strong></td>
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<tr>
<td></td>
<td>JK advised that PE will provide an update to Audit Committee members on the current situation within the CCG and provide information relating to the capability and capacity review which has recently been undertaken by NHS England.</td>
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<tr>
<td></td>
<td>JK asked the Committee to introduce themselves and to explain their role.</td>
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<tr>
<td>1.1</td>
<td><strong>Apologies</strong>: Robin Baker, Iain Stewart, Christine Campbell</td>
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<tr>
<td>1.2</td>
<td><strong>Declarations of Interest</strong>:</td>
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<tr>
<td></td>
<td>No declarations of interest were made.</td>
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### Minutes of Previous Meeting/Action points of previous meeting held on 28th May 2014

The minutes of the previous meeting held on 28th May 2014 were agreed as a true and accurate record with the exception of the changes noted and agreed by the committee.

LTM asked for the title 2.4 on previous agenda to be changed from ‘receive the external Auditors progress report’ to be Receive the external Auditor Finding report (ISA260)

**Action CW to make amendment**

It was noted that the action tracker should be updated to reflect items completed or amended.

### Matters Arising:

No matters arising.

### ITEMS FOR DISCUSSION

#### Audit Workplan

JK and MB advised that they had met prior to this meeting to discuss the workplan and formed the basis for agenda in the meeting.

LTM advised that there are items on the workplan whereby the dates need to be amended for the future meetings.

**Action- CW to amend Workplan to state the changes made for Grant Thornton Papers**

#### Review assurance framework

The group members received and reviewed the report noting that it has been to a past Governing Body meeting and that the current changes are highlighted in red.

#### Receive risk management system

The group received and noted the report.

JK advised that if any members have any issues with regards to the Audit Committee these can be escalated via MB.

#### Note business of other committee’s and review inter relationships

PE advised that a lot of work had taken place to develop both the proposed constitution amendments and the action plan in response to the review and these will have implications for the committee structures of the CCG. The
work to date prior to the review recommendations has shown that the CCG is on the right track and in line with the review findings. The plan is to be in position by the middle of November to submit a revised Constitution to NHS England.

JK advised that we will need a separate Audit Committee meeting to look at the document after submission, to give assurance to GB and identify any issues.

KB advised he is happy to work alongside PE to review the changes.

### 2.5 Review other sources of assurance

PE presented the sources of assurance diagram to the committee.

PE has sent the committee the governance review describing that a different organisational structure is needed.

PE advised that the refresh to the CCG Constitution is a significant piece of work which will require further approval by membership and NHS England.

PE advised that through September and October the CCG will be consulting with patients and GPs.

### 2.6 Risks and controls around financial management and review changes to standing financial instructions and changes to accounting policies

MB introduced paper regarding approach to these issues and that there are no significant changes from last year. Majority of the work in the paper is consistent with the requirements of the constitution document highlighting current meeting arrangements and linkage between QPF and GB.

MB advised the committee that the CCG are always looking to improve reporting arrangements and would welcome feedback as appropriate.

MB explained that the QIPP planning has been impacted upon by the ongoing contract issue with WUTH. This is one of the areas for improvement and joined up contractual approach will help us moving forward.

MB advised he was happy to take any questions the committee had on the paper.

JK pointed out that the structure reflects the current consortia and this will need to close as per earlier discussion. MB agreed would need amendment once final refresh to constitution document has been prepared.

JK reaffirmed that the first task will be to make sure we have the new constitution approved by NHS England/GB Members and wider stakeholders including MIAA and Grant Thornton.

Once completed there may be a need to have a separate meeting in December/January to review.
LTM agrees that this was an important piece of work that will need to be reviewed as appropriate.

MB assured the members that during this transition that business is still going ahead as normal even while the CCG is in a transformation period and again would need to review arrangements in line with the new constitution.

2.7 **Review of losses and special payments**

MB advised that there have been no losses or special payments at this time.

2.8 **IG Update**

MB presented the IG Toolkit update to group members and assurance was provided to the committee that there is a plan in place re IG Compliance and that the CCG are currently in line with workplan requirements and toolkit submission.

JK advised that the update states that a 14/15 workplan should be included.

MB apologised that this was not included and will send it through to committee members separately.

2.9 **Internal Audit Progress report**

AMH presented the Internal Audit Progress Report to the committee and explained that this progress report provides the committee with an update in respect of the assurances, key issues and progress against the internal plan for 2014/15.

The report details findings, recommendations and agreed actions provided to the CCG.

2.10 **Safeguarding**

Key messages for the Audit Committee’s attention is that the Safeguarding review received the assurance level of significant with 2 medium and 1 low recommendation.

AMH advised that the workplan for this year is in progress, on schedule and there are no issues to note.

AMH advised she has separate brochure to hand out to committee members regarding up and coming events.

2.11 **Audit Committee handbook (MIAA)**

JK advised that this was a very helpful document which the Audit Committee will be paying close attention to going forward.

JK explained that there has been a meeting organised for the Lay Members to meet with the External Auditors Grant Thornton. JK advised that he is also
2.12 **Approvals Committee – Approval & Monitoring of Schemes (MIAA)**

KB presented the MIAA Approvals Committee- Approval and Monitoring of Schemes Final Report to the group members.

KB advised that this wasn’t an assurance piece of work but the organisation can take a level of assurance from the areas of good practice identified within and areas for improvement.

KB advised that it is important to recognise the role of the Approvals Committee, and there were areas for improvement such as although there was clear evidence of discussion, the minutes did not necessarily reflect and possibly therefore difficult to evidence the level of appropriate challenge.

MIAA had reviewed the relevant items and had looked at the evidence for judgments made and decision making process.

The principals of the committee that needs to be improved are discussion, debate, challenge and outcome as outlined in improvement areas.

KB explained that the Approvals Committee should provide assurance to the Audit Committee. There is also a requirement to have an evaluation process once schemes are embedded; the plan states that the executive should put a plan together to make appropriate improvements going forward.

JK advised that he and the lay members have had a previous discussion regarding the report before the meeting.

JK queries whether PE should become a permanent member of the Approvals Committee, given the current restructure and governance elements. It was agreed Paul Edwards is to become a permanent member of the Approvals Committee and will be actioned in refresh of constitution.

MB welcomed the findings from MIAA and takes on the learning to improve arrangements in house.

MB explained that the CCG have already reflected on areas of improvement have begun to implement some of the changes.

JK Invited comment from committee members

SC & BH highlighted that the Approvals Committee would need to improve its scrutiny in order to be assured in the audit trail and that it may be helpful to have a standard template to benchmark the score against.

TF also queried how expenditure is deemed to be a success

SW advised this report has brought a different perspective. In the past there has been no schemes rejected and that the committee needs to have a
greater grasp of the schemes.

SW explained that monitoring post approval and that of expenditure should come to the Approvals Committee to give assurance.

MB assured the group that the CCG are starting to look at the outcomes and evaluate things better going forward.

AC explained that it is important to note that funding had been given to consortia’s that had to be spent by the end of the financial year and that the CCG need to learn from this for planning in the future.

AC explained that we have a more structural process and the report was really helpful.

JK explained that his personal experience of the Approvals Committee is it is always under great time pressure and that there are a few things the Approvals Committee can do and that potentially the Committee is distanced from GB.

The executive will lead on preparing an action plan for the Approval Committee and for review by the Audit Committee. Lay members also agree with JK’s approach.

SC advised that we need to ensure that there is an appropriate Conflicts of Interest in approval papers going forward.

AC explained that he believes that this is more fundamental than Approvals, this goes back to Governance and organisational approach.

MB reminded the group that the CCG is undergoing a transformation into own approach to Wirral wide commissioning and should not forget this as a contributing factor.

KB viewed that there is a good level of healthy discussion going on; the committee just needs to operate in a more effective manner. MB agrees the CCG needs to have a wider context not just committee, but there is a lot of good work undertaken and areas of improvement need to be implemented especially around the evidence within minutes and evaluation monitoring.

MB agreed to review report and provide action plan for next meeting.

### MIAA Prescribing incentive scheme report

AMH presented the MIAA Prescribing incentive scheme report to the group and explained that the review of the Prescribing incentive scheme has been conducted in accordance with the requirements of the 2014/15 Internal Audit Plan, as approved by the Audit Committee.

The review has found that there is limited assurance in this area with a number of recommendations. MB reflected that he held a number of conversations with internal audit regarding this and AMH described the key areas within the report.

JK advised that he and CW have had a discussion around clear sense of how to move forward with Approval Committee minutes and which ones are of the
2.14 **Audit tracker**

JK advised that committee have received and noted the document. MB advised that there is nothing exceptional to report and that by the next meeting members will start to see some of the actions being signed off.

2.15 **External Auditors update**

LTM presented the committee with the External Auditors update. The paper provides the Audit Committee with a report on progress in delivering responsibilities as the CCG’s external auditors. The paper also includes a summary of emerging national issues and developments that may be relevant to the CCG and includes a number of challenge questions in respect of these emerging issues which the Committee may wish to consider.

2.16 **External Auditors progress report and value statement**

LTM presented the progress report and value statement from Grant Thornton. LTM explained that Grant Thornton are currently waiting for the Department of Health Guidance for dates of submission. The guidance will be available to the committee once it has been published.

LTM advised the committee that Grant Thornton have received very good feedback on the Value statement report to highlight other services.

JK advised that the reports are very helpful.

2.17 **External Auditors annual Audit letter**

LTM presented the committee with the Annual Audit Letter. The purpose of the letter is to summarise the key findings arising from the work that Grant Thornton had carried out at the CCG for the year ending 31st March 2014. The letter is intended to communicate the key messages from Grant Thornton to the CCG and external stakeholders, including members of the public. This letter has been prepared in the context of the statement of responsibilities of Auditors.

LTM advised the group that Grant Thornton confirmed what they had done with regards to the opinions which are stated in the Audit Report Letter.

The conclusion of the report are as follows:

**Financial statements opinions**- Grant Thornton issued an unqualified opinion on the CCGs financial statements, confirming they provided a true and fair view of the CCG’s financial position as at 31st March 2014 and of recorded net expenditure recorded for the year.
Regularity opinion- As well as an opinion on the financial statements, Grant Thornton are required to give regularity opinion on whether expenditure has been incurred ‘as intended by parliament’.

LTM stated that the findings of the review of the CCG’s expenditure led to an unqualified regularity opinion.

Value for Money (VfM)-

Grant Thornton had issued a ‘non-standard’ value for money conclusion reflecting concerns that had been raised about the leadership of the CCG.

The context to this being that in May 2014, NHS England had raised some concerns about leadership of the CCG, primarily in relation to the roles of the Chief and Chief Clinical Officer. As a result, the CCG’s Governing Body voluntarily asked NHS England to support it in the delivery of its duties and functions, specifically with the leadership arrangements within the CCG. A Capability and Governance review had been undertaken and the Chair and Chief Clinical Officer had agreed to voluntarily step aside, with an Interim Accountable Officer supporting the CCG at present.

Whole of Government Accounts (WGA)-

A group assurance certificate was issued by the National Audit Office in respect of Whole Government Accounts and did not note any issues for the group auditor to consider.

On a local NHS Wirral CCG’s ledger was used to record transactions for the Isle of Man and audit view was that this was not the necessarily appropriate accounting treatment. The Chief Financial Officer agreed to amend the accounts for the material income and expenditure element but not for the non-material balances included within the Statement of Financial Position.

It was noted that going forward the CCG should consider whether it continues using its ledger for transactions under this arrangement. MB confirmed he is currently reviewing this approach.

Grant Thornton would like to record their appreciation for the assistance and co-operation provided during the audit by the CCG’s officers, members and lay advisors.

JK advised in his view the CCG has been provided with a highly supported service from both auditors and gave his thanks to them for their work in the previous financial year.

2.18 Review clinical audit progress reports

JK advised that he has spoken with LQ to revise the workplan in relation to receiving clinical audit progress reports.

JK advised that LQ will implement a revised scheme that will look at different aspects of the clinical area.

ACTION – LQ to update at next Audit Meeting
2.19 **Counter Fraud progress report**

JH presented the counter fraud update to the committee. JH advised that as the current situation stands there are no ongoing cases that group members need to be made aware of.

The previously reported ongoing issue regarding bogus patient is now with the police.

JH explained that the National Fraud Capture Exercise is at the beginning of October and will follow up next year.

2.20 **Self-assess Committee’s effectiveness**

JK advised that he is currently working on the results and will feedback to the committee before the next meeting.

JK proposed for another survey to be done and committee agreed.

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<th>AC14-15/03</th>
<th>ITEMS FOR INFORMATION</th>
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<tr>
<td>3.1</td>
<td>PE advised that he will provide an update re the sustainability work at the next meeting.</td>
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**Action- PE to send report to committee before next meeting**

PE advised the committee that the CCG are undertaking an audit of minutes of all the committees in line with previous agenda item re Approvals/Prescribing incentive scheme audit.

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<th>AC14-15/03</th>
<th>ANY OTHER BUSINESS</th>
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<td>4.1</td>
<td>There was no other business.</td>
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<tr>
<th>AC14-15/03</th>
<th>DATE AND TIME OF NEXT MEETING</th>
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<tr>
<td></td>
<td>The next meeting will be held on:</td>
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**13th November 2014, 10am -12pm, Room 539, Old Market House.**

Please forward apologies / agenda papers to chelsea.worthington@nhs.net
**WIRRAL CLINICAL COMMISSIONING GROUP**

Quality Performance and Finance – informal meeting

**Notes & Actions of Meeting**

**Tuesday 16th December 2014**

1pm Room 539, 5th Floor, Old Market House

**Present:**

- James Kay (JK)  Lay Member (Audit & Governance) WCCG
- Simon Wagener (SW)  Lay Member (Patient Champion)
- Christine Campbell (CC)  Head of Partnerships
- Mark Green (MG) (Chair)  GP Lead
- John Wicks (JW)  Interim Accountable Officer
- Lesley Doherty (LED)  Asst. Interim Accountable Officer
- Sue Smith (SS)  Lead Nurse for Quality & Patient Safety
- Mark Bakewell (MB)  Chief Financial Officer

**Guest Speakers:**

- Suzanne Crutchley (SC) Senior Governance Manager

**Minute Taker/Support:**

- Allison Hayes (AJH)  WCCG Corporate Officer
  - Programme Manager
- Sarah Boyd Short (SBS)  Programme Manager
- Heather Harrington (HH)  Programme Manager
- Pauline Bolt (PB)  Programme Manager

**In attendance:**

- Sarah Boyd Short (SBS)
- Heather Harrington (HH)
- Pauline Bolt (PB)

**Ref No.** | **Minute**
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QPF 14-15/0044 | **1.0 Standing Agenda Items**

<table>
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<tr>
<th><strong>1.1 Apologies for absence</strong></th>
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Apologies were received from: Paul Edwards, Sean Daly, Sue Wells, Laura Wentworth, Peter Naylor, Iain Stewart, John Oates, Andrew Cooper and Lorna Quigley.

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<th><strong>1.2 Declarations of Interest</strong></th>
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There were no declarations of interest.

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<th><strong>1.3 Minutes of Previous meeting from 25th November 2014</strong></th>
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The minutes from the previous meeting held on 25th November were agreed as true and accurate record, notwithstanding typographical and grammatical errors.

**Action - AJH to send ratified minutes from 25th November to GB in January.**

Actions from the previous meeting – please refer to action sheet.

**Outstanding Actions**

Members discussed the outstanding actions from the previous meeting. JK updated members regarding the governance arrangements of the Health and Wellbeing Board and further discussions are to take place.

**Matters Arising**

**2.0 Items for approval**
There were no items for approval.

3.0 Items for Discussions

3.1 Performance Reports

LQ presented the Key Performance Indicator Report to the group for the period of October 2014 and committee members were asked to note the following:

**Referral to treatment target (RTT)**
Due to national drive to clear the backlog of patients waiting more than 18 weeks for treatment.

Admitted breaches in:
- Gynaecology (87.7%)
- Other (71.8%)
- ENT (87.1%)

Non Admitted breaches in:
- Cardiology (94.9%)
- Gastroenterology (94.3%)
- Ophthalmology (85.5%)
- General Surgery (93.9%)

Incomplete breaches in General surgery (91.8%), Neurology (83.3%), Plastic Surgery (90.2%)

Pressures remain at Alder Hey. As these patients are specialist commissioning the performance issues are being managed by the AT.

**Over 52 week waiters**
No issues – performance will continue to be monitored to identify any future breaches.

**A&E waiting times**
This has been below target at 94.8%. A&E at Arrowe Park fell short of the target in October; however WIC performance has met the target.

**C Difficile**
In October there were four new cases in WUTH.

Other areas included:
- Same sex accommodation
- Family and Friend Tests Maternity & A&E Inpatient WUTH
- Reducing Healthcare acquired infections
- Emergency Ambulance
- Cancer

Members noted the current performance report.

3.2 Finance Reports

MB presented the Finance report to the group. The report sets out the financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of November (Month 8) within the 2014/15 financial year and performance against the measures outlined in the CCG Assurance Framework for 2014/15.

As at the end of November (Month 8) the year to date position for Wirral CCG shows an
operational over performance against required surplus of £1015k, an adverse movement compared to the previous month of £358k.

Areas included:

- NHS Contracts
- Non NHS contracts
- Prescribing
- Commissioned out of hospital
- Third sector
- Intermediate care
- Locally enhanced services
- QIPP
- Running costs
- Risks
- Balance Sheet

MB highlighted that a number of adjustments have been made to the CCG forecast outturn position in respect of risks previously identified. These still contain a number of assumptions for the remainder of the financial year. Further issues regarding CHC restitution/ DOLS and NHS Property Services still require further review.

NHS Wirral CCG’s Quality, Performance and Finance Committee were asked to note:

- The CCG financial position as at the end of November 2014
- Movement in the CCG forecast outturn position as declared above
- Performance against indicators based on the information available
- The associated financial risks within the declared position including the impact of potential resource allocation issues.

CC highlighted the importance of monitoring spend in relation to Continuing Health Care and suggested that this should be incorporated in the CCGs future financial planning model.

MB followed up his report with details of a ‘deep dive’ conducted with the local area team and the issues discussed in relation to Wirral Hospital contracts.

MB informed members of the current position regarding the WUTH contract and asked the committee to be aware that an under spend may occur depending on future activity.

JK sought clarity around the CCGs potential underspend position at the end of year and MB provided a rational regarding this.

SW sought clarity regarding the Referral to Treatment Target (RTT) activity and the money implications and MB explained the procedures relating to this.

Members of the QPF committee noted the Financial report presented at today’s meeting.

3.3 Dementia Diagnosis Briefing Paper

CC presented a briefing paper which provided an update on the current dementia diagnosis rate, and steps that are being taken to improve this rate in line with the NHS England target of meeting 67% of expected prevalence by April 2015.

There are a number of initiatives available to practices in order to increase their diagnosis rate:
Dementia DES
A DES has been recently released by NHS England, only running until 31.03.15, which pays practices for each diagnosis of dementia made.

Given the number of written communications issued, it is considered most beneficial to highlight this matter face-to-face, and particularly with practice managers. It is suggested that this is taken through existing engagement processes. It may be helpful if the clinical lead for dementia (who is a GP at one of the practices that has run the toolkit and increased the diagnosis rate significantly) is part of this process.

JK requested that the data analysis report is provided at a later date and CC is to arrange this.

SW raised concerns regarding the dementia diagnoses costs and sought clarity around the dementia diagnostic tool kit which CC clarified for the group.

Members of the Quality, Performance and Finance Committee were asked to note the content of this report and make any recommendations around next steps.

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4.0 Items for Information and Noting

4.1 Contracting Issues

- **CWP** – CC updated the committee regarding the current situation in relation to the CWP contract. Areas included: mental health PBR.
- **CT** – LED provided an update for members relating to the CT contract. Areas included duplication of on costs and the CCGs commissioning intentions.
- **WUTH** – LED informed members that the CCG have issued their commissioning intentions. An audit regarding admission rates is also to be conducted in the future around non-elective thresholds. The CCG have discussed how they are to take these negotiations forward. JK sought clarity regarding the timescales in which the CCG are working to in relation to the new financial year and MB informed members that the initial sign off date will be in February/March 2015. MB highlighted to members the respective financial gap between the organisations.
- **WLA** – MB provided an update regarding the current position in relation to the WLA. Discussions, although challenging are positive and encouraging and MB went on to update members in relation to the Better Care Fund.

4.2 Complaints Update

SS reported on the complaints and MP enquiries received by NHS Wirral CCG on behalf of Laura Wentworth. Due to the timing of the meeting data has not yet been received by the CCG.

4.3 FOI (Freedom of Information) Update

SS reported that there has been a reduction of FOI requests and that future FOIs are now being dealt with the CCG in house.

The report details the number of FOI requests received and closed during the reporting period of November 2014.

This report also provides a brief description of each request, details the types of applicants, the average response time and reasons for delay, where possible.

Members noted the FOI report presented today.

4.4 Serious Incidents
SS provided the committee with details of the new serious incidents reported in November.

The quality and performance committee are asked to note the 16 new serious incidents reported to the Strategic Executive Information System (StEIS) in November 2014, relating to:

- 13 Wirral University Teaching Hospital Trust.
- 2 Cheshire and Wirral Partnership NHS Foundation Trust
- 0 Wirral Community NHS Trust
- 1 One to One Midwives

As per the serious incident reporting framework, a root cause analysis will be undertaken on the incident, the report and action plan will be monitored at the CCG SI Group

The QPF committee noted the incidents reported for the month of November and that all serious incident reporting will now be conducted by the Corporate support team of the CCG.

It was noted that Lorna Quigley and Dr P Naylor attended the meeting from this point onwards.

### 5.1 Minutes for Noting

#### 5.1 Information Governance Report

SC, Senior Governance Manager, provide the committee an update regarding the Wirral Clinical Commissioning Group Information Governance performance, and to demonstrate that the correct support and programmes of work are underway to meet the Information Governance Toolkit Requirements by 31st March 2015.

Areas included:

- Spot checks
- Information Asset Register Report
- 2014/15 Information Governance Work Plan
- Information Governance Toolkit
- Assurance

The Committee is asked to note the current position and receive the updated 2014/15 Work Plan, to receive the Report on the Information Asset Register, to receive the IG Spot Checks report and recommendations, and consider if any further actions should be taken to further mitigate data protection and confidentiality breaches and to commit to support compliance with the Information Governance Toolkit, in preparation of the March 2015 submission.

Members of the QPF committee noted the Information Governance Report presented today.

#### Subgroups minutes for noting:

- WUTH Quality & Clinical Risk Minutes of 29th October 2014
- WUTH Contract Monitoring Minutes of 2nd October 2014 and 6th November 2014

Members of the committee noted the minutes of the subgroups detailed above.

### 6.0 Risk Register

Members discussed the current risk register and all items were reviewed and noted accordingly.

### 7.0 Any Other Business

#### 7.1 Nursing Home patient Moves
Ref No. | Minute
---|---

LQ reported following the closure of Highground Nursing Home all patients have now been placed in alternative homes and patient tracking will take place over the next 12 months.

7.2 CQC Report

LQ reported that the CCG is now in receipt of a CQC report dated 12/12/14 in regards to non-compliance to CQC standards within WUTH. The report summarised the issues with the CQC inspection and gave guidance to the committee on the recommendations. The full inspection report has now been published. The CCG is to undertake a single item Quality Surveillance Group meeting regarding the outcome of the report and to consider other intelligence collected in relation to the quality of services within the Trust.

Members of the CCG noted the results of the inspection and the Trust’s response and action plan and agreed for the report and action plan to go to the Governing Body meeting in January.

Chair thanked members for their attendance and the meeting closed at: 15:33pm.

Date and Time of next meeting

The date and time of the next QPF meeting is scheduled for:
Tuesday 27th January at 1pm in Room 539 OMH
****Latest submission date for papers is Friday 16th January 2015 ****

Please forward any apologies to Allison.hayes@nhs.net
| Risk ID | Date added | Source | Division | Risk Description | Organisational Objectives (reference to detail) | Consequence | Likelihood | Matrix Score | Key Control Established | Key Gaps in Control (reference to evidence) | Assurance on Controls (reference to evidence) | Consequence | Likelihood | Previous Risk Rating | Owner | Date of next review | Date of last review | Last review |
| 10-13 A | 10-13 | Financial Year | Gov Body | Impact of 111 on quality. | | 3 | 3 | 3.00 | None | Increased demand for clinical input and lack of influence of national specification. | | | | | | | | | |
| 10-15 A | Apr-14 | CCG | Gov Body | Safeguarding and the completion of the GP assurance toolkit. | | 3 | 4 | 12.00 | Process in place for completion of toolkit | Number of doctors trained to complete toolkit from a safeguarding perspective. | Monitoring of the completion of the GP assurance toolkit | Training has been carried out for doctors to ensure compliance. | 4 | 4 | 10.00 | LG | May | January 15-QPF | New risk discussed. To be monitored at Governing Body. Action plan to be agreed with lead. | |
| 10-15 C | Jun-14 | CCG | Gov Body | A&E 4 hour Target, including quality of care & standards provided to patients. | | 4 | 5 | 20.00 | Ongoing monitoring. | Target not being met by Wirral economy & rated high risk by NHS England and Monitor. | Target continues to not be met. | | 4 | 4 | 10.00 | LG | February | January 15-QPF | New risk discussed at June GB. To be monitored at Governing Body. Action plan to be agreed with lead. | |
| 10-15 D | Jun-14 | CCG | Gov Body | Cdifficile Targets | | 5 | 4 | 20.00 | Monitoring on performance against targets | Health economy are ahead of threshold for the threshold for Cdifficile | | | | | | | | | |

Notes:
- 10-13 A: In the reviewed at September QPF. Updated AP reviewed at December QPF. Risk represented, need due for review at December QPF. FP reviewed, need due at January QPF upon completion. Reviewed at Jan QPF & agreed that a review of the non-modification strategy. Agreed for next QPF. Updated AP reviewed at April QPF with a full risk assessment due in 10-14 E.
- 10-14 E: New risk discussed. To be reviewed at Governing Body. Action plan to be agreed with lead. Oct 14 - Work still being undertaken to ensure the completion of the plan, therefore for further review at December 14 GB. Action discussed at Nov GB and decision made for this to be rescored at the Dec QPF committee. Updated AP reviewed at Jan QPF and agreed to send score. Safeguarding team to provide a further updated action plan, need due for review at May QPF.
- 10-15 A: New risk discussed at June GB. To be monitored at Governing Body. Action plan to be agreed with lead. Reviewed at Jan QPF & agreed for threshold to be amended to 5. Action plan for further review at February QPF.
- 10-15 C: New risk discussed at July QPF. Action plan to be agreed with lead. To be brought back to August QPF. Updated AP reviewed at August QPF and due back for further review upon completion at the December QPF. Reviewed at Jan QPF & agreed for consequence to be amended to 5. LG to provide further updated action plan for February QPF.
<table>
<thead>
<tr>
<th>Week</th>
<th>Date</th>
<th>Executive</th>
<th>Scope</th>
<th>Issue Description</th>
<th>Type</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Consequence</th>
<th>Status</th>
<th>Next Review</th>
<th>Risk Score</th>
<th>Scored At</th>
<th>Risk Summary</th>
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<tbody>
<tr>
<td>16-15K</td>
<td>Aug 15</td>
<td>CCG</td>
<td>Gov Body</td>
<td>Supreme Court Judgement Deprivation of Liberty Safeguards (DoLS)</td>
<td>Quality / Patient Safety</td>
<td>6</td>
<td>3</td>
<td>12.00</td>
<td>To work with Provider Organisations. To work with Local Authority to assess the impact fully. Provider Organisations to ensure that this is on their Risk register also.</td>
<td>4</td>
<td>1</td>
<td></td>
<td>New risk discussed at July QPF. Action plan to be agreed with lead. To be brought back to August QPF. AP renewed at August QPF and due back for further review upon completion at December GB meeting. AP reviewed at Jan QPF &amp; it was noted that processes and training are in place to manage the risk. Noted that Supreme Court Judgement has not yet been received. For further review at April QPF.</td>
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<td>16-15L</td>
<td>Aug 15</td>
<td>CCG</td>
<td>Gov Body</td>
<td>Continuing Healthcare issues with the service provided, the CHC process followed, general performance &amp; quality &amp; inconsistency of complaint response letters</td>
<td>Quality / Patient Safety</td>
<td>5</td>
<td>3</td>
<td>15.00</td>
<td>Action plan in place and ongoing monitoring of performance Continuing Healthcare service provided, the CHC process followed, general performance &amp; quality &amp; inconsistency of complaint response letters</td>
<td>5</td>
<td>3</td>
<td>15.00</td>
<td>New risk discussed at August QPF. AP to be completed by IS. For noting at September GB &amp; to be reviewed at December GB meeting. AP from lead.</td>
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<tr>
<td>16-15L</td>
<td>Sept 15</td>
<td>CCG</td>
<td>Gov Body</td>
<td>Community Trust Contracts &amp; performance of certain services as raised via Contract queries</td>
<td>Quality / Financial</td>
<td>3</td>
<td>2</td>
<td>6.00</td>
<td>Action plan in place to monitor &amp; manage the performance issue, which is reviewed by the Community Trust Contracts Monitoring meeting. Identified as a risk to the CCG and to be monitored via CT contract meetings going forward</td>
<td>4</td>
<td>3</td>
<td>15.00</td>
<td>New risk discussed at September QPF. AP to be agreed &amp; completed by MG / AC, new risk for review at November GB. Risk reviewed at the November GB and it was agreed to reduce the consequence score from 4 to 3. Jan 15 - Discussion with Lead to advise that there is an AP in place to monitor &amp; manage the performance issues, which is reviewed by the Community Trust Contracts Monitoring meeting. For discussion at QPF to decide if this risk can be de-escalated.</td>
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<tr>
<td>16-15L</td>
<td>Dec 15</td>
<td>CCG</td>
<td>QPF</td>
<td>Quality of care provided to patients at Wirral University Teaching Hospital NHS Foundation Trust</td>
<td>Quality / Patient Safety / Financial</td>
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## Risk to Non Medical Prescribers policy as out of date.

### Quality / Patient Safety

New NMP policy ratified at QPF held on 27th Jan, implementation to commence to all INPs following small amends.

Increased risk identified due to out of date NMP policy being utilised by Independent Nurse Prescribers (INP) in General Practice.

Risk visible during implementation phase of new NMP policy.

Further documentation for GP’s & Practice Managers to be created to support implementation of new NMP policy.

### Impact Values

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<th>Impact Values</th>
<th>Negligible</th>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
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<td>2</td>
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### Probability Values

<table>
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<th>Unlikely</th>
<th>Likely</th>
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### Green/Yellow/Red Threshold Values

<table>
<thead>
<tr>
<th>Green/Yellow/Red Threshold Values</th>
<th>Green</th>
<th>Yellow</th>
<th>Red</th>
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<tbody>
<tr>
<td>Green - maximum score</td>
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<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Yellow - maximum score</td>
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<td>15</td>
<td></td>
</tr>
<tr>
<td>Red - minimum score</td>
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