AGENDA

<table>
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<tr>
<th>Ref No.</th>
<th>No.</th>
<th>Time</th>
<th>Item</th>
<th>Action</th>
<th>Papers</th>
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<tbody>
<tr>
<td>GB16-17/0025</td>
<td>1.</td>
<td>1.00pm</td>
<td>PRELIMINARY BUSINESS/ADMINISTRATIVE ITMES (Chair)</td>
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<td>1.1 Apologies for Absence</td>
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<td>1.2 Chair’s Announcements</td>
<td>To Note</td>
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<td>1.3 Declarations of Interest</td>
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<td>1.4 Welcome and Comments/questions from members of the public (10 mins)</td>
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<td>1.5 Minutes and Action Points of Last Meeting – 1st November 2016</td>
<td>To Approve</td>
<td>Draft GB Minutes Copy of WCCG PUBLIC MEETING 01 Formal GB Action Pack</td>
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<td>Action Points</td>
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<td>1.6 Matters Arising</td>
<td>To Approve</td>
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<td>1.7 Patient Story</td>
<td>To Note</td>
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<td>1.8 Chief Officer’s Update (Paul Edwards)</td>
<td>To Note</td>
<td>Verbal</td>
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<td>GB16-17/0026</td>
<td>2.</td>
<td>1.20pm</td>
<td>RISK MANAGEMENT</td>
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<td>2.1 Risk Register (Paul Edwards)</td>
<td>To Discuss</td>
<td>Copy of MASTER Risk Register - Janua</td>
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<tr>
<td>GB16-17/0027</td>
<td>3.</td>
<td>1.30pm</td>
<td>FINANCE</td>
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<td>3.1 Chief Financial Officer's Report (Mike Treharne)</td>
<td>To Note</td>
<td>GB Cover sheet Wirral CCG Finance Chief Financial Officer Committee Report 16</td>
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<td></td>
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<td>3.2 Presentation on 17/18 &amp; 18/19 Financial Plans (Mike Treharne)</td>
<td>To Note</td>
<td>Presentation</td>
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<td>GB16-17/0028</td>
<td>4.</td>
<td>1.50pm</td>
<td>PERFORMANCE AND COMMISSIONING</td>
<td>To Note</td>
<td><img src="GB_cover_sheet.png" alt="GB Cover Sheet" /> <img src="director_report.png" alt="Director of Commissioning Report" /> Copy of Supporting Narrative for plans 2X Cover sheet GBFV Jan 17.docx GB report GPFV Jan 17.docx General Practice Wirral Primary Care Forward View April1Transformation Plan GB report All Age Disability Strategy-G 1.Learning Disability Strategy_2</td>
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<td>GB16-17/0029</td>
<td>5.</td>
<td>2.20pm</td>
<td>QUALITY &amp; PATIENT SAFETY</td>
<td>To Note</td>
<td><img src="GB_cover_sheet.png" alt="GB Cover Sheet" /> Director of Quality &amp; Patient Safety re</td>
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<td>GB16-17/0030</td>
<td>6.</td>
<td>2.50pm</td>
<td>GOVERNANCE AND ENGAGEMENT</td>
<td>To Note</td>
<td><img src="GB_cover_sheet.png" alt="GB Cover Sheet" /> Director of Corporate Affairs Report (Paul Edwards) Cover Sheet - Assurance Framework AF JanBody narrative.docx Copy of Wirral CCG Assurance Framework</td>
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<tr>
<td>GB16-17/0031</td>
<td>7.</td>
<td>3.10pm</td>
<td>COMMITTEE REPORTS</td>
<td>To Note</td>
<td><img src="GB_cover_sheet.png" alt="GB Cover Sheet" /> Terms of Reference-PCCC Terms of Reference-Primary M</td>
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<td>GB16-17/0032</td>
<td>8.0</td>
<td>3.30pm</td>
<td>ANY OTHER BUSINESS</td>
<td>To Note</td>
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Date and time of Next meeting: Tuesday 7th February 2017 – 1pm – 4pm Nightingale Room OMH
Please forward any apologies to allison.hayes@nhs.net
WIRRAL CLINICAL COMMISSIONING GROUP  
GOVERNING BODY BOARD MEETING  
Minutes of Meeting – Public Session  

Tuesday 1st November 2016  
1pm  
Nightingale Room, Old Market House  

Present:  
Dr Sue Wells (SW) (Chair) Medical Director  
Jon Develing (JD) Chief Officer  
Mark Treharne (MT) Chief Financial Officer  
Nesta Hawker (NT) Director of Commissioning  
Paul Edwards (PE) Director of Corporate Affairs  
Dr Sian Stokes (SS) GP Lead – Long Term Conditions  
Lesley Doherty (LD) Registered Nurse  
Alan Whittle (AW) Lay Member (Audit & Governance)  
Fiona Johnstone (FJ) Director of Public Health  
Dr Laxman Ariaraj (LA) GP Lead – Planned Care  
Dr Simon Delaney (SD) GP Lead – Primary Care  
Dr Paula Cowan (PC) GP Lead – Unplanned Care  
Lorna Quigley (LQ) Director of Quality and Patient Safety  
Dr Bennett Quinn (BQ) LMC Representative  

In Attendance:  
Allison Hayes (AJH) Corporate Officer  

Ref  
No.  

Minute  

Action  

GB16-17/0017  

Preliminary Business  

1.1 Apologies for absence  

Apologies were received from: Dr James Sowery, Dr Arpan Guha, James Kay and Graham Hodkinson.  

1.2 Chairs Announcements/Opening Remarks  

Chair welcomed members and the public to the meeting.  

1.3 Declarations of Interest  

Chair reminded the Governing Body members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Wirral Clinical Commissioning Group.  

Declarations declared by members of the Governing Body are listed in the CCGs Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link: https://www.wirralccg.nhs.uk/Downloads/AboutUs/WhosWho/Register%20of%20Interests%20Version%20Updated%20June%202016.pdf  

There were no declarations of interest received at today’s meeting.
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<td>1.4</td>
<td><strong>Comments/questions from members of the public</strong>&lt;br&gt;There were three members of the public who attended the meeting but did not want to address the Governing Body.</td>
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<td>1.5</td>
<td><strong>Minutes &amp; Action Points from previous meeting held on 4\textsuperscript{th} October 2016</strong>&lt;br&gt;The minutes of the previous meeting held on 4\textsuperscript{th} October were agreed as a true and accurate record notwithstanding grammatical/typographical errors which will be rectified.&lt;br&gt;&lt;br&gt;&lt;strong&gt;Action Points:&lt;/strong&gt;&lt;br&gt;LQ advised that the following policies were approved at the Quality Performance and Finance Committee and are now being prepared for implementation.&lt;br&gt;• Products of Limited Clinical Value Prescribing Policy&lt;br&gt;• Self Care Prescribing Policy&lt;br&gt;PE advised that he has spoken to Midlands and Lancashire Commissioning Support Unit (MLCSU) in relation to developing a dashboard that will be used as a basis for managing the CSU contract.&lt;br&gt;MT advised that with regards to potential ‘double counting’, this is now being reviewed and the findings will be fed back to the December Governing Body.</td>
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<td>1.6</td>
<td><strong>Matters Arising</strong>&lt;br&gt;There were no matters arising.</td>
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<td>1.7</td>
<td><strong>Patient Story</strong>&lt;br&gt;LQ provided a story regarding the impact CDifficile has on patients and advised members of the Governing Body that it is Self-Care week the week commencing 14\textsuperscript{th} November and how highlighting issues regarding CDifficile would be useful for patients.&lt;br&gt;LQ highlighted a number of lessons learnt from a particular case and members discussed how we can communicate the right messages to patients.&lt;br&gt;&lt;br&gt;&lt;strong&gt;Action – LQ to link CDifficile self-care in to Self-Care week.&lt;/strong&gt;</td>
<td>LQ</td>
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<td>1.8</td>
<td><strong>Chief Officer’s Update</strong>&lt;br&gt;JD presented a report which summarises the key activities undertaken by the Chief Officer for noting by the Governing Body.&lt;br&gt;&lt;br&gt;JD advised members of the current STP (Sustainability and Transformational plans) in relation to the Five Year Forward View and advised that the final draft of the plan was submitted to NHSE on 21\textsuperscript{st} October 2016.&lt;br&gt;&lt;br&gt;Other areas of activities included:&lt;br&gt;• Advancing Quality Alliance have been commissioned to support the development of providers coming together more closely on Wirral&lt;br&gt;• The implications of the new Planning Guidance&lt;br&gt;• The work being undertaken by Price Waterhouse Cooper at present on the CCG’s Capability and Capacity</td>
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<td>GB16-17/0018</td>
<td>The Governing Body noted the Chief Officer’s update.</td>
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<td>2.0 Risk Management</td>
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<td>2.1 Risk Register</td>
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<td>PE highlighted the main risks recently reviewed at the Quality</td>
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<td>Performance and Finance Committee (QPF) in the line with their review</td>
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<td>dates, which had been updated on the Risk Register for Governing Body</td>
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<td>review:</td>
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<td></td>
<td>• A &amp; E four hour target</td>
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<td>• Continuing Health Care</td>
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<td>• Finance</td>
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<td>• IAPT recovery</td>
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<td>Members accepted the latest narrative as proposed by QPF and PE asked</td>
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<td>members to bear these in mind if there were any items of the agenda</td>
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<td>(such as the performance pack) that had a bearing on these risks.</td>
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<td>GB16-17/0019</td>
<td>3.0 Finance</td>
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<td>3.1 Chief Financial Officer’s Report</td>
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<td>MT presented the report which sets out the headline financial position</td>
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<td>for NHS Wirral CCG as at the end of September (month 6), and</td>
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<td>highlighted the following:</td>
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<td>• £7.654m YTD overspend against Resource Limit</td>
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<td>• Year-end forecast remains at a £9.028m deficit which is consistent</td>
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<td>with the position reported for month 5</td>
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<td>• QIPP delivery and reduction of operational overspends is required</td>
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<td>of at least £5m in order to achieve the forecast out turn position.</td>
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<td>MT informed the group that the deficit of £7.654m which includes</td>
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<td>QIPP achieved to date of £3,641k or 36% of the requirement for the</td>
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<td>year and a number of operational overspends.</td>
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<td>MT drew members attention to a new graph that will now be included in</td>
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<td>all financial reports detailing the total actual expenditure by month,</td>
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<td>currently for months 1 to 6, and then the forecast by month for the</td>
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<td>remaining 6 months which would be required to deliver the forecast</td>
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<td>deficit of £9,028k.</td>
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<td>MT went on to highlight the current, best and worst case forecasts</td>
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<td>and the following key areas of detail within the report:</td>
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<td>• NHS Contracts</td>
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<td>• Non NHS contracts</td>
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<td></td>
<td>• Prescribing</td>
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<td></td>
<td>• Continuing Health Care (CHC)</td>
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<td>• Better Care Fund (BCF)</td>
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<td>• QIPP</td>
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<td>• Running Costs</td>
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<td>SW sought clarity around the governance of the Better Care Fund and</td>
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<td>MT advised that future minutes and action points from BCF meetings</td>
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<td>will need to be formally reported to</td>
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the CCG in future and it was agreed that the Quality Finance and Performance Committee would be the most appropriate place to receive them.

In conclusion, NHS Wirral CCG’s Governing Body was asked to note:

- Month 6 Operational Overspend of £7,654k. If no more QIPP is delivered, there is forecast to be a worst case £15.2m deficit based on the current level of operational overspends and utilising 0.5% contingency but no use of 1% headroom.
- Current forecast reported to NHSE remains at £9.028m following discussions with NHSE.
- Every effort still needs to be made quickly to confirm and implement a robust recurrent QIPP plan.

The Governing Body noted the Chief Financial Officer’s report.

4.0 Performance and Commissioning

4.1 Director of Commissioning’s Paper

NH updated the Governing Body on the CCGs Operational Plan and the Quality, Innovation, Productivity and Prevention (QIPP) Plan and how her team have been working to deliver the requirements of both plans.

Key areas within the report included:

- Primary Care Transformation
- Urgent Care Redesign
- Care closer to home – Better Care Fund
- Long Term Conditions
- Parity of Esteem
- Learning Disability – Transforming Care Programme
- Children’s Mental Health
- Maternity
- Frailty Pathways
- Cancer
- Palliative and End of Life Care
- Financial Recovery Delivery

NH advised that the 4 hour A&E target continues to be a challenge and performance has not achieved the 95% target. In August, the performance for the Arrowe Park site was 89.15% which, although demonstrates a consistent improvement since April, remains below the national 95% standard. The Emergency Care Improvement Programme team has undertaken a review in October of the health and care pathways within Wirral and any resulting recommendations will be adopted as a priority.

NH went on to inform the Governing Body that, aligned with the A&E performance, the ambulance standards continue to be a challenge, in particular the ‘time to clear’ with a weekly average at 33 minutes which is above the 30 minute standard. NH reported that this has an impact on the availability of ambulance vehicles and in August Wirral is below the targets for the most urgent calls and advised that the newly formed A & E Delivery Board, of which the CCG is a member, is tasked with addressing this performance.

In terms of the performance for the Improving Access to Psychological Therapies (IAPT) NH advised that the implementation of the action plan for recovery is continuing and additional action plans and scrutiny have been implemented in order to improve
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<td>performance and meet the improvement trajectories. The 6 week waiting time target was not met at 67.58% (standard 75%) however this is an improvement from June when performance was 60.14%.</td>
<td>GB16-17/0021</td>
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<td>BQ drew members attentions to a national waiting time survey which indicated that Wirral has the longest waiting times for IAPT services and NH advised that improvement trajectories are being developed and that appropriate contractual levers are being applied.</td>
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<td>NH went on to advise members of the delayed transfers of care at WUTH which have increased significantly and the year to date activity is now 171% higher than 2015/16 which equates to 1,491 bed days lost. NH advised that the CCG and Local Authority Social Services are undertaken further work to validate this data.</td>
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<td>On a positive note, NH informed the Governing Body that the CCG is meeting a number of targets consistently and has improved the dementia diagnosis rate. The target for delivery of the new Early Intervention in Psychosis model continues to be met.</td>
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<td>4.2 Performance Pack</td>
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<td>NH introduced the Performance pack and the Governing Body noted the contents.</td>
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<td>5.0 Quality &amp; Patient Safety</td>
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<td>5.1 Director of Quality and Patient Safety’s Report</td>
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<td>LQ provided members with details of the following areas contained within her report:</td>
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<td>• Safeguarding</td>
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<td>• Transforming Care for People with Learning Disabilities</td>
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<td>• Mixed Sex accommodation breaches</td>
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<td>• Friends and Family</td>
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<td>• Serious incidents</td>
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<td>The Governing Body noted the contents of the report presented.</td>
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<td>5.2 Ofsted Report</td>
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<td>LQ reported that an Ofsted inspection visit was undertaken in August 2016 to review Children in Need of help and review of the effectiveness of the Local Safeguarding Board, which included:</td>
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<td>LQ advised of the key findings which included:</td>
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<td>Children’s services in Wirral have been assessed as Inadequate</td>
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<td>o Children who need help and protection Inadequate</td>
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<td>o Children looked after and achieving permanence Requires Improvement</td>
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<td>o Adoption performance Requires Improvement</td>
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<td>o Experiences and progress of care leavers Inadequate</td>
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<td>Leadership, Management and Governance - Inadequate</td>
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<td>LQ reported that 19 recommendations were made for the domains of children who need help and protection and children looked after and achieving performance and 7 further</td>
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recommendations have been made for the Children’s Safeguarding Board.

LQ informed the Governing Body that an Improvement Board has been established which the CCG is a member of and the first meeting held to agree Terms of Reference, governance and reporting arrangements. LQ advised that the board will appoint an independent chair and will hold the relevant organisations and safeguarding board to account for delivery of the improvement plan.

Members noted the contents of the report and SW advised that regular updates will go to the Quality Performance and Finance Committee and then reported to the Governing Body through the Chair’s report in the future.

5.3 Health Protection Report

FJ presented a report for information regarding the first Annual Report of the Wirral Health Protection Group and explained that this is a forum of local partners working collaboratively to tackle key threats to the health of local people.

FJ explained that the Wirral Health Protection Group has responsibility to ensure that Wirral has a robust health protection system which effectively controls and prevents population level health issues and that all partners discharge their roles effectively for the protection of the local population. The report was endorsed, and the associated programme of action supported, by the Wirral Health and Wellbeing Board on 13th July 2016.

The Governing Body thanked FJ and noted the report.

5.4 Medical Optimisation

LA introduced a paper around weight management and smoking cessation prior to referral and commencement of non-elective surgery and asked the Governing Body for approval to introduce active interventions regarding these.

LA informed members that as part of the implementation process, a clear and comprehensive communications and engagement process will take place with primary care colleagues and information will be produced to inform the public regarding these policies.

Members discussed the capacity that GPs have to deal with this and LA advised that clinicians across the system will be provided with clear guidance regarding the process of implementation and the effectiveness of this will be monitored by the CCG. LA went on to inform the Governing Body that all GPs in Wirral will be supported with materials to educate patients and inform them of the benefits of their health optimisation period.

LA went on to advise that it is anticipated that any potential short term impacts on people with lifestyle risk factors will be balanced by a longer term reduction in health inequalities and highlighted that although people excluded within the policy will not be expected to complete a 6 month health optimisation period if they smoke or are obese, they will also be supported to address lifestyle factors.

LA drew members’ attention to the following risks in relation to the impact on CCG stakeholders which have been identified:

- An increase in the number of referrals to Tier 2 weight management services.
- An increase in referral to smoking cessation.
- An increase in number of GP appointments required during pre and post health optimisation periods.
An increase in the number of referrals, for exceptional circumstances, through the IFR Panel.

The following reputational risk has been identified:

- The public and other key stakeholders may have concerns about these proposals.

LA sought the Governing Body’s approval for the introduction of a period of health optimisation before referral and commencement of non-urgent elective surgery as part of the strategic approach to improving the health and wellbeing of the population of Wirral and asked the Governing Body to review the contents of this paper and approve the following commissioning policies as part of a wider holistic approach to ensure patients have optimised their health prior to surgery:

- All non-urgent referrals to surgical specialties with a BMI of ≥ 30 to be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery

- All non-urgent referrals to surgical specialties where the patient is a smoker to be offered a referral to smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If the smoking cessation provider confirms a positive quit to the patient’s GP within this period then the referral could be expedited

- Patients with a BMI of ≥ 30 who also smoke will be offered referral to both Tier 2 weight management and smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If Tier 2 weight management attendance and a positive quit are confirmed to the patient’s GP then a referral could be expedited.

Members of the Governing Body approved the proposal subject to the Quality, Performance and Finance Committee approving the details. It was agreed that LQ would lead on this piece of work.

Action – LQ to lead on the development of the policy

6.0 Governance and Engagement

6.1 Director of Corporate Affair’s Report

PE asked members of the Governing Body to note his report and the following key areas:

- Emergency Preparedness, Resilience and Response (EPRR)
- Commissioning Support
- Communications and Engagement
- Policies
- Statutory and Mandatory Training
- Complaints
- Patient Advice and Liaison Service (PALS)
- MP Enquiries
- Subject Access Requests
- Freedom of Information requests (FOIs)
The Governing Body noted the Director of Affair’s Report.

**6.2 Communications and Engagement Implementation Report**

PE presented the above paper to the Governing Body and explained the key initial implementation milestones for the Communications and Engagement Strategy which was approved by the CCG Governing Body in July 2016. PE advised that given the rapidly changing landscape which exists within the NHS nationally and locally, the principle basis of this plan is twofold. Firstly, to provide a platform and structure for the CCG to communicate and engage in order to meet its statutory duties and secondly to provide the mechanisms for the CCG to work as part of the wider health and social care system as transformation activity gathers pace in the short/medium term. PE explained that in addition, the plan details how the CCG will communicate and engage with staff and members.

PE also informed members that a new website function has been developed and further developments are to be made in early 2017.

Members of the Governing Body noted the report and gave thanks to the Communications and Engagement Team for this work.

**7.0 Committee Reports**

- **Medical Director’s Report**
  Members noted the Medical Director’s report and AW sought clarity around co-commissioning. SW advised that further engagement is required with practices regarding this as the CCG’s intention is to apply for level 3 delegated co-commissioning.

- **Audit Chair’s Report**
  Members noted the report.

- **Finance Committee Chair’s Report**
  Members noted the report.

- **Clinical Senate Chair’s Report**
  Members noted the report.

- **QPF Chair’s Report**
  Members noted the report.

**7.2 Committee Meeting Minutes**

- **QPF Minutes from July 2016** – members noted the QPF minutes from July 2016.

Members agreed that ratified Clinical Senate meeting minutes would be reported each month.

**Any Other Business**

There were no other items of business.

**Date and Time of Next Meeting**

Tuesday 10\(^{th}\) January 2017 1pm – 4pm Nightingale Room, OMH, Please forward any apologies to allison.hayes@nhs.net
Board meeting ended at: 15:50pm
<table>
<thead>
<tr>
<th>No.</th>
<th>Date of meeting</th>
<th>Title of Item</th>
<th>Agenda Ref</th>
<th>ID</th>
<th>Action</th>
<th>Lead(s)</th>
<th>Deadline</th>
<th>Progress Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>01.03.2016</td>
<td>Equality Act</td>
<td>GB/16-17/0002</td>
<td>LQ to present an update on Equality &amp; Diversity</td>
<td>LQ</td>
<td>Jan-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>03.05.2016</td>
<td>Quality &amp; Patient Safety Report</td>
<td>GB/16-17/0002</td>
<td>LQ to invite WUTH to a Governing Body meeting to take through their action plan in relation to the CQC report</td>
<td>LQ</td>
<td>Oct-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>06.09.2016</td>
<td>Chair’s Announcements</td>
<td>GB/16-17/0009</td>
<td>PE and AJH to review format of future agendas and papers</td>
<td>PE/AJH</td>
<td>Oct-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>06.09.2016</td>
<td>Action Points</td>
<td>GB/16-17/0009</td>
<td>AJH to amend current action log to reflect numerical recordings</td>
<td>AJH</td>
<td>Dec-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>06.09.2016</td>
<td>Director of Corporate Affairs</td>
<td>GB/16-17/0010</td>
<td>PE to develop a dashboard highlighting areas of concern in regarding the CSU</td>
<td>PE</td>
<td>Dec-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>06.09.2016</td>
<td>Financial Recovery Plan Update</td>
<td>GB/16-17/0010</td>
<td>MT to review duplication of schemes</td>
<td>MT</td>
<td>Dec-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>06.09.2016</td>
<td>Risk Register</td>
<td>GB/16-17/0011</td>
<td>PE to add an aspirational risk column to the risk register</td>
<td>PE</td>
<td>Nov-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>04.10.2016</td>
<td>Matters Arising</td>
<td>GB/16-17/0012</td>
<td>PE to include amendment to the previous minutes from the September meeting will include a comment by Alastair Cannon in relation to assurances and controls in place with regards to the Financial Recovery Plan.</td>
<td>PE</td>
<td>Oct-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>04.10.2016</td>
<td>Products of Limited Clinical Value Prescribing Policy</td>
<td>GB/16-17/0013</td>
<td>The Wirral CCG Governing Body, having considered the evidence and the consultation outcome, supported Option 1 to stop prescribing the three products deemed to be of low clinical value and it was agreed that LQ would progress this action.</td>
<td>LQ</td>
<td>Nov-16</td>
<td>Completed. Policy approved at QPF 25th October 2016</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>04.10.2016</td>
<td>Self Care Prescribing Policy</td>
<td>GB/16-17/0013</td>
<td>The Wirral CCG Governing Body accepted the recommendations set out within the proposal and agreed that option 2 is adopted. LQ to oversee the development and implementation of the policy.</td>
<td>LQ</td>
<td>Nov-16</td>
<td>Policy approved at QPF 25th October 2016</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>04.10.2016</td>
<td>Gluten Free Product</td>
<td>GB/16-17/0013</td>
<td>The Wirral CCG Governing Body approved option 2, and tasked LQ with developing a revised policy that took into account the factors discussed.</td>
<td>LQ</td>
<td>Nov-16</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>04.10.2016</td>
<td>Homeopathy and Iscador Service Review</td>
<td>GB/16-17/0013</td>
<td>The Wirral CCG Governing Body members agreed that Option 3 to stop funding the Homeopathy and Iscador services should be supported. NH to implement the decision and notify the provider.</td>
<td>NH</td>
<td>Nov-16</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>04.10.2016</td>
<td>Development of Wirral Health and Social Care</td>
<td>GB/16-17/0014</td>
<td>The Governing Body noted the presentation given by the Chief Officer and he agreed to take on board the comments and suggestions and feed these back to the Senior Leadership Group.</td>
<td>JD</td>
<td>Nov-16</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>01.11.2016</td>
<td>Patient Story</td>
<td>GB/16-17/0017</td>
<td>LQ to link Cdifficile self-care in to self care week</td>
<td>LQ</td>
<td>November</td>
<td>On track for discussion at Clinical Senate and Members meeting (January)</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>01.11.2016</td>
<td>Medical Optimisation</td>
<td>GB/16-17/0021</td>
<td>Policy to be developed</td>
<td>NH</td>
<td>November</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# NHS Wirral CCG

**CORPORATE RISK REGISTER**

To be reviewed at Governing Body - 10th January 2017

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
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</table>

[Table content filled with values]
<table>
<thead>
<tr>
<th>Issue 3</th>
<th>3</th>
<th>3</th>
<th>Number of significant issues raised by MIAA report into resource by NHS England.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>14-15V</td>
<td>Feb-16</td>
<td>CCG QPF Wirral CCG is aiming to increase the number of Personal Health Budgets being undertaken by CHC with regular reviews not being established.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>14-15T</td>
<td>Nov-15</td>
<td>CCG QPF Delivery of Continuing Healthcare (CHC) risks in place. Meeting with council around accommodation meeting to progress CCG / LA integrated care.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>14-15X</td>
<td>Dec-15</td>
<td>CCG QPF 3 54 12.00 Wirral CCG Improving Personal Health Budgets.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>15-16V</td>
<td>Jan-16</td>
<td>CCG QPF Wirral CCG Improving Personal Health Budgets.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>15-16S</td>
<td>Sep-16</td>
<td>CCG QPF Wirral CCG Improving Personal Health Budgets.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>15-16F</td>
<td>Nov-16</td>
<td>CCG QPF Wirral CCG Improving Personal Health Budgets.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>15-17S</td>
<td>Nov-17</td>
<td>CCG QPF Wirral CCG Improving Personal Health Budgets.</td>
</tr>
<tr>
<td>Wirral CCG Improving Personal Health Budgets.</td>
<td>16-17S</td>
<td>Nov-16</td>
<td>CCG QPF Wirral CCG Improving Personal Health Budgets.</td>
</tr>
</tbody>
</table>

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**Risk to remain on the register for: 1 - 2017**

- **Reputational risks associated with patients who are over due a care plan.**
  - Risks of relationship damage between CCGs and Local Authorities as joint packages of care procedure is applied robustly.
  - Complex patients
  - Packages of care

- **Non-NHS Provdiers**
  - Personal Health Budgets
  - Reputational and financial / Contracts
  - Quality / Patient Safety
  - Procedures have also been worked through via Joint Risk Process. A memorandum of understanding has been drafted and reviewed and care needs may not change but framework is applied robustly.

- **Financial / Contracts / Quality / Patient Safety**
  - Risks to the organisation will not be closing. Agreed to leave risk on the register with the same scores.

- **Risks of relationship damage between CCGs and Local Authorities as joint packages of care procedure is applied robustly.**
  - Complex patients
  - Packages of care

- **Non-NHS Provdiers**
  - Personal Health Budgets
  - Reputational and financial / Contracts
  - Quality / Patient Safety
  - Procedures have also been worked through via Joint Risk Process. A memorandum of understanding has been drafted and reviewed and care needs may not change but framework is applied robustly.

- **Financial / Contracts / Quality / Patient Safety**
  - Risks to the organisation will not be closing. Agreed to leave risk on the register with the same scores.
Master 16-17

Increase in potential patient safety issues leading to moderate or severe harm at acute provider organisation.

Minutes of Serious Incident Review Group.

Potential patient safety issues.

4 3 12.00 LQ February 2017 QPF

Scores to be agreed at QPF to be held in December 2016.

08/12/2016 - Updates provided in relation to actions being taken in relation to this:
- 72 hour concise reviews being undertaken
- External review of the ophthalmology service
- Serious incidents reported on the national reporting system (StEIS)
- Contract meetings with provider organisation

Discussed at December 16 QPF and scores agreed.

Next due for review at QPF in February 2017.

Scores agreed as 4 for consequence and 3 for likelihood.

Impact Values
- Negligible
- Minor
- Moderate
- Major
- Catastrophic

Probability Values
- Rare
- Unlikely
- Possible
- Likely
- Almost Certain

Green/Yellow/Red Threshold Values
- Green - maximum score
- Yellow - minimum score
- Red - maximum score

<table>
<thead>
<tr>
<th>Event Details</th>
<th>Impact</th>
<th>Probability</th>
<th>Green/Yellow/Red Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Risk Register Process**

**Before QPF Meeting**
E-mail to be sent to QPF members to request any new risks.
Risk added to Register by Laura Wentworth.

**At QPF Meeting:**
New Risks and corresponding action plan to be considered for inclusion - either keep or decision escalated to risk owner.
Current risks to be reviewed in line with action plan progression.

**After QPF Meeting**
Laura Wentworth to update Monitoring column with decisions made at group.
Laura Wentworth to amend residual risk rating in line with actions.

**At Governing Body**
Review new and escalated risks
Agree to include or de-escalate risks

**After Governing Body**
Laura Wentworth to update Monitoring column with decisions made at group.
Laura Wentworth to amend residual risk rating in line with actions.
Add removed risks to the Removed risks Tab.
Save and copy for next review.
<table>
<thead>
<tr>
<th>GB</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>QPF</td>
<td>Quality, Performance and Finance Committee</td>
</tr>
<tr>
<td>PCMH</td>
<td>Primary Care Mental Health</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not Attend</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>NWCSU</td>
<td>North West Commissioning Support Unit</td>
</tr>
<tr>
<td>MD</td>
<td>Managing Director</td>
</tr>
<tr>
<td>DMIC</td>
<td>Data Management Information Centre</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours</td>
</tr>
<tr>
<td>NHSD</td>
<td>NHS Direct</td>
</tr>
<tr>
<td>DOS</td>
<td>Directory of Services</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>AT</td>
<td>Area Team</td>
</tr>
<tr>
<td>Chief Financial Officer’s Report</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Agenda Item:</strong> 3.1</td>
<td></td>
</tr>
<tr>
<td><strong>Reference</strong> GB 16-17/0027</td>
<td></td>
</tr>
<tr>
<td><strong>Public / Private</strong> Public</td>
<td></td>
</tr>
<tr>
<td><strong>Meeting Date</strong> 10th January 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Lead Officer/Author of paper</strong> Mike Treharne – Chief Financial Officer</td>
<td></td>
</tr>
<tr>
<td><strong>Contributors</strong> Mike Cunningham – Deputy CFO</td>
<td></td>
</tr>
<tr>
<td><strong>Link to CCG Strategic System Plan</strong></td>
<td></td>
</tr>
<tr>
<td>1 Patient and primary care centric and based on high quality primary care, secondary and community services</td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>3 Commissioned services which have a sound evidence base</td>
<td></td>
</tr>
<tr>
<td>4 Provides greater equality of access to all</td>
<td></td>
</tr>
<tr>
<td><strong>Link to current strategic objectives</strong></td>
<td></td>
</tr>
<tr>
<td>2 Enhance the quality of life for people with long term conditions</td>
<td></td>
</tr>
<tr>
<td>4 Ensuring people have a positive experience of care</td>
<td></td>
</tr>
<tr>
<td><strong>To Approve</strong></td>
<td></td>
</tr>
<tr>
<td><strong>To Note</strong> Yes</td>
<td></td>
</tr>
<tr>
<td><strong>To Ratify</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Summary</strong> Report summarizes the financial position of the CCG as at the end of 30th November 2016 (Month 8)</td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong> N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Next Steps/Recommendations</strong> • Note the update report</td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| Financial | Does the report consider the financial impact? | Any financial aspects of the update report are included within this report |
| Value For Money | Does the report consider value for money? | As above |
| Risk | Is there a documented risk assessment? | Any risks arising from the content of update report will be detailed in supplementary reports included on the Governing Body agenda (Risk Management). The update report will indicate this where applicable. |
| Legal | Are there any legal implications and has legal advice been obtained? | Any legal implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda. If any legal advice has been obtained in relation to any aspect of the update report then this will be indicated in the report content. |</p>
<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? Any Patient and Public Involvement aspects of the update report will be included within the Director of Corporate Affairs’ Report (where applicable)</th>
</tr>
</thead>
<tbody>
<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 <em>(statutory duty for new / changes to services)</em> Any Equality &amp; Human rights implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda with an associated Equality Impact Assessment (EIA)</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? Any workforce related aspects of the update report will be included within the Director of Corporate Affairs’ Report (where applicable)</td>
</tr>
<tr>
<td>Partnership Working</td>
<td>Does the report evidence a partnership working in its development? Evidence of partnership working will be incorporated into the update report (where applicable)</td>
</tr>
<tr>
<td>Performance Indicators</td>
<td>Does the report indicate any relevant performance indicators for this item? Any performance related aspects of the update report will be included within the Director of Commissioning’s Report (where applicable)</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Does the report address economic, social and environmental sustainability <em>(should be addressed for new / change projects)</em>? n/a</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>
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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.
1) INTRODUCTION

1.1 This report sets out the headline financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of November (Month 8) 2016/17. The main headlines are;

- £9.628m YTD deficit against Resource Limit.
- The CCG has calculated a forecast outturn at month 8 of £11.989m deficit, reflecting the month 8 YTD position, and QIPP/financial recovery measures not delivering as we expected.
- This forecast outturn has been discussed with NHSE who has advised that in order to comply with NHSE internal reporting procedures, the CCG forecast should remain at £9.028m as it was at month 7.
- The CCG has agreed to maintain the forecast deficit at £9.028m, but has signalled to NHSE that it will be seeking approval to change this deficit to £11.989m at month 9. This will have worst case risk of £1.91m and probability adjusted risk of £1.0m attached to it, and therefore a worst case deficit of £13.899m and a risk adjusted deficit of £12.989m respectively.
- The forecast outturn which will be reported to NHSE at month 9 is consistent with the position the CCG was initially reporting at month 6, prior to identification of recovery measures. However it shows an improvement compared to the forecast of £15.7m highlighted in the financial recovery plan considered by the Governing Body on 6th September.
- The QIPP required to achieve this forecast will be £4.912m, of which £1.035m is to be identified, but it is expected that prescribing financial recovery measures will deliver £0.6m reducing the unidentified requirement to £0.435m.

2) FINANCIAL POSITION

2.1 As at the end of November, NHS Wirral CCG has a reported deficit of £9.628m. The year to date operational overspend and forecasted outturn is shown below:
Wirral CCG Financial Position as at 30\textsuperscript{th} November 2016 (Month 8)

<table>
<thead>
<tr>
<th>Expenditure Area</th>
<th>M8 YTD variance £'000</th>
<th>M7 YTD variance £'000</th>
<th>Movement £'000s</th>
<th>M8 Forecasted Year End Outturn £'000s</th>
<th>M7 Forecasted Year End Outturn £'000s</th>
<th>Movement £'000s</th>
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</thead>
<tbody>
<tr>
<td>NHS</td>
<td>724</td>
<td>833</td>
<td>(109)</td>
<td>1,151</td>
<td>(286)</td>
<td>1,437</td>
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<tr>
<td>Non NHS</td>
<td>424</td>
<td>252</td>
<td>172</td>
<td>85</td>
<td>73</td>
<td>11</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(869)</td>
<td>(942)</td>
<td>73</td>
<td>(1,919)</td>
<td>(1,919)</td>
<td>0</td>
</tr>
<tr>
<td>Commissioned out of Hospital</td>
<td>2,889</td>
<td>2,558</td>
<td>331</td>
<td>4,403</td>
<td>2,954</td>
<td>1,450</td>
</tr>
<tr>
<td>Primary Care</td>
<td>(95)</td>
<td>(78)</td>
<td>(17)</td>
<td>(17)</td>
<td>(19)</td>
<td>1</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>(89)</td>
<td>(13)</td>
<td>(76)</td>
<td>(134)</td>
<td>106</td>
<td>(240)</td>
</tr>
<tr>
<td>QIPP (incl reserves/contingency)</td>
<td>6,985</td>
<td>6,031</td>
<td>955</td>
<td>5,890</td>
<td>8,471</td>
<td>(2581)</td>
</tr>
<tr>
<td>Running costs</td>
<td>(79)</td>
<td>(93)</td>
<td>14</td>
<td>(35)</td>
<td>42</td>
<td>(78)</td>
</tr>
<tr>
<td><strong>Operational performance</strong></td>
<td>9,891</td>
<td>8,549</td>
<td>1,343</td>
<td>9,422</td>
<td>9,422</td>
<td>0</td>
</tr>
<tr>
<td>Surplus</td>
<td>(263)</td>
<td>(230)</td>
<td>(33)</td>
<td>(394)</td>
<td>(394)</td>
<td>0</td>
</tr>
<tr>
<td><strong>CCG YTD overall performance</strong></td>
<td>9,628</td>
<td>8,319</td>
<td>1,310</td>
<td>9,028</td>
<td>9,028</td>
<td>0</td>
</tr>
</tbody>
</table>

2.2 This deficit position reported includes QIPP achieved to date of £2.392m, and a number of operational overspends as discussed (starting at paragraph 2.5) below. A full breakdown of the CCG position by contract and spend area is within Appendix 1.

2.3 At month 7 the Committee considered the following table which illustrated how the financial recovery measures of £3.6m agreed by directors in October were to be implemented.

<table>
<thead>
<tr>
<th>Financial Recovery Measures</th>
<th>Identified As Required Directors Meeting 05.10.16 £</th>
<th>Revised Requirement At Month 7 reporting £</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Contract overperformance – forecast to balance</td>
<td>2,700,000</td>
<td>1,485,145</td>
<td>Actioned in Ledger at month 7 and budget holders targeted to achieve.</td>
</tr>
<tr>
<td>Maintain current contract underperformance</td>
<td>1,000,000</td>
<td>0</td>
<td>No further Action required</td>
</tr>
<tr>
<td>Further Prescribing Savings</td>
<td>1,500,000</td>
<td>600,000</td>
<td>Actioned in Ledger at month 7 and budget holders targeted to achieve.</td>
</tr>
<tr>
<td>Continuing Healthcare reduction in overpend</td>
<td>800,000</td>
<td>800,000</td>
<td>Actioned in Ledger at month 7 and budget holders targeted to achieve.</td>
</tr>
<tr>
<td>Reablement Overspend</td>
<td>200,000</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
2.4 It is however apparent from reviewing the month 8 financial position that with the exception of prescribing £0.6m, these recovery measures are unlikely to impact as expected. The table below shows how the forecast of £9.028m at month 7 was predicated on these measures being achieved. It also shows the month 8 position and how the forecast has changed to £11.989m, as a consequence of the measures listed in month 7 not gaining traction.

<table>
<thead>
<tr>
<th>Month 8 Reporting distance from £9.028m control total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team forecasts @ M8 (prior to adjustment)</td>
</tr>
<tr>
<td>Target FOT (in line with M6 &amp; M7 FOT - £9.028m bottom line)</td>
</tr>
<tr>
<td>Difference (Adjustment required)</td>
</tr>
</tbody>
</table>

Adjustments applied to the following:

- **West Midlands Ambulance Service**: £51,777 - Managing back overperformance
- **Royal Liverpool & Broadgreen University Hospitals NHS Trust**: £122,407 - Managing back overperformance
- **Aintree University Hospitals NHS Foundation Trust**: £513,355 - Managing back overperformance
- **Liverpool Heart & Chest NHS Foundation Trust**: £280,900 - Managing back overperformance
- **Central Manchester University Hospitals NHS Foundation Trust**: £81,031 - Managing back overperformance
- **Warrington & Halton Hospital NHS Foundation Trust**: £11,013 - Managing back overperformance
- **University Hospital of South Manchester NHS Foundation Trust**: £26,151 - Managing back overperformance
- **Walton Centre NHS FT**: £24,219 - Managing back overperformance
- **Wirral Community NHS Trust**: £200,000 - Managing back overperformance
- **NHS**: £1,485,145 - Managing back overperformance
- **Primary Care Prescribing**: £600,000 - Spend Review
- **Prescribing**: £600,000 - £600,000
- **Continuing Healthcare/ Fully Funded Packages of Care**: £158,169 - £158,169 - Spend Review
- **Continuing Healthcare/ Joint Funded Packages of Care**: £411,820 - £411,820 - Managing back overperformance
- **Children with Special / Safeguarding Needs**: £230,011 - £230,011 - Managing back overperformance
- **QIPP**: £435,982 - £697,002 - To be applied to QIPP line

Total Adjustments: £1,035,982 - £3,582,147 - £2,546,165

---

**NHS Contracts**

2.5 NHS contracts are currently showing a £724k year to date overspend as at month 8 which represents a favourable movement of £109k when compared to the month 7
position. Of the £724k overspend; £301k is attributable to the Countess of Chester Hospital. This is predominantly due to critical care which is overspending by £291k.

2.6 The Liverpool Heart and Chest Hospital contract is also over performing by £150k as at month 8 predominantly due to day cases including an intraventricular pacemaker, percutaneous interventions and percutaneous ablations which equate to £172k. This is offset by underspends in other PODs.

2.7 The weekly activity management group (AMG) continues to look into significant contract variances and there is an activity log to monitor actions which is reviewed and task and finish groups set up to report back on items identified.

Non NHS Contracts

2.8 Non NHS contract over performance is £424k at the end of month 8. This represents an adverse movement in the position of £172k when comparing to the month 7 position.

2.9 Spire Murrayfield is £712k over the planned level of spend as at November which represents an adverse movement of £216k when compared to October’s position. This continues to be caused by elective T&O activity. This is partially offset by under performance against planned levels at Peninsula (£73k) and Spa Medica (£78k).

2.10 Monthly practice visits continue to take place in order to attempt to address the issue of over performance.

Prescribing

2.11 The month 8 financial position for prescribing has been informed by September’s data. This shows a year to date position of £867k underspent, of which £871k relates to practice prescribing, £50k against central drugs, but a pressure of £52k against Air Liquide.

Continuing Healthcare

2.12 As at the end of November, Joint/ Fully Funded and Children’s packages are overspent by £2.9m. This is an adverse movement of £331k when compared to the month 7 position. Of this, approximately £50k is the result of the FNC rate increase approved by government. The remaining pressure has been caused by a number of new packages, existing package price increases and also the impact of QIPP non delivery (£89k).

2.13 The CHC position has seen a rapid deterioration in the financial position in the last 8 months of the financial year, the breakdown by month is shown below.

<table>
<thead>
<tr>
<th>Month</th>
<th>Position Overspend £000</th>
<th>Movement from previous month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td>28</td>
<td>-</td>
</tr>
</tbody>
</table>
2.14 The main movements however this month include the following:

Continuing Healthcare

- 12 new CHC eligible packages have been agreed totalling an estimated value of £297k, with an increase in existing package costs totalling £23k. 21 packages have ceased totalling £274k. We have also seen a number of new PHB packages with a total cost of £30k.

Funded Nursing Care

- The impact of the weekly rate increase has seen an in month impact of £50k.

Better Care Fund

2.15 BCF is reporting a £89k underspend as at month 8, this is 8/12ths of the Care of the Elderly pressure, less further slippage reported against some of the schemes. The forecasted out turn position is showing an underspend of £134k which represents a favourable movement to month 7 of £240k. This is due to slippage on a number of BCF schemes.

Running Costs

2.16 Running cost budgets are showing a £79k underspend as at month 8 which represents an adverse movement of £14k when compared to the month 7 position. The position as at the end of November is due to income from Western Cheshire CCG for the provision of contracting services and some staff vacancies offset by pressures in other areas.

2.17 The forecasted running cost position is £35k underspent by the end of the financial year. Of this, the pay position is contributing a large proportion of the underspend due to a
number of fortuitous savings from staff not currently part of the NHS pension scheme and other vacancies. There is therefore a risk that if all staff took part in the pension scheme and all vacancies were filled then the running cost position could potentially be overspent by approximately £213k during this financial year which poses a risk to the CCG’s statutory duty to spend within the running cost allocation.

2.18 It should also be noted that there continues to be an anticipated pressure of circa £209k by Property Services Limited for the vacant space within Old Market House. This is the space that the Community Trust used to occupy, as host tenant, the CCG is liable for the charges until the space is occupied. (This is included in forecasts but is disguised due to income recovery for services provided to Western Cheshire CCG as noted above)

3) QIPP

3.1 The CCGs QIPP challenge started at £17.6m (excluding BCF £0.6m). However since the start of the year the forecast outturn has been revised from a surplus of £0.4m to a deficit of £9m (to become £12m at month 9). The QIPP requirement has consequently been revised. At month 7 QIPP forecast outturn was £6.087m which has now reduced to £4.912m recognising that a number of QIPP schemes are failing to deliver.

The table below reconciles the movement between the month 7 and the month 8 forecast outturn. The pie chart illustrates the current status of the £4.912m

<table>
<thead>
<tr>
<th>Month 7 Forecast Outturn</th>
<th>£M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Transport Services</td>
<td>6.087</td>
</tr>
<tr>
<td>South Manchester Follow Ups</td>
<td>(0.098)</td>
</tr>
<tr>
<td>Royal Liverpool Broadgreen Follow UPs</td>
<td>(0.112)</td>
</tr>
<tr>
<td>COCH Follow Ups</td>
<td>(0.012)</td>
</tr>
<tr>
<td>Second Eye Surgery</td>
<td>(0.041)</td>
</tr>
<tr>
<td>Other Provider Activity</td>
<td>(0.480)</td>
</tr>
<tr>
<td>LD Funding Review</td>
<td>(0.838)</td>
</tr>
<tr>
<td>Management of Repeat Prescriptions</td>
<td>0.014</td>
</tr>
<tr>
<td>Reserves Review</td>
<td>0.061</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>0.338</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month 8 Forecast Outturn</th>
<th>£M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schemes implemented and started 68%</td>
<td>3,324,268</td>
</tr>
<tr>
<td>Schemes implemented but not yet started 11%</td>
<td>553,124</td>
</tr>
<tr>
<td>Schemes to be identified 21%</td>
<td>1,035,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
<th>£4,912,392</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1 – QIPP Identification and Implementation
4) UNDERLYING POSITION

4.1 Due to the sizeable challenge the CCG faces, it must be noted that the underlying position of the CCG finances is a significant deficit.

<table>
<thead>
<tr>
<th>Wirral CCG Underlying Recurrent Position</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Resource Limit</td>
<td>494,169</td>
</tr>
<tr>
<td>Programme Costs</td>
<td>491,347</td>
</tr>
<tr>
<td>Running costs</td>
<td>7,099</td>
</tr>
<tr>
<td>Contingency</td>
<td>-</td>
</tr>
<tr>
<td>Total Application of Funds</td>
<td>498,446</td>
</tr>
<tr>
<td><strong>Underlying Surplus /(Deficit)</strong></td>
<td><strong>(4,277)</strong></td>
</tr>
</tbody>
</table>

4.2 £4.3m deficit would mean contingency and headroom have been utilised. In order to return to business rules (1% surplus/ 1% headroom and 0.5% contingency (£12.2m)), the underlying position could be closer to £16.5m deficit.

5) RISKS

5.1 The CCG has in earlier periods reported risk in relation to the QIPP forecast. It is expected that this risk has now crystallized into the forecast for the year (reference QIPP failure identified in section 3.1 above).
5.2 As referenced in the introduction the revised forecast outturn (£11.989m) at month 9 will have worst case risk attached of £1.91m and probability assessed net risk of £1m attached to it.

6) TREASURY

6.1 The BPPC monitors public sector organisations on the timeliness of its financial payments in terms of both volume and value. Guidance recommends 95% of payments within 30 days, the CCG performance was 99.53% for November. The following table shows the number of invoices paid against target.

<table>
<thead>
<tr>
<th>Month</th>
<th>Period Number</th>
<th>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>1</td>
<td>16</td>
<td>866</td>
<td>860</td>
<td>99.31%</td>
<td>£33,456,211.22</td>
<td>£33,444,805.71</td>
<td>99.97%</td>
</tr>
<tr>
<td>MAY</td>
<td>2</td>
<td>16</td>
<td>1032</td>
<td>1014</td>
<td>98.26%</td>
<td>£53,350,413.32</td>
<td>£53,321,457.60</td>
<td>99.95%</td>
</tr>
<tr>
<td>JUNE</td>
<td>3</td>
<td>16</td>
<td>1318</td>
<td>1298</td>
<td>98.48%</td>
<td>£18,709,856.47</td>
<td>£18,689,113.64</td>
<td>99.89%</td>
</tr>
<tr>
<td>JULY</td>
<td>4</td>
<td>16</td>
<td>1031</td>
<td>1030</td>
<td>99.90%</td>
<td>£40,173,367.99</td>
<td>£40,120,156.39</td>
<td>99.87%</td>
</tr>
<tr>
<td>AUGUST</td>
<td>5</td>
<td>16</td>
<td>1253</td>
<td>1244</td>
<td>99.28%</td>
<td>£35,662,459.16</td>
<td>£35,654,083.17</td>
<td>99.98%</td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>6</td>
<td>16</td>
<td>1099</td>
<td>1090</td>
<td>99.18%</td>
<td>£35,889,499.67</td>
<td>£35,862,128.53</td>
<td>99.92%</td>
</tr>
<tr>
<td>OCTOBER</td>
<td>7</td>
<td>16</td>
<td>1040</td>
<td>1033</td>
<td>99.33%</td>
<td>£38,417,565.13</td>
<td>£38,379,976.62</td>
<td>99.90%</td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>8</td>
<td>16</td>
<td>845</td>
<td>841</td>
<td>99.53%</td>
<td>£33,905,551.55</td>
<td>£33,843,665.90</td>
<td>99.82%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>-</td>
<td>-</td>
<td>8484</td>
<td>8410</td>
<td>99.13%</td>
<td>£289,564,924.51</td>
<td>£289,315,387.56</td>
<td>99.91%</td>
</tr>
</tbody>
</table>

6.2 The CCG cash balance at the end of November was £33k. This is in line with current NHSE guidance that CCGs aim towards 1.25% month end cash balance of the drawdown.

6.4 Expenditure incurred above £25k is collected monthly and published on the CCG website.

6.5 There are no significant aged debtors or creditors to highlight as at November.

7) CONCLUSION

7.1 NHS Wirral CCG’s Governing Body Committee is asked to note:

- Month 8 Operational overspend of £9.628m.
- Current forecast reported to NHSE remains at £9.028m but this will change to £11.989m at month 9 with £1.0m of net risk and £1.91m of worst case risk attached.

Mike Treharne
Chief Financial Officer
Governing Body Report M8
<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Annual Budget</th>
<th>Budget to Date</th>
<th>Spend to Date</th>
<th>Variance</th>
<th>YTD Variance</th>
<th>Change in YTD Variance</th>
<th>Forecast Variance</th>
<th>Prior YTD Variance</th>
<th>Change in Forecast Variance</th>
<th>Variance</th>
<th>Target Forecast Variance</th>
<th>VWI Forecast Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>427,077,000</td>
<td>131,084,630</td>
<td>151,084,639</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-106,977,000</td>
<td>261,053,000</td>
<td>105,000</td>
<td>-106,977,000</td>
<td>261,053,000</td>
<td>261,053,000</td>
</tr>
<tr>
<td>Ambulance and Other</td>
<td>3,668,000</td>
<td>2,121,000</td>
<td>2,121,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1,547,000</td>
<td>1,547,000</td>
<td>0</td>
<td>-1,547,000</td>
<td>1,547,000</td>
<td>1,547,000</td>
</tr>
<tr>
<td>West Midlands Ambulance Service</td>
<td>806,443</td>
<td>516,138</td>
<td>575,813</td>
<td>58,420</td>
<td>43,213</td>
<td>14,587</td>
<td>147,000</td>
<td>51,777</td>
<td>95,913</td>
<td>0</td>
<td>147,000</td>
<td>51,777</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>2,796,886</td>
<td>1,873,612</td>
<td>1,968,083</td>
<td>68,469</td>
<td>71,414</td>
<td>(2,945)</td>
<td>11,792</td>
<td>12,407</td>
<td>(635)</td>
<td>11,792</td>
<td>12,407</td>
<td></td>
</tr>
<tr>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>1,046,664</td>
<td>860,392</td>
<td>637,887</td>
<td>51,051</td>
<td>105,177</td>
<td>(52,889)</td>
<td>851,614</td>
<td>897,770</td>
<td>46</td>
<td>851,614</td>
<td>897,770</td>
<td></td>
</tr>
<tr>
<td>Liverpool Women's NHS Foundation Trust</td>
<td>4,214,294</td>
<td>2,813,022</td>
<td>3,127,137</td>
<td>301,213</td>
<td>385,029</td>
<td>(84,894)</td>
<td>414,100</td>
<td>513,855</td>
<td>(99,755)</td>
<td>414,100</td>
<td>513,855</td>
<td></td>
</tr>
<tr>
<td>Liverpool Heart &amp; Chest NHS Foundation Trust</td>
<td>1,297,932</td>
<td>323,153</td>
<td>203,193</td>
<td>54,841</td>
<td>47,266</td>
<td>8,575</td>
<td>83,702</td>
<td>83,091</td>
<td>629</td>
<td>83,702</td>
<td>83,091</td>
<td></td>
</tr>
<tr>
<td>Alder Hey Children's NHS Foundation Trust</td>
<td>3,164,388</td>
<td>2,643,999</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>1,226,562</td>
<td>1,226,562</td>
<td>0</td>
<td>1,226,562</td>
<td>1,226,562</td>
<td></td>
</tr>
<tr>
<td>St Helens &amp; Knowsley NHS Trust</td>
<td>1,046,664</td>
<td>860,392</td>
<td>637,887</td>
<td>51,051</td>
<td>105,177</td>
<td>(52,889)</td>
<td>851,614</td>
<td>897,770</td>
<td>46</td>
<td>851,614</td>
<td>897,770</td>
<td></td>
</tr>
<tr>
<td>Chester &amp; Wirral Partnership NHS Foundation Trust</td>
<td>2,660,550</td>
<td>1,773,872</td>
<td>1,773,873</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
<td>3,164,388</td>
<td>2,643,999</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>1,226,562</td>
<td>1,226,562</td>
<td>0</td>
<td>1,226,562</td>
<td>1,226,562</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Greater Manchester West MHT NHSF. Veterans</td>
<td>3,164,388</td>
<td>2,643,999</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>1,226,562</td>
<td>1,226,562</td>
<td>0</td>
<td>1,226,562</td>
<td>1,226,562</td>
</tr>
<tr>
<td>Mental Health</td>
<td>NHSFTs (Various Providers)/ Merseycare NHS Trust</td>
<td>3,164,388</td>
<td>2,643,999</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
<td>2,534,830</td>
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**Notes:**
- **Full Contracts** are agreements for services that exceed £1 million in value.
- **FHA** stands for Foundation Hospital Authorities.
- **Variance** denotes the difference between the actual expenditure and the planned expenditure.
- **Variance** is calculated as the actual expenditure minus the budgeted expenditure.
- **Variance** is also calculated as the forecast expenditure minus the actual expenditure.
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<th>Forecast Variance</th>
<th>Prior YTD Forecast</th>
<th>Change in Forecast Variance</th>
<th>Target Forecast Variance</th>
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<td>(122,316)</td>
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<td>(120,712)</td>
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<td>(7,078)</td>
<td>(7,078)</td>
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<td>(3,228)</td>
<td>(27,055)</td>
<td>(28,843)</td>
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<td>13,004,337</td>
<td>414,272</td>
<td>9,422,190</td>
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* Running costs budget is vired non recurrently each year to cover programme spend - actual running costs expenditure against the original allocation is shown on the line below.
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<th>Reference</th>
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<td>Public / Private</td>
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<td>Meeting Date</td>
<td>10th January 2017</td>
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<tr>
<td>Lead Officer</td>
<td>Nesta Hawker Director of Commissioning</td>
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<tr>
<td>Contributors</td>
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</table>

**Link to CCG Strategic System Plan**

**Edit as applicable:**

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

**Link to current strategic objectives**

**Edit as applicable:**

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

**To approve**

**To note** Yes

**Summary**

Governing Body members are asked to note the reported performance of the CCG, to approve the draft All Age Learning Disability Strategy and to note the submissions made to NHS England as part of the annual planning process.

**Comments**

**Next Steps**

**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>Value For Money</td>
<td>Does the report consider value for money?</td>
<td>YES</td>
</tr>
<tr>
<td>Risk</td>
<td>Is there a documented risk assessment?</td>
<td>YES/NO</td>
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<tr>
<td></td>
<td>If YES, what are the key risks &amp; what is being done to mitigate</td>
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<tr>
<td>Category</td>
<td>Question</td>
<td>YES/NO</td>
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<tr>
<td><strong>Legal</strong></td>
<td>Are there any legal implications and has legal advice been obtained? YES/NO</td>
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<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? YES/NO</td>
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<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) YES/NO</td>
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<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? YES/NO</td>
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<tr>
<td><strong>Partnership Working</strong></td>
<td>Does the report evidence a partnership working in its development? YES/NO</td>
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<td><strong>Performance Indicators</strong></td>
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<tr>
<td><strong>Sustainability</strong></td>
<td>Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)? YES/NO</td>
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</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.

Report History/Development Path

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<tr>
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<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
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Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960). The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

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

This paper provides Governing Body with a report on the key strategic and operational issues and developments related to the delegated duties of the Director of Commissioning.

2 STRATEGY DEVELOPMENT AND REFORM IMPLEMENTATION

**GP Forward View submission**

A report is attached to this paper that details the submission made by the CCG to NHS England in response to the General Practice Forward View as required by the national Planning Guidance. The report also includes next steps to complete the development of a Wirral Primary Care Transformation Plan.

**Wirral All Age Learning Disability Strategy**

The draft Strategy is attached to this report and Governing Body members are asked to approve the draft.

**Planning Narrative submission**

As per the national Planning Guidance, Wirral CCG was required to submit activity and constitutional planning assumptions to NHS England by the 23rd December. This submission also included a narrative to outline transformational changes that will impact on activity levels and deliver planned savings. Due to the tight deadline, the draft narrative was forwarded to Governing Body members via email prior to the submission date. The attached is the final submission which incorporates additional wording to capture the work related to the diabetes and respiratory under the NHS Right Care methodology. The narrative will form the basis of the updated Wirral CCG Operational Plan which is planned for February Governing Body.

Governing Body members are asked to formally note the submission made.
3. PERFORMANCE AGAINST THE NHS CONSTITUTIONAL STANDARDS (October 2016)

The following is a summary of the performance against the NHS constitutional standards by exception only. A performance report is available upon request which has the detailed information of performance at October 2016.

The 4 hour A&E target continues to be a challenge and performance has not achieved the 95% target. In October the performance for the Arrowe Park site was 88.49% and this is a continued deterioration since August 2016. WUTH continue to meet the performance trajectories agreed with NHS Improvement as part of their Sustainable Transformational Fund. Following their visit the Emergency Care Improvement Programme (ECIP) team have developed an action plan across the three areas – Out of Hospital care, Hospital Flow, and Care Navigation. The ECIP team gave positive feedback to the Wirral system on progress made since their previous visit. Progress against the action plan is monitored by the Wirral A & E Delivery Board and reported to the CCG Quality and Performance Committee.

Aligned with the A&E performance, the ambulance standards continue to be a challenge, in particular the ‘time to clear’ with a weekly average at 35 minutes which is above the 30 minute standard and a deterioration from the August performance. This has an impact on the availability of ambulance vehicles and in October Wirral is below the targets for the most urgent calls. For Category A red calls (life threatening) the target is for 75% of responses to be within 8 minutes and the performance for Wirral is 61.90%. Whilst this is an improvement from September (59.78%), both October and September’s performance is a deterioration from April to August performance. The newly formed A & E Delivery Board, of which the CCG is a member, is tasked with addressing this performance.

The referral to treatment (RTT) 18 week wait for incomplete pathway was not met in October with the performance of 87.5% for Wirral CCG. The CCG has asked for a recovery plan from WUTH due to their poor performance on this standard and alongside monitoring its implementation, we have requested the RTT Improvement Team from NHS Improvement supports WUTH with its performance. WUTH has not met their STF target since July 2016.

The CCG did not achieve two of the cancer standards during October for first treatment within 62 days, and 2 week urgent referral for breast investigation. All breaches are monitored and action plans instigated to reduce avoidable delays in the pathway and work is underway to improve CCG performance by individual Trusts. Additional clinical capacity for breast referrals is being established.

In terms of the performance for the Improving Access to Psychological Therapies (IAPT) the implementation of the action plan for recovery is continuing and additional action plans and scrutiny have been implemented in order to improve performance and meet the improvement trajectories. Performance has continued to deteriorate and all four targets were not met in October. The CCG has liaised with NHS England in terms of additional support from the national IAPT team and also from quality leads due to the ongoing deterioration in performance.

4. CONCLUSION

Governing Body is asked to:-
- To note submission to NHS England of the CCG in response to General Practice Forward View and planned progress to conclude a final Primary Care Transformation Plan 2016-2020 for April 2017.
- To approve the draft All Age Joint Learning Disability Strategy
- To note the narrative of planned savings submitted to NHS England as per Planning Guidance.
- Note the review of recent performance against constitutional standards.
<table>
<thead>
<tr>
<th><strong>Transformational change</strong></th>
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<tbody>
<tr>
<td>Description of the application of the impact of transformation / allocative efficiency. To include for example: NCMs, UEC, RightCare, Prevention, Self care and procedures of limited clinical value.</td>
</tr>
</tbody>
</table>
Right care transformation – to offer alternative pathways or refine threshold for referral to acute care and/or preventative health and wellbeing intervention for:

- Heart failure
- Atrial fibrillation
- Constipation
- Gastritis
- Headache
- Seizures
- Hypertension
- Diabetes
- Respiratory

Specifically, it is anticipated that pathway redesign will impact on referrals, outpatient attendances, follow-ups and admissions in the following areas:

- Gastrointestinal-Gallbladder, biliary tract and pancreas
- Gastrointestinal 13X-Unilateral or unspecified inguinal hernia, without obstruction or gangrene
- Lower GI-Diverticular disease of large intestine without perforation or abscess
- Neuro 7A Chronic Pain-Chronic Pain - Back, Joint Chest Unspecified
- Neuro conditions 7A-Headache/Migrain
- Circulation -Coronary Heart Disease
- Rhythm-Atrial Fibrillation/Bradycardia/Sick Sinus Syndrome
- Other Circulatory Problems-Varicose veins of lower extremities without ulcer/Heart Failure/Suspected Cardio Disease
- Gastrointestinal-Review of Gastrointestinal prescribing

The total RightCare impact on GP referrals over 17/18 and 18/19 is:

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
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<td>2017/18</td>
<td>1259</td>
</tr>
<tr>
<td>2018/19</td>
<td>1259</td>
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</table>

In addition, further CCG Transformational Change in relation to referral management will have the following impact:
Referral Management- Reduction in GP referrals and First Outpatient attendances (over and above RightCare impact):
2017/18 - 1758

This will be facilitated in the following three key areas:

1. Primary Care Quality Scheme offered to CCG constituent practices which includes an emphasis on improving their respective demand management around referral activity. The Scheme promotes a reduction in variation between practices with performance indicators set for practices to improve the relative position across quartiles compared to peers.

2. Assessment of the feasibility of a further referral management system tool in 2017/18 (referenced locally as a “virtual basket”) whereby GP referrals are submitted electronically to the “basket” for clinical triage by local consultants to determine whether the referral should continue to a confirmed booking or is returned to the GP with a suggested clinical management plan.

3. Development and implementation of a methodology for practice indicative budgets for commissioning to be introduced in 2017/18 where groups of practices are enabled to take closer control of budgetary expenditure for commissioned services and will be set budget efficiency outcomes which are underpinned by a risk share agreement with the CCG. The CCG believes that aligning GP clinical decision-making more closely with available budgetary resources will yield improved efficiencies in matching spend to patient clinical needs.

RTT Management

Action plan in place at WUTH for achievement of the RTT standard. Support from NHSI has been requested. Key components of the plan are:

- Development of a methodology for greater understanding of RTT performance, including validation of data and ‘clock stops.
- Implementation of digital dictation for consultants to support 5 day clinical typing turnaround. Commenced 27.10.2016
- Introduction of daily performance reporting, including outcomes, variation and RAG dashboards. Commencing early 2017
- Validation and accuracy of pivot data through monitoring and auditing of all systems and clear tracking of all patients with a ‘pull model’. Recruitment in progress.
- Introduction of mandatory training and weekly action learning sets for staff in RTT/Validation. E-learning package in place Jan 2017
- Completion of IST model with robust capacity plans where required. RRT target by specialty to be agreed to ensure upon compliance by March 2017
- Robust governance and reporting arrangements in place detailing clear lines of accountability and escalation for non-achievement. Completion 31.12.2016
- Extensive use of Electronic Patient Record for both inpatient and outpatients and greater management of waiting lists.

MSK Redesign

- Transformation of musculoskeletal services will introduce a triage service to ensure patients are directed to the right service, first time – this will reduce duplication and associated demand

Management of Procedures of Low Clinical Priority

- Extensive service review undertaken to ensure opportunities for minimising all activity relating to procedures of low clinical priority. New approval process developed and implemented to enforce use of of approval code where appropriate - use of code linked with payment
Rightcare - The following pathways will be redesigned to reduce Non-Elective Admissions:
- Rhythm-AF
- Other Circulatory Problems-Congestive Heart Failure
- Cerebrovascular Disease-Cerebral Infarction, Unspecified
- Other problems gastrointestinal system 13X-Gastroenteritis and colitis unspecified
- Lower GI-Diverticular disease of large intestine
- Upper GI-Gastrointestinal haemorrhage, unspecified
- Neurological Tendency to Fall 7X-Falls Pathway and services, Syncope and collapse
- Neurological Epilepsy-Epilepsy
- Neurological Chronic Pain 7A-Chronic Pain - Back, Joint, Chest Unspecified
- Neurological - Chronic Pain 7A-Pain localised to other parts of lower abdomen
- Neurological Chronic Pain 7A-Headache/Migrain

The total impact will be achieved over 17/18 and 18/19:
2017/18 - 2225
2018/19 - 2225

Out-of-Hospital Schemes

In addition to the RightCare areas of focus listed above, it is anticipated that out-of-hospital schemes will continue to impact on non-elective admissions. These schemes are commissioned via the BCF pooled fund which will be subject to review for 2017/18 to further increase efficiency and maximise impact on non-elective activity reduction. Schemes include:
- Wirral Independence Service (equipment, assistive technology and falls prevention)
- Intermediate Care and Discharge to Assess provision
- 7-day community offer – Rapid Community Response, Integrated Care Coordination Teams, domiciliary care, reablement, mobile night service
- IV antibiotics at home
- Homeless service
- Street triage
- Green car
• Mental health and dementia support
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<th>E.M.7a</th>
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<td>E.M.8</td>
<td>Consultant Led First Outpatient Attendances</td>
<td>Non-recurrent activity changes to be confirmed</td>
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<td>E.M.9</td>
<td>Consultant Led Follow-Up Outpatient Attendances</td>
<td>Non-recurrent activity changes to be confirmed</td>
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<td>E.M.10</td>
<td>Total Elective Admissions</td>
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Description of the modelling assumptions to capture the effect of for example, changing definitions, boundaries, reporting standards.
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<td>Total A&amp;E Attendances excluding Planned Follow Ups</td>
<td>Wirral Community Trust (RY7) began submitting A&amp;E data to SUS from 2015/16 which almost doubles the A&amp;E activity figure at a CCG level. The impact of this change on the national activity template is estimated to be 54671, which was taken off to derive the final planned figure for 17/19</td>
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<tr>
<td>E.M.7b</td>
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<tr>
<td>E.M.8</td>
<td>Consultant Led First Outpatient Attendances</td>
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<tr>
<td>E.M.9</td>
<td>Consultant Led Follow-Up Outpatient Attendances</td>
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<tr>
<td>E.M.10</td>
<td>Total Elective Admissions</td>
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<tr>
<td>E.M.11</td>
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<tr>
<td>E.M.12</td>
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<td>Reference</td>
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<tr>
<td>Public / Private</td>
<td>Public</td>
<td>Meeting Date</td>
</tr>
<tr>
<td>Lead Officer/Author of paper</td>
<td>Nesta Hawker, Director of Commissioning &amp; Contracting Iain Stewart, Head of Direct Commissioning</td>
<td></td>
</tr>
<tr>
<td>Contributors</td>
<td>Martyn Kent, Head of Primary Care Transformation Barbara Dunton, Commissioning Support Manager</td>
<td></td>
</tr>
<tr>
<td>Link to CCG Strategic System Plan</td>
<td>Edit as applicable:</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>
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<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>
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</tr>
<tr>
<td></td>
<td>3 Commissioned services which have a sound evidence base</td>
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<td></td>
<td>4 Provides greater equality of access to all</td>
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<tr>
<td>Link to current strategic objectives</td>
<td>Edit as applicable:</td>
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</tr>
<tr>
<td></td>
<td>1 Prevent people from dying prematurely</td>
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<tr>
<td></td>
<td>2 Enhance the quality of life for people with long term conditions</td>
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<td></td>
<td>3 Helping people to recover from episodes of ill health or following injury</td>
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<td></td>
<td>4 Ensuring people have a positive experience of care</td>
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<tr>
<td></td>
<td>5 Ensuring people are treated and cared for in a safe environment and protected from avoidable Harm</td>
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<tr>
<td>To approve</td>
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<tr>
<td>To note</td>
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<td>To Ratify</td>
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<td>Summary</td>
<td>This report provides an update to Governing Body on the process to-date on compiling a CCG response to the General Practice Forward View (GPFV) which was submitted on 23rd December 2016.</td>
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<tr>
<td>Comments</td>
<td>None</td>
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<td>Next Steps Recommendations</td>
<td>Governing Body to note submission of CCG response to General Practice Forward View and planned progress to conclude a final Primary Care Transformation Plan 2016-2020 for April 2017.</td>
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<td>What are the implications for the following (if not applicable please state why):</td>
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<tr>
<td><strong>Financial</strong></td>
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<tr>
<td>Does the report consider the financial impact?</td>
<td>YES</td>
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<tr>
<td>The GPFV requires a CCG investment of £3 per patient to support transformation from 2017-18. It is proposed to split the investment across two financial years (2017/18 and 2018/19) e.g. £1.50 per patient in each year. The investment decision is subject to the CCG Primary Medical Co-Commissioning Committee having considered the associated business case proposal and determining a recommendation to Governing Body.</td>
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<tr>
<td><strong>Value For Money</strong></td>
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<td></td>
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<tr>
<td>Does the report consider value for money?</td>
<td>NO</td>
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<tr>
<td>The £3 per patient investment for transformation business case proposal has not yet been considered by the CCG Primary Medical Co-Commissioning Committee</td>
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<td><strong>Risk</strong></td>
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<tr>
<td>Is there a documented risk assessment?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>£3 per patient investment proposal: - business case proposal will include risk assessment and value for money rationale for Primary Medical Co-Commissioning Committee to consider.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Legal</strong></td>
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<td></td>
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<tr>
<td>Are there any legal implications and has legal advice been obtained?</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>No legal implications to submitting the CCG General Practice Forward View plan</td>
<td></td>
<td></td>
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<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td></td>
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<tr>
<td>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Limited patient involvement so far in preparing the draft plan via the primary care strategy working group.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wider and more extensive involvement planned for January 2017 with patients, professionals and other stakeholders to conclude a final Plan for April 2017.</td>
<td></td>
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<tr>
<td><strong>Equality &amp; Human Rights</strong></td>
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<tr>
<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></td>
</tr>
<tr>
<td>Not directly applicable to the GPFV submission to NHS England. However, any commissioning of services as a result of implementation of the GPFV elements and/or the wider Primary Care Transformation Plan 2016-2020 will be subject to the usual commissioning decision process (as described in the CCG Commissioning Decisions policy).</td>
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<tr>
<td><strong>Workforce</strong></td>
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<tr>
<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>YES</td>
<td></td>
</tr>
<tr>
<td>Reference is made to the importance of appropriate staff resources to support extensive engagement with member practices, patients and other stakeholders in early 2017. The impact of implementation of the Primary Care Transformation Plan (including GPFV elements) on CCG staff has not yet been determined.</td>
<td></td>
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</table>
**Partnership Working**

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

The primary care strategy working group consisting of GP federations representatives (two GPs and two practice managers), two patients from practice Patient Participation Groups; CCG Lay member for patient involvement, Wirral LMC representative and senior colleagues from local main providers (hospital, community services and mental health services) , illustrates a strong degree of partnership working and the commitment to secure wide-ranging support to primary care transformation.

---

**Performance Indicators**

Does the report indicate any relevant performance indicators for this item? **YES**

In relation to the GPFV submission the respective sections describe a range of metrics related to the components of the programmes.

---

**Sustainability**

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

Not directly applicable to the GPFV submission, however, any commissioning of services as a result of implementation of the GPFV elements and/or the wider Primary Care Transformation Plan 2016-2020 will be subject to the usual commissioning decision process (as described in the CCG Commissioning Decisions policy).

---

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)

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

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<th>Submitted to</th>
<th>Date</th>
<th>Brief Summary of Outcome</th>
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**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).
The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

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

1.1 This report provides an update to Governing Body on the process to-date on compiling a CCG response to the General Practice Forward View (GPFV) which was submitted on 23rd December 2016 to NHS England.

1.2 Guidance on GPFV was published in April 2016 (appendix 1) which incorporated details the Government’s planned investment into primary care between 2016 and 2020.

1.3 In September 2016 the NHS Operational Planning and Contracting guidance 2017-2019 was published which included a requirement of CCGs to submit a response to GPFV by 23rd December 2016.

1.4 The CCG response to GPFV is to provide assurance to NHS England that the CCG is ready to maximize the resource opportunities through the whole range of programmes on offer, by describing our local plans for each element in order to support primary care sustainability and transformation on the Wirral.

1.5 The development of a draft Wirral Primary Care Transformation Strategy was already underway and a specific Primary Care Strategy Working Group established. Membership of this group included representatives from both GP Federations (two GPs and two practice managers), two patients from practice Patient Participation Groups; CCG Lay member for patient involvement, Wirral LMC representative and senior colleagues from local main providers (hospital, community services and mental health services). The wider draft Primary Care Transformation Plan is not subject to NHSE assessment as part of the national December submission requirement, however by incorporating the GPFV elements in the Plan, it provides a coherent and connected approach to how primary care on Wirral can begin to transform into a new offer to patients by 2020.

1.6 The CCG Primary Medical Co-Commissioning Committee Chair agreed for expediency that a draft version of the Primary Care Transformation Plan to be circulated via email to Committee members and to Governing Body members, in order to secure feedback/suggestions on the GPFV elements. The comments received have been reflected in the submitted plan to NHS England.

2. KEY ISSUES / MESSAGES
2.1 The draft Primary Care Transformation Plan is now at a stage where wider engagement with member practices will help to refine and ultimately conclude for April 2017 commencement, an agreed Wirral-wide strategy for primary care transformation over the next four years. The extended engagement approach will start in January 2017 and will consist of a mixture of attendance at scheduled Members Council meetings; evening meetings; use of the scheduled and on-going practice visits by commissioning support managers; attendance at Wirral Local Medical Committee meetings; attendance at Practice Manager/Nurse Forums.

2.2 Wider engagement with patients and local stakeholders (main NHS providers and Local Authority) will again look to take advantage of existing engagement mechanisms to share the Plan, e.g Patient Voice, attendance at PPG meetings; attendance at Health & Wellbeing board; use of the intended clinician to clinician meetings; attendance at HealthWatch Wirral meetings.

2.3 The final draft Plan will be submitted to Governing Body March 2017 meeting for approval.

3. IMPLICATIONS

3.1 Wider engagement with member practices, Wirral LMC, patients and other stakeholders, on the draft Plan, will be fundamental to putting in place a realistic, achievable and impactful strategy for primary care on Wirral for the next four years. Therefore, it must be regarded as one of the key CCG priorities early in 2017 with explicit commitment to deploy all appropriate staffing resources, non-clinical and clinical, to supporting and promoting the required outcome of an agreed Primary Care Transformation Plan 2016-2020 by April 2017.

3.2 Within the GPFV guidance is a commitment by the CCG to invest £3 per patient to support transformation. It is intended for this investment to be split over two years (i.e. £1.50 per patient in both 2017/18 and 2018/19). This investment decision is subject to the Primary Medical Co-Commissioning Committee having considered the associated business case proposal and determining a recommendation to Governing Body.

4. CONCLUSION

General Practice Forward View provides an opportunity to secure resource support (either financial or access to programmes of support) for Wirral member practices, to enable them to transform into a primary care service that is sustainable and remains a “personal and population-orientated primary care” (General Practice Forward View April 2016).

The CCG submission to NHS England on 23rd December 2016 describes the state of readiness and local plans for each element of the GPFV programme so as to take full advantage of all available resources.

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

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<th>No.</th>
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<td>General Practice Forward View April 2016, NHS England</td>
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<tr>
<td></td>
<td>Draft Primary Care Transformation Plan 2016-2020, NHS Wirral CCG</td>
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Appendix 1

Appendix 2
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<td>GP services for the future: Dr Arvind Madan</td>
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<tr>
<td>Chapter 1: Investment</td>
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<tr>
<td>We will accelerate funding of primary care</td>
<td></td>
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<td>Chapter 2: Workforce</td>
<td>12</td>
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<tr>
<td>We will expand and support GP and wider primary care staffing</td>
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<tr>
<td>Chapter 3: Workload</td>
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</tr>
<tr>
<td>We will reduce practice burdens and help release time</td>
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<tr>
<td>Chapter 4: Practice infrastructure</td>
<td>36</td>
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<td>We will develop the primary care estate and invest in better technology</td>
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<td>Chapter 5: Care redesign</td>
<td>46</td>
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<tr>
<td>We will provide a major programme of improvement support to practices</td>
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<tr>
<td>Conclusion</td>
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</table>
There is arguably no more important job in modern Britain than that of the family doctor.

GPs are by far the largest branch of British medicine. A growing and ageing population, with complex multiple health conditions, means that personal and population-orientated primary care is central to any country’s health system. As a recent British Medical Journal headline put it – “if general practice fails, the whole NHS fails”.

So if anyone ten years ago had said: “Here’s what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs”, they’d have been laughed out of court. But looking back over a decade, that’s exactly what’s happened. Which is why it’s no great surprise that a recent international survey revealed British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access.

A recent report on GP workload pressures by the Primary Care Foundation and NHS Alliance said this:

“The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice.”

So rather than ignore these real pressures, the NHS has at last begun openly acknowledging them. We need to act. This document sets out exactly how. It contains specific, practical and funded steps – on investment, workforce, workload, infrastructure and care redesign.

**On workforce:** pulling out all the stops to try to double the growth rate in GPs, through new incentives for training, recruitment, retention and return to practice. Having taken the past 10 years to achieve a net increase of around 5,000 full time equivalent GPs, aiming to add a further 5,000 net in just the next five years. Plus 3,000 new fully funded practice-based mental health therapists, an extra 1,500 co-funded practice clinical pharmacists, and nationally funded support for practice nurses, physician assistants, practice managers and receptionists.

**On workload:** a new practice resilience programme to support struggling practices, changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, cuts in redtape, legal limits on administrative burdens at the hospital/GP interface, and action to cut demand on general practice.

**On investment:** by 2020/21 recurrent funding to increase by an estimated £2.4 billion a year, decisively growing the share of spend on general practice services, and coupled with a ‘turnaround’ package of a further £500 million. Investments in staff, technology and premises, and action on indemnity and redtape.
On infrastructure: new rules to allow up to 100% reimbursement of premises developments, direct practice investment tech to support better online tools and appointment, consultation and workload management systems, better record sharing to support team work across practices.

On care redesign: support for individual practices and for federations and superpartnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services.

One of the great strengths of general practice in this country has been its diversity across geographies and its adaptability over time. So one size will not fit all when it comes to the future shape and work of primary care. But in the round, this support package is likely to herald a ‘triple reinvention’ - of the clinical model, the career model, and the business model at the heart of general practice. In his preface to this document Arvind Madan describes what this could mean from the practice and the patient perspective.

Thanks go to the many GPs, other NHS professionals and patient groups who’ve helped shape this urgent ‘to do’ list - including particularly our partners at the Royal College of General Practitioners, the British Medical Association’s General Practitioners Committee, Department of Health, Health Education England, the National Association of Primary Care, NHS Alliance, the Family Doctors Association and in local CCGs and Local Medical Committees right across England.

Looking back over nearly seventy years, there have been key moments in NHS history when the health service has stepped up to support and strengthen general practice and wider primary care. Think: the New Deal for GPs in 1966. Think: new contractual models in the 1990s and 2000s. If properly implemented, the wide-ranging measures in this document may perhaps come to be seen as a similar inflexion point.

But be that as it may, the vital thing is to roll our sleeves up, get practical, and together begin to make a tangible difference, now, for practices and for our patients.

Simon Stevens
Chief Executive, NHS England
GP services for the future:
Dr Arvind Madan

The public relies on general practice services for the health and wellbeing of themselves and their family. It is one of the great strengths of the NHS, and is recognised time and again in international comparisons.

Over my 20 years as a GP demand for appointments, and particularly their complexity, has increased beyond recognition.

There has been a steady rise in patient expectations, a target driven culture and a growing requirement for GPs to accommodate work previously undertaken in hospitals, or in social care. This has resulted in unprecedented pressure on practices, which impacts on staff and patients. Small changes in general practice capacity have a big impact on demand for hospital care, so the need to support general practice in underpinning the whole NHS has never been greater.

However, a typical morning in general practice currently comprises a long arduous struggle through appointments, phone calls, repeat prescriptions, results, letters and home visits. Before you get time to look up, much less take a break, it is the afternoon and you have to start all over again.

Running the practice or having a meaningful conversation with staff is relegated to the edges of the day. Almost every practice is struggling to balance rising workload within tighter financial constraints. Add to this the strain of recruitment issues and it becomes easy to see why morale is so challenged. Clinicians increasingly feel unable to provide the care they want to give, and understandable resentment of working under this pressure is growing.

Yet patients rightly expect and deserve high quality care from a familiar team of healthcare professionals they know and trust. We know these relationships rest at the heart of how every general practice functions. They are fundamental to what we do, namely person-centred coordinated care of complex physical, mental and social issues, within the context of the individual, their families and the wider community.

I joined NHS England at the end of last year, in part driven by my frustration with how I felt high quality primary care for patients was being undervalued. Since starting I have made three observations. Firstly, there is a deep-seated recognition of how a strengthened version of general practice is essential to the wider sustainability of the NHS. Secondly, there is acknowledgement of historic underfunding in general practice and the need for this to be reversed. Thirdly, practices themselves seem more open to new ways of working than at any time I can recall. As much because we want patient care to improve, as we recognise our survival depends on it.

Most observers now agree that the solution lies in a combination of investment and reform. It requires action from NHS England, clinical commissioning groups (CCGs), health and care organisations, and practices themselves. We know there is no single cause for the issues we face, and that no single part of the system acting in isolation can fix it either. We need a concerted approach of initiatives, involving all stakeholders, across a number of key areas.
The General Practice Forward View represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services. NHS England is committing to an increase in investment to support general practice over the next five years. Furthermore this will be supplemented by GP-led CCGs as they act to transform local care systems. This transformation will be built around patients, around the wider workforce, around the redesign of our workload and organisation of care, and creating a satisfying and rewarding career for everyone working in general practice.

Some patients want to be partners in their own care. They want the knowledge, skills and confidence to take more responsibility for their health and feel more in control of their outcomes. Channelling this growing patient appetite for services that help patients to help themselves unlocks both a better patient experience and a way to alleviate practice workload. No amount of reform of the existing system will work unless we also partner with our patients to manage demand more efficiently.

The GP is an expert medical generalist and must be properly valued as the provider of holistic, person-centred care for undifferentiated illness, across time within a continuous relationship. These are core strengths of general practice and must be preserved within any change. However, patient demand and GP shortages mean that we no longer have the time to use our expertise on patient issues that can be safely and competently managed by others. Wider members of the practice-based team will play an increasing role in providing day-to-day coordination and delivery of care. Greater use of skill mix will be key to releasing capacity, if we are to offer patients with complex or multiple long-term conditions longer GP consultations.

In the way we currently view practice nurses as an integral part of the practice team, the GP Access Fund schemes are already showing how a broad range of healthcare professionals can contribute to providing care, for example advanced nurse practitioners, clinical pharmacists, physician associates, physiotherapists and paramedics. Staff are navigating patients to a wider range of alternative services such as primary care access hubs, social prescribing initiatives (including the voluntary sector) and pharmacy minor ailment schemes. Pharmacists remain one of the most underutilised professional resources in the system and we must bring their considerable skills in to play more fully.

We all accept that we have a long way to go to hit the ambitious recruitment targets set for primary care, but we must use every effort to try, as this will be necessary for much of the reform required. NHS England, alongside Health Education England and CCGs, will support a series of initiatives to grow and train the workforce in response to this challenge.
A common reason for poor morale is the daily struggle with growing workload. Much of this is generated by a fragmented system, over which practices feel they have little influence. Our first and most pressing priority must be to alleviate this wasteful burden, which takes away from direct patient care. We know we cannot work any harder, so we have to find ways to work differently. A key requirement for wider system change is the urgent need to identify and eliminate needless workload.

But this is a challenge when it is difficult to find time to look up from the day job. For GPs to believe in a better future we must first start to feel the impact of changes now. Some of the new measures within this document are specifically designed to provide immediate relief to existing pressures. We need to tackle issues such as irrelevant communications, duplicate reporting, unwieldy payment systems and streamline oversight and regulation.

Teams need support and space if they are to adopt new ways of working. This is why NHS England plans to invest in a national development programme at individual, practice and network or federation level. I have been struck by how positively received the recent NHS England and BMA roadshows on releasing capacity have been. However, this should be viewed as the start of a journey in supporting practices to build the capacity and capabilities required within our teams. We must and will go much further.

We will also develop different ways of managing clinical demand. In addition to increasing self-care, use of different triage methods and a broader workforce sharing the burden, we also need to grow capacity through a network of locality primary care access Hubs (as seen in the GP Access Fund areas) and increase clinical personnel behind services such as 111, for example, nurses, pharmacists and dentists.
It is becoming increasingly normal for general practices to work together at scale, and already over half the country have formed into networks or federations of practices. In the future there will be greater opportunities for practices to work collaboratively in larger groupings for the benefit of more sizeable populations, yet maintain their unique identity and relationship with their own patients. Larger organisational forms will enable greater opportunities for practices to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers, including community health services, social care and voluntary organisations.

GPs must feel confident in the vision of where general practice could go and how it will feel to be a GP in the future. A significant proportion of demand must be managed through helping patients to stay well, self-care and navigate to other team members, or alternate services. GPs’ core role will be to provide first contact care to patients with undifferentiated problems, provide continuity of care where this is needed, and act as leaders within larger multi-disciplinary teams with greater links to hospital, community and social care specialists.

Primary care professionals will increasingly work at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy. This will open up opportunities in pathway design, service leadership, education, training and research, or developing areas of clinical interest. Specialists will develop more community facing roles, supporting primary care colleagues in developing case management expertise, both in person and remotely. There will be greater use of technology to connect primary care with others, for the sharing of best practice and sourcing of timely advice. These changes will develop a more unified team approach, in a variety of career structures, with satisfying and rewarding opportunities for both clinicians and non-clinicians, and a more coordinated experience of care for patients.

The General Practice Forward View will not solve all the issues we face immediately, but it does set a new direction and opportunity to demonstrate what a strengthened model of general practice can provide to patients, those who work in the service, and for the sustainability of the wider NHS. General practice has risen to challenges in the past and, with support from leaders across the system, it will again.

Dr Arvind Madan
GP, Director of Primary Care, NHS England
Chapter 1: Investment
We will accelerate funding of primary care

We will increase the levels of investment in primary care:

• By investing a further £2.4 billion a year by 2020/21 into general practice services. This means that investment will rise from £9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21.
• Represents a 14 percent real terms increase, almost double the 8 percent real terms increase for the rest of the NHS.
• This is the expected increase nationally. Investment is likely to grow even further as CCGs build community services and new care models, in line with the Five Year Forward View.
• This includes capital investment amounting to £900 million over the next five years.
• Will be supplemented by a Sustainability and Transformation package, totalling over half a billion pounds over the next five years, to support struggling practices, further develop the workforce, tackle workload and stimulate care redesign.
• A new funding formula to better reflect practice workload, including deprivation and rurality.
• Consult the profession and others on proposals to tackle indemnity costs in general practice by July 2016.
The Five Year Forward View recognised that primary care has been underfunded compared to secondary care, and that this must change. The historic strength of general practice is being weakened by the relative under-investment in general practice that has occurred over the past decade.

Since the creation of NHS England in 2013, each year there have been real term increases in primary care funding. On the back of the Spending Review, which committed £10 billion a year more above inflation for the NHS by 2020 to back the Five Year Forward View, we know we need to sustain and accelerate growth in investment.
Package of investment in general practice

We are committed to increasing the proportion of investment going into general practice services. This should reach over 10 percent by 2020/21, and will rise further as CCG investment in general practice rises also. Overall investment to support general practice services will rise by a minimum of £2.4 billion a year by 2020/21. This represents a 14 percent real terms increase, significantly more than that anticipated for CCG allocations.

The additional investment we are making in introducing new care models will benefit general practice too – and this will ensure investment rises at least in line with the plans set out above, and potentially even more.

For 2016/17, NHS England has allocated an additional £322 million in primary medical care allocations, providing for an immediate increase in funding of 4.4 percent.

Plus local investment

For the first time, the Planning Guidance for the NHS has made securing the sustainability of general practice, and in particular addressing workforce and workload issues, one of nine national ‘must dos’. Every part of England has been asked to produce a Sustainability and Transformation Plan (STP), which will include plans to secure and support general practice, and enable it to play its part in more integrated primary and community services. These plans will be completed by July 2016. National actions on their own will not be enough – local leadership and investment will be vital.

Plus a five year general practice Sustainability and Transformation package

We have created a national £508 million five year Sustainability and Transformation package for general practice to help further support struggling practices in the interim, develop the workforce, stimulate care redesign and tackle workload.

This package will include:

- £56 million, to include a new practice resilience programme starting in 2016/17, and the offer of specialist services to GPs suffering from burn out and stress (see chapter 3)
- £206 million for workforce measures to grow the medical and non-medical workforce (see chapter 2)
- £246 million to support practices in redesigning services, including a requirement on CCGs to provide around £171 million of practice transformational support and a new national £30 million development programme for general practice (see chapter 5).

We will also continue to support capital investment in general practice through a programme of investment estimated to reach over £900 million over the next five years.

Fairer distribution of funding

The Carr-Hill formula applies a weighting (to General Medical Services (GMS) contracts only) to reflect the comparative workload associated with different patient groups.

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1 As part of agreed devolution arrangements, Greater Manchester has been allocated a transformation fund which includes an appropriate share of NHS England funding for primary medical care initiatives. It will be for Greater Manchester to determine how it is spent in the local area.
Many believe that the Carr-Hill formula is now out of date and needs to be revised to reflect changes in the population and the impact of this on comparative workload. NHS England is working with the BMA to review the Carr-Hill formula to specifically examine the impact of deprivation, age and other factors that influence practice workload. This work will be concluded in the summer of 2016, and form the basis of discussion with the BMA about changes that might be needed.

A minority of practices are yet to undergo their PMS contract reviews. We are committed to ensuring this process is completed in the interest of equity across all practices. However, in the interests of stability, these changes are being phased over a minimum of four years, ensuring there is a water tight reinvestment plan for all savings in local general practices, and engaging in individual conversations with practices that are particularly challenged.

CCG plans for reinvestment must be published before the full impact of Personal Medical Services (PMS) reviews are implemented for individual practices.

**Tackling rising costs of indemnity**

Indemnity costs have risen in the NHS in England significantly in recent years. This is the result of the rising number of claims, and the rising level of awards made by the courts, with the cost of care packages doubling every seven years. This is despite the fact that on objective measures, the quality and safety of care provided by GPs has never been higher. GPs tell us that these costs are distorting decisions about whether to remain in work (particularly for those choosing to work part-time), whether to work in GP out of hours and urgent care services for non NHS trust providers, and whether to deploy the wider clinical workforce (where costs for nurse indemnity can be the equivalent of medical indemnity).

NHS England has taken initial steps to alleviate these pressures through:

- the establishment in 2014/15 and 2015/16 of a £2.5 million ‘winter indemnity’ scheme to help with the costs of those working out of hours
- taking into account increases in indemnity costs, amongst other factors, in agreeing funding for the 2016/17 GP contract.
- working with the medical defence organisations and indemnity insurers to meet the needs of new ways of delivering care. For example, through products that treat the delivery of services across practices outside of core hours (with shared access to patient records) as similar to in-hours working, rather than charging the out of hours rate. This is in recognition of access to the patient record.

Some GPs have called for general practice to have Crown indemnity. This would mean it is not possible to sue for damages and that the small minority of patients who had suffered harm as a result of clinical negligence would not have recourse to any financial compensation. We do not believe that this is the intent of the profession, and this form of immunity does not apply to other health services.

Rather, we believe that the shared aim of all those working in the NHS is to bring down the overall costs associated with negligence claims in an appropriate fashion, and ensure that the way that those costs are borne does not dis-incentivise excellent clinical staff from working in the NHS or restrict access to justice.
The Department of Health will be consulting shortly on the options for introducing a Fixed Recoverable Cost scheme to cap the level of recoverable costs for claimant lawyers on clinical negligence claims. The aim is to make the cost of claimant lawyers more proportionate to damages and defence costs.

We and the Department of Health are also committed to reviewing the way in which costs are funded. Any changes would have a bearing on historical claims and handling of past liabilities. This is complex with the potential to create unintended financial consequences if mishandled. The Clinical Negligence Scheme for Trusts (CNST) is a risk-pooling arrangement for trusts, and requires every organisation to contribute funds. The rising costs of CNST has been an issue for providers in other sectors, and to date, we have not seen evidence that access to CNST would bring down the costs for practice partnerships. There would be significant implications for the treatment of historical claims, for the insurance market in general, and it might increase costs to practices. So this is not a simple solution.

The Department of Health and NHS England will instead bring forward proposals in July 2016 for discussion with the profession, medical defence organisations, the commercial insurance industry and the NHS Litigation Authority. This will consider potential solutions, including considering:

- how personal costs of indemnity and clinical insurance can be contained, provided certain clinical governance standards are met – with the objective of reducing the overall costs to the individual;
- reducing indemnity costs for individuals in particular circumstances, such as GPs who wish to remain in the workforce on a part-time basis past a certain age; and
- enable new models of care such as Multispeciality Community Providers (MCPs) to take on corporate indemnity, freeing up individuals working in those new models from the burden of personal indemnity costs.

In principle, GPs should be no more exposed to the rising costs of indemnity than our hospital doctors, and any solution will need to address this.

Taken together, this represents a significant programme of work to reform indemnity in general practice, addressing some short-term pressures whilst looking to bring down the overall costs to the system.
Better Care Fund

The Better Care Fund (BCF) requires CCGs and local authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. In 2016/17, the minimum size of the BCF has been increased to £3.9 billion.

From April 2016, CCGs, local authorities and NHS England will be able to pool budgets to jointly commission expanded services, including:

- additional nurses in GP settings to provide a coordination role for patients with long term conditions;
- GPs providing services in care and nursing home settings;
- providing a mental health professional in a GP setting; and
- hosting a social worker in a GP surgery.

CASE STUDY

Wider integration of health and social care - Sunderland (MCP vanguard)

Through the Better Care Fund all of Sunderland’s resources for out-of-hospital care from both the CCG and local authority are now contained within a single pooled budget of over £160 million. From April 2015, a Provider Management Board took on the leadership for redesigning existing services and investing new funds in additional GP and nursing sessions in integrated teams and a 24/7 Recovery at Home service.

Co-located multidisciplinary teams, working across several practices, provide an enhanced level of care to patients with complex needs. These are often frail older people and/or people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach.
Chapter 2: Workforce

We will expand and support GPs and wider primary care staffing

The General Practice Forward View cannot be delivered without sufficient recruitment and workforce expansion. Therefore NHS England and Health Education England (HEE) have set ambitious targets to expand the workforce, backed with an extra £206 million as part of the Sustainability and Transformation package. We will also support the development of capability within the current workforce and support the health and wellbeing of staff.

Expansion of workforce capacity
Plans to double the rate of growth of the medical workforce to create an extra 5,000 additional doctors working in general practice by 2020. This five year programme includes:

- Increase in GP training recruitment to 3,250 a year to support overall net growth of 5,000 extra doctors by 2020 (compared with 2014).
- Major recruitment campaign in England to attract doctors to become GPs, supported by 35 national ambassadors and advocates promoting the GP role.
- Major new international recruitment campaign to attract up to an extra 500 appropriately trained and qualified doctors from overseas.
- Targeted £20,000 bursaries in the areas that have found it hardest to recruit into GP training.
- 250 new post-certificate of completion of training (CCT) fellowships to provide further training opportunities in areas of poorest GP recruitment.
- Attract and retain at least an extra 500 GPs back into English general practice, through:
  - simplifying the return to work routes further, with new portfolio route, and other measures to reduce the length of time.
  - launch of targeted financial incentives to return to work in areas of greatest need.

A minimum of 5,000 other staff working in general practice by 2020/21. This five year programme will include:

- Investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an average of a full time therapist for every 2-3 typical sized GP practices.
- Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by new central investment of £112 million to extend the programme by a pharmacist per 30,000 population for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.
- Introduction of a new Pharmacy Integration Fund.
• A general practice nurse development strategy, with an extra minimum £15 million national investment including improving training capacity in general practice, increases in the number of pre-registration nurse placements, measures to improve retention of the existing nursing workforce and support for return to work schemes for practice nurses.

• National investment of £45 million benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time.

• Investment by HEE in the training of 1,000 physician associates to support general practice.

• Introduction of pilots of new medical assistant roles that help support doctors, as recommended by the RCGP.

• £6 million investment in practice manager development, alongside access for practice managers to the new national development programme.

• £3.5 million investment in multi-disciplinary training hubs in every part of England to support the development of the wider workforce within general practice.

**Health and wellbeing**

£16 million extra investment in specialist mental health services to support GPs suffering with burn out and stress, and support retention of GPs, in addition to the £3.5 million already announced.

Over the past decade, the number of GPs (full time equivalents) working in general practice has risen by over 5,000.

But we know that many practices now face recruitment issues and are increasingly reliant on temporary staff. Moreover, a higher proportion of older GPs are signalling that they are considering leaving the workforce early.
We aim to double the rate of growth in the primary care medical workforce over the next five years, to create an extra 5,000 doctors working in general practice. This needs to be supported by growth in the non-medical workforce – a minimum of 5,000 extra staff – nurses, pharmacists, physician associates, mental health workers and others.

**Work to date**
The Primary Care Workforce Commission, set up by HEE and chaired by Professor Martin Roland, called for a broader range of staff to be involved in providing care. Their report, *The future of primary care creating teams for tomorrow*, set out how we can better deploy the talents of the wider workforce to reduce the workload burden on GPs, meet patients’ needs and to free GPs up to do what they do best. The report also set out recommendations to increase the role of nursing, advanced clinical practitioners, medical assistants, practice pharmacists and physician associates along with stronger partnerships with the voluntary sector and better use of technology.

Last year, NHS England, HEE, Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) developed an initial 10 point action plan – *Building the Workforce a new Deal for General Practice* - to kick start initiatives to improve recruitment, retention and return to practice. Now that there is significant new investment for general practice, we will be working together – and with other professional bodies, such as the RCN, Queen’s Nursing Institute, Royal Pharmaceutical Society, National Association of Primary Care and NHS Clinical Commissioners to step up actions to grow the workforce and stimulate a more diverse range of workforce models within primary care.

Through the 10 point action plan, together we have:

- delivered a marketing campaign to encourage foundation year 2 doctors who are applying for specialty training to choose general practice;
- launched a scheme to offer up to £20,000 bursaries for 109 GP trainees to attract doctors to parts of the country where there have been consistent shortages of trainees;
- established new post-CCT fellowships to provide further training opportunities in areas of poorest GP recruitment that encourage new CCT holders to work as GPs in those areas, whilst pursuing special interests and meeting local need such as urgent care and learning disability care;
• committed to invest £3.5 million in 13 new multi-disciplinary training hubs (Community Provider Education Networks) across the country to support the development of the wider workforce within general practice, including placements in general practices, development for current staff and workforce planning;
• created a national induction and refresher (returner) scheme, offering a new £2,300 per month bursary to doctors looking to return to general practice to help with costs and improving entry routes – leading to an increase in the number of applicants and improving coverage, given previous local variation;
• invested an extra £1.75 million nationally to support practice nurse development;
• invested in leadership development and coaching for individual GPs; and
• piloted new ways of working including the development of Primary Care Physician Associates.

For the wider workforce, we agreed a major £31 million scheme to pilot the deployment of over 470 clinical pharmacists in just over 700 practices over the next three years, helping practices with the costs of employment and training. We have published a practice and community nursing education and career framework, and are developing a strategy for supporting the practice nursing workforce.

Building the workforce for 2020
To double the rate of growth of the medical workforce, and accelerate use of the wider workforce, we set out below the new programmes of work that will be needed. This will be backed by an extra £206 million over the next five years on top of previously announced initiatives.

Recruiting doctors into general practice
HEE has increased GP training capacity and increased recruitment to 3,250 doctors per annum recurrently. In the first round recruitment for 2016, 2,296 posts - 70 percent - have already been filled.

This represents a welcome increase of around 7 percent on last year's first round of recruitment.

HEE will in partnership with the RCGP, and the profession continue refining and developing GP specialty training to provide greater career flexibility while maintaining standards in order to maximise recruitment.
We know we need to improve the number of medical school graduates choosing to join general practice. There is a strong correlation between training placements in general practice and eventually working in general practice. HEE is currently working with the Medical Schools Council, higher education institutions, the RCGP and the GPC to increase the profile of general practice in medical schools and in their curricula.

A working group, chaired by Professor Valerie Wass OBE, will publish recommendations in summer 2016 about recruitment and selection, finance and curriculum and the promotion of general practice as a speciality.

The recommendations will improve the medical school experience of general practice through greater exposure to the diverse and stimulating reality of general practice professionally and personally. More graduates will be encouraged to make a positive choice of general practice as a career.

HEE and the RCGP will continue to develop the current recruitment campaign to raise the profile of general practice as a career. The campaign showcases the variety of different opportunities and the flexibility of the specialty, as well as the central role that GPs play in the community and their patients’ care. HEE has recruited and trained 35 campaign ambassadors and advocates to support and promote national and regional activities including attendance at recruitment events and through social media.

We will supplement this with a major international recruitment drive, to attract up to 500 appropriately trained and qualified doctors – and possibly more - from overseas over the next five years.

Working with HEE we will evaluate its £20,000 bursary scheme to attract trainees into hard to fill areas and identify if more needs to be done.

HEE will roll out a total of 250 post CCT fellowships by summer 2017 to offer wider and more varied training opportunities in areas of poorest GP recruitment.

Retaining the current medical workforce
One of the strengths of general practice as a career is its flexibility, with the chance to work part-time or combine general practice with work in other settings. We want to make it easier and more attractive for GPs to return to work in English general practice.

Already, the new induction and refresher (returner) scheme has seen:

- the end to multiple different policies, with one single national policy, supported by single website, a consistent set of written guidance to applicants, and a new single point of contact;
- a significant increase in NHS England bursaries for the period of time that the doctor is in a supervised placement - £2,300 per month – up from a range of £0 to £500 per month previously depending on which part of the country you are in;
- the end to requiring doctors working overseas to return to England to start the application process, with the ability to hold interviews now via Skype and sit initial assessments in countries all round the world; and
- a review of the appropriate and relevant content of all assessments, leading to a doubling of pass rates in the last nine months.
As a direct result, we have seen a significant rise in the number of doctors applying to return to work in general practice, with an increase of 40 percent in the number of doctors booking to sit the multiple-choice questions (MCQ), one of the routes for returning to practice, in 2015/16 compared to 2014/15.

We need to accelerate this further so that we can attract at least an extra 500 doctors over the next five years back into general practice. The RCGP has sought feedback on some of the main barriers experienced by returning doctors, and this has formed the basis of our action plan for improvement. Our aim is to start measuring the time it takes for a doctor to return to work, and halve the average time.

We will build on the improvements to establish a straightforward route for doctors to return to work in England.

In addition, we will:

- create a central contact point for any doctor wishing to return to work in English general practice, so that doctors are supported in navigating any regulatory issues and to support and guide them through the process;
- address delays in securing Disclosure and Barring Service checks – taking several weeks and sometimes months – and sort out information governance issues to enable checks to be valid across different parts of the system;
- increase the financial compensation available through the current GP retainer scheme from 1 May 2016; and introduce a new GP retainer scheme more fit for purpose from 1 April 2017; and
- offer targeted financial incentives to GPs from May 2016 for returning to work in areas of greatest need.

We also need to find ways to attract GPs to remain in practice towards the end of their career. The published evidence on retention suggests that the single biggest enabler would be to address concerns over workload, and create a greater sense of ‘status’ for general practice within society. The totality of the General Practice Forward View is aimed at addressing these fundamental issues.

In addition, we will invest further in leadership development, coaching and mentoring skills for experienced doctors – enabling them to build on their skills and offer the value of their experience to younger doctors. We will take stock of the findings of evidence on retention, and address any further issues identified.
Building the wider workforce

The success of general practice in the future will also rely on the expansion of the wider non-medical workforce—
including investment in nurses, pharmacists, practice managers, administrative staff and the introduction of new roles such as physician associates and medical assistants.

Our ambition is to use some of the extra investment going into general practice to support the employment of a minimum of 5,000 extra staff.

To achieve this, at a national level, NHS England and HEE, over the next five years, will:

- invest an extra £15 million nationally in general practice nurse development, including support for return to work schemes, improving training capacity in general practice for nurses, increases in the number of pre-registration nurse placements and other measures to improve retention;
- extend the clinical pharmacists programme with a new £112 million offer to enable every practice to access a clinical pharmacist across a minimum population on average of 30,000 - leading to an extra 1,500 pharmacists in general practice. Appetite for the original pilot scheme was high. We will need to learn more from the evaluation but early indications suggest clinical pharmacists may have a role in streamlining practice prescription processes, medicines optimisation, minor ailments and long term conditions management. We will roll this out further across the country over the next five years, so that every practice can benefit. We will also open up the clinical pharmacist training programme to practices that have directly funded a clinical pharmacist;
- introduce a Pharmacy Integration Fund, worth £20 million in 2016/17 and rising by a further £20 million each year, to help further transform how pharmacists, their teams and community pharmacy work as part of wider NHS services in their area. Subject to a separate consultation, our proposals include better support for GP practices, for care homes and for urgent care for the use of the fund;
- invest in an extra 3000 mental health therapists to be working in primary care by 2020 to support localities to expand the Improving Access to Psychological Therapies (IAPT) programme;
- provide £45 million extra funding nationally over five years so that every practice in the country can help their reception and clerical staff play a greater role in care navigation, signposting patients and handling clinical paperwork to free up GP time. This builds on successful pilots tested through the Prime Minister’s GP Access Fund schemes and vanguard sites where the majority of clinical correspondence can be managed through trained staff;
- pilot new medical assistant roles that help support doctors;
- pilot the role of primary care physiotherapy services;
• invest an extra £6 million in practice manager development;
• roll out the recently published HEE Community (District) and General Practice Nursing Service Education and Career Framework and the accompanying HEE Education and Career Framework;
• implement the Queen’s Nursing Institute Voluntary Education and Practice Standards for District and General Practice Nursing; and
• work with general practice to ensure general practice nurses have access to mentorship training.

This also needs to be supplemented at a local level, and for the first time - through the Planning Guidance – the NHS locally has been asked to produce plans to address workforce issues in general practice. We will review these plans in the summer, and identify any further actions that need to be taken or ideas that can be spread nationally to accelerate the growth, retention and development of the general practice workforce.

The vanguard sites that are testing new integrated models of care and the GP Access Fund schemes are already developing many different ways of using the wider workforce, and proving that this can be better for patients and free up GP time.

**A balanced GP workforce**

The model of independent contractor status and partnership has proved a valuable foundation for general practice. Partners provide leadership and continuity, and in recent years this has been invaluable as general practice has come under pressure.

We also recognise that a more flexible workforce better enables practices to secure short-term support to cover sick leave, parental leave or transition periods between leavers and joiners. However many practices now report that a shift to reliance on locums is undermining service continuity and stable team working.

It is therefore in the interests of GPs and practices to improve the relative attractiveness of partner and salaried positions versus a shift to a more unstable and short term workforce.

First, we will work with the profession to introduce new measures entitling GPs who want flexible working but who can commit to working in a practice or an area for a period of time, additional benefits relative to undertaking a rolling series of short term locum roles. In other words, while continuing to incentivise partnerships and salaried commitments to practices on the one hand, we also want to create an alternative to day-by-day or week-by-week locuming for those at a point in their career or family life who need more flexibility.

Second, NHS England will set indicative rates for locums and will ask practices to indicate in the annual e-declaration information where they are having to pay above those rates. This is to understand the scale of the issues practices are facing and help plan how we can target workforce support to areas facing the greatest pressures.

Third, we envisage ‘at scale’ working in larger practice groupings will create opportunities to embed a more locally focused team based approach which incorporates locums.
Promoting health and wellbeing to combat burnout
A new national service is being established to improve GPs’ access to mental health support. Support for GPs suffering mental health problems is part of NHS England’s plans to retain a healthy workforce. NHS England has already committed to spend up to £3.5 million in this new service, and will now increase that investment by a further £16 million. The procurement will start in June 2016 and the service is expected to be available across England from December 2016. This means all GPs will be able to access free, confidential local support and treatment for mental health issues, supporting GPs who are at risk of suffering stress or burnout.

Implementation
We will establish a new Workforce 2020 oversight advisory group, with representation from national bodies, to steer the delivery of this ambitious programme, and review where further actions need to be taken in light of progress nationally and locally over the next five years.

CASE STUDY

Multidisciplinary workforce - West Wakefield Multispecialty Community Provider (MCP)

West Wakefield Health and Wellbeing Ltd is a GP Federation in West Yorkshire serving a population of 65,000 and is a wave one GP Access Fund site. It is now leading one of the new care models MCP vanguard sites with two other GP networks covering a total population of 152,000 people.

Among a series of initiatives designed to relieve pressure on GPs, they are training care navigators to break down the automatic assumption that a GP appointment is the best first place to go for any problem.

As well as reduce the number of patients needing to access their GP, care navigators are able to ‘queue bust’ at reception by offering patients who arrive at the practice advice to signpost them to the most appropriate solution for their needs.

Over 70 staff have received training on available resources, services and innovations within the practice and MCP programme, and in the wider voluntary and third sector.
Chapter 3: Workload
We will reduce practice burdens and help release time

Support for general practice with the management of demand, diversion of unnecessary work, an overall reduction in bureaucracy and more integration with the wider health and care system including:

- Major £30 million ‘Releasing Time for Patients’ development programme to help release capacity within general practice (see also Chapter 5).
- New standard contract measures for hospitals to stop work shifting at the hospital/general practice interface.
- New four year £40 million practice resilience programme, starting in 2016.
- Move to maximum interval of five yearly CQC inspections for good and outstanding practices.
- Introduction of a simplified system across NHS England, CQC and GMC.
- Streamlining of payment processes for practices, and automation of common tasks.

Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff. Latest research, published in the Lancet, suggests that there has been an average increase in workload in general practice of around 2.5 percent a year since 2007/8, taking account of both volume and acuity. Whilst some of this rise can be addressed by increasing the workforce, we also want to support practices in moderating demand and reforming how we support and organise services.

The Primary Care Foundation and NHS Alliance have identified the changes that will have the biggest impact in reducing bureaucracy and reshaping demand. Their report, Making Time in General Practice, identified a number of practical, high-impact ways to remove unnecessary pressures on general practice and free up time for patient care.

The report found that the top three sources of bureaucracy experienced in general practice are: the processes used to make and claim payments; keeping up to date with information from commissioners and national bodies, and reporting for contract monitoring or regulation.
The report also estimated that **around 27 percent of appointments could potentially be avoided** if there was more coordinated working between GPs and hospitals, wider use of primary care staff, better use of technology to streamline administrative burdens, and wider system changes.

NHS England is therefore taking immediate action in the following areas:

**Managing demand more effectively**

NHS England is investing in a major new £30 million ‘Releasing Time for Patients’ development programme to support practices release time (see Chapter 5).

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.

In addition, by September 2016, we will have launched a **national programme to help practices support people living with long term conditions to self-care**. Practices will be offered tailored support to offer high quality care planning to patients who have low levels of knowledge, skills and confidence to manage their own health and wellbeing. The aim is to equip the workforce with the tools and skills to do this. This should help improve patient outcomes, and over time, reduce the demand in general practice. We will design this in conjunction with the wider national development programme for general practice.

GPs can also influence the commissioning of local pathways for community pharmacy to help patients with self-care and minor ailments. The developments in digital interoperability and access to a shared primary care record provide practices with an opportunity to harness this potential for reducing demand for urgent appointments.
Alongside a reformed 111 service, we will also work with CCGs to ensure they institute plans to address patient flows in their area using tried and tested ideas such as access hubs, social prescribing and evidence based minor ailment schemes.

**Building practice resilience**

In 2015, NHS England committed to invest £10 million to support vulnerable practices. Eligible criteria for accessing this additional support was developed with NHS Clinical Commissioners and other national stakeholders, with around 800 practices identified as meeting the criteria.

This support is designed to build resilience in primary care and to support delivery of new models of care. RCGP support for inadequate rated practices will continue as part of this programme. A multi-supplier (call off) framework will be available to commissioners from September 2016 to support the programme. This is likely to include a range of local and national providers and may be expanded over time. In order to maximise the impact of this support, from April 2016, NHS England will offer support to eligible practices that are willing to match fund this additional support, or offer the equivalent resources commitment ‘in kind’.

In addition, a further **£40 million** will now be committed to develop a **practice resilience programme**, starting with a **£16 million** boost in 2016/17. We will work with the RCGP and the BMA to develop this programme as quickly as possible, and consider introducing practice resilience teams.

**New standards for outpatient appointments and interactions with other providers**

We have introduced a number of **new legal requirements in the NHS Standard Contract for hospitals** in relation to the hospital/general practice interface from April 2016. These should relieve some of the administrative burden on practices.

The changes include:

- **Local access policies**: hospitals will not be able to adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral. Also a new requirement on hospitals to publish local access policies and evidence of having taken account of GP feedback when considering service development and redesign.

- **Onward referral**: unless a CCG requests otherwise, for a non-urgent condition related to the original referral, onward referral to another professional within the same hospital is permitted, and there is no requirement to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.

- **Discharge summaries**: hospitals will be required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours, with local standards being set for discharge summaries from other settings. Furthermore, the hospital should provide summaries in the standardised format agreed by the Academy of Medical Royal Colleges, so GPs can find key information in the summary more easily.

- **Outpatient clinic letters**: hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information that the GP needs quickly in order to manage a patient’s care (certainly no later than 14 days after the appointment). For 2017/18, the intention is to strengthen this by requiring electronic transmission of clinic letters within 24 hours.
• **Results and treatments:**
  new overarching requirement on hospitals to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, telephoning the patient.

• **Medication on discharge:**
  a new requirement on providers to supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

These changes apply to all acute and community providers. GPs should notify their CCG in the event that the contract is not being followed. The CCG is responsible for holding providers to account for the contract changes.

A new NHS England, NHS Improvement, RCGP and GPC Working Group will drive action to improve the current interface between primary and secondary care. The Group’s work will include practical steps to enable better communication between GPs and consultants, and how to improve GP access to consultant advice on potential referrals, and managing complex cases in the community.

As part of this, NHS England has established a **Rapid Testing Programme in three sites across the country to review ways of better managing outpatient demand.** This will include assessment of the practical application of consultant hotline and advice services, enabling GPs to get rapid advice rather than referring the patient. In light of the outcome of this programme, the most effective measures will be rolled out for use by CCGs from late summer 2016 onwards. Alongside this, work is underway to make the current functionality of the Choose and Advice system more functional for use by GPs.

**New software to automate common tasks**
Clinicians are frequently required to undertake a series of tasks on the computer when putting a care plan in place or responding to incoming correspondence. We will work with innovative practices, federations and software suppliers to develop, test and implement the technical requirements for a new task automation solution to reduce workload. It is expected that practices will have access to the new automation function in 2017/18.
Streamlining Care Quality Commission (CQC) practice oversight

In October 2014, the Care Quality Commission (CQC) began to inspect general practice services. CQC ratings have, for the first time, provided a comprehensive assessment of the quality of care provided by practices. By April 2016, they had inspected over a third of practices (35 percent) and found that the vast majority (87 percent) are providing care that is good or outstanding.

The CQC will complete its first round of comprehensive inspections of all practices in 2016/17. CQC is consulting on changes to its regulatory model for its work thereafter.

These proposals will reduce the workload related to inspection for those practices that deliver good or outstanding care, while encouraging improvement and ensuring a proportionate approach that protects patients from the risks of poor care.

Another issue related to CQC has been that of the fees increase for registration. In recognition of this, NHS England agreed with the GPC to reflect these costs in the 2016/17 GP contract settlement to address this cost pressure for practices.

What can practices expect nationally?

- A reduction in inspections from CQC. This will apply once all GP practices have been inspected later this year. CQC will tailor its inspection activity, taking a more risk-based approach where it monitors and acts on intelligence and information. It will reduce the frequency of some inspections, so that it targets its resources on those practices where there is a risk of poor care. CQC will agree with NHS England and local CCGs a shared framework to understand and report on quality. Practices rated good and outstanding - currently the vast majority - will move to a maximum interval between inspections of five years, subject to the provision of transparent data, available to CQC, NHS England and CCGs; and also to CQC remaining assured that the quality of care has not changed significantly since the previous inspection. Where CQC has concerns, it may revisit sooner.

- New streamlined approach to inspection for new care models and federated or super-partnerships practices. CQC will continue to develop the way it inspects to take account of changes to the way the sector is organised and delivered, for example, through new models of care or federated practices – with a focus on the leadership, governance and learning culture of the provider, not necessarily on inspecting every single site.

- Funding for CQC. NHS England will discuss with the GPC how best to recognise any further fee increases and will ensure practices are appropriately compensated.

- Improving and simplifying transparency of information about general practice. A report from the Health Foundation to the Department of Health made a number of recommendations on valid quality indicators for general practice. A set of key ‘sentinel’ indicators will therefore be published on My NHS in July 2016.
A successor to the Quality and Outcomes Framework (QOF)

QOF has created a more focussed approach to chronic disease management and provides a structured way of engaging in secondary prevention. However, some argue that it has served its purpose and requires review or even replacement and that it is a barrier to holistic management of health conditions. **NHS England has agreed to undertake a review of QOF with the GPC in the coming year** to address these issues, whilst recognising that it is one of the best public health databases in the world and, done right, can support population-based healthcare.

**There are already areas of the country exploring local alternatives to QOF.** For practices opting into the proposed new voluntary MCP contract (see Chapter 5) QOF will be replaced with more holistic team-based funding.

NHS England and GPC have agreed that we will discuss during the next round of negotiations the GPC’s wish for avoiding the unplanned admissions enhanced service to be discontinued from April 2017.

**Reporting requirements and information, and streamlining the payment system**

We will introduce a simplified system for how GP data and information is requested and shared across NHS England, CQC and GMC. This will be backed by a programme of work to cut the bureaucratic burden of oversight.

We are also taking action to simplify the general practice payment system. It is unacceptable for hard-pressed practices to have to waste time chasing or reconciling payments. Where technical issues arise that may delay payments to practices, NHS England has introduced failsafe procedures that allow practices to submit activity data manually into CQRS, therefore ensuring practices cash flow is maintained.

**In addition, based on a recent review of the payment processes and systems for general practice, we will now work with the payment providers to focus on:**

- improvements in the consistency and accuracy of payments;
- increasing the transparency and availability of information to support them; and
- the feasibility of a single payment vehicle as a single view with an itemised bank statement like reconciliation of claims and payments.

**Accelerating paper free at the point of care within general practice**

General practice already has the most computerised records in the NHS, and many practices are already considered to be paperless. However, owing to a lack of interoperable systems across the NHS, its dealings with other providers are often on paper, creating risks and inefficiencies that we are committed to reducing.
Examples include tackling the significant workload involved in every practice receiving, checking and processing many prescriptions every day. Rolling out electronic prescriptions is speeding up processes for practices and helping to reduce clinical risk for patients. Work is almost complete which removes the need for practices to print paper copies of records when a patient moves practice. This is already in place for practices using the most up-to-date software, and final testing of updates for the remaining systems is expected to be completed in May 2016.

A major programme is also underway to ensure that by 2020 all incoming clinical correspondence from other NHS providers is electronic and coded. This will reduce practice workload and the risks of errors in data entry, as well as improve the usefulness of incoming information and facilitate more seamless patient care.

**Promoting best practice and monitoring improvements**

We hosted a series of BMA and NHS England workshops to share evidence and examples with practices of the opportunities to release staff capacity. 95-98 percent of practices that attended reported that these gave them new practical ideas to release staff time.

We will continue to support the spread of good ideas. We will monitor the impact of work to reduce pressure on practices, and we want to empower practices to also do this. We are therefore commissioning a new audit tool to be available for all practices that will allow practices to identify ways they could reduce appointment demand. This will use the same methodology as in the ‘Making Time in General Practice’ report and allow practices to compare themselves with the national data.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

**Mandatory training**

Practices have told us that there seems to have been a growth in mandatory training requirements for clinicians and other practice staff. Examples include basic life support, safeguarding, information governance, health and safety, complaints handling, fire safety, fridge procedures etc. Whilst it is easy to see the justification behind each one, the sum of them all creates a significant burden on staff, and crowds out the more targeted training needs of individuals.
NHS England will work with relevant bodies to review and reduce these requirements to ensure a far more proportionate approach is taken. We will also keep in mind the impact of appraisal and revalidation requirements in the analysis.

Support for more integration across the wider health and care system

Social support

Voluntary sector organisations can also play an important role in supporting the work of general practice. For example, local models of social prescribing can enable GPs to access practical, community-based support for their patients, including access to advice on employment, housing and debt. Some areas have developed call-off services for specific groups such as carers.

Local leadership

We want all local Health and Wellbeing Boards (HWBs) to recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. The Department of Health will issue guidance to Health and Wellbeing Boards asking them to ensure that joint health and wellbeing strategies (JHWSs) include action across health, social care, public health and wider services to build strong and effective relationships with general practice services.

This will ensure that they understand our vision for general practice and how they can and should support it.

Work and health

There is clear evidence that good quality work is good for health and, conversely, being out of work has significant negative impacts on health. The Five Year Forward View set out a vision for the NHS to play a stronger role in prevention, including a focus on helping people at risk of falling out of work. Easier access to health services for people in employment should help individuals to seek help at an early stage, and general practice staff have a role to play in recognising when early referral or treatment may be indicated for someone at risk of falling out of work.

This means that GPs will have greater access to treatment pathways, especially for conditions that have an impact on the ability to work for large numbers of people, such as mental health conditions (IAPT) and musculoskeletal problems.

Over the last year, the Government has set up Fit for Work and will continue to develop this approach. Fit for Work offers a free advice, assessment and case management service for people who are employed and off sick. It is intended to help GPs by improving outcomes and reducing demands on them for fit notes and detailed work-related advice.

In addition, the Government will now consider whether ‘early dialogue on work and health’ and the resulting sickness certification (fit note) - currently restricted to registered medical practitioners - could be undertaken by other healthcare professionals.

To promote the development of social prescribing, a key measure by which patients can benefit from wider support, NHS England are appointing a new National Champion for Social Prescribing.
CASE STUDIES

General practice and community collaboration managing patient demand and making a difference to people’s wellbeing - Robin Lane Medical Centre MCP

Robin Lane Medical Centre in Leeds has nine doctors, employs 50 people, has 13,000 patients and is growing. It also has a wellbeing centre, a cafe and 19 groups run by over 50 volunteer champions every week. By taking a new approach they have seen no increase in demand for primary or secondary care consultations despite patient lists increasing by 4,500 people. The practice has now established a charity to support the wellbeing centre which is run by a board of volunteer champions.

Redirecting administrative tasks away from GPs to release capacity - Brighton and Hove

In Brighton and Hove some practices have developed a robust protocol to allow clerical staff to read, code and where appropriate take action on incoming clinical correspondence, rather than the GP having to deal with every letter. Forty eight practices have now been trained and implemented workflow redirection with substantial changes demonstrated. On average, only 20 percent of letters previously directed to a GP required their direct input. This is saving an average of 40 minutes of each GP’s time per day, with no significant events in the first 15,000 letters to be processed. Feedback clearly demonstrates reduced workload pressures and with the time savings generated, increased opportunity for activities related to direct patient care.

Training includes clear mechanisms to provide internal governance and auditing of activity. GPs report being satisfied with the safety of the approach, the improved quality of coding and the release of their time. Clerical staff report that they are confident to run the new process and describe renewed job satisfaction.
Chapter 4: Practice infrastructure
We will develop the primary care estate and invest in better technology

We will go further faster in supporting the development of the primary care estate:

• Investment for general practice estates and infrastructure – supported by continued public sector capital investment, estimated to reach over £900 million over the course of the next five years. This will be backed with measures to speed up delivery of capital projects.
• New rules on premises costs to enable NHS England to fund up to 100 percent of the costs for premises developments, up from a previous cap on NHS England funding of 66 percent (with a proposed date of introduction of September 2016).
• New offer for practices who are tenants of NHS Property Services for NHS England to fund Stamp Duty Land Tax for practices signing leases from May 2016 until the end of October 2017, and compensate VAT where the ultimate landlord has chosen to charge VAT.
• New funding routes for transitional funding support for practices seeing significant rises in facilities management costs in the next 18 months, in leases held with NHS Property Services and Community Health Partnerships.
Development of the primary care estate
In 2015/16, NHS England began a multi million investment programme to support primary care and general practice make improvements in premises and in technology, as part of the overall estates strategy for the local NHS. This was backed by both capital and revenue funding, and will continue as the Estates and Technology Transformation Programme. Additional capital investment will also be flowing into general practice beyond this programme, bringing the estimated overall total of capital investment in general practice over the next five years to over £900 million.

NHS England is inviting CCGs to put forward recommendations for investment in primary care infrastructure in future years by the end of June 2016. CCGs are developing commissioning plans designed to provide health care services for the future and producing Local Estates Strategies, in conjunction with Community Health Partnerships and NHS Property Services.

Greater use of technology to enhance patient care and experience, as well as streamlined practice processes:

- **Over 18 percent increase** in allocations to CCGs for provision of IT services and technology for general practice.
- **£45 million national programme** to stimulate uptake of online consultations systems for every practice.
- Online access for patients to accredited clinical triage systems to help patients when they feel unwell.
- Development of an approved Apps library to support clinicians and patients.
- Actions to support the workload in practices reduce, and achieve a paper-free NHS by 2020.
- Actions to support practices offer patients more online self-care and self-management services.
- Actions to make it easier for practices to work collaboratively, including achievement of full interoperability across IT systems.
- **Wi-Fi services in GP practices for staff and patients.** Funding will be made available to cover the hardware, implementation and service costs from April 2017.
- A nationally accredited catalogue and buying framework for IT products and services, supported by a network of local procurement hubs offering advice and guidance.
- Work with the supplier market to create a wider and more innovative choice of digital services for general practice.
- Completion of the roll out of access to the summary care record to community pharmacy, by March 2017.
Investment in the GP estate is needed not just to improve or extend existing facilities. We also need to increase the flexibility of facilities to accommodate multi-disciplinary teams and their training, innovations in care for patients and the increasing use of technology. And new premises may be needed to cater for significant population growth, and to facilitate primary care at scale or enable patient access to a wider range of services.

Investment in infrastructure can require planning permissions, building regulation approvals, procurements and construction. Given concerns about delays, and the handling of revenue consequences, we have made some changes in response:

- Firstly, the programme of capital investment will now accommodate schemes that need support over more than one year.
- Secondly, we will invest in ‘at scale’ project support for schemes to enable them to move quickly through the financial, legal and design processes.
- Thirdly, we have discussed with the GPC changes to the rules governing the funding of premises so that over the next three years NHS England will be able to increase the levels of funding for a wider range of improvements to practices and new facilities. NHS England will work with the Department of Health with the aim of introducing new rules from September 2016 which will enable NHS England to fund up to 100 percent of the costs of premises developments, rather than the previous cap of 66 percent funding.

NHS England will agree arrangements to come into place from 1 May 2016 until 31 October 2016 to provide additional support to practices in three areas:

- Stamp Duty Land Tax for practices
- VAT on premises, where the ultimate landlord has elected to charge VAT
- Transitional support where practices have seen a significant increase in the costs of facilities management on leases held with NHS Property Services and Community Health Partnerships. We will work quickly to clarify the route by which this new funding support can be provided.

NHS Property Services and Community Health Partnerships are working with CCGs in local areas to agree local estates strategies. CCGs will agree the improvements that will be made so that buildings are used productively and provide the capacity and flexibility that is required. While there are some GP practices that urgently require improvement, there are buildings which are unused or underutilised. Working with their CCGs and estates advisors, general practices will need to help to ensure that buildings are all used productively and effectively.

We will also work more closely with NHS Property Services using existing premises rules to unlock opportunities to transform primary care services, for example, considering wider commissioning gains against underwriting lease arrangements or buying out GP or third party owned premises.
In addition, the Department of Health is working with Community Health Partnerships to mobilise the potential of public and private sector partnerships in the development of the primary care estate, building on the LIFT programme which covers almost half the country.

**Investment in better technology**
New technology is already playing an important role in improving patient care. Practices round the country are using technology to move from paper to digital records, offering online transactions including online registration, appointment booking, ordering of repeat prescriptions and viewing of medical records. Some practices have gone far beyond these more transactional interactions, and we now need to support much more widespread adoption of their innovations.

A growing number of practices are introducing new apps and web portals that help patients assess and manage their own health risks. These provide information, symptom checkers and sign posting to alternate services, such as community services, expert patient groups and community pharmacies that also have a large role to play in health promotion. They also can include online and telephone consultations.

**What does this mean for practices?**
Our ambition is to support the adoption and design of technology which:

- enables self-care and self-management for patients;
- helps to reduce workload in practices;
- helps practices who want to work together to operate at scale; and
- supports greater efficiency across the whole system.

We will do this in three ways:

- through **extra investment** – with an increase of over 18 percent going into allocations for CCGs for the provision of IT and technology services for general practice, and a specific **£45 million** multi-year programme to support the uptake on online consultation systems;
- through **setting new core requirements** – making it clear what general practice should be able to expect from IT services, and creating a new framework to assess progress – the Digital Primary Care Maturity Index; and
- through **national enabling work** – to both stimulate the development of the supplier market, and provide certain functions at a national level where that makes sense.

**Core GP information technology (IT) services**
NHS England is introducing a greater range of core requirements for technology services to be provided by vendors to general practice through the CCG-controlled GPIT budget. During 2016/17, services should include:

- the ability to access digital patient records both inside and outside the practice premises, for example, on home visits;
- specialist support including services for information governance, IT and cyber security, data quality, clinical system training and optimisation, clinical (systems) safety and annual practice IT review;
- outbound electronic messaging (for example, SMS) from the practice for direct individual patient clinical communication;
- the ability for patients to transact with the practice through online appointment management, repeat prescription requests and access to their detailed record and test results, with the aim that at least 10 percent of patients will be using one or more online services by the end of this year;
the ability for electronic discharge letters/summaries from secondary care to be transmitted directly into GP clinical systems – from June 2016; and

specialist guidance and advice for practices on information sharing agreements and consent based record sharing – from December 2016.

This will be extended further in 2017/18 with:

- funding for Wi-Fi for staff and patients within practice settings;
- the ability to access data and tools that aid GPs (and local commissioners) in understanding and analysing demand, activity and gaps in service provision allowing effective planning, resourcing and delivery of practice services - from June 2017;
- a national framework for the cost-effective purchase of telephone and e-consultation tools - from December 2017;
- funding to support education and support for patients and practitioners to utilise digital services to best effect and impact - from December 2017; and
- enhancements to the Advice and Guidance platform on the e-referral system to allow two way conversations between GPs and specialists, alerts to let GPs or other practice support staff know when a response (or no response) is received, interoperability with the clinical software system, easier conversion from advice to referral where clinically necessary, and decision support tools to help direct referrals correctly.

Each locality is different with its own mix of demographics, service pressures, commissioning priorities, and local relationships. So, in addition to funding for core GPIT services, CCGs will also have access to funding for subsidiary technology services to support their GP practices. Over time, some of these local investments may become core service offerings once adoption becomes widespread and benefits evaluated. These will include technologies and digital tools:

- to help practices operate collaboratively, such as shared care planning, or telephone and appointment management systems;
- to help practices in becoming more efficient (for example, reduced printing and filing of paper records, online ordering of diagnostic tests); and
- to join up pathways between different healthcare sectors and professional groups, for example, pharmacists.

At a national level, NHS England will continue with its programme of work that supports this direction of travel. This includes:

- the development of online access for patients to clinical triage systems to help patients when they feel unwell;
- the development of an approved Apps library to help GPs to recommend apps that might best suit patients’ needs and where there is evidence of clinical efficacy; and
- a range of technology initiatives to drive towards improved practice efficiency and a paper-free NHS by 2020:
  - increase uptake of the electronic prescription system (EPS) and training for batch prescribing;
  - increase electronic transfer of records between practices
  - improve remote data extraction to reduce manual processes;
• access to summary care records in community pharmacies;
• accelerate access to patient records across different services;
• interoperability of different clinical software systems;
• automation of tasks and appointment software to help match appointment supply to demand.

To stimulate the uptake of new technologies, NHS England will be clear that practices can bid for additional technology resource as part of the Estates and Technology Transformation Programme.

In addition, from 2017/18 NHS England will launch a new programme to offer every practice in the country over the coming years support to adopt online consultation systems. Depending on uptake, there will be up to £45 million extra investment to support this.

Building on the successes of existing procurement approaches, future primary care digital services will be available through a national accredited catalogue with national and regionally negotiated buying frameworks, supported by a network of local procurement hubs offering advice and guidance.

We expect practices and CCGs to work closely together to realise the benefits of this approach and to exploit the opportunities of collaboration through GP federations, locality footprints and local procurement hubs. A new system for measuring the maturity of digital primary care will help CCGs improve commissioning.

NHS England has also published an overarching Interoperability Strategy that enables information sharing, based on Open Application Interfaces (APIs) using open industry standards (HL7 FHIR) and underpinned by key digital standards (the GP Connect project). The standards prioritised will:

• support federated practices by enabling appointments in one practice to be booked from another or an administrative hub using different clinical systems; and
• let healthcare professionals from different settings inform and update a practice through the sending and management of tasks.

NHS England will work with professionals to ensure that these standards on interoperability and control of patient data will become embedded in the minimum standards required for accreditation of future digital primary care systems. NHS England and HSCIC will work with the supplier market to create a wider and more innovative choice of digital services for practices, helping them to improve the way they work and the care they deliver.

The forthcoming publication of the National Data Guardian’s review of data security and consent/opt-outs will support GPs by clarifying data security standards, resolving issues around data flows, and proposing a new model for data sharing.

Practices have identified that one way of doing this is to assist patients in managing a greater proportion of their minor self-limiting illnesses for themselves by using online resources. We will therefore use some of the funding for workforce and technology, outlined elsewhere in this document, to support practices in doing so.
Redesign of space to enhance capacity for clinical consultation - St Helen’s, Merseyside

NHS England has provided a £63,790 contribution to support the development of St Helens Rota, Albion Street. The development, which included an extension to the existing building, will allow the practice to create an additional consulting room plus additional office / meeting room space.

The project will also create an additional Skype triage room within the current patient waiting room. This will allow clinicians to undertake more urgent care such as children’s clinics and general clinics especially during the day-time, for example, in hours, particularly during times of increased winter demand, when urgent care services such as A&E are under most pressure.

Major expansion to practice buildings offering a wider range of treatment areas and access to care - New Hayesbank Surgery, Kennington

NHS England funding is being used to fund a major extension of the practice building, adding seven clinical rooms, a theatre for minor operations, along with recovery rooms and a larger reception area. The additional treatment areas will enable the practice to offer more appointments and provide more vital local treatment. Building work started in November 2015 and the new premises are to be open to patients later in 2016.
Digital services - Modality

Modality MCP, recognising that Birmingham has the highest proportion of smartphone users in the UK and that more than 80 percent of people make transactions on broadband, developed an app through which people can book appointments, send messages to clinicians and provide real-time feedback.

Individuals with long term conditions who previously might have attended A&E at the weekend and been admitted to hospital are often now able to avoid a crisis by ‘sending a quick message to their doctor’.

Modality’s call centre handles up to 1,300 calls per day, with most patients now given advice or treatment without visiting a surgery. Around 90 percent of both Skype consultations and call-backs by GP partners are closed without a surgery visit. Salaried GPs and advanced nurse practitioners close nearly half of their telephone consultations in the same way.

Modality’s work to improve access has seen:
- a 72 percent fall in ‘did not attends’ (because fewer patients book well in advance as they are confident of speaking to a clinician when they need to)
- the ability to meet increases in demand within existing resources
- average remote consultation times falling to under five minutes
- 70 percent of patients say the new system has improved access
- 100 percent of clinicians agree they would not go back to the old system.
‘My Healthcare’ - Birmingham South and Central

My Healthcare is extending GP opening hours and reshaping how over 120,000 patients, from 23 practices, access health services. The scheme joins up primary care, community based services and urgent care providers, including local walk in centres, via a single point of contact. Services can be accessed and delivered physically and virtually through a hub system, across three sites, seven days a week, from 8am – 8pm by a multi-disciplinary team, including an advanced nurse prescriber, GPs, community nurses, pharmacists, a roving doctor and an out-of-hours doctor.

Using digital technologies (once patient consent is obtained), clinicians working within any hub, have access to patient records from all of the member GP practices. Interoperability, across the system, enables staff to access clinical records and send an electronic summary of the consultation to the patient’s registered practice, enabling continuity of a fully informed healthcare record. With a variety of choices for patients, including booking appointments and ordering prescriptions online and telephone or video consultations, the services suit different lifestyles, health needs and personal circumstances.

A roving doctor service, designed to see patients within two hours of contacting their GP, has helped reduce the number of patients needing emergency care. The service, triaged by an on-call GP, is for patients who need a home visit but are not at the point of needing hospital care. This model of service delivery, when in full operation, is expected to create over 90,000 additional appointments per year, with no patient in the area being more than three miles from a hub.

Other future improvements will include a click and collect prescribing service for prescriptions and a lifestyle app to help GPs gain a holistic view of patient health. Patients using the app will benefit from video consultations via the app, instant messaging, a symptom checker, and feedback to/from patients. Patients and clinicians who have used the service have provided positive feedback. NHS Birmingham South and Central CCG has already commissioned two extra hubs, in response to the success of My Healthcare so far. The CCG is now working to expand the scheme to include all of its 55 member practices.
Chapter 5: Care redesign
We will provide a major programme of improvement support to practices

Support to strengthen and redesign general practice:

- Commissioning and funding of services to provide extra primary care capacity across every part of England, backed by over £500 million of recurrent funding by 2020/21. This forms part of the proposed increase in recurrent funding of £2.4 billion by 2020/21.
- Integration of extended access with out of hours and urgent care services, including reformed 111 and local Clinical Hubs.
- £171 million one-off investment by CCGs starting in 2017/18, for practice transformational support.
- Introduction of a new voluntary Multispeciality Community Provider contract from April 2017 to integrate general practice services with community services and wider healthcare services.

A new national three year ‘Releasing Time for Patients’ programme to reach every practice in the country to free up to 10 percent of GPs’ time.

- Building on recent NHS England and BMA roadshows, spread the best innovations across the country, helping all practices use 10 High Impact Actions to release capacity.
- Learn from the GP Access Fund and vanguard sites to support mainstreaming of proven service improvements across all practices.
- Fund local collaboratives to support practices to make implement new ways of working.
- Provide free training and coaching for clinicians and managers to support practice redesign.
Support to strengthen and redesign general practice, including delivering extended access in primary care

Public satisfaction with general practice remains high, but increasingly, we are seeing patients reporting more difficulty in accessing services. We know that many practices report that they would like to offer better access, but that they are experiencing increasing pressure and are having difficulties in offering their patients timely appointments. This is frustrating for practice staff, and for patients alike.

NHS England will provide additional funding, on top of current primary medical care allocations – over £500 million by 2020/21 - to enable CCGs to commission and fund extra capacity across England to ensure that by 2020, everyone has access to GP services, including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services.

So how is this achievable at a time of such challenge to general practice?

Of course, good access is not just about getting an appointment when you need it. It is also about access to the right person, providing the right care, in the right place at the right time. Experience from the £175 million investment over the last two years in the GP Access Fund sites covering 18 million patients has demonstrated that enhanced access relies on working across providers and redesigning the way services are delivered, working with patients and making best use of four key elements:

- enabling self-care and direct access to other services, for example, online self-management and signposting to other services;
- better use of the talents in the wider workforce, such as advanced nurse practitioners, clinical pharmacists, care navigators, physiotherapists and medical assistants;
- greater use of digital technology, for example, apps connecting patients to their practice, phone and email consultations, webcams links with care homes.

- working at scale across practices to provide extended access collectively, in a similar way to how many GPs currently collaborate within GP co-operatives to provide out of hours care. These services are often called Primary Care Access Hubs and offer additional clinical capacity across a group of practices. Patients are referred there by the local practices, often after some degree of triage process to ensure they are suited. They are then seen and managed at the hub, often by a local GP or nurse, with the benefit of access to the patient’s medical record.
We will now build on the lessons learned from the GP Access Fund schemes to support CCGs in commissioning additional capacity more consistently across the country, and in developing closer links with urgent care and out-of-hours services. Done well, this can lay the foundations for transforming the way in which other general practice and community services can be delivered collectively too.

We have set out below some of the key questions raised.

Who will be responsible for commissioning and providing these services?
CCGs, working in conjunction with their urgent and emergency care networks, will be responsible for commissioning these services to expand capacity. CCGs will be required to ensure that this extra investment in general practice dovetails with plans to develop a single point of contact to integrated urgent care and GP out of hours services, accessed through a reformed 111 service.

In addition, we will be seeking more joined-up services, for instance, hubs hosting GP out of hours bases, community nursing teams and greater access to diagnostic services. CCGs will be required to meet minimum requirements before accessing the additional funding.

Does this mean every practice will have to open at evenings and weekends?
Delivering improved evening and weekend access is not about every GP or every practice nurse having to work seven days a week. Nor does it mean that every practice in the country needs to be open seven days a week. It will mean that groups of local practices and other providers will be offered the funding and opportunity to collaborate to staff improved in and out of hours services.

The provider could be a Federation if local GPs decide to express interest. It could also be a mix, for example, a Federation supplying additional capacity on weekdays and Saturdays, with an existing urgent care organisation providing pre-bookable GP appointments on a Sunday.

Who decides what the service looks like?
The balance of pre-bookable and same-day appointments, and the level of capacity required on different days of the week, will be up to individual commissioners and schemes to determine in light of patient demand in their area and to ensure best value for money.

There will be some minimum requirements and these will be published later in the year. They will be tested with the current GP Access Fund sites during 2016/17, ahead of further roll out to more parts of the country in 2017/18 and years beyond.

How will it be rolled out?
Waves of increasing recurrent funding will be made available each year, linked to CCG plans, to support the overall improvements in general practice. This phased increase in investment is designed to match the planned growth in the workforce.

What support will there be?
This document sets out a range of national action to provide support to practices over the coming years, whilst the core funding for general practice increases. In addition, NHS England will ask CCGs to provide £171 million of practice transformational support.

This is designed to be used to:
• stimulate development of at scale providers for extended access delivery;
• stimulate implementation of the 10 high impact changes in order to free up GP time to care;
• secure sustainability of general practice to improve in-hours access.
CCGs have a responsibility to ensure a balanced financial position, and will want to target investment in practice support where it can have most impact.

**What does this do to my existing workload?**
Offering a greater range of evening and weekend appointments, for example, through a local access hub, should improve overall patient flow and help reduce avoidable demand across the system. GP Access Fund areas are already reporting improvements and the intention is that all practices will benefit from this reduction in workload as they are rolled out.

It is vital that alongside extending hours we also strengthen in-hours services. In addition to improving local appointment capacity, there will be investment in online resources that will help patients self-manage, for example, more self-help content on NHS Choices, online consultations and 111 Online, which is currently in development. As part of the review into urgent and emergency care there will also be a step change in the 111 phone service.

**A new Multispeciality Community Provider (MCP) contract**
Through the actions in this document we aim to sustain, renew and strengthen general practice. The MCP model is a fundamental element of this plan, currently being developed by 14 MCP vanguards across the country.

Today the range of services funded within general practice owes much to history rather than optimal working arrangements for GPs or patients.

**The MCP model is about creating a new clinical model and a new business model for the integrated provision of primary and community services, based on the GP registered list, but fully integrating a wider range of services and including relevant specialists wherever that is the best thing to do, irrespective of current institutional arrangements.**

At the heart of the MCP model, the provider ultimately holds a single whole population budget for the full breadth of services it provides including primary medical and community services.

Armed with that larger budget and the flexibility to deploy it, the job of the MCP is to focus on better population health management, to suit different groups of the population, and get away from the treadmill of the ‘one size fits all’ 10 minute consultation followed by outpatient referral or prescription. This means:

- a stronger focus on population health, prevention, and supporting and mobilising patients and communities;
- more integrated urgent care as part of a reformed urgent and emergency care system;
- integrated community based teams of GPs and physicians, nurses, pharmacists, therapists, with access to step up and down beds, in reach into hospitals, for example, redesigning outpatients, geriatric care, and diagnostics as part of extended community based teams.

NHS England will shortly publish the MCP Care Model Framework and contract elements describing the emerging model options in more detail. Six local healthcare systems are working intensively with us to complete the design of the contract, with the aim of going live, on a voluntary basis, in April 2017.
We are working through the legal, contractual and payment options, but anticipate that key features are likely to include:

- the MCP defined as an **integrated provider** not a form of practice based commissioning or total purchasing. Its scope is the services it will itself be providing, not all acute and specialised services;
- **a choice of different organisational forms**, for example, a community interest company, LLP or joint venture with a local trust. Some GP federations, working with partners, may well want to become MCPs and explore this as part of the work CCGs are leading within the STP process;
- a new payment model based on combining all the existing relevant budgets within the MCP service scope;
- a new blended pay for quality and performance scheme that **replaces CQUIN and QOF at MCP level**, with the ability for the MCP to flex its own internal arrangements according to local circumstances and the arrangements it makes with its constituent clinicians;
- depending on the degree of integration of existing practices, there will be an ability for some activities/requirements currently at practice level to be performed at MCP level, including potentially elements of CQC inspections;
- NHS England will develop a model procurement process and criteria for commissioners to let MCP contracts, with a funding model dependent on the number of patients on the registered list of the practices within the MCP; and
- **new employment and independent contractor options** for MCPs to offer clinicians, whether GPs or others, including equity partnership or salaried roles. These could be instead of existing GMS or PMS, with the right for existing GMS or PMS practices either to hold a ‘dormant’ contract that can be reactivated, or a right to return. Moving ‘off’ GMS or PMS contracts to new arrangements within an MCP will be entirely voluntary.

**Working at scale**

The majority of GP practices are now working in **practice groups or federations**. We are seeing that these can have benefits for patients, practices and the wider system:

- **Economies of scale**: practices can create common policies and procedures once, sharing the work between all members. They can also combine their purchasing power to achieve best value.
- **Quality improvement**: some federations are becoming a focus for sharing professional development, clinical governance and service improvement, and are building in-house expertise to benefit all practices.
- **Workforce development**: many are also providing new opportunities to train and support staff, improving resilience and enabling new ways of working.
- **Enhanced care and new services**: the GP Access Fund and vanguard programmes are demonstrating how collaboration at scale makes it possible to improve access, introduce new members of the workforce and provide innovative care in ways that are simply not possible at the level of a single practice.
• Resilience: a growing number of federations are helping practices improve their resilience through sharing back office functions, developing business intelligence systems and creating shared pools of staff.

• System partnerships: establishing a shared identity across practices makes it easier for primary care to have a larger voice in the local health and care system, and facilitates partnership working with other providers. This is key to creating new models of care for the future.

These are welcome developments we wish to see grow in coming years. We will share these examples more widely to ensure that all emerging groups are able to benefit from opportunities to expand services, stabilise practice income and realise the benefits that working at scale offers.

We will continue to ensure that national investment programmes, such as on access and new care models, support the development of at-scale infrastructure.

National three year ‘Releasing Time for Patients’ development programme
For many years, the improvement support offered to other parts of the NHS such as the acute sector has not been matched by equivalent support for primary care.

In 2014/15, NHS England established an initial development programme for general practice, offering support to practices that were part of the GP Access Fund schemes – to enable them to work together, and to introduce new ways of delivering care, such as telephone consultations or different use of other professionals in the general practice workforce. The feedback on this programme from GPs has been positive, with 96 percent reporting that it had a large impact on their ability to lead rapid service redesign.

We want to scale up the offer of support to practices to accelerate change. So in 2016/17 we will establish a new national development programme, available to all practices, with an investment of £30 million over three years.

The main components proposed for the programme are:

• Innovation spread: a national programme to gather and disseminate successful examples and measure impact. This will include support on implementation of the Ten High Impact Actions, and a specific focus on addressing inequalities in the experience of accessing services, where there are national trends.

• Service redesign: locally hosted action learning programmes with expert input, supporting practices and federations to implement high impact innovations which release capacity and improve patient care.

• Capability building: investment and practical support to build change leadership capabilities in practices and federations, enabling providers to improve quality, introduce care innovations and establish new arrangements for the future.
Measuring workload and improvement

Currently it is difficult for practices or commissioners to assess their workload, identify specific priorities for action or track improvements. Creating new tools to measure demand and activity is therefore important to empower practices and monitor progress.

A rapid clinical audit was developed for the ‘Making Time in General Practice’ report which allowed practices to measure appointment demand. We will commission a simple online version of this for all practices, to allow them to identify ways they could reduce pressure for GP appointments and compare themselves with others.

Practices in the GP Access Fund are about to begin testing of an automated appointment-measuring interface to give them detailed information about their activity and how it varies over time. This will help practices match their supply of appointments more closely to demand. We will make it available for every practice from 2017/18.

Ten High Impact Actions to release capacity

1: **ACTIVE SIGNPOSTING**
   - Online portal
   - Reception navigation

2: **NEW CONSULTATION TYPES**
   - Telephone
   - E-consultations
   - Text message
   - Group consultations

3: **REDUCE DNSs**
   - Easy cancellation
   - Reminders
   - Patient recording
   - Read-back
   - Report attendances
   - Reduce ‘just in case’

4: **DEVELOP THE TEAM**
   - Advanced nurse practitioner
   - Physician associates
   - Therapists
   - Medical assistants
   - Paramedics
   - Pharmacists

5: **PRODUCTIVE WORK FLOWS**
   - Matching capacity and demand
   - Efficient processes
   - Productive environment

6: **PERSONAL PRODUCTIVITY**
   - Personal resilience
   - Computer confidence
   - Speed reading
   - Touch typing

7: **PARTNERSHIP WORKING**
   - Productive federation
   - Community pharmacy
   - Specialists
   - Community services

8: **SOCIAL PRESCRIBING**
   - Practice based navigators
   - External service

9: **SUPPORT SELF CARE**
   - Prevention
   - Acute episodes
   - Long term conditions

10: **DEVELOP QI EXPERTISE**
    - Leadership of change
    - Process improvement
    - Rapid cycle change
    - Measurement

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#GPforwardview
Stimulating local support

CCGs have a legal responsibility to improve the quality of care in general practice. A growing number are also focusing on the need for significant provider developments in order to meet the changing needs of their population and address current pressures.

CCGs will need to strengthen arrangements for protected learning time and backfill to enable GPs time and space for development. Many are already providing significant support for practices and federations to redesign care and build more sustainable organisations for the future, but the current provision of support is too patchy. We wish all practices in England to benefit from locally funded development.

CCGs who have already been involved in provider development are finding that three things are most effective: creating space for practices to meet and plan together, through funding backfill; providing expert facilitation to make rapid progress on reviewing options and creating improvement plans; and focusing development on improving care and ways of working before addressing questions of organisational form. CCGs are encouraged to ensure their Sustainability and Transformation Plans contain details of their approach and plans for provider development. NHS England will review these in summer 2016.

Support, consultancy and capability-building for general practices are available from a range of regional and local bodies. We will work with them to ensure that practices and federations have ready access to credible, relevant and high quality support for the full range of their development needs. We will develop frameworks to enable practices to choose the support that is right for them.

This national development programme will be designed in collaboration with practices, professional leaders and improvement experts. Further details, including how federations and practices can join, will be published in the summer.
Same day access - Southern Hampshire

In the Better Local Care (Southern Hampshire) vanguard, four practices have created a Same Day Access Service (SDAS) which pools the same day primary care workload and workforce for the four practices into a single service, operated from a central location at Gosport War Memorial Hospital. The SDAS operates from 8am-7pm, Monday – Friday. Patients call their own surgery and those who require same day advice or care are managed in the SDAS.

Of 5,500 patients referred to the service in its first six weeks of operation, 3,350 (61 percent) were able to have their needs met on the telephone. The remaining 2,150 patients attended a face-to-face SDAS consultation. The face-to-face consultation service is staffed by GPs, emergency nurse practitioners, paediatric nurses and practice nurses.

The initiative has contributed to greater GP availability in the practices; better working conditions for practice staff; longer appointments available for patients with complex needs; and reduced waiting time for routine appointments.

Providing 8am-8pm access to GP services - Morecambe

This involved five pilot practices where patients at all sites have access to a GP triage service between the times of 6.30pm-8pm during the week (above usual offering of until 6.30pm) and 8am-8pm on the weekend.

Both the weekday telephone triage and pre-bookable weekend services are provided at a central site at Morecambe Health Centre, chosen because of its co-location with the same day service (SDS) and the out of hours (OOH) service.

The service is staffed by existing GPs from the participating practices and is supplemented by an Advanced Nurse Practitioner (ANP) at weekends. Since the 8am-8pm service has been operational, an additional 31 hours of non-core GP time has been made available per week to provide both access to GP triage calls or face to face appointments at weekends. Over this period, an additional 16,400 appointments have been made available of which 79 percent were by telephone. Over the Easter bank holiday weekend, over 400 calls were received by the service. Of these, 300 were triaged and resolved and only 5 percent were required to be booked in elsewhere in the system (SDS or their own GP practice for example).
Conclusion

General practice is under pressure. This affects patients, and it impacts on the wider NHS. Yet, given the nature of future health needs, never have we as a country needed great general practice services more.

Implementation
This is a substantial package of investment and reform. What matters now is getting on and delivering it so that practices can start to feel the difference. An advisory oversight group with patients and partners (including the GPC and the RCGP) will steer the implementation of the measures outlined in this General Practice Forward View. This is a five year programme of work, and it will be important that we continue to learn and respond to changing circumstances.

Overview of measures
Our priorities will be:
• investing a further £2.4 billion a year by 2020/21 into supporting and growing general practice services. This represents a 14 percent real terms increase, reversing the decline in general practice funding, and raising the proportion of investment in general practice to over 10 percent of the NHS England healthcare budget. It is likely to grow even further as CCGs shift care and resources into the community;
• supplementing this with a one off Sustainability and Transformation package of non-recurrent investments, totalling over half a billion pounds over the next five years.

The package will include:
• £40 million for a new practice resilience programme starting in 2016/17, and an extra £16 million to provide services for doctors suffering from burn out;
• £206 million for workforce measures to grow the medical and non-medical workforce, including:
  • Major national and international recruitment campaigns to double the growth rate of doctors working in general practice;
  • A new offer to every practice in the country to access a clinical pharmacist – leading to an extra 1,500 pharmacists in general practice;
  • Support for every practice to help their reception and clerical staff play a greater role in signposting patients and handling paperwork to free up GP time;
• Investment in practice nurse development and return to work schemes;
• Investment in practice manager development
• Piloting medical assistant roles; and
• Training and investment for 1,000 new physician assistants, and 3,000 new mental health workers to support practices;

All supported by a network of multi-disciplinary training hubs;

• £246 million to support practices in redesigning services, including a requirement on CCGs to provide around £171 million of Practice Transformational Support and a new national £30 million Releasing Time for Paatients development programme for general practice, to help practice release capacity and work together at scale, enable self-care, introduce new technologies, and make best use of the wider workforce, so freeing up GP time and improving access to services;
• Supporting the increased use of technology backed by both increases in recurrent funding for GP IT, and investment to support the take up of online consultation systems in every practice;
• Adopting an intelligent approach to introducing extended access through flexibilities in delivery of the Government’s access commitment, enabling integration with out of hours provision, the ability for extended access to boost overall capacity and reduce demand in normal working hours, and an understanding that no GP will be forced to open seven days or work seven days;
• Supporting new models of care in vanguard sites, to spread innovative solutions, and the development of a voluntary MCP contract for larger GP groups and community health services;
• Improving the interface between hospitals and general practice, beginning with changes to the NHS Standard Contract from April 2016;
• Continuing to make capital investments, with the estimated likely capital investment over the next five years to reach over £900 million;
• Bringing forward proposals to tackle indemnity costs; and
• Reducing the frequency of CQC inspection for good and outstanding general practices, whilst continuing to protect patients and drive up quality.

Taken together, these measures represent the most far-reaching support offered to general practice in a decade.
Wirral Primary Care Transformational Plan 2016 - 2020

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Foreword

This document sets out Wirral CCG’s vision for a new Wirral Primary Care for 2020, focusing on general practice recognising its key role as the building block for wider system reform and fully acknowledging the wider imperative to integrate the role of pharmacists, dentists, ophthalmologists and other parts of the system into a whole economy integrated service provision model of care.

General practice exists to contribute to preventing ill health, providing early diagnosis and treatment and as a universal service is accessible to all citizens. Primary care provides the first point of contact for people with a health related concern.

Provision of primary care through general practice has been the cornerstone of UK health systems since 1948, the foundation of NHS care provision. The majority of NHS contacts take place within it. GPs and their teams provide care, coordinate care and also commit system resources through prescribing and referral decisions. An important role of primary care clinicians is acting as the patient’s advocate. This involves signposting people who require specialist or additional health support and or coordinating the care of people who have multiple health problems to community, secondary or tertiary health services. The role of UK general practice provision incorporates:

- Improving population health, particularly among those at greatest risk of illness or injury;
- Managing short-term, non-urgent episodes of minor illness or injury;
- Managing and coordinating the health and care of those with long-term conditions;
- Managing urgent episodes of illness or injury;
- Managing and coordinating care for those who are nearing the end of their lives;
- Maintaining independent living.

It is a universal service, providing the first-point-of-access advice, diagnosis and treatment for patients; however UK general practice is facing significant challenge. The financial challenge on the health and social care systems is unprecedented when demand is rising due to more people living longer with multiple long-term conditions. Primary care demand has increased significantly over the last decade.

By 2020 Wirral Primary Care will be described as;

“an integrated, high quality provider of person-centred ongoing care, that meets the health needs of its population, co-ordinating support services to sustain patients in the community and calling upon specialist care for complex health needs”

A new Wirral Primary Care will mean new experiences for patients, new motivation for professionals, and a new sense of health and wellbeing living in Wirral.
Executive Summary

NHS England has requested that all CCGs in England submit a plan by 23rd December 2016 in response to how they will deliver the GPForward View (GPFV) programme locally. Wirral’s plan will allow us to secure multi-million pounds of funding and other additional support to be invested in local General Practice services.

In addition to describing plans to secure the investment from the GPFV programme the plan also describes our preliminary longer term strategic vision for the primary care system.

A Primary Care Transformational Plan Development Group was established in the summer which included representatives from all key local stakeholder organisations as well as patients. The CCG’s Primary Care GP Lead is a member of the group as are senior clinical and managerial representatives from both Wirral GP Federations.

The plan was also on the agenda for the GP Member Forum meeting in November 2016. The outline framework of the plan including the four priority areas was presented and attendees had opportunity for table discussion. Additional engagement opportunities will be made available regarding some of the more local strategic aspects of the plan over and above the bids made for GPFV monies.

Wirral is one of the 20% most deprived unitary authorities in England and life expectancy is 13.1 years lower for men and 10.0 years lower for women in the most deprived areas of Wirral. Rates of alcohol related harm, self-harm, deaths from smoking and levels of physical activity are worse than the England average.

To provide primary care services to this population Wirral currently has 53 GP practices who hold a variety of General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Medical Service (APMS) contracts. During 2016 two emerging GP Federations have been established in Wirral to support practices provide services amongst one other. NHS Wirral CCG is a Level 2 Primary Care Co-Commissioning organisation which entails jointly commissioning primary care services with NHS England.

General Practice services are predominately provided at an individual GP practice level between the hours of 8am and 6.30pm, Monday to Friday. There is also significant variation in operational service delivery and variation of outcomes between individual practices. As a CCG overall GP Referral levels are lower than our RightCare comparator CCGs whilst Non-Elective admission rates are in the majority higher.

In terms of Primary Care workforce Wirral has a General Practice population that is although slightly younger than others still has 27% aged over 55. As 23% are between the ages of 55-64 this gives a strong indication of the likely number of staff who will be retiring in the next 5-10 years. Only 36% of GPs in the CCG are male compared to 51-55% nationally.

In terms of overall numbers of GPs Wirral has 50 per 1,000 compared to the Cheshire and Merseyside average of 51 per 100,000. Wirral has not yet taken widespread advantage of diversifying the primary care workforce such as the use of Pharmacists or Physiotherapists in General Practice.
In regard to primary care estate out of 53 general practice premises, 19 are converted buildings, generally a mixture of residential housing and other commercial buildings. The remainder include purpose built premises with some of the larger sites including those at St Catherine’s Health Centre and Birkenhead Medical Centre both in Birkenhead. Utilisation across community clinical estate is generally poor with rates of less than 50% room utilisation in some instances.

In line with the GPFV our Primary Care Transformational Plan 2016-2021 will be delivered across four priority areas.

1) Care Redesign

We intend to embark on a major primary care transformational programme to reduce unnecessary clinical variation within existing primary care services. In addition we will also commission new ‘RightCare’ out of hospital services with increased integration between existing acute, community, mental health, third sector and primary care services. NHS RightCare will be at the heart of our evidenced based approach to commissioning as we aspire to ensure Wirral is in the top quartile for our comparator CCGs.

Primary, Community, Acute, Mental Health and Third Sector service providers will increasingly work together to deliver integrated services which are geographically ‘place based’ with populations of circa 30-50,000 patients. There will be different tiers of service provision including at a unit GP practice level, new Primary and Community Care (PCC) Hubs and PCC ‘Place Based’ delivery footprints. Some primary care services will operate at different levels depending upon local need.

**Table 1: Wirral Primary Care Service Configuration by 2020/21**

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<td>Community Diabetes Service</td>
<td>A small number of Pan Wirral specialist out of hospital services operated</td>
</tr>
<tr>
<td>NHS RightCare Pathways</td>
<td>Respiratory Diabetes Service</td>
<td></td>
</tr>
<tr>
<td>Care Navigators</td>
<td>Near Patient Testing e.g. Anti-Coagulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS Right Care Pathways</td>
<td></td>
</tr>
</tbody>
</table>

DRAFT
GP practice In reach Community Nursing and Therapy Services

<table>
<thead>
<tr>
<th>Extended Primary Care Workforce Services e.g. Physiotherapists/Pharmacists/Care Navigators/Medical Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub Level Community Nursing and Therapy Services from single delivery sites.</td>
</tr>
</tbody>
</table>

Improved Access to General Practices will be delivered via the introduction of new GP practice unit level access standards (75 appointments per 1,000 patients). In addition new Wirral GP Access hubs in each of Wirral's parliamentary constituencies will be commissioned to provide GP appointments to patients between 6.30-8pm Monday to Friday and on a Saturday between 10am-2pm. Furthermore, new ‘at scale’ primary care services will be commissioned that offer universal services to all Wirral patients such as to supporting patients in care homes.

(2) Workload

The CCG will support GP practices review their own operating models to consider new ways of working which will reduce patient demand on their services. All GP practices will be offered the opportunity to undertake the General Practice Improvement Programme (GPIP) by March 2020. In addition practices will be able to assess, review and apply the relevant Time for Care 10 High Impact Actions (HIA) by March 2019.

To support primary care reform from within new emerging clinical leaders will be supported to undertake the GP Improvement Leaders Programme. This programme will equip clinicians with quality improvement tools as well as leadership techniques.

Components of the Care Redesign and Workforce priority areas of the plan will also be used to reduce the workload on GP practices. For example, investment in Online Consultation software will support reducing demand on GP appointments. Recruitment of extended members of the workforce such as care navigators will allow more patients with non-medical needs to be signposted to more appropriate services.

(3) Workforce

Our primary care workforce strategy aims to ensure we have the necessary workforce in Wirral in order to deliver upon our Clinical Redesign programme objectives. This will entail not only being able to retain existing levels of staff but also develop new roles as we commission a new range of integrated out of hospital services.

The three main areas of our workforce reforms include:

a) Ensuring future supply: Using both local pipelines such as Enhanced Training practices as well as national programmes such as GP Returners scheme to support primary care workforce retention and recruitment.
b) Upskilling the existing workforce: This involves using funding pipelines such as from Health Education North West (HENWW) to enhance the skills and knowledge of the current clinical and non-clinical workforce. We aim to develop a full primary care educational portfolio that offers both mandatory training and the opportunity to learn new skills and competencies.

c) New ways of working: The introduction of new roles within primary care to reduce demand on traditional primary care workforce roles such as GPs and Practice Nurses. These new extended primary care team members may include pharmacists, physiotherapists, physician associates, care navigators and/or medical assistants.

(4) Infrastructure

This priority of the plan includes the necessary infrastructure developments which will act as key enablers for our Care Redesign programme. The four main areas include:

A. General Practice Estate Reform

The Estates Technology and Transformational Fund (ETTF) will be the key enabler to reform our existing primary care estate. This includes the development of full business cases for a range of projects deemed ‘ready to proceed’ including significant estate developments. New premises developments will support the transformation of primary care at scale by creating premises infrastructure that offer a wider range of patient services; co-location with partner organisations; leading to community-based hub services for patients.

In addition further submissions are being made to the ETTF fund for improvement grants to existing premises.

B. New Technologies

Our primary care digital roadmap for Wirral includes the availability of EMIS Remote Consultation software. This technology will allow all practices in primary care to access non-registered patient medical notes if consent is given. The first service to take advantage of this opportunity will be the Wirral GP Access Hubs service in 2017. Other technologies to be rolled out across Wirral’s General practice system include:

a) Electronic Document Transfer to enabler bi-directional referrals and other patient documents between hospital, community and primary care providers
b) Mobile working solution for General practice
c) (COIN) Community of Interest Network, enabling network services together more efficiently such as voice, data and video communications.
d) Online Consultation systems from 2017/18 offering practices an extended range of methods to access the practice.
C. Primary Care Co-commissioning

Our plan is to undertake further engagement with member practices and Wirral LMC in order to secure Fully Delegated (Level 3) Primary Care Co-commissioning status by 2018. The CCG sees this commissioning tool as allowing more local decision making to ensure strategic plans are better aligned with those of the wider health and social care system in Wirral.

D. GP Federations

To allow primary care services to be delivered ‘at scale’ the CCG will support the organisational development of GP Federations. This will include the CCG increasingly commissioning services from groups of practices aligned with our vision for ‘placed based’ service provision. We also expect GP Federations to be able to support GP practices work jointly together in the delivery of their existing GMS, PMS and APMS services.

The CCG intends to undertake further engagement with stakeholders following submission of the plan regarding the wider strategic vision for the primary care system between January and April 2017. From a primary care perspective this will include invitation to interested parties to attend focus groups such as an evening GP development workshop.

The CCG will also work with primary care providers to deploy the GPFV resources secured such as for Reception and Clerical Training, Care Navigators/Medical Assistants, Online Consultation Software, GP Resilience Programme and GP Access services.
Case for Change

Current state national picture

The scale of the challenge faced is illustrated by the following information:

- Primary care provides 90% of NHS contacts with only 9% of the budget
- Consultations in general practice increased by 75% between 1995 and 2009
- There has been an increased clinical workload in general practice of over 40% since 2008 with evidence of:
  - Increasing disease prevalence and diagnosis
  - More patients dying at home
  - Patients living longer with disease

There has been a growth in new technologies, enabling patients to have greater access to information and therefore involvement in their care and new innovative treatments (medicines and therapies) that enable patients to be cared for at home or close to home.

These together with a number of other factors are driving primary care transformation and include:
- Increasing patient expectations
- Increasing demand for GP appointments
- Increasing pressure for general practice to resume responsibility for out-of-hours care
- Increasing workforce pressures, such as ageing workforce, insufficient trainees to meet future need and demands on GP time to support clinical commissioning.

The vast majority of people in Wirral are registered with a local GP. Most people will see their GP 8 times a year. The GP record is the only place where all of an individual’s health data is coordinated, thus containing the best potential to deliver integrated and coordinated care.

General Practice is best placed to be the cornerstone of health system reform, to deliver care coordination and preventive public health approaches, complex case management, and to manage effective utilisation of medicines and referrals for the system.

The strategy also recognises the need to invest in primary care in order to shape the structure of system supply towards the national aspiration of care closer to home as primary care continues to experience substantial increases in the number of appointments required, the complexity of presenting problems, plus associated workforce and economic pressures.

New models of care will be developed to meet these challenges. The formation of general practices, offering primary care at scale, improving the resilience of primary care provision, will create a strong, transformed Wirral Primary Care, better able to sustain standards of a high quality service within a complex health system and rising demand from patients.

The Primary Care workforce is subject to problems of recruitment and retention. In England, between 2003 and 2013, nationally, the number of hospital consultants increased by 48% compared to just 14% increase in the number of GPs (Primary Care Workforce Report, HEE, 2016). Primary Care needs to change by having a stronger population focus and an expanded healthcare professional workforce.
The development of new types of roles such as physician associates and having different roles available within general practices such as clinical pharmacists and prescribing paramedics, will support the rising demand from patients on primary care services.

Health economy context

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

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

The older population (aged 65 years and above) are expected to increase at the fastest rate (than any other age group) over the next decade; between 2012 and 2022 it is estimated that this population group will have increased by 17.4%.

The population aged 85 years and above is projected to increase from 8,600 in 2012 to 11,400 in 2022, which equates to a 32.6% increase.

The biggest decrease is in the 40-49 year age group, from 46,400 in 2012 to 36.3 in 2022 which equates to a 22% decrease.

Births reached a 15 year high in 2014.

Health in summary – Wirral Health Profile 2016 (JSNA)

The health of people in Wirral is varied compared with the England average. Wirral is one of the 20% most deprived districts/unitary authorities in England and about 23% (13,100) of children live in low income families. Life expectancy for both men and women is lower than the England average.
Health inequalities - Life expectancy is 13.1 years lower for men and 10.0 years lower for women in the most deprived areas of Wirral than in the least deprived areas.

Child health - Children and Young People under the age of 20 make up 23.3% of the population of Wirral. 7.3% of school children are from a minority ethnic group. 19.6% (645) of children are classified as obese; 9.3% of children aged 4-5 years and 19.6% of children aged 10-11 years are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 61.2 per 100,000, worse than the average for England. This represents 41 stays per year.

Levels of teenage pregnancy and breastfeeding initiation are worse than the England average. Levels of GCSE attainment are better than the England average.

Adult health - The rate of alcohol-related harm hospital stays is 819 per 100,000*, worse than the average for England. This represents 2,591 stays per year. The rate of self-harm hospital stays is 274.2*, worse than the average for England. This represents 846 stays per year. The rate of smoking related deaths is 320*, worse than the average for England. This represents 641 deaths per year. Estimated levels of adult physical activity are worse than the England average. The rate of sexually transmitted infections is worse than average. The rate of TB is better than average. The rate of early deaths from cardiovascular diseases is worse than average. Rates of statutory homelessness and violent crime are better than average.

Wirral was the 66th most deprived authority (of 326 authorities) in England according to the 2015 Index of Multiple Deprivation (IMD) - the being most deprived, 326 the least deprived – this is an improvement as Wirral ranked 60th in the previous IMD in 2010. This ranking of 66 means Wirral is no longer classified as being one of the 20% most deprived authorities in England. This could mean that relative to other authorities, Wirral has become less deprived, or that other authorities in England have become more deprived (the IMD is a relative Index, areas are always judged in relation to one another, they are not compared historically).

Wirral has a predominance of social demographic groups which are at the polar extremes of the income spectrum, indicating that the differential between people on very low and very high incomes is pronounced within Wirral.

Addressing Variation

Inequality gaps

- Figures from 2016 show that life expectancy continued to widen between the most deprived and least deprived areas. Increase in Wirral
- England also continued to improve however, so the gap between England and Wirral remained
- The gap between men and women is narrowing however, this is a trend which is apparent nationally, as well as locally
- Birkenhead had the lowest life expectancy of the four Wirral parliamentary constituencies; Wirral West had the highest

- Wirral had the widest inequalities in DFLE (Disability Free Life Expectancy) of any local authority in England. Men living in the most deprived areas of Wirral can expect to spend 20 more years of their lives living with ill-health or disability than men living in the most affluent areas. For women, the difference is 17.1 years
- Health inequalities are apparent right across the life course, even before birth. For example, mothers in deprived areas of Wirral are more likely to smoke in pregnancy, more likely to have low birth-weight babies and are less likely to breast-feed
- Lifestyle related issues such as smoking, drinking too much alcohol and obesity all show strong associations with deprivation in Wirral (and nationally) and contribute to health
inequalities. For various and complex reasons, these behaviours are all more prevalent in the most deprived areas of Wirral.

- Those living in the most deprived areas of Wirral have higher emergency hospital admission rates than those living in the most affluent areas

**How do we compare with the rest of our CCG peers?**

NHS Wirral is underfunded for the population it serves by around 2.3%, this equates to £11.4m of resource shortfall.

We have higher levels of residents who are "over 60" and also "over 80" years of age compared to England as a whole and to some of our CCG peers.

We have high rates of disease prevalence in those high cost disease areas most associated with old age such as COPD, cancer and stroke. We also have higher incidence of obesity and diabetes in our population.

**NHS RightCare Programme**

NHS England is investing in this programme to enable every health economy in England to embed the NHS RightCare approach at the heart of their transformation programmes.

It is a programme committed to improving people’s health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources.

NHS RightCare is all about:

- **Intelligence** – using data and evidence to shine a light on unwarranted variation to support an improvement in quality
- **Innovation** – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy
- **Implementation and improvement** – supporting local health economies to carry out sustainable change.
When using NHS RightCare to compare NHS Wirral CCG to other comparable CCG’s two high level observations can be made:

1) Wirral has lower levels of GP Referrals than the NHS England average and all our RightCare comparator CCG’s

![Graph showing GP Referrals Comparison](image1)

2) Wirral has higher levels of non-elective admissions than the majority of our NHS RightCare comparator CCG’s and the NHS England average

![Graph showing Non-elective Admissions Comparison](image2)

Engagement with patients and key stakeholders

**Patients** - As a CCG we are mandated to involve patients in every aspect of the commissioning cycle to utilise their knowledge, experience and understanding of interactions with the healthcare system. There are a number of rich data sources currently managed nationally that can be used to understand patient satisfaction and current primary care outcomes. An example of this would be the national patient survey, this can be used to analyse patient satisfaction trends. These resources will be collated and used to inform outcomes about how services are being utilised across Wirral with regard to primary care.

The Wirral Patient Voice group is one method of face to face involvement that the CCG will continue to build upon as a means of listening and understanding local patients’ service experience and to discuss/debate commissioning intentions, healthcare initiatives and service development. They will remain a direct reporting mechanism into each of our practices patient groups which in turn can convey this commissioning information to wider patient networks.
Patients will continue to be involved in each stage of development and shaping of future commissioning for primary care. It is imperative that a representative cross section of the population is targeted to design future services. We will also be looking to adopt patient champions for specific pieces of work.

The CCG will seek the advice and expertise of HealthWatch Wirral in securing patient experience of commissioned services from primary care and establish regular two-way communication on the implementation and progress of GPFV.

**Key stakeholders**

The current engagement mechanisms between the CCG and its member practices will be consulted upon with practices and the LMC in 2017 to make sure implementation of the GP Forward View (GPFV) and engagement on the financial challenges faced by the CCG, are clearly defined and achievable.

The continued use of regular practice visits to help recognize the ongoing challenges facing member practices will include progress on GP Forward View implementation. Also, use of existing scheduled meetings such as Practice Manager Forum, Practice Nurse Forum and Members meetings will progress the respective components of GPFV.

The Primary Care Operations Group, a sub-committee of the Primary Medical Care Commissioning Committee, will have its role extended to provide oversight to the primary care transformation programme and will involve a broader range of stakeholders.

The emerging GP Federations will play an increasing role in driving forward primary care transformation, particularly at scale solutions for meeting rising patient demand for services. The CCG is committed to developing budgetary mechanisms such as indicative practice budgets to enable GPs to more closely align their clinical decision-making with available resources in the drive for releasing recurring efficiencies back into primary care.

Clinical networking opportunities will continue to be created between Wirral GPs and clinicians from main local providers (Wirral University Teaching Hospitals NHS Foundation Trust; Community NHS Foundation Trust; and Cheshire Wirral Partnership NHS Foundation Trust) to promote positive clinical exchange and insight into dealing with local challenges.

As primary care provision transforms over the next 4 years, so will the commissioning system; in to an integrated health and social care commissioning hub. This will support the direction of travel to accountable care delivery by integrated providers. Wirral Local Authority Social Care commissioners already include Public Health commissioning and through commissioning integration, this will provide the opportunity for an improved whole system approach to securing services from a transformative primary care.

**Action areas for continued engagement and involvement:**

- Targeting a wider representation of patients, including mental health and socially isolated
- Identifying patient champions through various programmes of work with specific regard to commissioning primary medical services
- Ensuring that at least one representative from each Patient Participation Group attend our Patient Voice meetings
- Conducting patient feedback pieces following engagement exercises to understand lessons learnt and how processes can be improved to engage with patients
- Utilise social networks and virtual patient groups
- Engage with Members Council and Wirral LMC to review engagement mechanisms in order to determine a preferred optimum approach that works for member practices
- Develop an annual schedule of clinician to clinician meetings between Wirral GPs and local main provider clinicians
- Inform and update member practices and Wirral LMC on progress of the local integrated health and social care commissioning hub

Primary Care Guarantee

Patients in Wirral should expect to receive a standard of care that is equitable across the borough, irrespective of their practice of choice. All General Practices will continue to achieve nationally set standards, complemented with the development of local initiatives for continuous improvement in the provision of high quality primary care. Access to general practice services will extend to be available at weekends and evenings as part of a normal primary care service, delivered through a number of primary care hubs throughout the Wirral peninsula.

Wirral general practices will provide increasing integrated services to patients, in partnership with other health, social and third sector care providers as part of a health community system-wide approach to managing urgent care services.

Wirral patients will experience the benefits of continuing technological developments within primary care through increased online booking of general practice appointments; electronic prescribing systems extending to improved repeat prescribing arrangements for patients and increased access to personal medical information to aid self-care management, especially for patients living with long-term conditions.
Sustainability and Transformation Plan (STP)

Key challenges faced by the Cheshire and Merseyside (C&M) STP, include:

• high rates of diseases associated with ageing, including dementia and cancers;
• high rates of respiratory disease;
• early years and adult obesity;
• high hospital admissions for alcohol;
• poor mental health and wellbeing; and
• high rates of teenage conceptions.

Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our Communities. At the same time, there are significant pressures on health and social care budgets. Both these issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery.

Primary Care transformation is a fundamental requirement within this complex health and social care system and the resources on offer from the General Practice Forward View programmes are crucial to enabling Wirral general practices to develop alternative, innovative patient care delivery models.
In line with the General Practice Forward View, NHS Wirral's Primary Care Transformational Plan 2016-2021 will be delivered across four priority areas. For each priority area a standardized approach below describes the CCG intentions to realise a new Wirral Primary Care by 2020.

## Our Vision for 2020 – A new Wirral Primary Care

### 1.0 Aim

1.1 We will undertake a major primary care ‘Care Redesign’ programme to ensure the CCG is in the top quartile of our comparator NHS RightCare CCGs.

### 2.0 Current Position: Where are we now?

2.1 Listed below are key characteristics of Wirral’s Primary Care system in 2016.

- a) 53 GP practices each holding their own individual contract (General Medical Services (GMS) / Personal Medical Services (PMS) / Alternative Provider Medical Services (APMS)

- b) Two Emerging GP Federations have been formed to represent unit GP practices as provider groups – Wirral GPW-Fed Limited & Primary Care Wirral Limited.

- c) Contractual opening hours of unit GP practices are mostly 8am – 6.30pm. Some GP practices open outside these hours such as 7am-8am or 6.30-8pm for 1 or 2 days per week funded via a national Enhanced service by NHS England.

- d) A limited number of Locally Commissioned Services (LCS) are available that are over and above GP core contractual requirements including: Anti-Coagulation, Dementia, IUCD, Near Patient Testing.

- e) No ‘at scale’ services are available currently via GP practices and/or GP Federations working together collaboratively

- f) Primary Care has a high patient satisfaction feedback in Wirral of x% compared to England’s average of x% (National annual GP Survey).

- g) No consistent ‘proactive’ primary care service offered to Wirral Care Homes

- h) GP referral rates in Wirral are below our RightCare comparator CCG levels and the England average.

- i) Non-elective admission levels in Wirral are mostly above our RightCare comparator CCG levels and the England average.
3.0 Strategic Objectives: Where do we want to get to?

**Objective:** A Wirral Primary Care offer that meets the clinical needs of patients and fulfils the Primary Care Guarantee by 2020.

**Objective:** New ‘at scale’ primary care services which provide an enhanced, consistent and universal service to all Wirral patients by 2020.

**Objective:** Integrated Primary & Community Care Hubs providing integrated services to patients between 8am and 8pm Monday to Friday and no less than 4 hours access on the weekend by 2020.

4.0 Outcomes: How will we know we have got there?

a. A new range of NHS RightCare services and pathways led by primary care will be available in an out of hospital setting. These will aim to move NHS Wirral to the top quartile range of RightCare CCGs.

b. Unnecessary operational and clinical outcome variation between General Practices will be reduced by setting new primary care standards via Wirral’s Primary Care Quality Scheme (PCQS).

c. GP practices will work together to deliver integrated services geographically based with whole population budgets made available to provide and commission services on behalf of their population.

d. Enhanced Primary Care in ‘Care Homes’ service to deliver a 10% reduction in admissions from care homes from 16/17 baseline.

e. Primary and Community Care Hubs will be operational in each of Wirral’s Parliamentary constituencies providing a new range of integrated community and general practice services.

f. All General Practice providers will provide a minimum of 75 GP appointments with a prescribing clinician per 1,000 patients per week from 18/19. By 2019/20 additional capacity outside of core hours of 8am-6.30pm will be 45mins per 1,000 patients.

g. We will continue to be above the England average for the percentage of patients who rate their overall experience of their General Practice as Very Good or Good (National GP Patient Survey).

h. Reduction in GP appointment demand by (1) Signposting patients to more appropriate alternative services via Care Navigators and Medical Assistants (2) Extended Primary Care Workforce such as Pharmacists and Physiotherapists.
### 5.0 Operational Delivery Plan 2017/18 – 2020/21: When are we going to get there?

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
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</thead>
<tbody>
<tr>
<td><strong>Wirral General Practice Forward View</strong></td>
<td><strong>Primary Care Quality Scheme 2017/18-2018/19 (Year 1)</strong></td>
<td><strong>Primary Care Quality Scheme 2017/18-2018/19 (Year 2) – Includes new GP access standard</strong></td>
<td><strong>Expansion of Wirral Primary Care GP Access Hubs Service (£6 per patient)</strong></td>
<td><strong>New out of hospital NHS RightCare Pathways launched – year 4</strong></td>
</tr>
<tr>
<td><strong>Care Redesign Delivery Milestones</strong></td>
<td>New Wirral Primary Care GP Access Hubs service fully live</td>
<td>New out of hospital NHS RightCare Pathways launched – year 2</td>
<td>New out of hospital NHS RightCare Pathways launched – year 3</td>
<td>New out of hospital NHS RightCare Pathways launched – year 4</td>
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<tr>
<td></td>
<td>New Enhanced Primary Care ‘Care Home’ service</td>
<td>Primary and Community Care Hubs go live</td>
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<tr>
<td></td>
<td>New out of hospital NHS RightCare Pathways launched – year 1 (CVD, Neurology and Gastroenterology)</td>
<td>Expansion of Wirral GP Access Hubs Service (£3.34 per patient)</td>
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<tr>
<td></td>
<td>Extended Primary Care Workforce role out: Care Navigators, Medical Assistants, Pharmacists and Physiotherapists</td>
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</table>
Workload

6.0 Aim
To establish sustainable programmes of practice support and development which enables continuing practice capability to meet demand for patient services.

7.0 Current Position: Where are we now?

Wirral general practices have continued to identify rising pressures in workload through increased patient demand, increased bureaucracy and reporting requirements and transfer of work from hospitals (predominantly test results follow-up; patient contact, and consequence of cancelled hospital treatment leading to further repeated patient contacts), and support issues such as practice payments from Primary Care Support England (PCSE).

The *Making Time in General Practice*" study commissioned by NHS England, Primary Care Foundation, NHS Alliance identified the following areas impacting upon general practice nationally which align with Wirral practices’ experiences and opinions expressed;

<table>
<thead>
<tr>
<th>Most burdensome area for practice</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Getting paid</td>
<td>27%</td>
</tr>
<tr>
<td>Processing information from hospitals</td>
<td>26%</td>
</tr>
<tr>
<td>Keeping up to date with changes</td>
<td>21%</td>
</tr>
<tr>
<td>Reporting other information</td>
<td>18%</td>
</tr>
<tr>
<td>Supporting patients dealing with the NHS</td>
<td>7%</td>
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</table>

‘Getting paid’ has become a much bigger burden since CCGs and local authorities have been commissioning services from practices, and that the use of different systems for reporting, claiming and reconciliation has exacerbated this. They also highlighted ways in which the Command and Query Responsibility Segregation (CQRS) system for automated processing could be improved to reduce manual workload.

The next biggest burden related to processing incoming information from hospitals. Here, the use of paper based communication in a wide variety of different formats was reported to place a burden on practices, where structured electronic medical records are used.
The third issue was **keeping up to date with changes in the health and care system**. Here, interviews indicated this relates chiefly to information sent by national bodies, especially NHS England, and that there are particular challenges in later trying to retrieve information sent by email, letter or via a bulletin.

The fourth most burdensome issue was **reporting for contract monitoring or regulation**. Here, interviews revealed frustration caused by multiple requests for similar information, sometimes from different teams in the same organisation, often at very short notice (eg 24 or 48 hours), and often formulated in ways which differed from how the information was stored. NHS England and Care Quality Commission (CQC) were described as frequently asking for information about the same aspect of the practice, but in different ways, at different times, and in a series of requests rather than a single one.

**Processing information from other providers** comprised a significant proportion of administrative time, and practices reported this has increased in recent years. Supporting patients to **navigate the health and care system** was also an area where practice workload was increasing.

### Causes of potentially avoidable GP consultations

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Unavoidable</td>
<td>74%</td>
</tr>
<tr>
<td>Other in practice</td>
<td>7%</td>
</tr>
<tr>
<td>Self care/pharmacy</td>
<td>6%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>3%</td>
</tr>
<tr>
<td>Sick notes/appeals</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
<tr>
<td>Care navigation</td>
<td>3%</td>
</tr>
<tr>
<td>Organisation in practice</td>
<td>2%</td>
</tr>
</tbody>
</table>

The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the clinical commissioning group (CCG). The biggest three categories were where the patient would have been better served by being directed to **someone else in the wider primary care team**, either within the practice, **in the pharmacy** or a so-called ‘wellbeing worker’ (e.g. care navigator, peer coach, health trainer or befriender).
Together, these three, which could be improved by more active signposting and new support services, accounted for 16 per cent of GP appointments. An additional 1 per cent were to inform a patient that their test result was normal and no further action was needed. A further 1 per cent of appointments would not have been necessary if continuity of care or a clear management plan had been established.

The second most common issue lay within the control of hospitals. Demand created by hospitals accounted for a total of 4.5 per cent of appointments. The largest category, creating 2.5 per cent of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment, or a patient failing to attend an appointment, necessitating an entirely new GP referral). The other, creating 2 per cent, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care.

8.0 Strategic Objectives: Where do we want to get to?

Objective: All general practices to have completed the General Practice Improvement Programme by March 2020;

Objective: All general practices to assess, review and apply the relevant Time for Care High Impact Actions (HIA) that releases capacity within their practices by March 2018.

Objective: Minimum 10 Improvement Leaders identified from practices by 2018 through the General Practice Improvement Leaders (GPIL) programme to help develop and support continuous quality improvement processes across primary care

9.0 Outcomes: What do we want to deliver?

- Reductions in hospital activity for high volume user patients are within the top quartile range of our RightCare comparator CCGs by 2020

- Wirral-wide Capacity and Demand Plan for primary care by 2018 that illustrates a flex ability to meet fluctuating patient demand within assigned resources;

- Adoption of standardised approach to peer review across primary care by 2018 for reducing (but not absolutely removing) variation between clinicians;

- Implementation of workplace systems within practices by 2019 to maximize time and communication and reduce completion time of tasks

- Primary Care Continuous Improvement Champions within practices to lead the ongoing application of business quality improvement processes at both practice and scaled up levels.
## Operational Delivery Plan 2016-2020: How are we going to get there?

<table>
<thead>
<tr>
<th>Year</th>
<th>Releasing Time for Care:</th>
<th>Time for Care:</th>
<th>GP Resilience Programme:</th>
<th>Building capability for improvement (GPIL):</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>Increase take-up by practices in General Practice Improvement Programme (GPIP) – 26 completed in 16/17 Additional 10 practices in 17/18</td>
<td>First cohort of practices to implement 10 High Impact Actions – Phase 1 - 15 practices</td>
<td>Practices identified as needing support to access central programmes</td>
<td>Identify up to 5 general practice staff to undertake cohort 1 GPIL programme to become QI champions</td>
</tr>
<tr>
<td>2018/19</td>
<td>Increase take-up by practices in General Practice Improvement Programme (GPIP) – 36 completed in 17/18 Additional 10 practices in 18/19</td>
<td>Second cohort of practices to implement 10 High Impact Actions – Phase 2 - 20 practices</td>
<td>Practices identified as needing support to access central programmes</td>
<td>Identify up to a further 5 general practice staff to undertake cohort 2 GPIL programme to become QI champions</td>
</tr>
<tr>
<td>2019/20</td>
<td>Increase take-up by practices in General Practice Improvement Programme (GPIP) – 46 completed in 18/19 Additional 8 practices in 19/20</td>
<td>Final cohort of practices to implement 10 High Impact Actions – Phase 3 - 18 practices</td>
<td>Practices identified as needing support to access central programmes</td>
<td>Design and implement local Improvement Plan led by local GPIL-trained practice champions</td>
</tr>
<tr>
<td>2020/21</td>
<td>Review impact of GPIP across general practices to determine future support programme</td>
<td>Review impact of the 10 HIA across general practices to determine future support programme</td>
<td>Identify CCG resources for ongoing practices resilience support</td>
<td>Review impact of GPIL across general practices to determine future support programme</td>
</tr>
</tbody>
</table>
Workforce

10.0 Aim
11.0 To have a detailed understanding of the “out of hospital” workforce, in order that the CCG can plan and deploy workforce and education investment into primary care.

12.0 Current Position: Where are we now?

Health Education North West undertook a workforce data capture exercise with Wirral general practices in 2016; 63% of NHS Wirral CCG practices responded to the survey, covering close over 600 general practice staff (headcount) and the main points identified through the analysis are:

13.0 Pressure on an ageing workforce: The age profile of the general practice workforce across NHS Wirral CCG is slightly younger than that of the region and North West. Despite this, an important consideration is that 27% of the total workforce are aged over 55, with 23% aged between 55 and 64, which gives a strong indication as to the proportion and number of staff who will be retiring in the next 5-10 years. The figures also emphasise the disproportionate age of general practice staff compared to the population.

Gender split. The gender split across NHS Wirral CCG is broadly consistent with both the regional (Cheshire & Merseyside) and North West position, with females accounting for more than 4 in 5 of the total workforce. There are typically very small numbers (<10%) of males working in general practice, other than in GP roles. 36% of GPs in the CCG are male, which is notably low compared to regional and North West averages (51-55%). Nationally this split is changing as male GPs are generally older, as also seen at NHS Wirral CCG where 38% of male GPs are over the age of 55 compared to 13% of female GPs.

Profile of staff: Administrative and managerial staff form the largest staff group, accounting for 56% of all FTEs across NHS Wirral CCG, comparable to the geographic averages. The next largest staff group are GPs, who account for 23% of all FTEs, which is also about average. Nurses and DPC (direct patient care) staff make up the remaining percentage, where the proportion of nurses is slightly higher than regional, North West and national averages. These values are, however, only indicative of staff type ratios relative to each other and not of actual volumes of staff in post (per head of population).

Staff rates per 100,000 people: When considered per head of population NHS Wirral CCG has an about average number of all staff types compared to geographic averages. Practices across the CCG have a rate of 50 GPs per 100,000 people, which is slightly below the regional average of 51 per 100,000, North West average of 56 per 100,000, and the England average rate of 60 per 100,000. When registrars and retainers are excluded, the CCG and region values move relatively little compared to the North West, suggesting a lower use of these staff.

The rate for nursing staff is on a par with averages for the region, North West and England (25 vs. 23-27 per 100,000). DPC staff (9 vs. 9-16 per 100,000) and admin staff levels (114 vs. 110-113 per 100,000) are also about average.
Participation – part-time working: NHS Wirral CCG have a marginally higher proportion of general practice staff working part-time hours (55% vs 53% regionally and 53% across the North West). Taken in isolation, a higher proportion of GPs also work part-time hours (52% versus 44% regionally and 45% across the North West). A gender bias is also evident across NHS Wirral CCG where 58% of female GPs work part-time, compared to 40% of male GPs.

When participation is considered alongside age, a strong pattern emerges. Across all roles, the proportion of staff working part-time typically increases with age. Across the North West the degree of part-time working increases from 55% for those aged over 45, to 61% for those aged over 55 and to 79% for those aged over 65. A similar pattern is observed across NHS Wirral CCG where, across all roles, the degree of part-time working increases from 55% for those aged over 45, to 61% for those aged over 55, and 64% for those aged over 65.

Staff retention: Data clearly shows that retirement is not the only reason why people are leaving roles in general practice, with resignation being the most frequent reason. The profile of reasons for leaving across NHS Wirral CCG is similar to that observed across the region and North West.

Clinical skills: NHS Wirral CCG have a similar pattern of reported nursing clinical skills to geographic averages, although the levels are slightly lower in some cases. The profile of reported DPC staff skills across NHS Wirral CCG is also very similar. As expectations increase about more care being delivered in Primary Care, maintaining the correct level of staff with the right degree of clinical skills will be a challenge faced by all general practices. Although a wide range of clinical skills are evident, typical rates of 30% or less across the region suggests potential to invest in the up-skilling of the existing nursing and DPC workforce at scale, to ensure a minimum core competency and minimise the risk of increasing variation in the next 5-10 years.

Across all workforce areas assessed, NHS Wirral CCG is broadly similar to both the regional and North West average position; however, general practice staff across the CCG are generally younger. A greater than average proportion of GPs across the CCG are female, which reflects a national shift. Typically, female general practice staff are more likely to work part-time, and a higher than average proportion of staff across the CCG do work part-time, including GPs. Average levels of clinical skills are present across the CCG, although remain below 30% suggesting that increasing the levels of skilled nursing and DPC clinical skills across the patch may help to mitigate increasing future demands on general practice.
Strategic Objectives: Where do we want to get to?

Objective: Wirral Primary Care Workforce Strategy by April 2017 detailing trajectory of programme implementation to mitigate impact of general practice staff leaving the service.

Objective: Establishment of a Primary Care Academy to support continuous development of clinical commissioning skills across the primary care workforce in order to enhance the recruitment and retention of traditional and emerging roles within primary care.

14.0 Outcomes: What do we want to deliver?

15.0 Ensuring future supply via;
15.1 Primary care workforce stabilised and increasing recruitment and retention levels across traditional and new roles
15.2 Providing placements for funded Cadet programmes for clinical and non-clinical roles;
15.3 Support “Return to Practice” programme in conjunction with Health Education North West;
15.4 Support the national programme for GP recruitment;
15.5 Respond to the Ten Point Plan for GP recruitment

16.0 Upskilling existing workforce via;
16.1 Support the use of apprenticeships programmes within general practice;
16.2 Support the implementation of the Care Certificate as a set of minimum core competency standards for support workers in health
16.3 Support the Assistant Practitioner programme for general practice;
16.4 Support preceptorship to develop competence and confidence of newly qualified, new to NHS non-medical professionals;
16.5 Support applications to the Core Foundation Programme General Practice Nursing
16.6 Access the HENW CPD and SLA funding streams to support general practices;

17.0 New ways of working via’
17.1 Physician Associates in support of the “New Deal for General Practice”
17.2 Support development and implementation of potentially new or enhanced roles, e.g. medical assistants, paramedics and clinical pharmacists
17.3 Support applications to become an Enhanced Training Practice;
17.4 Learning applied from the Core Skills Framework pilots supported by HENW
17.5 Increasing the workforce planning capabilities of general practice
## 18.0 Operational Delivery Plan 2016-2020: How are we going to get there?

<table>
<thead>
<tr>
<th>Year</th>
<th>Primary Care Workforce Strategy:</th>
<th>Practice Nurse Development Strategy:</th>
<th>Practice Manager Development:</th>
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<tbody>
<tr>
<td>2017/18</td>
<td>Agreed Workforce Strategy by March 2017 for implementation from April 2017 onwards</td>
<td>Implement the Health Education England Practice Nursing national strategy which includes:</td>
<td>Maximise uptake by local practice managers of NHSE Network events</td>
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<tr>
<td></td>
<td></td>
<td>Improve training capacity in general practice</td>
<td>Complete training needs analysis and Development Plan for practice managers</td>
</tr>
<tr>
<td>2018/19</td>
<td>Continued implementation of Workforce Strategy</td>
<td>Continue to implement the Health Education England Practice Nursing national strategy</td>
<td>Review local Development Plan and update if required</td>
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<tr>
<td></td>
<td></td>
<td>Improve training capacity in general practice</td>
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</tr>
<tr>
<td>2019/20</td>
<td>Continued implementation of Workforce Strategy</td>
<td>Continue to implement the Health Education England Practice Nursing national strategy</td>
<td>Refresh local Development Plan based on updated training needs analysis</td>
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<tr>
<td>2020/21</td>
<td></td>
<td>Improve training capacity in general practice</td>
<td>Implement updated Development Plan</td>
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<tr>
<td></td>
<td><strong>Primary Care Workforce Strategy:</strong></td>
<td><strong>Practice Nurse Development Strategy:</strong></td>
<td><strong>Practice Manager Development:</strong></td>
</tr>
<tr>
<td></td>
<td>Review impact and refresh Workforce Strategy</td>
<td>Review impact of national strategy and refresh local action plans for continuing development for practice nursing</td>
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</tbody>
</table>

**Wirral General Practice Forward View**

**Workforce Delivery Milestones**
<table>
<thead>
<tr>
<th>Reception &amp; Clerical Training:</th>
<th>Reception &amp; Clerical Training:</th>
<th>Reception &amp; Clerical Training:</th>
<th>Reception &amp; Clerical Training:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement locally designed Training Plan via GP Federations</td>
<td>Implement locally designed Training Plan via GP Federations</td>
<td>Review impact of locally designed Training Plan and refresh for continuing development</td>
<td>Implement refreshed Training Plan via GP Federations</td>
</tr>
<tr>
<td>Mental Health services for GPs: Promote availability of new NHS GP Health service provided by The Hurley Clinical Partnership via email bulletin/members meetings/practice visits/LMC meetings</td>
<td>Mental Health services for GPs: Continued promotion of the NHS GP Health service at both opportunistic and scheduled contact with GPs</td>
<td>Mental Health services for GPs: Undertake GP satisfaction survey about NHS GP Health service and feedback to service provider</td>
<td>Mental Health services for GPs: Repeat GP satisfaction survey about NHS GP Health service and feedback to service provider</td>
</tr>
<tr>
<td>Undertake GP awareness survey about NHS GP Health service</td>
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</table>
19.0 Aim

To enable transformational programmes delivery by 2020 facilitated through state of the art primary care estate; digital innovation and whole system commissioning responsibility.

20.0 Current Position: Where are we now?

Primary Care Estates

The primary care estate has been incrementally improved over the past ten years, however, in order to meet rising expectations and improvements in health outcomes for Wirral patients, continuing development is required.

CCG Strategic Estates Plan (SEP) developed in conjunction with NHS Property Services (NHSPS) has identified the following high level considerations for primary care;

- Population growth over next 5 years in Wirral Waters (1480 housing units); Suburban Birkenhead (889 housing units); and Bromborough/Eastham (715 housing units)
- Out of 53 general practice premises, 19 are converted buildings, generally a mixture of residential houses and other commercial buildings.
- Conditions surveys (also known as 6 Facet surveys) undertaken for 8 of the 19 converted premises and the key findings can be themed as follows:
  - Asbestos
  - Heating systems
  - Drainage

Detailed practice survey reports are held by respective practices to action recommended areas.

Utilisation across community clinical estate is considered generally poor therefore utilisation studies undertaken for 3 key sites to identify scope for increased clinical capacity across primary care at St Catherine’s Health Centre, Victoria Primary Care Health Centre and Civic Medical Centre. Each site is a combination of primary care delivery and community services delivery. The utilisation studies show;

St Catherine’s Health Centre:-

The building has overall achieved a Fair Category C rating. However with careful management of the building a Category B rating is achievable, as through the analysis of the building wings, the building does have a large amount of peak activity within the Category A-B utilisation.

The St Catherine’s Surgery has low utilisation of a number of administrative rooms although the surgery is a recent formation from two merged practices and the availability of this space for other service provision could assist in increasing the utilisation percentage of the building.
Victoria Primary Care Health Centre:-

The overall utilisation of the whole site is 44.4% and rated a Category C which is a fair rating. However upon investigating the data further fluctuations have occurred which have resulted in achievement of this rating. The findings discovered that two weeks of the assessment month fell within the half term school holidays and registered lower than expected readings in areas which which registered higher readings at other times. The study also discovered there are areas in the building which could be better utilised, certainly within the clinical space on the second floor, as most of Clinical rooms there are vacant. In the whole site there are currently 12 vacant Clinical Rooms. It is important to note however that all buildings should optimally look to reach a Good rating of 60 – 80% Category B.

Civic Medical Centre:-

- Clinical rooms within this practice are very highly utilised; 7 out of the 11 clinical rooms registered between 60 – 80% utilisation
- No available clinical space on the ground floor to accommodate future growth, however the practice does have available space upstairs currently used for library/seminar rooms;
- This may not be an ideal long term solution, however in the short term it could be viewed as an opportunity to cope with the current pressures and possible increase in patient list size due to housing redevelopment in the area.

There are a number of general practices that have expressed their intention to seek new premises by March 2019, therefore the CCG will support the development of business cases for these practices.

In order to support the commissioning of wider integration of service delivery across the Wirral economy, the CCG and partners will complete an economy-wide Strategic Estates Plan to ensure estates utilization is maximized to the benefit of providing the right treatment, at the right time, in the right place.

Potential consideration could be given to improving/updating the general practice estate through strategic practice combinations into existing purpose-built or new build health buildings. Any practice combination will be determined by individual general practices taking that decision.

Digital readiness

Wirral Care Record

The Wirral Care Record is a new confidential digital care record that is being developed as part of the Healthy Wirral Programme which aims to improve clinical outcomes, patient experience and enhance efficiency. The record will contain important information about patient’s health and social care in order to help improve the care provided.

Primary care professionals have completed a Wirral Care Record questionnaire seeking opinion on the benefits and concerns of the Record, to inform its continuing development.
The implementation of the Wirral Care Record will enable the system to:

- Support and enable targeted intervention and prevention and contribute to reducing inequalities and gaps in care, both at an individual Patient/Service User level, and on a broader Population Health basis.
- Enable staff across all organisations to view patients and service users holistically, and have an informed history and relevant information to identify the most appropriate treatment, care and support.
- Improve patient experience by enabling information to be shared, to prevent patients having to tell their story and provide information more than once.
- Streamline processes for front-line staff by reducing and removing the administration burden.
- Enable culture change and true integration, by sharing information and working together across existing boundaries.
- Provide insight and analytics to inform commissioning and resource management for the whole population.
- Inform the changes of the funding and contracting model and future landscape of services.
- Reduce duplication and waste, enable and drive end-to-end service redesign to maximise efficiency and reduce costs. For example, domiciliary carers access to the record will enable them to see if their clients have been admitted to hospital and will prevent them from carrying out an unnecessary visit. Instead they can contact the hospital to inform discharge planning.

Local Digital Roadmap

Our aim for Wirral is to continue to be an exemplar for the use of digital technology to transform the health and care of the local population. The Local Digital Roadmap guidance outlines four national digital themes which will contribute towards delivering these challenges:

1. Paper Free at the Point of Care
2. Digitally Enabled Self Care
3. Real Time Analytics at the Point of Care
4. Whole Systems Intelligence to support population health management and effective commissioning, clinical surveillance and research

Population Health Management

Our ‘unique to England’ model of integrated care, supported by informatics-enabled Population Health, is developed from an emerging and strong evidence base from the development of Accountable Care Organisations in the USA. We aim to learn from this evidence base to implement population health in Wirral enabling us to drive technology to enable proactive approaches to integrated care. As part of the NHS strategy, Wirral will progress with finding new ways of managing population health.

We aim to use technology to enable a transformational shift toward proactively managing the health of a population we have to manage one person at a time. Our citizens will be enabled to take an active role as part of the care team, and our care providers will to come together in clinically-integrated networks to take on the responsibility, and often the financial risk, to deliver the health outcomes for the populations they are serving.
Care Registries

Through the implementation of the longitudinal care record (Wirral Care Record) the CCG will take a targeted approach to the health of the local population. Joint clinical teams have worked in partnership with informatics leads to co-design five “registries” for Respiratory and Diabetes care which are predicated upon the best national, international and local care standards to drive a consistent delivery of high quality care to the local population. These registries have been designed for children and adult cohorts. We have commenced development on the next phase of registries including depression and social wellness. The registries will provide analytics which, when used proactively will drive improved clinical outcomes, patient experience and efficiencies.

Data streams from Primary and Acute Care, quickly followed by Community Care, will flow into the new care record enabling care staff from across the whole economy to view a single version of an individual’s care record for the sole purpose of care-giving. Data streams from Mental Health and Social care services will flow into the care record enabling a whole system view for health care professionals that enable a targeted approach to care planning and outcomes-based commissioning across the triangle of patient need.

- CCG continues to utilise its GP IT contingency budget to maintain and improve the IT assets for primary care use; all primary care computer/servers are less than 4 years old; all general practices are now on the same clinical system (EMISWEB) offering greater interoperability in support of developing integration programmes of work.
- A replacement programme for clinical system servers at each practice will be completed during 2016.
The Primary Care Transformation Fund recommendation by the CCG will include Multiprotocol Label Switching (MPLS) technology solution for the Wirral economy to increase and improved economy-wide connectivity.

Wirral CCG is considering supporting the provision of remote clinical support & decision making capabilities for patients and residents in Care Home settings with the potential to also install the service within general practices allowing them to conduct remote patient reviews as required.

Co-commissioning of Primary Care

The CCG currently undertakes formal joint commissioning arrangements enabling the CCG to locally determine the primary care delivery model and primary care service design in conjunction with NHS England. We now have the ability to utilise our local commissioning knowledge in collaboration with local clinicians and patients to make key decisions around primary care. A Primary Medical Care Commissioning Committee has been established as a sub-committee of the CCG Governing Body as this facilitates the formal governance structure for decision making. Co-commissioning directly integrates with the CCG’s wider commissioning intentions and enables joined up working to truly take place with primary care being at the centre of patient interactions with the system.

Key objectives and benefits of co-commissioning:

- Achievable through planning with local clinicians, commissioners and patients
- Enabling primary care to be aligned to other key commissioning areas i.e. urgent care

- Opportunity to support all aspects of primary care quality improvement (currently operating in silos) and align to future place based planning initiatives
- Tackle local health inequalities and clinical variation

- We can work at scale to agree priorities for General Practice
- Support of federated GP models of working

- Co-commissioning is a key driver in commissioning for outcomes from primary care, acquiring this responsibility enables the CCG to manage this at scale for this sector in collaboration with membership practices.
- Achieve greater consistency of outcomes across local service provision for patients
21.0 Strategic Objectives: Where do we want to get to?

22.0 Objective: An improved primary care estate by 2020 that supports models of care for 7 day service access to primary care and improved capability through technological innovations to increase the functionality of primary care IT systems for patient benefit.

23.0 Objective: Full delegated commissioning rights to the CCG by 2018 to enable whole system commissioning for integrated service provision.

24.0 Objective: Implementation of approved technology projects via the national Estates & Technology Transformation Fund (ETTF), to enhance the digital infrastructure for primary care by 2020.

25.0 Outcomes: What do we want to deliver?

**Estates**

In 2016:
- Completed conditions (6 Facet) surveys on non-purpose built general practices;
- Completed utilisation studies on 3 sites
- Action plan for outcomes of surveys and studies
- CCG submission to Estates & Technology Transformation Fund (ETTF)

In 2017:
- Utilisation studies undertaken for remainder of primary care sites
- Identification of Primary Care Hubs to support economy-wide 7 day access to routine primary care services
- Identification of potential practice combinations and associated business case development
- Review further opportunity from ETTF

In 2018:
- Review further opportunity from ETTF

**Digital readiness**

In 2016:
- Implementation of approved technology bids from ETTF;
  - Software for remote consultations to support 7 day access pilot across primary care
  - Electronic Document Transfer to enable bi-directional referrals and other patient documents to hospital, community healthcare providers
Between 2017-2019:

- Implementation of approved technology bids from ETTF;
  - Mobile working solutions enabling full GP consultations away from practice settings
  - (COIN) Community of Interest Network, enabling network services together more efficiently, converge voice, data, and video communications, and create bespoke solutions to meet primary and community care digital needs.

- Online consultation systems for general practices offering patients an extended range of methods to access primary care services

### 26.0 Operational Delivery Plan 2016-2020: How are we going to get there?

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral General Practice Forward View Estates &amp; Technology Transformation Fund:</td>
<td>Implement approved Technology bids</td>
<td>Implement approved Technology bids</td>
<td>Digital readiness: Continue support/promote use of care registries by member practices</td>
<td>GP Federations: Support assessment of state of readiness of Federation(s) to participate in accountable care delivery</td>
</tr>
<tr>
<td></td>
<td>Develop Outline and Full Business Cases for Estates projects deemed “potential to proceed”</td>
<td>Develop Outline and Full Business Cases for Estates projects deemed “potential to proceed”</td>
<td>Online consultations: Implement agreed online consultation system across all practices</td>
<td>Co-commissioning: Define integrated commissioning approach required to secure integrated service provision.</td>
</tr>
<tr>
<td>Wirral Care Record (Primary Care phase) Digital readiness: Support on-going development and implementation of Wirral Care Record (Primary Care phase)</td>
<td>Online consultations: Implement agreed online consultation system across all practices</td>
<td>Digital readiness: Review progress of Wirral Care Record (Primary Care phase) and support implementation where required</td>
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<tr>
<td>Co-commissioning: Define commissioning intentions for &quot;at scale&quot; services from GP Federations</td>
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<tr>
<td>Support/promote use of care registries by member practices</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td><strong>GP Federations:</strong> Implement 7 Day GP Access pilot</td>
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<tr>
<td><strong>Co-commissioning:</strong> Full engagement plan with member practices and other stakeholders to include learning from neighbouring CCGs already with fully delegated responsibilities.</td>
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<td>Continue support/promote use of care registries by member practices</td>
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<tr>
<td><strong>GP Federations:</strong> Review impact of 7 Day GP Access pilot to inform future commissioning</td>
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<td>Engage with constituent practices of federations about development of GP networks/clusters</td>
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<tr>
<td><strong>Co-commissioning:</strong> Commencement of fully delegated commissioning responsibilities</td>
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### Local capitated amount by year

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<th>2019</th>
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<td>[Notional capitated amount]</td>
<td>£94k</td>
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<td>£175k (notional)</td>
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### Checklist of funding streams

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<thead>
<tr>
<th>Fund</th>
<th>Amount</th>
<th>Timeframe</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice resilience fund</td>
<td>£40 million (£16m in 2016/17, £8m per year for 3 years)</td>
<td>4 years From 2016/17</td>
<td>National programme. NHS England local teams to decide allocations.</td>
</tr>
<tr>
<td>Retained doctor scheme</td>
<td>£76.92 per session per week</td>
<td>3 years 1 July 2016 – 30 June 2019</td>
<td>No additional decision making process. Retained GP and practice must meet criteria to be eligible.</td>
</tr>
<tr>
<td>General Practice Development Programme</td>
<td>£30 million</td>
<td>Expressions of interest cut off August 2018</td>
<td>Expressions of interest submitted to NHS England.</td>
</tr>
<tr>
<td>General Practice Improvement Leader Programme</td>
<td>Free to attend</td>
<td>3 years</td>
<td>Applications to NHS England. 300 places free over the next 3 years.</td>
</tr>
<tr>
<td>Training for Reception and Clinical Staff</td>
<td>£45 million (£5 million in year 1 and £10 million per year over the next 4 years)</td>
<td>5 years 2016/17 – 2020/21</td>
<td>Central funding will be allocated to CCGs on per-head-of-population basis.</td>
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<tr>
<td>Practice Manager Development</td>
<td>unknown</td>
<td>3 years From 2016/17</td>
<td>No information published</td>
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<tr>
<td>Online Consultation Systems</td>
<td>£45 million (£15m year 1, £20 million year 2, £10 million year 3)</td>
<td>3 years From 2017/18</td>
<td>Funding allocated to CCGs. CCGs to be disseminated in the most appropriate way.</td>
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<tr>
<td>New care models funding</td>
<td>unknown</td>
<td>2017/18</td>
<td>Bids from practices with partners to NHS England and NHS Improvement</td>
</tr>
<tr>
<td>Vulnerable practices fund</td>
<td>£10 million</td>
<td>2016/17</td>
<td>NHS England to decide in consultation with CCGs</td>
</tr>
<tr>
<td>Clinical Pharmacists in General Practice</td>
<td>£112 million</td>
<td>unknown</td>
<td>NHS England to decide regional allocations</td>
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<td>NHS GP Health service</td>
<td>£19.5 million</td>
<td>5 years From 2017</td>
<td>National scheme open to all GPs</td>
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<tr>
<td>Estates and Transformation Fund</td>
<td>£900 million</td>
<td>5 years</td>
<td>CCG bids to NHS England</td>
</tr>
<tr>
<td>Prime Minister’s GP Access Fund</td>
<td>£500 million</td>
<td>5 years</td>
<td>National funding provided to CCGs (process unknown)</td>
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</table>

| Total                         | £1.1m | £1.9m |
10 High Impact Actions to release time for care

1: ACTIVE SIGNPOSTING
2: NEW CONSULTATION TYPES
3: REDUCE DNAs
4: DEVELOP THE TEAM
5: PRODUCTIVE WORK FLOWS
6: PERSONAL PRODUCTIVITY
7: PARTNERSHIP WORKING
8: SOCIAL PRESCRIBING
9: SUPPORT SELF CARE
10: DEVELOP QI EXPERTISE
## All Age Learning Disability Strategy 2016-20

### Agenda Item:
4.1

### Public / Private
Public

### Lead Officer/Author of paper
Nesta Hawker, Director of Commissioning

### Contributors
- Paul Wormald
  Commissioning Support Manager
- Norma Currie
  Commissioning Manager

### 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. Ensuring people have a positive experience of care
4. Ensuring people are treated and cared for in a safe environment and protected from avoidable harm

### To approve
The Governing Body is asked to approve the All Age Joint Disability Strategy

### Comments
No additional comments

### Next Steps
The Local Authority and Cheshire and Wirral Partnership Trust will be notified of the outcome of the Governing Body meeting of this paper.

### 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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</thead>
<tbody>
<tr>
<td></td>
<td>There will be no additional resource required; however, the strategy will ensure that services are delivered in line with overall available resources.</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>Value For Money</td>
<td>Does the report consider value for money?</td>
<td>YES</td>
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<tr>
<td></td>
<td>The strategy will seek to ensure that services are delivered within available resources</td>
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<tr>
<td>Risk</td>
<td>Is there a documented risk assessment?</td>
<td>NA</td>
</tr>
<tr>
<td>Legal</td>
<td>Are there any legal implications and has legal advice been obtained?</td>
<td>NA</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>
</tr>
<tr>
<td></td>
<td>To ensure that our plans and programmes of work meet the needs of people locally, the engagement and consultation process was divided into 3 Phases.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Professionals involved in the commissioning and delivery of services for people with learning disabilities.</td>
<td></td>
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<tr>
<td></td>
<td>2. People with learning disabilities and carers (Wirral Mencap survey).</td>
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<td></td>
<td>3. People with Learning Disabilities in day centres</td>
<td></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>YES</td>
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<tr>
<td></td>
<td>Equality and quality impact assessments have been undertaken and there will be no specific impact on protected groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The strategy will explore ways to ensure mainstream activities/services are accessible to people with learning disabilities, in line with Equality Act duties, including those services aimed at preventing or reducing anti-social or offending behavior.</td>
<td></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>YES</td>
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<tr>
<td></td>
<td>We will need to up-skill workforce in order that they are better able to support people with LD in the community</td>
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### Partnership Working

<table>
<thead>
<tr>
<th>Does the report evidence a partnership working in its development?</th>
<th>YES</th>
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<tbody>
<tr>
<td>The report has been co-produced with the Local Authority with the help from service users, advocates, carers and families.</td>
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### Performance Indicators

<table>
<thead>
<tr>
<th>Does the report indicate any relevant performance indicators for this item?</th>
<th>YES</th>
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<tr>
<td>We will be measuring impact against the 9 Core Principles</td>
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### Sustainability

<table>
<thead>
<tr>
<th>Does the report address economic, social and environmental sustainability <em>(should be addressed for new / change projects)</em>?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Strategy has been designed in line with the core principles of the Transforming Care programme, which will support the implementation of the Strategy</td>
<td></td>
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</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>
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### Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960). The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to an x.
If you require any additional information please contact the Lead Officer.
1. INTRODUCTION

This Strategy has been developed between NHS Wirral CCG and Wirral Council in consultation with people with learning disabilities, their families, carers and other key partners and stakeholders.

The All Age Learning Disability Strategy 2016-20 contributes to the wider Wirral Plan which has been developed between all key public sector partners in Wirral and sets out a commitment to work together over the next four years and beyond to achieve 20 pledges for 2020, which includes supporting more people with disabilities to increase their independence, gain access to work, education and volunteering, and to ensure access to good and timely health and care services.

The Strategy aims to address inequalities in society that are often faced by people with learning disabilities and identified following reviews conducted by MENCAP in 2007 and the Winterbourne View inquiry 2012.

The aim of the Strategy is to develop a future model for health and social care based on the principles of person centred care and the promotion of independence and social inclusion. We will work closely together to consider how we best use our resources, and most importantly offer the best services to the population we serve.

The aim is by 2020 to further improve the services we commission, to achieve real measurable and positive outcomes and increase independence and individual wellbeing for people with a learning disability and their carers in Wirral.

2. KEY ISSUES / MESSAGES

The Strategy aims to deliver two key priorities in line with the following ‘Nine Core Principles:

- **Priority One** - People with learning disabilities have a good and meaningful life with the support needed to live in the community:-

  1. I have a good and meaningful everyday life
  2. My family and paid support and care staff get the help they need to support me to live in the community
  3. I can access specialist health and social care support in the community
  4. If I need it I am supported to stay out of trouble
  5. I have choice about where I live and who I live with
People with learning disabilities should have the same opportunities as everyone else to live a
good and meaningful life. For some people to achieve this there may be a requirement for
additional support to ensure that their disability is not a barrier to accessing mainstream
activities, social opportunities and services. They may also need additional support at home to
ensure that they are safe and looked after. Through this priority the aim is to ensure that any
support that is required is provided as early as possible and is person centred to maximise
positive outcomes

- **Priority Two** - People with Learning Disabilities have access to good and timely health and
care services:

6. My care and support is person-centred, planned, proactive and coordinated
7. I have choice and control over how my health and care needs are met
8. I get good care and support from mainstream health services
9. If I am admitted for assessment and treatment in a hospital setting because my health
   needs can’t be met in the community, it is high-quality and I don’t stay there longer than I
   need to.

Evidence suggests that there is high prevalence of obesity and/or long term health conditions
in people with learning disabilities. People with learning disabilities are also three times more
likely to die prematurely when compared to the overall population. It is therefore important that
people with learning disabilities have access to good quality and timely health and care
services in order to improve health outcomes. As part of this priority the aim to increase the
number of people with learning disabilities who have an annual health check to ensure that any
health conditions are identified as early as possible and increase health promotion and disease
prevention programmes.

**Monitoring**

Measures identified within the Strategy and also from the Learning Disability Self-Assessment
Framework (LDSAF) and the Transforming Care Programme (TCP) will be used to determine
whether the we have been successful in delivering against this Strategy. The LDSAF and the
TCP are national programmes that look at evidence of how well we are supporting people with
learning disabilities.

**Next steps**

- This forms part of the wider ‘Transforming Care for People with Learning Disabilities
  Programme’, which is a joint piece of work between the NHS England, the LGA, ADASS, the
  Care Quality Commission (CQC), Health Education England (HEE) and the Department of
  Health (DH).
• If the Strategy is approved, an action plan will be produced based on the high level activity outlined within each of the priority sections. Twice yearly progress against this action plan will be reported to Wirral CCG Governing Body.

10. CONCLUSION

Governing Body is asked to note the report and approve the draft All Age Learning Disability Strategy.

5. 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>All Age Learning Disability Strategy 2016-20</td>
</tr>
</tbody>
</table>

Appendix 1
Please Note:
An EIA is required for the strategy.
A Cabinet report is not required for the strategy, as a number of strategies will be taken to Cabinet one Cabinet report will be corporately produced.

All Age Learning Disability Strategy
2016-20

Draft
Version: 16.4
Date: 13/09/2016
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6.0 Conclusion ............................................................................................................. 15
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8.0 References ........................................................................................................... 16
1.0 Foreword

We are proud to present this integrated strategy for people with learning disabilities in Wirral. Our pride comes from not only having worked together to produce a vision for learning disability services but also from knowing that we have produced this based on the views of people with a learning disability and their carers. We are very grateful for the support of all those who took the time to give their views about the strategy either in person, written feedback or participation in the consultation and engagement process.

This strategy aims to address inequalities in society that are often faced by people with learning disabilities and identified following reviews conducted by MENCAP in 2007 and 2012 and Winterbourne View.

This strategy contributes to the wider Wirral Plan which has been developed between all key public sector partners in Wirral and sets out a commitment to work together over the next four years and beyond to achieve 20 pledges for 2020, one of which is to support more people with disabilities to increase their independence and gain access to work, education and volunteering.

Our aim is to develop a future model for health and social care based on the principles of person centred care and the promotion of independence and social inclusion. We will work closely together to consider how we best use our resources, and most importantly offer the best services to the population we serve.

**Jon Develing** - Chief Officer, Wirral CCG

**Eric Robinson** - Chief Executive Wirral Local Authority
2.0 Introduction

Wirral Local Authority’s All Age Disability Strategy, has been developed in order to deliver on this national pledge, which is about people; ‘of all ages, abilities and backgrounds; it is about all types of disability and how people can be supported to achieve their full potential.’ The All Age Learning Disability Strategy is one of the key strategies underpinning this. This Strategy has been developed between NHS Wirral CCG and Wirral Council in consultation with people with learning disabilities, their families, carers and other key partners and stakeholders.

This Strategy will drive forward planning and decision making for people with a learning disability in Wirral. Throughout the development of this strategy we have considered the impact of the new Care Act (2014) and the new Children and Families Act (2014) on services for people with learning disabilities. It has also been informed by, and will continue to respond to the overarching priorities and principles set out in the documents listed in section 7.

‘The Wirral Plan: a 2020 Vision’ has been developed working alongside key partner organisations in Wirral, with the aim of transforming Wirral to a place where people and businesses thrive. As part of this plan the partnership aims to deliver 20 pledges for 2020; one of which is ‘People with Disabilities Live Independently’:

It is our aim to support more people with disabilities to increase their independence and to gain access to work, education and volunteering

To do this we are listening to people with disabilities to fully understand their needs and aspirations, how to best support them to be ready for work and to access employment opportunities over the next five years

Overall responsibility for delivering this strategy will sit with the All Age Disability Partnership Board.

Our Vision

An individual with a Learning Disability is defined as having ‘a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a significantly reduced ability to cope independently (impaired adaptive and/or social functioning) which is apparent before adulthood is reached and has a lasting effect on development.’

Our joint vision is that;

People with learning disabilities in Wirral live good lives as part of their community with the right support, at the right time, from the right people.

This is challenging given the current economic outlook for public sector organisations and against a background of increasing legislation. We aim to deliver this vision
through joint commissioning and an increased focus on person-centred outcomes for individuals.

As part of this vision we aim to ensure that all people with a learning disability in Wirral have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a suitable home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

Whilst our joint vision remains our focus for the next four years, this strategy builds on progress so far, and seeks to maintain the very positive service developments achieved to date, delivering even better health and wellbeing outcomes for people with learning disabilities and their carers in Wirral.

**Our Approach**

We aim by 2020 to further improve the services we commission, both now and in the future, to achieve real measurable and positive outcomes and increase independence and individual wellbeing for people with a learning disability and their carers in Wirral.

The priorities identified within this strategy are aligned to the ‘Nine Core Principles’ as outlined in the ‘Service Model for Commissioners of Health and Social Care Services’ (October 2015) listed below:

1. I have a good and meaningful everyday life
2. My care and support is person-centred, planned, proactive and coordinated
3. I have choice and control over how my health and care needs are met
4. My family and paid support and care staff get the help they need to support me to live in the community
5. I have a choice about where I live and who I live with
6. I get good care and support from mainstream health services
7. I can access specialist health and social care support in the community
8. If I need it, I get support to stay out of trouble
9. If I am admitted for assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high-quality and I don’t stay there longer than I need to.

This model was published by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) and has been designed to improve the care of people with learning disabilities, shifting services away from hospital care and towards community-based settings.

This forms part of the wider ‘Transforming Care for People with Learning Disabilities Programme’, which is a joint piece of work between the NHS England, the LGA, ADASS, the Care Quality Commission (CQC), Health Education England (HEE) and the Department of Health (DH).

**Engagement**

Engagement will continue to be an on-going process throughout the delivery of the various streams of work outlined in this strategy. We will continue to work
collaboratively in seeking views. We recognise the value of being visible and accessible to a range of organisations, and to our local partners. To ensure that our plans and programmes of work meet the needs of people locally, the engagement and consultation process was divided into 3 Phases.

1. Professionals involved in the commissioning and delivery of services for people with learning disabilities.

2. People with learning disabilities and carers (Wirral Mencap survey).

3. People with learning disabilities in day centres

Some of the key themes were:

- employment opportunities,
- appropriate housing,
- learning new things,
- keeping healthy,
- Getting support when visiting hospitals and doctors’ surgeries.
3.0 What We Know

9.1% of Wirral school children receive support for a Special Educational Need. Almost 50% of those receiving this support have been diagnosed with a Learning Disability.

Even though Cancer Screening Rates for people with a Learning Disability are rising, they are still below the overall rate of screening taking place for the general population.

In 2014-15 70% of Learning Disability patients had an overall health assessment.

A significant number of people assessed had health issues including Diabetes, Asthma, Dysphagia and Epilepsy.

There are around 5914 adults in Wirral with a Learning Disability.

It is estimated that this will rise to 5,942 by 2018 and 6042 by 2030.

People with Learning Disabilities in Merseyside and North Cheshire are 3 times more likely to die prematurely than the general population with an average age at death of between 55 and 60 years old.

3.5% of people with learning disabilities known to social services have access to employment and training opportunities.

The Joint Strategic Needs Assessment (JSNA)² for Wirral provides further information on the prevalence of Learning Disabilities in Wirral and can be found using the link in section 8.
4.0 Our Priorities

4.1 Priority One - People with learning disabilities have good and meaningful life with the support needed to live in the community

We aim to deliver this priority in line with the following core principles from the ‘Nine Core Principles: Service Model for Commissioners of Health and Social Care Services’:

- I have a good and meaningful everyday life
- My family and paid support and care staff get the help they need to support me to live in the community
- I can access specialist health and social care support in the community
- If I need it I am supported to stay out of trouble
- I have choice about where I live and who I live with

People with learning disabilities should have the same opportunities as everyone else to live a good and meaningful life. For some people to achieve this there may be a requirement for additional support to ensure that their disability is not a barrier to accessing mainstream activities, social opportunities and services. They may also need additional support at home to ensure that they are safe and looked after. Through this priority we will ensure that any support that is required is provided as early as possible and is person centred to maximise positive outcomes.

By 2020, partners in Wirral aim to deliver 300 extra care homes for people with additional needs, such as vulnerable older people and people with physical and/or learning disabilities. These homes will provide a wider range of options when deciding where to live and will help to maximise independence.

The evidence in section 3 above tells us that only 3.5% of the people with learning disabilities known to Social Services in Wirral have access to employment and training opportunities. The ability to get, and keep, a job and then to progress in work is the best route out of poverty, and a central part of social inclusion. Under representation of people with learning disabilities in the labour market not only has financial consequences for people with learning disabilities and their families, but also means that those individuals miss out on the social inclusion and personal fulfilment that comes through work.

As part of this priority we will ensure that employment is a key aspect of the assessment and planning process for young people and adults with learning disabilities and ensure that they benefit from wider employment initiatives through further promotion and working closely with businesses and Jobcentre Plus.

There should be no difference in the quality of support provided to children or adults with learning disabilities. In order to provide more seamless, holistic and consistent whole life support to disabled people and their families, we aim to implement an all age integrated disability service in Wirral. We will also link closely with the delivery group for the Wirral Carers’ Strategy to ensure that carers of people with learning
disabilities are provided with the support they need to ensure that they are able to maintain a good quality of life alongside their vital caring role.

What people with learning disabilities, their families, carers and organisations who support them have told us

Professionals involved in the commissioning and delivery of services for people with learning disabilities told us:
- There is a need for greater integration between health and social care including IT systems, records, function and co-location
- There should be person centred planning and outcomes
- Care and support staff should be able to deliver proactive and reactive strategies for managing behaviour that is challenging
- There is a need to identify and meet training needs of staff involved in the care and support of people with learning disabilities
- There should be an all age disability service with no need for transition - ensuring that disabled people of all ages are able to control the way in which they are supported to live fulfilling lives
- Engagement with parents should begin at an early stage - all families or carers who are providing care and support for people who display behaviour that challenges should be offered practical and emotional support and access to early intervention programmes
- Anyone who requires additional support to prevent or manage a crisis should have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home, or in other appropriate community settings
- There should be one funding panel and one pooled budget and consider allowing individuals with a personal health budget to use some of their budget to contribute to housing costs

A survey of carers of people with learning disabilities found that:
- 79% of carers felt that the person they care for has opportunities to develop new and existing skills
- 66% of carers have concerns over their future housing needs
- 46% of carers felt that the person they care for were reaching their full potential
- 45% of carers felt well supported
- 48% of carers have financial concerns for the future

People with learning disabilities told us:
- In the future they would most like to learn new things, make new friends, be involved in more activities and get a job
- They are most worried about getting to places, staying safe when out and about, the future and staying healthy
How we are going to get there

Implement an integrated all age disability service to ensure seamless and holistic health and social care support.

Explore ways to ensure mainstream activities/services are accessible to people with learning disabilities, in line with Equality Act duties, including those services aimed at preventing or reducing anti-social or offending behaviour.

Consider innovative, collaborative approaches to enable more disabled people to access employment – including self-employment – working in collaboration with Jobcentre Plus and local employers and promoting the support that is available to support organisations when employing people with learning disabilities.

Enable more people with learning disabilities to access mainstream employment by ensuring that this is a priority requirement in the service specifications as we commission future services, across the all age disability partnership. We will also ensure that there is a focus on employment and volunteering within the annual review for Young People with disabilities in schools from year 9 onwards and within the assessment, support and care planning process for disabled adults, where appropriate.

Ensure availability of a range of flexible support and training for families, carers and professionals in health and community support settings, including early intervention programmes.

Explore innovative ways to maintain provision of shorts breaks and respite placements for children and adults with disabilities, including learning disabilities.

Continue to support carers to maintain a good quality of life and their vital caring role by;
- Improving carer support networks
- Signposting to, and encouraging the development of carer support services
- Continuing to encourage General Practitioners (GPs) and other front line staff to identify carers who may benefit from health checks and utilise preventative techniques such as the Carers Emergency Contact Card
- Promoting the rights of working carers; building stronger links to education and training to support carers to continue to work and / or to undertake training / education to develop new skills.

How we will measure if we are getting it right

- The percentage of people with learning disabilities known to Social Services who have access to employment and training opportunities
- % of people who use services and carers who find it easy to find information about support
- Overall satisfaction of people with learning disabilities who use services with their care and support
- Overall satisfaction of carers
- People with learning disabilities living in their own home or with their family
Measures from the Learning Disability Self-Assessment Framework (LDSAF) will also be used to determine whether we have been successful in delivering on this outcome. The LDSAF is a national framework that looks at evidence of how well we are supporting people with learning disabilities. A full list of measures from within the LDSAF can be found in section 5.

4.2 Priority Two - People with learning disabilities have access to good and timely health and care services

We aim to deliver this priority in line with the following core principles from the ‘Nine Core Principles: Service Model for Commissioners of Health and Social Care Services’:

• My care and support is person-centred, planned, proactive and coordinated
• I have choice and control over how my health and care needs are met
• I get good care and support from mainstream health services
• If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to

Evidence suggests that there is high prevalence of obesity and/or long term health conditions in people with learning disabilities. People with learning disabilities are also three times more likely to die prematurely when compared to the overall population. It is therefore important that people with learning disabilities have access to good quality and timely health and care services in order to improve health outcomes. As part of this priority we aim to increase the number of people with learning disabilities who have an annual health check to ensure that any health conditions are identified as early as possible and increase health promotion and disease prevention programmes.

People with learning disabilities have told us that they sometimes find it challenging to access health settings such as a health centre, GP surgery or hospital. To address this we aim to put in place targeted adjustments such as longer appointment times, better signage and further promote the use of a health passport, so all professionals involved in a person’s care is aware of their learning disability and medical history and therefore able to offer more tailored support.

Through this priority we will also ensure that all people with learning disabilities have the opportunity to have a person centred care and support plan and are also offered a Care and Support navigator.

Where people require hospital admission we will ensure that this takes place as close to home as possible and that this is supported by a clear rationale of assessment and treatment with pre-planned admission and discharge. We will also
continue to work together to ensure more timely discharges into appropriate community based services, where required, to reduce delayed transfers of care.

**What people with Learning Disabilities, their families, carers and organisations who support them have told us**

Professionals involved in the commissioning and delivery of services for people with learning disabilities told us:

- People should be able to get “wraparound” support in their own environment when they need it
- Partners should look at ways to protect an individual’s home tenancy if they are admitted to hospital
- Contingency plans should be in place for the most complex cases, that may be at risk
- Seven day working can be achieved from existing resources with consideration of new ways of working and on-going team skill mix reviews
- There is a need for more proactive rather than reactive working

A survey of carers of people with learning disabilities found that:

- 81% of service users have been offered a health check from their GP
- 52% of service users have a health passport

People with learning disabilities told us:

- Over 25% of people told us that they are worried about staying healthy
- Around 23% told us that they are worried about their weight
- Around 38% said that they would like to get fit and be healthy
- When visiting hospital the doctors and nurses are very nice however they are worries about waiting times, getting lost, noisy wards, not being sure what’s happening and signage
- When visiting the doctor check in can be confusing, the doctor is not always understood, it can be noisy and people have to wait a long time. It was also noted that a health check is not always offered.

**How we are going to get there**

Ensure that people with a learning disability have a single person-centred care and support plan, not just those on the Care Programme Approach (CPA) and that everyone is offered a local care and support navigator or key worker, who works closely with the person and their families/carers where appropriate and ensures a consistent point of contact.

Continue to ensure provision of good quality advocacy services for disabled people and their families in Wirral and provide information to people about their care and support in formats that they can understand and appropriate support to help them communicate and make informed decisions.

Work in partnership with disabled people, their families and carers to ensure that they play an active part in the commissioning and delivery of health and social care
services.

Increase the number of disabled people accessing personal health budgets and direct payments, increase the number of people using direct payment pre-payment cards and explore opportunities for pooled budgets between individuals to increase value for money and provide more opportunities for social interaction.

Work with GP surgeries, hospitals and other health and support settings to ensure that the needs of people with a learning disability are taken into account, for example by providing longer appointment times and appropriate signage. We will also increase the range of health promotion/disease prevention programmes tailored to the needs of people with learning disabilities.

Increase the number of adults with a learning disability who have the opportunity to have a Health Action Plan, completed with assistance from a health facilitator and an annual health check provided by their GP. We will also increase the use of Health Passports through greater promotion to service users, families, carers and service providers.

Continue to ensure that hospital admissions are supported by a clear rationale of assessment and treatment, and desired outcomes, and that services are as close to home as possible. Work will also take place with individuals, families/carers, clinicians and local community services to ensure that the discharge planning process starts from the point of admission, or before.

Continue to ensure that hospital admissions are supported by a clear rationale of assessment and treatment, and desired outcomes, and that services are as close to home as possible. Work will also take place with individuals, families/carers, clinicians and local community services to ensure that the discharge planning process starts from the point of admission, or before.

Continue to ensure that admission to secure inpatient services only occurs when a patient is assessed as posing a significant risk to others.

Continue to ensure that children admitted to hospital are placed in an environment suitable for their age and have access to education. For adults, provision of single-sex accommodation will be essential.

Continue to ensure joint working endorses timely discharges thus avoiding delayed transfers of care.

**How we will measure if we are getting it right**

The number of people with Learning Disabilities in receipt of a personal health budget or direct payment

Measures from the Learning Disability Self-Assessment Framework (LDSAF) and the Transforming Care Programme (TCP) will also be used to determine whether we have been successful in delivering on this priority. The LDSAF and the TCP are national programmes that look at evidence of how well we are supporting people with learning disabilities.
5.0 How we will deliver this strategy

5.1 Action Plan

A more detailed action plan will be produced based on the high level activity outlined within each of the priority sections above. This action plan will be signed off and monitored on a regular basis by the All Age Disability Partnership Board.

5.2 How we will measure if we are getting it right

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Priority One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator One</td>
<td>The percentage of people with learning disabilities known to Social Services who have access to employment and training opportunitise</td>
</tr>
<tr>
<td>Indicator Two</td>
<td>% of people who use services and carers who find it easy to find information about support</td>
</tr>
<tr>
<td>Indicator Three</td>
<td>Overall satisfaction of people who use services with their care and support</td>
</tr>
<tr>
<td>Indicator Four</td>
<td>Overall satisfaction of carers</td>
</tr>
<tr>
<td>Indicator Five</td>
<td>The percentage of people with learning disabilities living in their own home or with their family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Priority Two</th>
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<tbody>
<tr>
<td>Indicator One</td>
<td>The number of people with Learning Disabilities in receipt of a personal health budget or direct payment</td>
</tr>
</tbody>
</table>

Alongside the above, the following measures from the LDSAF will be used to determine whether we have been successful in delivering the priorities within this strategy:

**Summary of Measure**

<table>
<thead>
<tr>
<th>Section A: Staying Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1: Encouraging building of accurate registers of people with Learning Disabilities</td>
</tr>
<tr>
<td>A2: Finding and managing long term health conditions (obesity, diabetes, cardiovascular disease and epilepsy)</td>
</tr>
<tr>
<td>A3: Annual Health Checks and Registers</td>
</tr>
<tr>
<td>A4: Generate meaningful health improvement targets in Primary Care</td>
</tr>
<tr>
<td>A5: Cancer screening programmes</td>
</tr>
<tr>
<td>A6: Communication of LD status to other healthcare providers</td>
</tr>
<tr>
<td>A7: LD Liaison function or equivalent process in acute setting</td>
</tr>
<tr>
<td>A8: Reasonable adjustments for dentistry, optometry, community pharmacy and podiatry</td>
</tr>
<tr>
<td>A9: Offender health and the criminal justice system</td>
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</table>

<table>
<thead>
<tr>
<th>Section B: Staying Safe</th>
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</thead>
<tbody>
<tr>
<td>B1: Individual health and social care package reviews</td>
</tr>
<tr>
<td>B2: LD services contract compliance</td>
</tr>
<tr>
<td>B3: Monitor assurances – ensuring healthcare providers are meeting essential standards</td>
</tr>
<tr>
<td>B4: Adult Safeguarding - Governance, safety, quality and monitoring</td>
</tr>
<tr>
<td>B5: Self-advocates and carer involvement in training and recruitment</td>
</tr>
</tbody>
</table>
6.0 Conclusion

Throughout the development of this strategy we have engaged with people with learning disabilities, their carers and key stakeholders, to ensure that the work we will undertake over the next four years will genuinely improve the lives of residents in Wirral with learning disabilities.

We will continue to work in partnership throughout the life of this strategy and beyond to ensure the best possible outcomes for individuals. We will also review this strategy on a regular basis to ensure that our priorities remain relevant.

7.0 Further Strategic Context

The following notable policies, documents and reviews have also been considered throughout the development of this strategy;

- Supporting people with a learning disability who have a mental health condition or display behaviour that challenges (Including Nine Core Principles) 2015.
- Winterbourne View – Time for Change (2014)
- Behaviour that challenges and learning Disabilities (2015)
- Winterbourne View – Time is running out (2015)
- Transforming Care for People with Learning Disabilities – Next Steps (2015)
- Delivering Effective Specialist Community Learning Disabilities;
- Health Team Support to People with Learning Disabilities and their Families or Carers (2015).
- Deprivation of Liberty Safeguards (DOLS) 2013/14 - The Care Quality Commission
Our Safeguarding Responsibilities

Safeguarding focuses on people who because of their vulnerable situation are least able to protect themselves from harm. At times it not just people with decision-making impairment but also adults with no underlying cognitive impairment but whose physical situation, or a brief period of illness, has temporarily affected their ability to protect their own interests.

It does not mean taking away individuals' rights to make choices and decide how to live their lives. People are entitled to decide how they manage their safety provided they have the mental capacity to make this decision and others are not also at risk.

The Local Authority and CCG have a statutory responsibility to safeguard our children and adults. For more information please see the web links below:

https://www.wirralccg.nhs.uk/About%20Us/safeguarding.htm
https://www.wirralsafeguarding.co.uk/
https://www.wirral.gov.uk/search/node/safeguarding

8.0 References

1 Supporting people with a learning disability who display behaviour that challenges, including those with a mental health condition- October 2015

2 Wirral Joint Strategic Needs Assessment (JSNA)
http://info.wirral.nhs.uk/oursna/wirral2009-10/learningdisabilities/
Learning Disability Self-Assessment Framework

Every year we are required to complete a national self-assessment return called the Learning Disability Self-Assessment Framework (LDSAF). A major part of this self-assessment looks at evidence of how well we are supporting people with a learning disability to improve their health.

We know from this evidence based return that the health needs of people with learning disabilities in Wirral are improving. However we also know from the national picture contained in the Confidential Inquiry into the premature deaths of adults with learning disabilities (2013) (CIPOLD) that more is required to improve people’s health.

In Wirral we commission a Specialist Learning Disability Health team who support people with a learning disability to access mainstream healthcare services. The team support the vision to ensure we have the right staff, with right skills and competency within health and social care to maximise each individual’s life potential in the care and treatment they require to succeed, empowering them to take an active role in their assessment and planning of their care and treatment.

More local preventative work is needed to catch illnesses sooner; for example, promoting access to national screening programmes such as cancer or vaccinations. We also need to ensure that all health services make reasonable adjustments such as longer medical appointment times, no waiting times or easy read tools such as hospital passports.

Although we do this well right now we want to achieve more and are committed to ensuring people with a learning disability are supported and enabled to improve their health.

The LDSAF is a single delivery and monitoring tool that supports Clinical Commissioning Groups, and Local Authorities, to check and report on progress and inform commissioning of areas that require further development. It focuses on the three main areas which are:

- Staying Healthy
- Being Safe
- Living Well

In the three main areas above there are 27 different indicators and we asked to rate ourselves for each indicator using a Red, Amber, Green (RAG status) and required to evidence the rating. The following are the results from the last four years.
Whilst there has been real improvement since 2011-12 there are three key areas where we need to continue to improve; these are:

- Recording of learning disability status by health services, e.g. GP practices and screening programmes
- Evidence of reasonable adjustments by services, such as lifestyle support services, primary and secondary health services
- Annual Health Checks and Health Action Plans completed by GP practices
## Director of Quality & Patient Safety Report

<table>
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<th>Agenda Item:</th>
<th>Reference</th>
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<td>January 2017</td>
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<tr>
<td>Lead Officer/Author of paper</td>
<td>Lorna Quigley – Director of Quality &amp; Patient Safety</td>
<td></td>
</tr>
</tbody>
</table>

### 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**
  2. Enhance the quality of life for people with long term conditions
  4. Ensuring people have a positive experience of care

### To Approve

### To Note

Yes

### To Ratify

### Summary

Report summaries the key activities undertaken by the Director of Quality & Patient Safety for noting by the Governing Body.

### Comments

N/A

### Next Steps/Recommendations

- Note the update report, and the actions taken.

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

<table>
<thead>
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<td>Any risks arising from the content of update report will be detailed in supplementary reports included on the Governing Body agenda (Risk Management). The update report will indicate this where applicable.</td>
</tr>
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<td>Legal</td>
<td>Are there any legal implications and has legal advice been obtained? Any legal implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda. If any legal advice has been obtained in relation to any aspect of the update report then this will be indicated in the report content.</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? Any Patient and Public Involvement aspects of the update report will be included within the Director of Corporate Affairs’ Report (where applicable)</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) Any Equality &amp; Human rights implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda with an associated Equality Impact Assessment (EIA)</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? Any workforce related aspects of the update report will be included within the Director of Corporate Affairs’ Report (where applicable)</td>
</tr>
<tr>
<td>Partnership Working</td>
<td>Does the report evidence a partnership working in its development? Evidence of partnership working will be incorporated into the update report (where applicable)</td>
</tr>
<tr>
<td>Performance Indicators</td>
<td>Does the report indicate any relevant performance indicators for this item? Any performance related aspects of the update report will be included within the Director of Commissioning’s Report (where applicable)</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Does the report address economic, social and environmental sustainability (should be addressed for new / change projects)? n/a</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.

Report History/Development Path
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

This paper provides Governing Body with a report on the statutory functions and duties that the Director of Quality and Patient Safety is responsible for. These reports also align to the external CCG.

2. KEY ISSUES / MESSAGES

- Equality Delivery System 2 (EDS2)

The CCG undertook their Annual Equalities Grading event on 5th December 2016. At the event key members of the CCG presented examples of how the CCG have worked to address the needs of the diverse Wirral population. Organisations and groups representing the communities of Wirral were asked to score in relation to how well they believed the CCG was doing in relation to the EDS goal - better health outcomes for all

Action A full report will be submitted to the next formal Governing Body

Seasonal Influenza Immunisation Programme

A snapshot report has been produced by NHSE and PHE of the progress made on the seasonal uptake for the season influenza immunisation programme for the CCG in 2016/17.

<table>
<thead>
<tr>
<th>Target group</th>
<th>Uptake ambition for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged under 65 ‘at risk’</td>
<td>55%</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>55%</td>
</tr>
<tr>
<td>Eligible children aged 2 years to 4 years (GP cohort)</td>
<td>40-65%</td>
</tr>
<tr>
<td>Aged 65 years and over</td>
<td>75%</td>
</tr>
<tr>
<td>Frontline health care workers (all)</td>
<td>75%</td>
</tr>
<tr>
<td>Eligible children in school year 1, 2 and 3 (school delivered programme)</td>
<td>40-65%</td>
</tr>
</tbody>
</table>

The Performance of the CCG as of the 30th November in relation to the uptake ambition is in the table below:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Year</th>
<th>Summary of Flu Vaccine Uptake %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>65 and over</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under 65 (at-risk only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Pregnant Women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Aged 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Aged 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Aged 4</td>
</tr>
</tbody>
</table>
Health Care Workers

There has been an improvement in the uptake rates by frontline health care workers compared to the same period last year. WUTH have achieved the 75% national ambition, rates at CWP remain a challenge.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Year</th>
<th>No. of HCWs with DIRECT Pt Care</th>
<th>No. Seasonal flu doses given since 01/09/16</th>
<th>% Seasonal flu doses given since 01/09/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>WUTH</td>
<td>2016</td>
<td>4750</td>
<td>3672</td>
<td>77.3</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>4543</td>
<td>2891</td>
<td>63.6</td>
</tr>
<tr>
<td>Wirral Community NHS Trust</td>
<td>2016</td>
<td>1153</td>
<td>669</td>
<td>58.0</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>1185</td>
<td>673</td>
<td>56.8</td>
</tr>
<tr>
<td>Cheshire and Wirral Partnership NHS Foundation Trust</td>
<td>2016</td>
<td>3039</td>
<td>1549</td>
<td>51.0</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>2519</td>
<td>921</td>
<td>36.6</td>
</tr>
</tbody>
</table>

There a number of local actions that are taking place in partnership with NHSE and LA to improve seasonal influenza uptake rate including:

- Robust data collection and validation processes in GP surgeries to ensure influenza immunisation data is being extracted by the automated process
- Practices have a call and recall system for those in the “at risk” cohort
- Health Care Worker uptake will be scrutinised by CCG in contract meetings as part of the monitoring schedule.
- Support Public Health in delivery of uptake campaigns.

**Action:** Governing Body to note the current performance against the national ambition, and be assured of the partnership working between the Public Health and the CCG and the measures in place in order to improve uptake.

- **Performance against Quality indicators (October data)**

Health Care Acquired Infections (HCAI)

C-difficile – In October there were 7 cases attributed to Wirral CCG, cumulative score stands at 51 incidents, now 7 over the trajectory cumulative figure (44), however Governing Body are reminded that this is an annual threshold. This is an improvement from the 2015/16 performance.
MRSA - There was 0 new cases in October, cumulative score is at 3. This is an improvement on last year.

All cases of Health Care Acquired Infections have a Post Infection Review undertaken to ascertain if these where unavoidable or due to lapse in care. Action plans are developed for any cases due to lapse in care.

**Action** Governing Body to note the progress made in relation to HCAI as part of the wider Health Protection agenda.

- **Mixed Sex Accommodation Breaches**

NHS organisations are expected to operate without having mixed sex accommodation except in very specific circumstances “sleeping accommodation” included areas where patients are admitted and cared for on beds and trolleys, even when they do not stay overnight. It is therefore includes all admissions assessment units (including decision making units) day surgery and endoscopy units. It does not include areas where patients have not been admitted such as Emergency Department cubicles.

There have been 7 breaches in month for CCG patients; all of which are from Wirral University Teaching Hospital and are from Critical Care areas due to poor bed state. The longest wait being 2 days, 5 hours and 32 mins.
In line with the NHS standard contract, due to the lack of improvement with this standard, a contract performance notice has been issued to the provider, a meeting held and an action plan submitted by the provider progress is being monitored via the contract meetings.

**Action** Governing Body to be assured that contractual levers have been instigated to bring about service change.

- **Friends and Family (FFT)**

There is no specific target to achieve in relation to FFT; however, providers have set themselves performance thresholds with regard to the recommend scores.

ED- in May, an electronic system has been introduced to capture FFT in emergency Departments. This has led to an improvement in repose rate (from 2% to 16%), but a decrease in recommend scores. This is in line with national average of other hospitals, which have changed their collection methodology.

- **Serious Incidents (SI)**

Serious incident are events in healthcare where the potential for learning is so great, or the consequences to patient's families and carers, staff or organisations are so significant that the warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may affect patient safety or an organisations ability to deliver ongoing health care.


A SI requires a provider organisation to undertake a root cause analysis within 60 days of the incident occurring develop a remedial action plan and provide ongoing evidence of implementation of the action plan. This process is managed through the Wirral Serious Incident Review Group.
There was 28 SI's recorded in September, Governing Body is asked to note:

- A change in reporting guidance in maternity services for WUTH, and Pressure ulcers for WCFT which has led to an increase in reported incidents for both organisations

3. CONCLUSION

Governing Body members are asked to note the contents of the report and the following actions:

- To receive the CCG ratings against EDS 2 at the next formal Governing Body.
- The measures in place to improve performance of the seasonal influenza immunisation programme against the national ambition
- The contractual levers that have been instigated by the CCG in order to reduce the mixed sex accommodation breaches at Wirral University Teaching Hospital.
### Director of Corporate Affairs Report

<table>
<thead>
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<th>Agenda Item:</th>
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<tr>
<td>Lead Officer/Author of paper</td>
<td>Paul Edwards – Director of Corporate Affairs</td>
<td></td>
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<td>Contributors</td>
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**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. Help people to recover from episodes of ill health or following injury
4. Ensure people have a positive experience of care
5. Ensure people are treated and cared for in a safe environment and protected from avoidable harm

**To Approve**

**To Note**

**To Ratify**

**Summary**
Report summaries the key activities undertaken by the Director of Corporate Affairs for noting by the Governing Body.

**Comments**
N/A

**Next Steps/Recommendations**
- Note the update report

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

<table>
<thead>
<tr>
<th>Category</th>
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<td>Are there any legal implications and has legal advice been obtained?</td>
<td>Any legal implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda. If any legal advice has been</td>
</tr>
<tr>
<td><strong>Patient and Public Involvement (PPI)</strong></td>
<td>obtained in relation to any aspect of the update report then this will be indicated in the report content.</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</strong></td>
<td>There is a section on engagement included within the report.</td>
<td></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 <em>(statutory duty for new / changes to services)</em>? Any Equality &amp; Human rights implications arising from the update report will be detailed in supplementary reports included on the Governing Body agenda with an associated Equality Impact Assessment (EIA)</td>
<td></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? Workforce related issues such as Statutory and Mandatory Training are included in the report.</td>
<td></td>
</tr>
<tr>
<td><strong>Partnership Working</strong></td>
<td>Does the report evidence a partnership working in its development? Evidence of partnership working will be incorporated into the update report (where applicable)</td>
<td></td>
</tr>
<tr>
<td><strong>Performance Indicators</strong></td>
<td>Does the report indicate any relevant performance indicators for this item? Performance compliance in included against statutory targets</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>Does the report address economic, social and environmental sustainability <em>(should be addressed for new / change projects)</em>? n/a</td>
<td></td>
</tr>
<tr>
<td><strong>Do you agree that this document can be published on the website?</strong></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

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><strong>Report History/Development Path</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Name</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

This paper provides Governing Body with a report on the statutory functions and duties that the Director of Corporate Affairs is responsible for. These areas also align to the external CCG Assurance Framework.

KEY ISSUES / MESSAGES

- **Emergency Preparedness, Resilience and Response (EPRR)**
  - **Industrial Action**
    - No industrial action planned (within the period of October – December 2016).
  - **Feedback from groups**
    - **Local Resilience Forum (LRF):**
      - NHS England represents the NHS at the main LRF group.
      - No issues raised for the CCGs at the last meeting.
    - **Local Health Resilience Partnership (LHRP) meeting:**
      - No issues raised for the CCGs at the last meeting.
  - **Cold Weather Plan**
    - The 2016-17 programme has been launched and has been shared with on call managers for information.

- **Commissioning Support**
  - The CCG contracts for the following elements from Midlands and Lancashire Commissioning Support Unit (MLCSU): End to End services (including areas such as Human Resources and Communications), Medicines Management, Individual Exceptional Funding Requests and Retrospective Continuing Health Care.
  - Now that MLCSU has implemented new service structures and concluded its formal organisational change process, PE has initiated a monthly contract review meeting with MLCSU to monitor performance across the service lines.
  - This is supported by the development of a CSU performance dashboard.
  - CSU performance is also monitored across Cheshire and Merseyside via a ‘Collaborative CSU/CCG’ meeting, with senior staff from CCGs and CSU discussing common areas of concern and collective opportunities.
At present, the Communications offer remains a concern. The service model has not delivered the outcomes the CCG requires, so a meeting has taken place to change the service offer to be more in line with the CCG requirements. It is expected that the new service model will be in place by mid-December and the service will be reviewed again after that point.

Additionally, there has been limited activity around Emergency Planning, particularly in regard to training support. This has been raised with the CSU Service Director for attention.

- **Communications and Engagement**

  - **Communications and Engagement – Planning:**
    
    A draft communications and engagement plan will be submitted to Governing Body in early 2017 for the 2017/18 year. This will have four components: CCG Operational Planning/QIPP schemes, relaunch of the Healthy Wirral programme (as part of the Cheshire and Wirral Local Delivery System), staff engagement and member engagement.

    To support the public/patient facing activity, the legacy ‘Healthy Wirral - Engaging with People Group’ will be re-established along with the Healthy Wirral Champions. This will become the principle public/patient stakeholder group for the CCG.

  - **Communications and Engagement – Activity:** (Please note, this does not cover all activity but provides commentary on the principle workstreams)

    - **Consultation Activity** – Wirral CCG is leading on the joint consultation for the Service Review Policy across Cheshire and Wirral and this runs until 17th January 2017. Three public meetings have been held to date as well as multiple channel availability for people to express their views. This has been supplemented by a BBC North West Tonight broadcast on 15th December 2016 which featured commentary from the Village Medical Practice, a live interview with Dr Sue Wells in the BBC studio and a Facebook live session following the broadcast. This has maximized the exposure for the current consultation.

    Post consultation communications support has been given to the Over-the-Counter/Self Care and Gluten free QIPP schemes to ensure these proceed to implementation.

    Initial scoping has commenced for a methodology to support the Urgent Care Transformation project. It is anticipated that this will be a multi-agency approach which the CCG will lead.

    - **Winter campaign** - Wirral CCG has led a health economy wide approach to supplement the national Stay Well winter campaign. The intent of this has been to localise the campaign for Wirral. In addition to using the standard materials available from NHS England, the CCG has arranged for self-care messages to be put on the back of all Wirral issued Arriva (260,000) Stagecoach (190,000) bus tickets week commencing 19th December 2016 for 2 weeks. The first of a series of three videos has also been filmed which will focus on self-care, this will be released week commencing 19th December 2016 on social media channels. The second video will focus on appropriate use of urgent care and the last will encourage people to check on vulnerable friends/neighbours.

    This is the first stage of the local health economy working together on joint work programmes to send consistent NHS Wirral messages as outlined in the Communications and Engagement Strategy.
• **Internet/Intranet development** – The new NHS Wirral website is currently being built and it is anticipated that this will go live in February 2017; this will be followed by a new Members website and then a new staff intranet.

• **Sustainability and Transformation Plan (STP)** – Wirral CCG led on the publication of the Cheshire and Merseyside STP for the Cheshire and Wirral LDS area on 16/11/16. The Head of Communications and Engagement has been nominated to represent the Cheshire and Wirral LDS area on a task and finish group to develop the Communication and Engagement Strategy for the STP/LDS.

• **Policies**

  There were no corporate policies due for review or approval at the QPF meetings held in October or November 2016.

• **Statutory and Mandatory Training**

  The training compliance as at December 2016 is as follows:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Compliance (%) – Target is now at 90% as agreed at QPF held in November 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counter Fraud</td>
<td>91%</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>92%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>84%</td>
</tr>
<tr>
<td>Health &amp; Safety Awareness</td>
<td>91%</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>91%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>84%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>90%</td>
</tr>
</tbody>
</table>

The target compliance rate for all Statutory and Mandatory training is 90% and overall for the CCG the overall compliance rate is 90%. This target was agreed to be increased from 85% by QPF Committee members at the meeting held on 29th November 2016.

With regards to Information Governance training, face to face training sessions are being provided by the Information Governance team of Midlands and Lancashire Commissioning Support Unit, and 2 further dates are scheduled for January 2017, for outstanding staff members.

The new on-line training system continues to have the ability to provide reminder emails to staff one month prior to their courses expiring and reminder emails continue to be sent directly to staff members and copied to Line Managers from the Corporate Affairs team, to continue to address non-compliance.
• Complaints

Within the reporting period of 11th October 2016 to 30th November 2016, 85 new complaints were received, all of which were acknowledged within 3 working days of receipt in line with national guidance.

There have been a high number of complaints received in relation to the changes that had been proposed to the Phlebotomy Service from 1st December 2016. Within each of the responses to the complainants, an explanation has been provided to advise that there were a number of issues raised with regards to the quality and potentially the safety of the previous Phlebotomy Services model for Wirral patients and, as a result, the CCG has been working with Wirral Community NHS Foundation Trust (WCFT) to try to provide a solution to the issues of which the service has been facing. The response also included the following points with regard to the new model based on walk-in ‘hub clinics’ across a number of sites:

- The number of domiciliary visits will not be restricted
- The new model offers an additional 1000 slots per week and avoids the wastage of unused appointments (there were 1700 unused appointments in August 2016)
- That the funding for the service remains unchanged and that there is no drive to reduce costs on this service

For patients who raised concerns that there is no hub in the West Wirral area, it was confirmed that following feedback and comments, that the CCG is currently working with WCFT in order to try to set up a further hub to provide the service within this area.

There are currently 6 complaints being investigated by the Parliamentary and Health Service Ombudsman (PHSO). The CCG are awaiting the final outcomes and report with recommendations in relation to these cases and further updates will be provided at a future meeting.

There were 89 complaints closed within this reporting period (some of which were received in the previous reporting period). Of the complaints received, 3 were reopened within this reporting period as further queries were raised by the complainant for investigation, in relation to the original concerns raised.

Full details of each investigation, outcome and lessons learned, where applicable, were provided in all complaint responses, in line with the national standards for managing complaints and National Health Service Complaints (England) Regulations 2009.

A questionnaire feedback form is provided when a complaint is closed to determine how a patient feels their complaint has been managed. During this reporting period, of the 89 feedback forms sent, 1 was completed and returned to the Corporate Affairs Team which indicated positive comments in relation to the way the complainants concerns had been managed.

• Patient Advice and Liaison Service (PALS)

The PALS is commissioned by Wirral CCG and provided by Wired to provide ‘on the spot’ help whenever possible, with the power to negotiate immediate or speedy resolution (within 48 hours) of problems. Where appropriate, the PALS service will refer patients to independent advice and advocacy support from local and national sources including HealthWatch.
There were 32 PALS enquiries received within the month of October 2016 (to note, the information for November 2016 was not available at the time of writing this report). The two dominant areas of these were related to Wirral University Teaching Hospital NHS Foundation Trust and GP Practices.

Of the 32 calls received, 11 were formally raised as complaints with the relevant organisation, 2 were requests for information, 13 concerns were raised, 5 queries received and 1 compliment noted.

(Source: Monthly PALS report provided from Wired)

- **MP Enquiries**

  Within the reporting period of 11th October 2016 to 30th November 2016; 25 new enquiries were received, all of which were acknowledged within 3 working days.

  There were 17 MP enquiries responded to and closed within this period. All of these enquiries were investigated and responded to within the CCG’s Key Performance Indicator of 20 working days, with the exception of 1, as there was a delay in the response being provided by Wirral Community NHS Foundation Trust.

- **Freedom of Information (FOI) requests**

  Within the reporting period of 1st October 2016 to 30th November 2016, 51 new FOI requests were received (25 in October and 26 in November). The subjects of the FOI requests received are detailed below (split by month):

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Commissioning</td>
<td>15</td>
</tr>
<tr>
<td>CCG Structure / Intentions / Plans</td>
<td>3</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>4</td>
</tr>
<tr>
<td>Contracts and Procurement</td>
<td>1</td>
</tr>
<tr>
<td>Finance and Expenditure</td>
<td>14</td>
</tr>
<tr>
<td>ICT</td>
<td>2</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Primary Care</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>

The graphs below provide a breakdown of the subject of FOIs received by month:

**October 2016:**
November 2016:

All FOI requests received during this period were responded to within 20 working days, in line with the Freedom of Information Act 2000 and the CCG's Policy for Management of Freedom of Information requests. Therefore, the CCG were fully compliance in managing and responding to all FOI requests within this reporting period.
Subject Access Requests (SARs)

There were 2 SARs received within the period of 1\textsuperscript{st} October 2016 to 30\textsuperscript{th} November 2016.

All of SARs were responded to within 40 days, therefore the CCG were fully compliant in managing and responding to requests within this reporting period.

2. IMPLICATIONS

The CCG will actively seek to ensure Statutory and Mandatory training targets are continued to be complied with by reiterating messages for new starters in regard to early completion of all training modules.

3. CONCLUSION

Governing Body members are asked to note the contents of the report.
## AssuRance Framework

### Agenda Item:
6.1

### Reference
GB16-17/0030

### Public / Private
Public

### Meeting Date
10th January 2016

### Lead Officer
Paul Edwards, Director of Corporate Affairs

### Contributors
Governing Body Members, Mersey Internal Audit Agency

### 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

### To note
The Assurance Framework was developed by the Governing Body in conjunction with Mersey Internal Audit Agency and identifies key risks to NHS Wirral CCG’s Strategic Objectives.

When presented at Governing Body in June 2013, key controls and assurances were identified against each risk, with any gaps identified as requiring an action plan to address them. The Assurance Framework has been reviewed a number of times since then (see Report History), with the whole structure of the Assurance Framework structure itself being reviewed at the Informal Governing Body session held on 1st March 2016 where risks were re-aligned to refreshed CCG Strategic Aims. This session also suggested the inclusion of ‘risk appetite’ and this was discussed at July 2016’s Governing Body and was incorporated in the October 2016 iteration of the Assurance Framework. Additionally, the newly formed Finance Committee had suggested that a separate risk be added with regard to delivery of QIPP, with a further risk to be added regarding the capability and capacity to ensure the CCG meets its duties. These were agreed and added as new risks at October Governing Body and are included here.

Further proposed changes for consideration at Governing Body in January 2017 are outlined in the supporting paper.

### Comments
No additional comments

### Next Steps
Discuss and adopt updated Assurance Framework
### What are the implications for the following (if not applicable please state why):

<table>
<thead>
<tr>
<th>Category</th>
<th>Does the report consider financial impact?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Part of Assurance Framework refers to the financial duties of the CCG and identifies risks related to QIPP delivery and the economy wide financial challenge</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Does the report consider value for money?</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Is there a documented risk assessment?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Assurance Framework allows the Governing Body to consider the risks that may hamper the Clinical Commissioning Group from delivering its statutory duties and functions – these are the strategically significant risks facing the Clinical Commissioning Group. The Framework also outlines how the Governing Body is provided with assurance that these risks are being effectively managed and, as such, acts as a documented risk assessment.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Are there any legal implications and has legal advice been obtained?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All NHS organisations are required to develop and maintain an Assurance Framework in accordance with the governance regulations applied to the NHS. Legal advice was not deemed necessary for this paper.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Does the report provide evidence whether there could be a positive or negative impact on patients and public?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Assurance Framework details risks related to patient and public engagement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>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)</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Assurance Framework highlights reducing inequalities as a key strategic objective</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</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>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Does the report evidence a partnership working in its development?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The review of the Assurance Framework has been undertaken with input from Local Authority staff and Lay representation. Some of the risks identified are associated with Partnership Working and what measures are in place to strengthen this</td>
<td></td>
</tr>
</tbody>
</table>
**Performance Indicators**

Does the report indicate any relevant performance indicators for this item? The risk scores and mitigation actions will be regularly assessed by the Governing Body.

**Sustainability**

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

---

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

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

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This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path 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>Assurance Framework</td>
<td>GB16-17/0014 3.1</td>
<td>Governing Body</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; October 2016</td>
<td>Review scores and added risks</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB16-17/0006 2.2</td>
<td>Governing Body</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; July 2016</td>
<td>Review scores and add ‘risk appetite’ section</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>N/A</td>
<td>Informal Governing Body Session</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; March 2016</td>
<td>Updated to align to new refreshed Strategic Aims, facilitated by Mersey Internal Audit Agency</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 15-16/0046 2.2</td>
<td>Governing Body</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; November 2015</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>N/A</td>
<td>Informal Governing Body Session</td>
<td>6&lt;sup&gt;th&lt;/sup&gt; October 2015</td>
<td>Updated subject to ratification at November 2015 Governing Body</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 15-16/0024</td>
<td>Governing Body</td>
<td>7&lt;sup&gt;th&lt;/sup&gt; July 2015</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 14-15/0068 2.1</td>
<td>Governing Body</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; March 2015</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td></td>
<td>Informal Governing Body Session</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; February 2015</td>
<td>Agreed amendments</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 14-15/0026 2.3</td>
<td>Governing Body</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; August 2014</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td></td>
<td>Informal Governing Body Session</td>
<td>23&lt;sup&gt;rd&lt;/sup&gt; July 2014</td>
<td>Agreed amendments</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 13-14/062 2.2</td>
<td>Governing Body</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; February 2014</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Informal Governing Body Session</td>
<td>6&lt;sup&gt;th&lt;/sup&gt; January 2014</td>
<td>Agreed amendments</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------</td>
<td>----------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 13-14//033 4.3</td>
<td>Governing Body</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; September 2013</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>GB 13-14//014</td>
<td>Governing Body</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; June 2013</td>
<td>Approved</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Informal Board Session</td>
<td>25&lt;sup&gt;th&lt;/sup&gt; April 2013</td>
<td>Governing Body Members agreed risk ratings and scores. Actions to be added to address gaps in Assurance and present to Governing Body</td>
<td></td>
</tr>
</tbody>
</table>

**Private Business**

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

When presented at Governing Body in June 2013, key controls and assurances were identified against each risk, with any gaps identified as requiring an action plan to address them. The Assurance Framework has been reviewed a number of times since then, with the whole structure of the Assurance Framework structure itself being reviewed at the Informal Governing Body session held on 1st March 2016 where risks were re-aligned to refreshed CCG Strategic Aims. This session also suggested the inclusion of ‘risk appetite’ and this was discussed at July 2016’s Governing Body and is now incorporated with this iteration of the Assurance Framework, alongside the review of the risks.

Changes to the Assurance Framework agreed at October 2016 Governing Body

There were three new risks agreed as additions to the Assurance Framework at October’s Governing Body

1. The newly formed Finance Committee has suggested that a separate risk is added with regard to delivery of QIPP, (E3) with a score of 4 (likelihood) & 4 (impact) that mirrored the financial risk on the BAF
2. A new risk, suggested by the Lay Member for Quality and Outcomes, regarding the capability and capacity to ensure the CCG meets its duties (F3) score 3 (likelihood) & 3 (impact). It was agreed that the Price Waterhouse Cooper review, currently underway, would inform the narrative, controls and gaps and he would add these ahead of the next review
3. As the Assessment Framework baseline assessment of the 6 clinical domains had identified some areas that needed improvement, this was added a broader risk related to the rating resulting from the Assessment Framework. It was agreed to initially score these as 3 (likelihood) & 3 (impact).

All other risks were deemed to be accurate in terms of scores and narrative.
Proposed changes

- Engagement implantation plan approved at November GB as additional control on risks: A1, A2, C5, D1, D3, D4, D7 and E2
- Finance committee approval via NHS England added as a gap in control for risk: B3, C4, E3
- Need for approval of LDP and STP plans highlighted as a gap for risk: B1
- PMO added as control for risks: C4 and E3
- Clinical Senate added as a control on risk F4

The following score changes are recommended

- Risks A1, A2, C5, D1, D3, D4, D7 and E2– Likelihood reduced from 3 to 2 following production in Engagement Implementation Plan

Conclusion

Governing Body members are asked to approve the proposed changes, discuss new risks and assess whether any risk scores need to be modified.
## WIRRAL CLINICAL COMMISSIONING GROUP
### ASSURANCE FRAMEWORK FOR 2016-17
#### FOR CONSIDERATION AT THE GOVERNING BODY MEETING - JANUARY 2017

Workstream / Task Descriptions and *Strategically Significant* risks are detailed against the Strategic Aims:

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Task Description</th>
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<tbody>
<tr>
<td>A</td>
<td>To empower the people of Wirral to improve their physical, mental health and general well being</td>
</tr>
<tr>
<td>B</td>
<td>To reduce health inequalities across the Wirral</td>
</tr>
<tr>
<td>C</td>
<td>To adopt a health and well being approach in the way services are both commissioned and provided</td>
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<td>D</td>
<td>To commission and contract for services that: Demonstrate improved person centred outcomes; Are high quality and seamless for the patient; Are safe and sustainable; Are evidenced based and Demonstrate value for money</td>
</tr>
<tr>
<td>E</td>
<td>To be known as one of the leading Clinical Commissioning Groups in the country</td>
</tr>
<tr>
<td>F</td>
<td>Provide systems leadership in shaping the Wirral health and social care system so as to be fit for purpose both now and in five years time</td>
</tr>
</tbody>
</table>
A BRIEF GUIDE TO THE ASSURANCE FRAMEWORK

Introduction
1 All NHS organisations are required to develop and maintain an Assurance Framework in accordance with the governance regulations applied to the NHS. The Assurance Framework allows the Governing Body to consider the risks that may hamper the Clinical Commissioning Group from delivering its statutory duties and functions – these are the strategically significant risks facing the Clinical Commissioning Group. The Framework also outlines how the Governing Body is provided with assurance that these risks are being effectively managed.

2 Identification of a risk does not mean that it will occur. The Assurance Framework is a self-assessment process which allows the Governing Body to identify where it may need to prioritise the use of resources to improve services and internal processes.

Identifying Corporate Aims / Objectives
3 Each year the Clinical Commissioning Group’s Governing body agrees a set of corporate objectives which define what has to be delivered in the coming year (in this case from ). The corporate aims for 2013/14 can be seen on the front cover of this Assurance Framework. These are underpinned by a number of objectives and work streams.

Identifying and Scoring Risks
5 The Clinical Commissioning Group next considers those factors which may stop it from delivering each of these workstreams - these are the risks to delivery (Column 4), each of which is numbered (Column 1). Risks are considered in two stages, each of which is given a score in line with the Clinical Commissioning Group’s Risk Management Strategy.

a) The Clinical Commissioning Group considers what would be the effect upon the organisation should the risk, as described, actually occur. An impact rating score is then assigned based upon the impact on the Clinical Commissioning Group should the described risk occur - with a score of 5 meaning the risk occurring would be 'catastrophic' to the organisation and 1 having an 'insignificant' impact on delivering. The impact rating is shown in Column 5.
b) Once a risk has been identified, the Clinical Commissioning Group has to consider what controls are in place to mitigate the possibility of the risk from occurring. By having these key controls, the Clinical Commissioning Group attempts to reduce the likelihood of a risk actually occurring. A likelihood rating score is used to show how effective the Clinical Commissioning Group rates these key controls in mitigating the possibility of the risk occurring - with a score of 5 meaning a risk is 'certain' to occur and 1 meaning the chances are 'remote'. The likelihood rating is shown in Column 8.

6 A risk score is then calculated by multiplying the impact rating by the likelihood rating (Column 9). Using the matrix below, each risk is then assigned a risk rating (Column 10). Both the risk score and the risk rating are used by the Clinical Commissioning Group to help it prioritise the use of resources and development of action plans.

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Examples</th>
<th>Frequency / Occurrence</th>
<th>Consequence Likelihood 1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>Difficult to believe that this will ever happen/happen again</td>
<td>Annually</td>
<td>1 1 2 3 4 5</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>Do not expect it to happen/happen again, but it may</td>
<td>Bi-annually</td>
<td>2 2 4 6 8 10</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>It is possible that it may occur/recur</td>
<td>Monthly</td>
<td>3 3 6 9 12 15</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>Is likely to occur/recur but is not a persistent issue</td>
<td>Weekly</td>
<td>4 4 8 12 16 20</td>
</tr>
<tr>
<td>5</td>
<td>Almost certain</td>
<td>Will almost certainly occur/recur and could be a persistent issue</td>
<td>Daily</td>
<td>5 5 10 15 20 25</td>
</tr>
</tbody>
</table>

7 When considering the most appropriate impact and likelihood rating scores for a risk the GP Consortium will consider the following definitions:

*Impact Measures*
<table>
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<th>Level</th>
<th>Descriptor</th>
<th>Example, something that involves</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Negligible</td>
<td>No or minimal impact/ breach of stat duty/ financial loss/ business interruption</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>Minor adverse publicity/ reduced performance/ business interruption &lt;8 hours, small financial loss</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Reduction in public confidence, slippage in business objectives, financial loss &lt; 0.5% budget, Service interruption &gt; 1 day</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>Improvement notices, critical media coverage, major slippage in business objectives delivery, financial loss up to 1% of budget.</td>
</tr>
<tr>
<td>5</td>
<td>Catastrophic</td>
<td>Severly critical performance rating, adverse national media coverage, loss of public confidence, failure to meet statutory duties.</td>
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</tbody>
</table>

**Likelihood Measures**

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<th>Descriptor</th>
<th>Example, something that involves</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>an event that may only happen in exceptional circumstances/ Difficult to believe this would happen</td>
</tr>
<tr>
<td>2</td>
<td>unlikely</td>
<td>an event that could occur (recur) at some time/ Do not expect it to happen</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>an event that may well occur (recur) at some time</td>
</tr>
<tr>
<td>4</td>
<td>Highly likely</td>
<td>an event will occur (recur) in most circumstances</td>
</tr>
<tr>
<td>5</td>
<td>Almost Certain</td>
<td>an event is expected to occur (recur) in most circumstances</td>
</tr>
</tbody>
</table>

8 Risk scores are under constant review by the Clinical Commissioning Group. **Column 11**, with the use of arrows, simply showing if there have been any changes to a risk score since the Assurance Framework was discussed at the last Governing Body Meeting.

**Providing Assurance to the Governing Body**

9 One of the roles of the CCG Governing Body is to assure itself that the CCG has robust systems and processes in place which do what they say they will do. The Assurance Framework therefore maps out to the Governing Body where they can obtain that assurance for those risks that have been identified. This assurance takes 2 main forms:
a) **Assurance** (Column 7) - the Governing Body receives assurance from its own Committees, Members and Managers on the effectiveness of internal systems and controls. For example this can take the form of reports, performance data and minutes of meetings demonstrating that the *key controls* (identified in Column 6) are in place and operating effectively.

b) The CCG may also receive assurance on the effectiveness of internal systems and controls from other organisations. For example this includes assessments / reports from Mersey Internal Audit Agency (our internal auditor), Grant Thornton (our external auditor), NHS England, Care Quality Commission and other regulatory / statutory organisations.

**Gaps in Control and Assurance**

10 By identifying those risks that may stop the CCG from undertaking its duties together with the key controls which mitigate these risks, the organisation may identify gaps where it either has ineffective controls in place or cannot provide sufficient assurance to the Governing Body. **Column 12** identifies these *gaps in control and assurance*. Where a gap has been identified, the action necessary to address it is recorded in a detailed Action Plan. This should be monitored by the Director of Corporate Affairs.
### Strategic Aim A

**To empower the people of Wirral to improve their physical, mental health and general well-being**

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<tr>
<th>Risk</th>
<th>Risk Description</th>
<th>Key Controls</th>
<th>Assurance on Controls</th>
<th>Score</th>
<th>Gap to Control and Assurance</th>
<th>Score</th>
<th>Action Plan</th>
<th>Target Impact</th>
<th>Target Lead/Owner</th>
<th>Target Score</th>
<th>Timeline</th>
<th>Notes</th>
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<td>1</td>
<td>CCG fails to understand patient health experiences due to lack of engagement</td>
<td>Public Health Communication Strategy, Public Involvement and Engagement Strategy, Joint Strategic Commissioning Group, Clinical Commissioning Group, Health and Wellbeing Board, Joint Strategic Commissioning Group, Wirral CCG Planning Group, Joint Strategic Commissioning Group, Wirral CCG Planning Group, Joint Strategic Commissioning Group, Wirral CCG Planning Group</td>
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<tr>
<td>2</td>
<td>CCG fails to understand patient health experiences due to lack of engagement</td>
<td>Public Health Communication Strategy, Public Involvement and Engagement Strategy, Joint Strategic Commissioning Group, Clinical Commissioning Group, Health and Wellbeing Board, Joint Strategic Commissioning Group, Wirral CCG Planning Group, Joint Strategic Commissioning Group, Wirral CCG Planning Group</td>
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<tr>
<td>3</td>
<td>Wirral CCG</td>
<td>Director of Quality and Patient Safety, Chief Financial Officer, Director of Commissioning, Director of Quality and Patient Safety</td>
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### Strategic Aim B

**To reduce health inequalities across the Wirral**

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<th>Assurance on Controls</th>
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<th>Score</th>
<th>Action Plan</th>
<th>Target Impact</th>
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<tr>
<td>2</td>
<td>Wirral CCG</td>
<td>Director of Quality and Patient Safety, Chief Financial Officer, Director of Commissioning, Director of Quality and Patient Safety</td>
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</table>

### Strategic Aim C

**To adopt a health and well-being approach in the way services are both commissioned and provided**

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<th>Score</th>
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<tr>
<td>2</td>
<td>Wirral CCG</td>
<td>Director of Quality and Patient Safety, Chief Financial Officer, Director of Commissioning, Director of Quality and Patient Safety</td>
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</table>
Stategic Aim D

To commission and contract for services that: 

- Demonstrate improved person centred outcomes: Are high quality and seamless for the patient; Are safe and sustainable; Are evidenced based and Demonstrate value for money

Issues:

- Providers/ Health and Social Care clinicians fail to work together in partnership
- Providers/ Health and Social Care of understanding).
- CCG fails to get information skew expectations against self and local population) prevent inclusion.


dated QPF. Incidents reported and reviewed.

Meetings. Primary Care Quality Scheme introduced 2016

Reports brought to Governing Body November 2016

Engagement recruited Implementation Plan in place. Likelihood reduced to 2

Cultural and intellectual barriers may be demonstrated in particular target groups.

CCG fails to get information skew expectations against self and local population) prevent inclusion.

Cultural and intellectual barriers may be demonstrated in particular target groups.

CCG Strategic Plan, use of JABMs in plans, WSH, GICC and Plan. Patient and public feedback. Joint work on reshaping the health and wider system

Joint work with regional partners with neighbouring CCGs. CWW Chairs and Chief Officers.

Wealth Board. Better Care Fund Plan sign

Commissions Partnership Leadership Group (CPLL) to commission and contract for services that: Demonstrate improved person centred outcomes; Are high quality and seamless for the patient; Are safe and sustainable; Are evidenced based and Demonstrate value for money

Contract management meetings and minutes, External CCG Assurance

Engagement recruited Implementation Plan in place. Likelihood reduced to 2

SHIP Strategy Implementation Group

Sample interviewer: 4


to achieve these outcomes. JABM: Joint Area Board Meetings. Private & Public Health

Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.  External CCG Assurance

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Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.  External CCG Assurance

Commissioned by an Independent Third Party.
# Implementation Plan for Engagement Strategy

## Risk

<table>
<thead>
<tr>
<th>Risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Priority</th>
<th>Risk Appetite</th>
<th>Controls</th>
<th>Assurance</th>
<th>Gaps</th>
<th>Responsible Committee</th>
<th>Reporting Path</th>
<th>Target Score</th>
<th>Target deadline</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Wirral CCG</td>
<td>3 9</td>
<td>3 12</td>
<td>3 3 9</td>
<td>Quarter 4</td>
<td>Improvement Plan not finalised following end of Vanguard resource</td>
<td>Following end of Vanguard resource</td>
<td>SLG minutes</td>
<td>SLG minutes</td>
<td>Wirral CCG</td>
<td>3</td>
<td>2</td>
<td>Quarter 4</td>
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## Timeline

<table>
<thead>
<tr>
<th>Action</th>
<th>Start Date</th>
<th>End Date</th>
<th>Lead:</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Develop Organisational Development Strategy</td>
<td>Quarter 3 2015/16</td>
<td></td>
<td>Medical Director</td>
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<tr>
<td>Finalise implementation plan for Engagement Strategy</td>
<td>Quarter 3 2016/17</td>
<td></td>
<td>Director or Commissioning affairs</td>
<td></td>
</tr>
<tr>
<td>Review Clinical Senate, Membership Council and Provider Forum arrangements</td>
<td>Quarter 1 2015/16</td>
<td></td>
<td>Medical Director</td>
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<td>Implement Local Delivery Plan and Sustainability and Transformation plan, including clear governance arrangements to be established</td>
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## Terms of Reference – Primary Care Co-Commissioning Committee

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**Lead Officer/Author of paper**

Nesta Hawker/Iain Stewart

**Contributors**

**Link to CCG Strategic System Plan**

**Link to current strategic objectives**

**To approve**

Yes

**To note**


**To Ratify**


**Summary**

These terms of reference were reviewed by the Primary Medical Care Co-Commissioning Committee at its meeting in November and approved for submission to the Governing Body for ratification.

**Next Steps Recommendations**

Once ratified by the CCG Governing Body to be forwarded to NHs England

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

#### Financial

- Does the report consider the financial impact? NO
  
  If YES, please summarise the key issues
  
  If NO, please state why this is not included – no direct financial implication from these Terms of Reference
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<td>Is there a documented risk assessment? NO</td>
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<td>If YES, what are the key risks &amp; what is being done to mitigate</td>
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<td>Legal</td>
<td>Are there any legal implications and has legal advice been obtained? NO</td>
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<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? NO</td>
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<td>If NO, please explain why Patient and Public views have not been sought – these Terms of Reference incorporate latest guidance on PPE including core members who are Lay Members and with Healthwatch in attendance.</td>
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<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) NO</td>
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<td>If YES, does the report include equality impact assessment and what are the key issues</td>
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<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? NO</td>
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<td>If YES, please explain and summarise the key issues</td>
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<td>Does the report evidence a partnership working in its development? NO</td>
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If YES, please describe
If NO, please state why – there are no partnership issues arising from the adoption of these Terms of Reference and the document is in line with current guidance from NHS England.

### Performance Indicators

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

If YES, please describe
If NO, please explain why - the document is in line with current guidance from NHS England.

### Sustainability

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

If YES, please describe
If NO, please why not - no sustainability issues arising from the adoption of these Terms of Reference and the document is in line with current guidance from NHS England.

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)

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**Report History/Development Path**

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<tr>
<th>Report Name</th>
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<th>Brief Summary of Outcome</th>
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<td>Approved with minor</td>
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<td>2016</td>
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<td>January 2017</td>
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**Private Business**

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960). The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which
relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

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

If you require any additional information please contact the Lead Officer.
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<td><strong>Purpose</strong></td>
<td>Joint Commissioning Arrangements (including scheme of delegation)</td>
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<tr>
<td><strong>Date</strong></td>
<td>11th November 2016</td>
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Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1st May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

2. The NHS England and Wirral CCG joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Wirral

Statutory Framework

3. The National Health Service Act 2006 provides, at section 13Z, that NHS England’s functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be such on terms and conditions as may be agreed between NHS England and the CCG.

Role of the Joint Committee

4. The role of the Primary Medical Care Co-Commissioning Committee (PMCCC) shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.

5. This includes the following activities:

   a) GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual actions such as issuing breach/remedial notices, and removing a contract);
   b) Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
   c) Design of local incentive schemes as an alternative to the Quality of Outcomes Framework (QOF);
   d) Decision making on whether to establish new GP practices in an area;
   e) Approving practice mergers; and
   f) Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes)
   g) Receiving updates from the Primary Care Operational Group on progress of the transformation plan.

6. In performing its role the PMCCC will exercise its management of the functions in accordance with the agreement entered into between NHS England and Wirral CCG, which will sit alongside the delegation and terms of reference. This is the proposed agreement to deal with such information sharing, resource sharing, contractual mechanisms for service
delivery (and ownership) and interplay between contractual and performance list management.

Geographical Coverage

7. The PMCCC will comprise NHS England (Cheshire and Merseyside) and Wirral CCG. It will undertake the function of jointly commissioning primary medical services for Wirral.

Membership

8. The PMCCC shall consist of:

• Accountable Officer or Director of Commissioning
• Director of Finance
• GP and Primary Care Lead Wirral CCG
• GP and Members Council Chair Wirral CCG
• Director of Quality & Patient Safety (Nurse Directorate Lead)
• Governing Body member and Lay Member-Patient Champion, Wirral CCG
• Governing Body member and Lay Member-Audit & Governance, Wirral CCG
• Governing Body member and Lay Member (Quality & Outcomes), Wirral CCG
• Head of Primary Care, NHS England
• NHS England representatives

(The voting membership has a non-primary care medical majority)

The membership will meet the requirements of Wirral CCGs constitution

9. The Chair of the PMCCC shall be the Lay Member (Patient Champion) of the Wirral Clinical Commissioning Group

10. The Vice Chair of the PMCCC shall be the Lay Member (Quality and Outcomes) of the Wirral Clinical Commissioning Group

11. Non-voting attendees will be:

• Head of Direct Commissioning
• Head of Primary Care Transformation
• Commissioning Support Manager
• Health Watch representative
• Director of Adult Social Services (Health and Wellbeing Board Representative)
• LMC representative

12. Conflict of interest – The Chair will discuss the committee’s responsibility to manage conflict of interest. Explicit evidence must be recorded through minutes that the nature of any potential conflict of interest is recorded, who has the conflict and how the conflict was managed to ensure full transparency.
Individual’s appointment to the PMCCC will comply with the group’s standard of business conduct policy including the requirements for declaring conflicts of interest. All members are required to make open and honest declaration of the interest at the commencement of each meeting or to notify the PMCCC Chair of any actual, potential or perceived conflict of interest in advance of the meeting.

Meetings and Voting

13. The PMCCC shall adopt the Standing Order of Wirral CCG insofar as they relate to the:

   a) Notice of meetings (7 day prior to the meeting, this will also stand for the calling of unscheduled meetings)
   b) Handling of meetings;
   c) Agendas;
   d) Circulation of papers; and
   e) Conflicts of interest

14. Each member of the PMCCC shall have one vote (other than NHS England members). The PMCCC shall reach decisions by simple majority of members present, but with the Chair having a second and deciding vote, if necessary.

15. The PMCCC shall be quorate provided there are no fewer than 4 voting members present; they should comprise a lay majority (non-medical) and NHS England members present will always have 50% of the votes.

16. The PMCCC will meet bi-monthly with a view to review occurrence based on need. This panel will meet regularly at Wirral CCG – Old Market House. A list of scheduled dates will be made available on the CCG website.

17. Meetings of the PMCCC:

   a) Shall, subject to the application of 17(b) be open to the public
   b) The PMCCC may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

18. Members of the PMCCC have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective input to the best of their knowledge and ability, and endeavour to reach a collective view.
19. The PMCCC may call additional experts to attend meetings on an ad hoc basis to inform discussions.

20. Members of the PMCCC shall respect confidentiality requirements.

21. The CCG will provide a Secretariat to assist in all meeting planning and to take minutes. In the event of the Secretary being absent, a stand in Secretary will be asked to join the meeting.

22. The Secretary to the PMCCC will be:
   a) Administrative Assistant

   The secretariat will be responsible for:
   b) Circulate the minutes and actions notes of the PMCCC with 10 working days of the meeting to all members
   c) Present the minutes and actions notes to Wirral CCG and NHS England and the governing body of Wirral CCG

Decisions

23. The PMCCC will make decisions within the bounds of its remit as defined in 4, 5 and 6 above

24. The PMCCC will provide regular updates to Governing Body via a bi-monthly executive summary report. This report will also be presented to the Cheshire and Merseyside local office (NHS England)

25. The decisions of the PMCCC shall be binding on NHS England and Wirral CCG

26. Decisions will be published by both NHS England and Wirral CCG

Review Terms of Reference

27. These terms of reference will be formally reviewed by Cheshire and Merseyside regional area team of NHS England and Wirral CCG in April of each year, following the year in which the PMCCC is created, and may be amended by mutual agreement between Cheshire and Merseyside area team of NHS England and Wirral CCG at any time to reflect changes in circumstances which may arise.
1. INTRODUCTION

1.1: Dr Paula Cowan was elected to the role of Medical Director for Wirral CCG and assumed the position on December 1st 2016. This report provides Governing Body with an update on the CCG clinical leads and delegated duties of the Medical Director.

2. KEY ISSUES / MESSAGES

2.1: **Urgent care Update: Dr Paula Cowan, Acting Clinical Lead Urgent Care**

- **Care Navigation**: Ongoing work within the Single Point Access (SPA) continues. The co-location of all teams is almost completed at St Catherines. Discussions have taken place with psychological services with a view to their involvement at this point in the referral pathway. NWAS are referring to Rapid Community Service via Single Point Access (SPA). The respiratory hot clinics are being utilized to max. Regular communication to GP’s to encourage use of next day appointments. Acute Care Unit, accepting referrals from Out of Hours (OOH) GP’s, bookable for Mondays. This has been highlighted to those working in OOH.

- **VSA**: The third and final VSA day was held on the 30th November. Representatives from all partner organisations were present. The 4 models which were proposed by the 4 groups at the end of VSA day 2 were discussed in detail. From this it was agreed that 2 of the models be taken forward, reviewing financial implications and with a robust consultation period engaging public opinion.

- **Urgent Care Recovery Group**: Meeting fortnightly, with continued focus on admission avoidance, flow and discharge processes.

  **Admission Avoidance**
  A streaming and deflection task and finish group has been established to review and address operational issues associated with implementing this process. SPA is being considered as an option to facilitate redirection of patients.

  **Flow**
  SAFER is now implemented within Wirral University Teaching Hospital (WUTH) on all medical wards, Trauma and Orthopaedics and is also being rolled out in the community.
Streamlining North West Ambulance Service (NWAS) hand over in the Emergency Department. (ED)

Frailty flag on the WUTH IT system, allowing specialty nurses for the elderly to in-reach and manage patients via the older patients assessment unit.

Discharge
Home first, discharge to assess pilot currently underway. This is making significant progress with 5 patients accepted through the service at any given time.

SAFER is now implemented within Wirral University Teaching Hospital (WUTH) on all medical wards, Trauma and Orthopaedics and is also being rolled out in the community.

Escalation plans for winter from all partner organisations have been agreed and are being aligned to Operation Plan Escalation levels (OPEL) as set out by NHS England. A full day exercise to review and test escalation plans is being arranged for January during the Safer-Start week.

- **NWAS**: Progressing medical pathfinder with NWAS. Review of NWAS and VCH data. Model of care to be agreed in terms of governance.

- **Think Pharmacy**: Sign up thus far from 18 pharmacies. Communication has been sent to GP’s relating to the conditions managed with PGD and also the pharmacies signed up.

- **OPAT**: Continues to operate well with ongoing increases in bed days saved.

- **Golden Ticket**: Pilot underway with 5 practices signed up. Feedback and interim results will be shared in next report.

2.2: **Long Term Conditions Update: Dr Sian Stokes, Clinical Lead Long Term Conditions**

*Diabetes*: Funding has been agreed at Healthy Wirral Partners Board for the continuation of the community diabetes service for 17/18.

The Diabetes in the workplace health project is ongoing. This aims to support employers to be proactive in providing health promotion, education and screening within the workplace.

The National Diabetes Prevention Programme is now underway in Wirral with referrals already being made to the service. The programme will provide 9 months of education and support for patients with Pre-Diabetes, with the aim of reducing the progression to Diabetes.

A potential new national funding stream which may be bid for has been identified. No firm details are available at this point but once further details of the scheme have been identified, a bid will be made on behalf of Wirral.
• **Respiratory:** Funding has been agreed at Healthy Wirral Partners Board for the continuation of the community respiratory service for 17/18. Wirral Ways to Recovery have identified that there is a high mortality rate in their service users from COPD. There are a number of possible reasons for this and as such Wirral ways to recovery are looking to develop pathways for their COPD patients so that they can be supported regarding their COPD.

Hot slots at the community respiratory clinics, which support management of patients in the community, are bookable through Single Point of Access (SPA). To ensure that most benefit is gained from these appointments and they are utilised most appropriately, guidelines for their use are prepared by respiratory consultant and will be disseminated to practices in due course.

• **Elderly Care:** The service specification for the care home scheme has been drafted. Further work is being undertaken in order to address how this will be delivered. It is estimated that the funding for the scheme is likely to be approximately £1.50/Wirral patient

Work is being undertaken to develop an integrated falls service and to look at a dementia crisis service.

The care home teletriage pilot specification has been agreed by the Local Authority and will be delivered by Wirral Community Foundation Trust. This will start in 10 homes initially in February 2017, with roll out to 30 homes by July 2017.

• **End of Life Care:** A presentation relating to End of Life management was given to local GP’s at an education event earlier this month. Particular emphasis was given to the End of Life Care Plan which is being proposed for use of the community setting.

2.3 **Primary Care Update: Dr Simon Delaney, Primary Care Lead**

• **Co-commissioning:** In a recent survey of Wirral Practices, the proposed move to level 3 Co-Commissioning was rejected. Level 2 will remain at present.

• **Phlebotomy:** The new phlebotomy service was launched on 1/12/16. Wirral Community Foundation Trust has communicated advice around delivery of the service and advised timings of clinics and desired paperwork required to be completed for patients. There continues to be some feedback from practices however the system is now more streamlined and operationally smoother.
GOVERNING BODY BOARD REPORT

- **7 day working:** The outcome of the Estates and Technology Transformation Fund (ETTF) bid is still awaited. It is proposed that the service will be launched in April 2017, subject to contract agreement and sign off.

- **PCSE:** NHSE report ongoing problems.

- **Member engagement:** The GP education event (Protected Learning Time) was held on 8th December 2016. This was well attended with very positive feedback from attendee’s. The next Members council meeting will take place on 11th January 2017.

- **Prescribing:** The repeat prescribing pilot scheme has been launched. Initial feedback is positive with a reduction in prescribing and therefore costs, however there remains some concern from practices about the perceived effect on the workload of practice staff. This will continue to be monitored. The Over the Counter (OTC) and Products of Low Clinical Value (PLCV) policies have been launched and communicated to practices with supporting documentation on 16th December 2016.

- **GP forward view:** A draft transformation plan, Wirral Primary Care Transformation Plan 2016-2020, was submitted to NHSE on 23.12.16. This was shared with Governing Body members and discussed at Primary care strategy meeting. It was also shared with LMC and circulated to all GP’s. It has been agreed that further GP engagement and involvement in the development of the final plan is essential. This will be undertaken early in January 2017.

2.4: **Planned care update:** Dr Lax Ariaraj, Clinical Lead Planned Care

- **Rightcare:** Neurology: A key area of focus at present is the prescribing of generic vs trade antiepileptic agents. Discussions are underway with Neurology consultants to address this issue.

- **Rightcare:** Gastroenterology: Right Care has demonstrated significant variations around gastroenterology which is being addressed through engagement with secondary care.

- **Radiology:** Engagement required with Radiology and Colorectal team to include CT scanning *(to exclude pancreatic malignancy)* in those referrals made from Primary care for patients with symptoms of weight loss and altered bowel habit.

- **Upper Gastroenterology 2week referrals:** Engagement underway with secondary care on the referral forms and pathways.

3. **Clinical Senate:** The clinical senate did not meet in December. The next meeting is scheduled for January 17th 2017.
GOVERNING BODY BOARD REPORT

CONCLUSION

Governing Body is asked to support the work of the Clinical Team in progressing the objectives of Wirral CCG.

Dr Paula Cowan
Medical Director
Wirral CCG.
Wirral Clinical Commissioning Group - Audit Committee

Briefing from the Chair of the Audit Committee

Meeting 17th November 2016

Purpose

Wirral NHS CCG Audit Committee is a subcommittee of the Governing Body which provides assurance in relation to the operation of key financial, clinical and corporate control systems operated by and on behalf of the organisation. It receives and scrutinises progress reports from the external and internal auditors, assesses the accuracy and comprehensiveness of the Annual Governance Statement, and oversees the CCG’s approach to the identification, assessment, mitigation and management of those key risks which might prevent the achievement of the organisation’s strategic objectives.

The Audit Committee agrees an annual workplan, which drives the agenda for its meetings.

The Audit Committee is free to invite any officer of the CCG to attend a meeting, or to commission expert independent advice to assist in the discharge of its responsibilities.

Significant agenda items/key topics discussed

Revision of CCG Constitution to reflect changes to governance arrangements

Review of performance monitoring arrangements for Midlands and Lancashire CSU

Review of Final Accounts timetable and key related activities 2016/17

Receive assurance report from the Finance Committee relating to implementation of the “Lessons Learnt” report Action Plan

Annual review of Audit Committee Terms of Reference

Review progress on implementation of Internal Audit report recommendations (Audit Tracker)

Receive Clinical Governance Assurance Report from the Director of Quality and Patient Safety in relation to arrangements for the Safeguarding of Children and Adults at Risk

Receive progress reports from Internal Audit and External Audit, including approval of changes to the Internal Audit work plan 2016/17

Arrangements to undertake an assessment of the Audit Committee’s effectiveness

Outcomes/actions/assurances/risks

1. The Audit Committee noted and supported the proposed changes to the constitution to reflect:
   • the establishment of the Finance Committee and the addition of its agreed Terms of Reference
   • the establishment of the Primary Medical Care Co-Commissioning Committee and the addition of its agreed Terms of Reference.
   • the dissolution of the Approvals Committee
   • the change of name and function of the former Quality, Performance and Finance Committee to the Quality and Performance Committee
   • other minor amendments to the Scheme of Reservation and Delegation and Standing Financial Instructions
2. The committee was assured that appropriate monitoring arrangements of the CSU’s performance have been introduced through the production of a monthly report using KPIs.

3. The Finance Committee reviews progress in implementation of the actions identified in the Lessons Learnt report which are RAG rated. Progress to date is on target and more focus has appropriately been placed on the critical areas of QIPP delivery and the Better Care Fund financial control arrangements. The Audit Committee requested a sign off report from the Finance Committee when the action plan implementation is complete.

4. The annual review and approval of the Audit Committee Terms of Reference prompted a detailed discussion on proposals to undertake an assessment of the Committee’s effectiveness. This will include a gap analysis measured against the responsibilities set out in the Terms of Reference and a self-assessment questionnaire to be distributed through survey monkey to Audit Committee members and attendees.

5. The Audit Committee was assured that all agreed actions highlighted in internal audit reports have been implemented within the designated timescales.

6. The Director of Quality and Patient Safety presented for assurance a report setting out the detailed arrangements to ensure that all providers of commissioned services comply with their statutory obligations with regard to safeguarding and promoting the welfare of adults children and young people. This includes close liaison and cooperation with regulatory bodies this includes CQC and Ofsted. The Audit Committee will continue to receive regular reports on aspects of Clinical Governance as specified in its Terms of Reference.

Any formal recommendations

The recommendations to the Governing Body from the meeting are as follows:-

1. Approve the following amendments to the Internal Audit work plan 2016/17.
   
i. ADD review of the arrangements to manage Conflict of Interest (COI) in line with NHS England requirements. DEFER review of Partnership governance arrangements to 2017/18.
   
ii. ADD Pan Cheshire/Wirral review of complex care arrangements (CHC) DEFER review of commissioning investment/disinvestment arrangements to Q1 2017/18.

Chair Name: Alan Whittle

Chair of Audit Committee

Date 17/11/16
Finance Committee 20th December 2016

Chairman’s Report

The Finance committee met on the 20th December and ratified the November finance committee minutes. Dr P Cowan joined the meeting in her new role as MD.

Activity Management Group

An update was given on the activity management group meetings and the processes in place for the oversight and performance management of provider contracts.

Financial Report Month 8

The headline October month end financial position for NHS Wirral CCG is a

- £9.628m YTD deficit against resource limit.
- A CCG calculated forecast outturn at month 8 is 11.989m, however as advised by NHSE until review at month 9 the current CCG of £9.028m remains.
- The CCG has agreed to this but informed the NHSE that it will be seeking approval to change the deficit to £11.989m at month 9. This revision will include a worst-case risk of £1.91m and probability risk of £1.0m attached to it and therefore a worst-case deficit of £13.899m and a risk adjusted deficit of £12.989m respectively.
- The forecast outturn which will be reported to the NHSE at month 9 is consistent with the position the CCG was initially reporting at month 6, prior to the identification of financial recovery measures. However, this shows an improvement compared to the forecast of £15.7m, highlighted in the financial recovery plan considered by Governing Body on 6th September 2016.
- The QIPP required to achieve this forecast will be £4.912m, of which £1.035m is to be identified, it expected that the prescribing financial recovery measures will deliver £0.6m reducing the unidentified requirement to £0.435

The finance committee reviewed in detail the finance paper and run rate, the CCG needs to spend £1m less per month to achieve the £9m deficit at year end. Discussions and review of the current measures in place were considered with a focus on current expenditure for Out of hospital care package costs 16/17. Following an audit committee recommendation, it was noted that MIAA will review the current packages, however it was agreed by the finance committee that a wider review was required and the terms of reference will be developed building on the work already undertaken by the CCG team under LQ leadership.

17/18

The CCG’s submission was reviewed, noting that there is likely to be at least one more submission. It was prudently agreed that within the plans, the worst-case deficit scenario is identified.

Contracting update

The team are currently on track to meet the 23rd December NHSE deadline, the WUTH contract will return to a PbR contract.

HRG4+, following a number of CCG’s letters of objection, the NHSE response is expected.
Wirral Clinical Commissioning Group

Briefing from the Chair of the Clinical Senate Meeting November 8th 2016

Purpose
Wirral NHS CCG Clinical Senate is a subcommittee of Governing Body to provide a multidisciplinary, multi-organisational forum for clinical debate to provide the opportunity for clinicians to influence and give leadership in driving forward service transformation.

The Clinical Senate contributes to the delivery of our strategic and operational plans whilst providing clinical ownership of the objectives of the CCG

The Clinical Senate will ensure that improved health outcomes for the population of Wirral are underpinned by a focus on quality and safety.

Significant agenda Items/Key topics discussed
The CCG Conflicts of Interest policy was fully clarified.

Fractured Neck of Femur
It is expected that 85% of those with a fractured neck of femur will be taken to theatre for surgical treatment within 36 hours of entry to hospital.

Achievement levels have regularly been below this locally.

A presentation regarding this, the difficulties in achieving this standard and the work being done to support this was given by an orthopaedic surgeon from Wirral University Teaching Hospital.

This was then discussed by Clinical Senate with particular reference to what others across the system could contribute to the reduction of fractured neck of femur

Wirral Care Record Clinical Safety Case and Clinical Hazard Log
This had been noted at a previous meeting of the Clinical Senate and circulated to members for time for reflection and comment as to the content and in particular to consider if any other potential hazards need addressing.

Members had returned comments which were discussed and agreed.

Advancing Quality
The Associate Medical Director from WUTH presented and discussed results for the Advancing Quality areas of care locally
Clinical Senate discussed these areas of care with specific reference to linking activities to other parts of the system and work planned. An example given was Heart Failure which will be included in our first phase of work regarding Right Care.

**Service Reviews**

The clinical areas involved in the current consultation were discussed and members of Senate were encouraged to highlight the consultation to their organisation and encourage contribution to the feedback.

**Diabetes and Respiratory Pathways.**

An update was given regarding the pilot of integrated pathways in these clinical areas.

Senate strongly approved the integrated working across the system and hoped that the work will continue after the end of the first pilot phase (ie after March of this year) and wished that opinion to be passed to the Healthy Wirral Partners Board.

Governing Body are asked to note the report.

Sue Wells 10/11/16
Report from the Chair of the Quality, Performance and Finance Committee
October 2016

Purpose:
To report to the Governing Body on available levels of assurance and/or escalate risks and
issues requiring action arising from the Committee’s meeting on 25th October 2016.

Significant agenda Items/Key topics discussed:

- Considerable discussion took place regarding urgent care in terms of non-
  achievement of the A/E four hour target, the performance of NHS 111, ECIP review
  and ambulance performance. The Clinical lead for Urgent Care discussed the work of
  the A&E Delivery Board
- RTT performance is below constitutional standards. Details were discussed.
- Breeches in Mixed Sex Accommodation are disappointing as this constitutional
  standard is zero tolerance. WUTH have been issued a performance notice regarding
  this and their response to that will be brought to a future QP meeting
- Whilst C-diff levels are now over trajectory, the considerable improvement over
  figures from last year were highlighted.
- Concern regarding the increase in Delayed Transfers of Care may be due to a
  different definition being used. Further work regarding this will take place with the
  Local Authority.
- The Continuing Health Care performance report was discussed and concerns and
  risks highlighted. This will be kept as a standing agenda item for this committee.
- An update was received from the last Finance committee, currently a subcommittee
  of QPF

Items approved

- The results of the Think Pharmacy pilot were discussed. The committee decided
  following results of the review and in line with other policies recently determined by
  Governing Body to commission a Think Pharmacy Scheme – level 2 only via a
  Patient Group Directive Service. This would help with self-care for patients and urgent care

- Following the decision at October Governing Body to cease funding a range of
  products for minor/self-limiting illness, a policy has been developed which was
  discussed and approved. This will now be implemented, communicating the policy
  appropriately to GPs, nurse prescribers and others.

- The proposal for the cessation of funding Products of Limited Clinical Value was
  approved at October Governing Body. Following this a policy has been developed to
  enable implementation. This was approved.
Formal recommendation

Governing Body are asked to note the assurance of the activity areas of this meeting and the further development of the three policies approved at the October Governing Body.

Sue Wells
Chair Governing Body
Chair of this meeting
Wirral Clinical Commissioning Group

Report from the Chair of the Quality, Performance & Finance Committee (QPF)

Purpose:
To report to the Governing Body on available levels of assurance and/or escalate risks and issues requiring action arising from the Committee's meeting on 20th December 2016

Significant agenda Items/Key topics discussed:

- Review of Risk Register
- Monitoring report October 2016 – particular focus on IAPT and A&E
- Performance of WUTH in a range of areas
- WCCG HR performance

Outcomes/actions/assurances/risks

- Chair of QPF to write to WUTH on behalf of the committee to add gravitas to the concerns with regard to the Trust's performance in key areas that are regularly expressed by senior staff at contract meetings
- Committee was assured that performance with regard to staff PDR to be improved, PE to write to Managers. We therefore agreed to monitor the situation and consider this issue as a potential risk at the February meeting following a further report

Formal recommendations

- That the Governing Body notes the report above.

Linda Roberts
Chair of Quality, Performance and Finance Committee
20th December 2016
Wirral Clinical Commissioning Group
Primary Medical Care Co-Commissioning Committee (PMCCC)
Report to January 2017 Governing Body

Purpose of the PMCCC
The PMCCC is a joint Committee between NHS England (Cheshire and Merseyside) and Wirral CCG. It undertakes the activity of jointly commissioning primary medical services for Wirral and carries out functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.

Significant Agenda Items
Items considered at the meeting on the 8th November 2017 were as follows:

1. **The Final Terms of Reference of the PMCCC** were considered and amendments suggested which will be going forward to the Governing Body of the CCG and NHS England.

2. **Wirral Primary Care GP Access Hubs** – The Committee reviewed the draft service model and procurement strategy and accepted these with the rider that a patient feedback capacity be developed as part of the specification with specific focus on geographical location of hubs, to inform future commissioning decisions.

3. An outline was presented of the **Primary Care Operational Plan**. Noting that a final plan would need to be submitted by the 23rd of December, the Committee proposed an email consultation process prior to submission to the Governing Body for final approval.

4. An update was given on the member consultations around **Co-Commissioning Level 3 Application**. The early indications from a survey monkey poll were that the members might not support this application – in which case it could not go forward. The poll would not close for another three days and committee members would be briefed.

5. An update was provided on the **PCQS 16/17 Highlight Report and Performance**. PCQS 17/18 is to be discussed again at the GP Members meeting on the 17th November. The Committee agreed that a smaller number of indicators should be considered for next year’s scheme. The final draft of the proposed 17/18 scheme will need to be agreed in the January 2017 meeting of PMCCC.

6. **Primary Care Support Services** – an update was received from NHSE about a ‘Risk Summit and Improvement Plan’ agreed with the suppliers. Further updates were agreed for the next meeting.

7. **A PMCCC Annual Workplan** – was received and approved.

8. **A Risk Register** was received and updated.
Outcomes/Assurances/Risks

PMCCC would receive updates on the following items at its next meeting on the 17th July:

- Item 3 - an update on the submission of the Primary Care Transformational Plan / GP Forward View Plan
- Item 4 - review outcomes of Primary Care Co-Commissioning Level 3 member engagement and next steps
- Item 5 - Primary Care Standards 2017/18 review and sign off
- Item 6 - a progress report from NHSE on PCSE

Any Formal Recommendations?

Governing Body is asked to approve the final terms of reference for the PMCCC.

James Kay
Chair PMCCC
Dec 22nd 2016
WIRRAL CLINICAL COMMISSIONING GROUP
Quality Performance and Finance Committee

Minutes

Tuesday 30th August 2016
1pm Room 539, 5th Floor, Old Market House

Present:
Alastair Cannon (AC)  Chair of QPF – Lay Member Quality & Outcomes
Nesta Hawker (NH)  Director of Commissioning
Mike Treharne (MT)  Chief Financial Officer
Alan Whittle (AW)  Lay Member Audit & Governance
Lorna Quigley (LQ)  Director of Quality & Patient Safety
Dr S Wells (SW)  Medical Director/Acting CCG Chair
Dr S Stokes (SS)  Clinical Lead: Long Term Conditions
Sue Smith (SS)  Lead Nurse for Quality and Patient Safety
Laura Wentworth (LW)  Corporate Manager

Board Support
In attendance
Chelsea Worthington (CW)  Corporate Admin

Ref No.  | Minute
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QPF16-17/0029 | 1.0 Standing Agenda Items

1.1 Apologies for absence

Apologies were received from: Paul Edwards & Jon Develing.

1.2 Declarations of Interest

- There were no declarations of interest

1.3 Minutes of Previous meeting from 26th July 2016

The following amendments to the minutes from the previous meeting held on 26th July 2016 were made:

- On page 2 the date of the previous meetings minutes to be added
- Within the section on amendments to the previous minutes remove reference to specific providers and replace with the following text: ‘All reference to specific providers in the previous minutes to be replaced by reference to providers generically.’
- In each paragraph in the minutes referring to performance against a target, the target itself to be stated, eg the cancer performance target.

The minutes have been updated to show the amendments discussed.

With the above amendments the minutes from the meeting held on 27th July 2016 were agreed as a true and accurate record of the meeting notwithstanding grammatical/typographical errors which will be ratified.

Action Points
Members discussed the outstanding actions from the previous meetings and reviewed progress.

The Chair asked that in future the log be updated prior to the meeting to record progress on all open actions. Doing so is accepted as standard secretariat practice and saves valuable time in meetings.

Action: secretariat processes to be amended to ensure that the QPF action log is updated prior to meetings. Paul Edwards

Matters arising

IAPT: The Chair queried whether IAPT performance metrics continued to be confounded by the 800 patients erroneously recoded in the provider’s system. LQ confirmed that this was the case and that CCG’s lead for mental health is leading a meeting with the providers to resolve the matter. In the meantime the Committee noted that the absence of assurance as a concern needing addressing urgently with the provider.

QIPP

3.3 QIPP action plan. It was agreed that in addition to the Finance Committee overseeing QIPP delivery, the quality implications should be reviewed by QPF by reviewing the quality and equality impact processes.

Action – QIPP impact assessment process and worked example(s) to be brought to September’s QPF meeting  Nesta Hawker

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<td>2.0 Items for Decision</td>
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2.1 Safeguarding Supervision for Named Professionals  Policy

LQ introduced the paper by outlining the role of the CCG in providing professional oversight of named safeguarding leads in providers. This is a statutory responsibility for the CCG, and this policy has been reviewed in accordance with the best practice requirements. The amendments have been made in accordance to new guidelines and legislation for Safeguarding. In accordance with best practice, a review of this policy is undertaken every 2 years and amendments made accordingly. However, this policy may be subject to change in accordance with any changes in legislation or statutory guidance.

AC asked if it would be possible to add in one line to state the purpose of the policy on the front page. It was agreed that this would be undertaken.

AC asked what happens if the policy is not being adhered to. LQ explained that this would be addressed and providers held to account within the quarterly contractual process meetings.

Following discussion the committee was assured that effective arrangements remain in place to identify and address any clinical and effective performance concerns and therefore the policy was approved.

Conflicts of Interest Policy

LW presented the policy which has been revised in line with the new guidance from NHS England. Following the approval of this policy, this will be updated on the CCG’s website and staff intranet and declarations of interest/ hospitality will be collated and monitored by the Director of Corporate Affairs and Corporate Affairs Manager.
LW explained the key changes within the policy which include:
- Declarations of Interests to be recorded in line with a new template in meetings
- the requirement for the CCG to refresh the Declarations of Interest on a six monthly basis
- Declarations of Interest and Hospitality / Gifts to be recorded for all staff members and GP Partners (LW and SW will work together to draft a communication for GP practices regarding this)
- The Hospitality / Gifts register is also required to be published together with the register of interests.

The Committee considered that to be consistent, and in the spirit of the requirements of the guidance, in addition, the register of sponsorship should be published.

**Action: the policy to be amended to require the publication of the register of sponsorship. Paul Edwards**

The Committee approved the policy and agreed that because of the nature of the new requirements and novel implications for GP practices the policy should also be included as an agenda item at Governing Body.

The Committee agreed that any formatting, typological or grammatical amendments are to be sent through to LW following the meeting.

**Action: The Conflicts of Interest Policy to be included on a forthcoming Governing Body agenda for information. Paul Edwards**

Given the changes, the Committee sought assurance regarding plans to implement the requirements. LW explained that the revised requirements would be discussed with the chairs of individual committees prior to their next meetings.

SW suggested that there should be a Conflicts of Interest section at the beginning of each members meeting which will include all GPs. It was noted that a briefing regarding this could be included in the weekly Primary care Communications bulletin to advise of the revised process followed by a template with a deadline date to be filled in.

LW suggested that when this policy is rolled out to staff, drop in sessions could be made available to advise staff of the new policy and revised process.

Although no implementation plan was provided the Committee nevertheless was verbally assured that appropriate arrangements were in hand to implement the policy requirements.

The Committee expressed their thanks to LW for the considerable work undertaken to swiftly translate NHS E guidance into a new CCG policy.

**QPF16-17/0031**

**3.0 Items for Assurance**

**3.1 Quality & Performance Reports**

NH presented the Performance Report for the month of June 2016 to the Committee. A discussion took place regarding the report and whether all metrics are appropriate for monthly reporting and whether instead a different frequency might better illustrate trends and patterns.

**Action: NH to review performance pack metrics in terms of reporting frequency.**

AC brought to the committee’s attention the large increase in Delays in Transfer of Care
(DTOC) recorded in the Report and asked why there was no accompanying commentary or explanation. It was agreed that as a matter of course the Report should always include an explanatory narrative where there are deviations in measures.

**Action –** Performance pack preparation and quality assurance processes to be amended to ensure that before dispatch all significant changes and deviations in metrics have an accompanying narrative. Nesta Hawker

A & E (95% standard)
It was noted June’s combined A&E and WIC performance was below the national standard at 87.63%. Performance has failed to achieve with Wirral CCG’s trajectory of 89% but has achieved WUTH’/NHSI trajectory of 84% for June. The Committee was reminded that the CCG has not agreed this trajectory and continues to monitor the provider against CCG plan.

The Chair observed that there were now a number of groups, committees and initiatives with a role in relation to urgent care performance improvement, and that the System Resilience Group had been disestablished. In order to be clear and assured about how the work underway is coordinated and the effectiveness of the lines of accountability the Committee asked that a briefing paper be brought to the next meeting.

**Action –** NH to prepare a paper for the September QPF explaining how the various initiatives with a remit in relation to urgent care improvement are coordinated and to explain the lines of accountability.

RTT Performance 52 weeks
There are currently 0 patients waiting over 52 weeks in June 16/17. The CCG continues to monitor numbers posing a rising risk (40+ weeks) but has noted that this has been reducing month on month.

Mixed Sex Accommodation
There has been 1 breach in June (2 hours and 57 minutes awaiting transfer from ITU, this delay was due to poor medical bed state). This is an improvement but the measure continues to be monitored. However members were informed that despite a deep dive into the issues, the development of a SOP and focus at beds meetings, an increase in numbers has been recorded in the July figures. In view of the increase members were asked to note the action taken by the CCG with the issuing of a performance notice in line with the NHS Standard Contract in relation to these breaches.

Cancer Performance
The targets not met include:
- First treatments for Cancer within 31 days to treat target for June at 95% target is 96%
- First treatment within 62 days from an urgent GP referral for June 82.1% target is 85%

SW advised that it would be good to see a benchmark of the same month from the year before.

**Action** Year on Year benchmarking data to be provided as part of the performance pack.

IAPT

The figures indicate an improvement in access rates whilst the recovery rate has reduced as anticipated in the last report. However as noted earlier in the meeting the large number of patients erroneously not discharged from treatment means that the IAPT metrics currently cannot be relied upon. Furthermore, it has become clear that the national approach to reporting of waits until treatment is recorded only at the point of discharge. Hitherto therefore
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<td>there has been a considerable time lag incorporated in access performance metrics. The Committee welcomed that henceforth the CCG instead would report waits measured at the point of patients entering treatment.</td>
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|         | **Action: a further update on progress to resolve the data issues along with a summary of the provider improvement action plan to be provided at the September meeting.**  
Nesta Hawker |
|         | It was observed that given the poor provider performance last year, comparison data would not be a helpful benchmark.  
Members noted that penalties are being implied for IAPT. |
|         | **Healthcare Acquired Infections**  
- MRSA – there was 0 new cases in June, cumulative score for WCCG stands at 1 incident  
- CDiff – in June there were 8 cases attributed to WCCG, cumulative score stands at 19 incidents, which is on trajectory.  
- All cases of CDiff are subject to a post infection review to ascertain if these were unavoidable or due to a lapse in care. Action plans are developed for any cases due to lapse in care and shared with providers and progress against actions are monitored at the Health Protection Forum. |
|         | **Bed Availability**  
This is a quarterly NHS England Measure. Q1 16/17 overall performance is 84.71%.  
WUTH provider performance:  
- 85.37% of day rate beds were occupied in Q1 – there are 2 escalation wards also open  
- 84.68% of overnight beds were occupied during Q1  
These percentages appear to be significantly lower than comparative Trusts in the region and do not correlate with the position reported by WUTH of requiring opening additional escalation beds. It was reported to the Committee also that WUTH themselves had doubted the accuracy of the bed data provided. The Committee agreed that this was an important metric and doubts as to its accuracy risked confounding the Committee and others in seeking to understand and address patient flow challenges. Accordingly it was agreed that it would be appropriate for the Chair of the Committee to write to WUTH seeking an explanation. |
|         | **Action- Chair of QPF to write to WUTH to request clarification of the bed capacity numbers.** |
|         | **NHS 111**  
Performance continues to be a concern. Percentage of calls answered had increased but it was noted that was achieved against a background of significantly lower call volumes in June. There has been no appreciable improvement in ‘warm transfer’ and ‘call back’ performance. Of equal concern was the prolonged difficulty experienced by the Committee in obtaining details of the analysis of the reasons for the sustained underperformance, the actions agreed with the provider to bring performance back to standard, the date when that would be achieved, along with details of what penalties are being applied in respect of each target missed. The Committee welcomed the local comparative data requested at the previous meeting but expressed frustration that no data could be supplied to indicate comparative national performance. |
|         | **Action NH to contact the lead CCG directly and personally to obtain details of the improvement actions, the improvement trajectory and the contract penalties applicable and being applied.** |
GP Out of Hours

Wirral GP Out of Hours service was affected by a significant change due to the removal of local call handling as part of the national implementation of the NHS 111 service. The result of the imposed change to local service model has resulted in a service that was dealing with an average increasing demand of 3% in the first six months of the year experiencing a 19.5% reduction demand in the second six months of the year.

As the reduced demand has now been sustained for three consecutive quarters this suggests any initial rise or fall in demand anticipated through the change process has been established.

Reduced demand for GP Out of Hours is a positive outcome from the implementation of NHS 111, however there continues to be increased demand pressures in other areas of unplanned and urgent care services, therefore the consequences of change faced by GP Out of Hours needs to be further reviewed against the impact elsewhere in the system.

A further deep dive exercise analysing data from GP OOH and NHS 111 pre & post implementation needs to be conducted to make a full analysis on the impact of change. This also needs to be supported by reviewing and analysing data on A&E and Walk in Centre presentations to assess whether the achieved reduction in demand for GO OOH is at the cost displacement of other services. Therefore any potential cost savings that may be identified could well be offset against cost pressures elsewhere in the system.

The current model of GP OOHs will be reviewed as part of the Value Stream Analysis for urgent care.

3.2 Finance briefing paper

The second Finance Committee meeting had taken place the previous week and some further minor amendments were made to the Terms of Reference.

The main item discussed was an increase of 40% in cost for nursing home care. The committee had considered 3 options and agreed to go with the option to uplift the cost per week to £636 for any contracts that are currently costing £610 or more, in line with nationally set revised rates. For the contracts below £610 there will be no uplift. If challenged this will be examined on a case-by-case basis. However this will result in a year cost pressure of totalling £1.8m.

This Committee endorsed the Finance Committee’s decision.

MT highlighted the dilemma of meeting additional packages of care costs in order to discharge patients from hospital when clinically appropriate. However, because of having block contracts with acute providers there is no commensurate cost saving. This means that the CCG is incurring additional costs for the packages whilst under the block it already covers the cost of hospital activity. Discussion needs to be had therefore with providers about equitable sharing of the financial impact.

The CCG’s financial position continues to deteriorate with overspends in both NHS and Non-NHS activity. The Committee noted that MT will be taking a paper to the Governing Body which will show both the best case and worse case financial outturn. The CCG is due to meet NHS England in the coming week to discuss the CCG’s financial performance.

3.3 Corporate Report
Complaints and MP Enquiries
The committee is asked to review and note the contents of the Corporate Report and LW provided an overview of the contents of the report for this period.

Within the period of 14th June 2016 – 11th August 2016; 46 new complaints were received. One of the complaints received was redirected to NHSE and one was regarding a named provider which has been redirected to them. There have been 2 further ADHD/Autism complaints received regarding delays in appointments being allocated.

There have been 8 new MP enquiries received and 3 which are ongoing are still currently being investigated. There were 6 MP enquiries closed within this period.

Also, there were 17 patient enquiries/concerns during this period.

Two complaints had been escalated to the ombudsman during this period of which the Corporate Affairs Team are awaiting the final investigation reports for one of which confirmation had been received from the Ombudsman that they will not be upholding the complaint. A further update will be provided within the next report to QPF.

LW highlighted that a high number of complaints continue to be received for requests for reviews for Continuing Healthcare (CHC) decisions regarding eligibility and in these cases a full review is undertaken by a Retrospective Review Nurse to determine if the original decision is found to be robust and clinically sound. In the majority of cases, the Nurse did determine that the original decision was sound, however, in some cases a further review of some of the periods are required to be undertaken and following this, the outcome will be provided to the family members/solicitors.

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

In response to a question about the number of extension granted it was explained that the CCG Corporate team negotiate all extensions requested but asked members to note that WUTH’s complaints team work to different time scales for their complaint responses, and that further an extension might be requested depending on the complexity of the cases.

AC requested that the compliance report also include a table summarising the CCG performance against standards in providing responses.

Action: modify the compliance report to include a monthly and year-to-date CCG performance table. Paul Edwards

FOI’s
There were 19 requests received in June and 22 requests in July, giving a total of 41 received for the 2 months. This is a decrease of 7 from the last report. The top 2 areas were CCG Commissioning and Finance & Expenditure. All requests received were responded to within 20 working days. 8 requests remained open at the time of writing this report and their outcomes will be reflected on in the next report.

SARs
In the months of June and July 2016, 10 requests were received, which is an increase of 5 from the previous reporting period. During this period the main area of SAR’s received were requests for Care home/ CHC Assessment Records.

Serious Incidents
Within the period, of June and July Wirral had 51 new incidents reported on the StEIS system which are now being investigated and monitored. Members discussed the incidents reported within the table presented by SS. They noted that within the incidents reported by WUTH it states 2 incidents were reported for abuse/alleged abuse of adult patient by staff. One of these was in fact for a child who had bruises on their body. This has been reported to safeguarding.

Members discussed the high number reported for maternity/obstetric: mother only (foetus neonate and infant) this states that a number of 12 were reported in this period. SS advised the group that this large number is due to changes in the reporting criteria with NHS England so we are bound to see higher figures. The committee was asked to note that following an initial view of these incidents, the majority would be downgraded and not progress to a full RCA.

LQ advised that GPs seem to report more about providers rather self-refer. GPs are asked to report at least 3 per year for their appraisal. SW suggested trying something that will make it easier for GPs to be able to copy and paste information as currently this can be time consuming. SS advised that this is something that they are looking in to.

Members noted that there have been 2 ‘never events reported in August and further information will be presented in the next report.

3.4 IFR Annual Report

The Individual Funding Requests has been a service which has been provided to the CCG since 2013 by CMCSU and now MLCSU. The scope of the service is the management of applications for exceptional funding for residents within the CCG’s footprint which falls outside of the CCG’s contracts with their local, regional and national providers of clinical services. This includes managing a process for referring clinicians to make applications for treatments and interventions that are not routinely commissioned.

AC stated that he found this to be a comprehensive, thoughtful and accessible report which described a good quality service.

There is some learning from this report for practices to make sure they are compliant and more responsible with both IFR and PCLP which was introduced in May 2015. Any issues that are raised will be captured and reviewed in review of PLCP which will be taken through a consultation period.

It was noted that the IFRs received to the team, are referred from a number of resources, ie GPs and Hospital Consultants, and whilst reviewed and decision made on an individual basis, the information in this report is valuable to enable the CCG to review themes and identify if changes are required in commissioning.

AC stated that it would be useful to have a summary Improvements made following the PLCP review.

**Action: a report would be provided to the Committee summarising the actions taken in response to the improvement opportunities identified in the IFR report. Lorna Quigley**

Members welcomed this report and were assured that the CCG was receiving a good quality IFR service.
Members of the QPF committee noted the minutes from the above committees.

### QPF16-17/0033

#### 6.0 Risk Register

**6.1 Risk Register**

The risk register was reviewed by the Committee and members discussed the suggestion that risks be discussed earlier on the QPF agenda. The Committee agreed that henceforth it will give greater priority to reviewing risk by doing so substantively toward the start of its meeting. It was agreed that to support this improvement relevant risk owners will update risk commentary in advance of the meeting and provide a considered recommendation regarding current risk scores.

Members discussed risks due for review at the August meeting and LW provided updates against each of the risks.

MT advised that he will provide an update regarding risk 14-15P at the GB meeting next week following his meeting with NHS England.

*Action LW to revise the format of the risk register for September QPF meeting. Risk register to be moved toward the start of QPF*

#### 7.0 Any other items of Business

**7.1 AOB**

There were no further items discussed

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**Date and Time of next meeting**

The date and time of the next QPF meeting is scheduled for:

- **Tuesday 27th September at 1pm in Room 539 OMH**

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

The meeting ended at: 16:00pm
WIRRAL CLINICAL COMMISSIONING GROUP
Quality Performance and Finance Committee

Minutes

Tuesday 27th September 2016
1pm Room 539, 5th Floor, Old Market House

Present:
Alastair Cannon (AC)   Chair of QPF – Lay Member Quality & Outcomes
Mike Treharne (MT)   Chief Financial Officer
Alan Whittle (AW)   Lay Member Audit & Governance
Lorna Quigley (LQ)   Director of Quality & Patient Safety
Dr S Wells (SW)   Medical Director/Acting CCG Chair
Dr L Ajaria (LA)   Clinical Lead Planned Care
Sue Smith (SS)   Lead Nurse for Quality and Patient Safety

Board Support
Allison Hayes (AJH)  Corporate Officer
Paul McGovern (PM)  Programme Manager
Jackie Harvey (JH)  PWC
Laura Middleton (LM)  PWC
Wendy Farrington-Chad (WFC)  Recovery Director

In attendance
Paul McGovern (PM)
Jackie Harvey (JH)
Laura Middleton (LM)
Wendy Farrington-Chad (WFC)

Ref No. Minute
QPF16-17/0034 1.0 Standing Agenda Items

1.1 Apologies for absence
Apologies were received from: Laura Wentworth and Nesta Hawker. Chair welcomed Wendy Farrington Chad to the meeting and explained to the committee Wendy’s role as Recovery Director within the CCG.

1.2 Declarations of Interest
Chair reminded the QPF members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Wirral Clinical Commissioning Group.

Declarations declared by members of the QPF Committee are listed in the CCGs Register of Interests. The Register is available either via the secretary to the QPF or the CCG website at the following link:
https://www.wirralccg.nhs.uk/Downloads/AboutUs/WhosWho/Register%20of%20Interests%20Versio n%20Updated%20June%202016.pdf

There were no declarations of interest received at today’s meeting.

1.3 Minutes of Previous meeting from 30th August 2016
The minutes from the meeting held on 30th August 2016 were agreed as a true and accurate record of the meeting notwithstanding grammatical/typographical errors which will be ratified.

Action Points
Members discussed the outstanding actions from the previous meetings and reviewed the progress to date.
2.0 Items for Assurance

2.1 Risk Register

PE explained to the committee how the risk register will become more of a focal point throughout the meeting rather than being discussed in full at the end of a meeting, in order to raise and draw member’s attentions to any key risk factors.

PE advised that he will highlight any risks that are pertinent to the agenda item when being discussed and explained that any review status’s will be shortened in order to capture the most recent update. PE reminded members that risk owners are to take responsibility for risks allocated to them.

Members of the QPF Committee noted and were assured that all future risks will be captured appropriately.

2.2 Six Clinical Priority Areas

LQ advised that as part of the new CCG Improvement and Assessment Framework, an initial baseline rating position and process will be undertaken to monitor improvement against a set of metrics to measure the CCG’s performance against the national ambitions for transformation in six clinical areas: Cancer, Dementia, Diabetes, Learning Disabilities, Maternity and Mental Health.

LQ explained that the report presented at today’s meeting sets out the methodologies used for an initial assessment for each of the priority areas and advised that through the Clinical Senate meetings the process will be undertaken and monitored to improve progress against the priorities.

Members discussed how improvements will be measured and LQ assured members that as a CCG, we are able to gather the appropriate data, and source comparable data against other areas.

Action – members agreed that a performance report is brought back to the QPF committee on a quarterly basis and progress taken to the Clinical Senate meetings.

Action- PE to highlight overall risks to the CCGs strategic aim being one of the best CCGs in the County as part of the Assurance Framework review at Governing Body.

2.3 Quality & Performance Reports

NHS 111 – Chair welcomed Paul McGovern, Programme Manager to the meeting who gave an overview of the current NHS 111 performance. JD highlighted that based on national data the North West were answering approximately 95.9% of calls and in terms of abandoned calls the rate was very good. It was agreed that JD would contact Graham Rose and Yvonne Rispen in order to obtain the detailed recovery plan.

Regional & National Picture

NWAS regional performance against recovery targets for North West England
- 95% of calls answered within 60 seconds – 82.93% (July) – YTD 84.35%
- <5% of calls abandoned – 3.76% (July) –YTD 3.9%
- 75% Warm Transfers - 32.88% (July) – YTD 33.32%

In terms of turnaround performance progress is still needed on targets; however Wirral calls are above North West levels for Warm Transfer although still some distance from the KPI.

National comparative data is being collated and verified, early evidence suggests that nationally...
warm transfers are around 40% so there may be questions on the expectation of this KPI. There are between 20-25 providers of the NHS 111 service nationally of which the 5 largest are contracted to Ambulance Trusts with the largest single contract being North West England (population circa 11 million), other much smaller providers with significantly smaller populations make comparison across providers difficult. JD confirmed from the latest weekly Sitrep reports that NWAS are meeting call targets on the majority of working days.

**Wirral CCG activity**
- There was an increase of 519 calls in July on the previous month, whilst partly due to the fact that the previous month was a 30 day month on average July saw a daily average increase of 11.2 calls per day.
- Overall performance saw the percentage of warm transfers reduced by 2% to 38%, otherwise all other performance remained on a par with the previous month
- Out of 5,688 calls in month – 3160 were given a Primary or Community Care outcome, which would be either to the patients GP, GP OOH, or to a Walk in Centre

**Action – JD to contact NHS111 to obtain details regarding the recovery plan.**

**IAPT** – LQ provided an update on the IAPT service and explained that underperformance against the waiting time target which has been exacerbated by additional 800 patients entering treatment has now been resolved. i.e the cohort identified and the reasons why this has occurred. Some of the issues have been due to the discharging of patients onto different pathways.. LQ advised committee that the next performance data which will be for August will not show any improvement however; this will be monitored through various contract monitoring meetings.

**Action – IAPT performance to be monitored and reported to future meetings.**

**Bed Occupancy** – AC advised that he had written to Wirral University Teaching Hospital regarding bed availability but had not yet received a response. LQ fed back her findings following a conversation she has had regarding bed occupancy. The reason that WUTH’s bed occupancy is different to other trusts is that it included maternity, neonate cots, which are making bed occupancy lower. Committee did not feel assured with this reason and therefore NH is to email WUTH in order to receive a formal response. This would also be discussed at the contract monitoring meeting.

**Action – NH to email WUTH with regards to a response in relation to AC recent correspondence.**

**To be discussed in more detail at the WUTH monitoring meeting.**

**CHC Performance** – LQ drew member’s attentions to the CHC and Complex Care performance report for June 2016. Key areas included:
- Cost of care packages
- Eligibility
- Personal Health Budgets (PHBs)
- Overdue reviews and clinical risks
- Complaints

LQ advised that all PuPOcs are now closed and that any risks related to PuPocs (the reviewing of cases) recorded on the risk register can now be removed.

**Walk in Centres/All Day Health Centre activity** – PM pointed out to members that the data originally shown was incorrect and members noted the correct information.

Page 17 of the Wirral Performance report for A&E 4 hour target indicated that whilst in percentage terms the All Day Health was close to 100% the number of presentations had fallen off dramatically.
This was in contradiction to figures on page 22 which indicated that activity for this centre was on the rise. Investigation found a formula error in the data on page 17 which when corrected indicated no significant change in year on year activity comparison.

PM pointed out to members that the data originally shown was incorrect and members noted the correct information

**MRSA** – it was agreed that SS would produce a lessons learnt paper with in relation to 2 new cases being identified in July.

**Action – SS to produce a lessons learnt paper re 2 additional cases of MRSA**

The QPF committee noted the Quality & Performance reports presented at today’s meeting.

### 2.4 Finance Committee Chair Report

MT provided an overview of the Finance Committee meeting which was held on 27th September. MT highlighted the following headlines:

- £6,596m YTD Deficit against Resource Limit
- Change in year-end forecast to £9,028k deficit compared to a plan/forecast at month 3 of £39k surplus
- Due to the late timing of the change in forecast, the report still demonstrates the need to bridge a QIPP gap of £10.3m
- Conflicts of Interest Policy
- Board Assurance Framework
- Multi Systemic Therapy
- Recovery Director

AC sought assurance around the progress of the QIPP delivery and the operational overspend delivery plans to date and MT explained that the CCG are still yet to see the full impact of the work being carried out for example; activity being reduced and that he will be in a better position to report on this activity in a couple of weeks.

AW advised that the PMO lead will now be attending future Finance Committee meetings in order to respond to any challenges around the current project work that is being undertaken.

JD advised that he has written to all provider organisations in relation to operational overspends and is awaiting a response. JD also advised that any developments regarding this has not yet been translated into any savings however it was agreed that this information will be included in future financial updates and summaries.

MT informed the group that a detailed monthly revised finance profile showing the movement of figures will be reviewed at the next finance meeting.

SW reminded members that all future subcommittee reports are to include action points for the Governing Body to gain a line of sight on current developments.

**Action – MT to modify reports for governing Body in relation to Assurance processes**

**Action – PE to record that the risk is more focused on a new £9m deficit target.**

### Finance Committee Terms of Reference (TORs)

MT informed the committee that the Finance Committee’s Terms of References (TORs) have now been agreed and requested that the Quality Performance and Finance Committee note this.
SW explained how deputies would represent key committee members at the finance committee in order for the meeting to be quorate and members acknowledged that Lesley Doherty has been appointed as Chair and that Alan Whittle will be Vice Chair.

The Quality Performance and Finance Committee agreed the Finance Committees terms of reference and supported that the Finance Committee becomes a sub group of the Governing Body and therefore will report directly to the Governing Body Board.

**Action – MT to amend the Finance Committee’s Terms of Reference’s to reflect the Chair and Vice Chair positions and reporting methods.**

### 2.5 QIPP Equality & Quality Impact Assessments

LQ explained how equality and quality impact assessments form a vital part of the CCGs decision making process and explained how the process works during both pre and post consultation processes. LQ highlighted a number of examples for the committee to review and explained how the assessments provide assurance through each programme lead.

Members noted and where assured by the examples provided by LQ and noted the processes in relation to any QIPP projects.

### 2.6 Safeguarding/SBAR Report

LQ informed the QPF committee on the outcome of an Ofsted inspection which was undertaken in August 2016 to review children’s safeguarding services.

LQ advised that the review found widespread and serious failings in the services provided to children who need help and protection in Wirral by Wirral Council and explained how this demonstrates a significant deterioration in the quality of all services that children and young people received since Wirral was last inspected in 2011 and 2012.

LQ reported that nineteen recommendations had been made for specialist services and seven to the Safeguarding Board and explained that an improvement board has been established which the CCG is a member of and the first meeting has taken place and agreed the Terms of reference, governance and reporting arrangements.

**Action – LQ to report back to QPF in 3 months with an update on the recommendations detailed within the Ofsted report.**

### 3.0 Items for Approval

#### 3.1 Policies for Approval

**IG Handbook**

AC explained that the IG policy and handbook required the QPF approval following a previous review at the Audit Committee in September 2016. Members acknowledge that the policy has also been approved by the CCGs SIRO (Senior Information Risk Owner).

The QPF approved the policy and handbook in their current form.

**Non- Medical Prescribing**
SS introduced the Non-Medical Prescribing Policy and asked the committee to agree and approve the amendments shown. SS explained that the policy had been amended to enable standardization of 3 NMP policies across Warrington, West Cheshire and Wirral CCGs and highlighted that the current policy replaces a previous version which was approved in January 2015.

AC sought clarity around replacing the words clinical and supervision and SS explained how this had been amendments from a nursing perspective.

SS confirmed that the policy would be share with practice nurses and managers across the Wirral.

The QPF committee approved the policy and the amendments.

4.0 Items for Information

4.1 Other Committee Minutes

- Serious Incidents Review Group of 3rd August 2016.

  SS updated the group around two never events that have occurred and advised that a scoping exercise around ophthalmology is being conducted and that she will feedback any findings at a later date.

Members of the QPF committee noted the minutes from the above committee.

5.0 Risk Register

5.1 Risk Register

PE advised of a new risk regarding the accommodation situation in relation to Old Market House and assured the group that the lease arrangements are still being reviewed in conjunction with the council.

6.0 Any other items of Business

6.1 AOB

SW gave thanks to AC for his work with the CCG and wished him well for his future.

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The meeting ended at: 16:00pm
Minutes of the WCCG QPF Meeting – 29.11.2016 Page 1 of 9

WIRRAL CLINICAL COMMISSIONING GROUP
Quality Performance and Finance Committee

Minutes

Tuesday 29th November 2016
1pm Room 539, 5th Floor, Old Market House

Present: Linda Roberts (LR)  Lay member Quality and Outcomes Chair
Mike Treharne (MT)  Chief Financial Officer
Alan Whittle (AW)  Lay Member Audit & Governance
Lorna Quigley (LQ)  Director of Quality & Patient Safety
Dr S Wells (SW)  Medical Director/Acting CCG Chair
Dr L Ajaria (LA)  Clinical Lead Planned Care
Sue Smith (SS)  Lead Nurse for Quality and Patient Safety
Laura Wentworth (LW)  Corporate Affairs Manager

Board Support
Allison Hayes (AJH)  Corporate Officer
Susan Maire (SM)  Medicines Management
Gareth James (GJ)  HR Business Support Manager

In attendance

Ref No. Minute Action

QPF16-17/0044 1.0 Standing Agenda Items

1.1 Apologies for absence

Apologies were received from: Nesta Hawker, Paul Edwards and Jon Develing.

Chair introduced herself and welcomed members to the meeting. There were no chairs announcements.

1.2 Declarations of Interest

Chair reminded the QPF members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Wirral Clinical Commissioning Group.

Declarations declared by members of the QPF Committee are listed in the CCGs Register of Interests. The Register is available either via the secretary to the QPF or the CCG website at the following link:

LA declared that he was a part owner of a company that gave travel advice and vaccinations. Malaria vaccinations would be discussed in item 3.1. this was acknowledged by the chair

1.3 Minutes of Previous meeting from 25th October 2016

The minutes from the meeting held on 25th October 2016 were agreed as a true and accurate record of the meeting notwithstanding grammatical/typographical errors which will be ratified.

Action Points
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<tr>
<th>Ref No.</th>
<th>Minute</th>
<th>Action</th>
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<tr>
<td></td>
<td>Members discussed the outstanding actions from the previous meetings and reviewed the progress to date.</td>
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<td></td>
<td><strong>Matters Arising</strong></td>
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<td>Delayed Transfers of Care (DTOC) – The significant increase in in DTOC is due to changes in the reporting definitions. This needs to be monitored closely as there may be implications for the CCG. SW feedback that the CCGs constitutional amendments have now been submitted to Governing Body.</td>
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<td>QPF16-17/0045</td>
<td><strong>2.0 Items for Assurance</strong></td>
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<td><strong>2.1 Risk Register</strong></td>
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<td>On behalf PE, LW gave an overview of the current risk register. Committees members were asked to note the new risk appetite columns which include where the risk owner has detailed they expect the scores to be worked towards, together with a expected target date.</td>
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<td>14-15N Quality concerns following WUTHs CQC visit. Following the progress made the action plans and the presentation given by the Director of Nursing at the October GB Committee agreed that this risk should be removed.</td>
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<td>14-15P Financial risk MT gave an update and recommended that the risk score remains the same.</td>
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<td>14-15T CHC LQ advised the CHC joint committee risk register has now been received and the risks identified here has been included on the CCGs risk register. This risk remains at 16.</td>
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<td>14-15V. Delicate negotiations continue to take place regarding the sub lease of Old Market House and that PE will brief the Chair of this meeting regarding this. Committee agreed this needed to remain on the risk register.</td>
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<td>It was agreed that only actions pertaining to the current financial year should be included within the register. LW to ensure this is updated on future agendas.</td>
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<td><strong>Action</strong> – LW to remove outdated history feed on the current risk register.</td>
<td>LW</td>
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<td><strong>2.2 Quality and Performance Reports</strong></td>
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<td><strong>CHC Report</strong></td>
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<td>LQ gave an overview of the Cheshire and Wirral Continuing Healthcare and complex care performance report for September 2016 and drew member’s attentions to the Wirral Headline Measures and Summaries which included the following key highlights:</td>
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<td>• Number of checklists received – the numbers in month have increased. Number logged within 24 hours increased from 93.07% to 96.12%</td>
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<td>• Decisions reached within 28 days of receipt of checklist decreased in September from 33.3% to 17.9%</td>
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<td>• Fast Track cases with package in place within 48hrs decreased from 69% to 82%</td>
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<td>• Number of patients – increased by 34 (3%) in September</td>
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<td>• Activity in September has increased from August for Full Consideration by 6 (8% increase)and Review activity increased for September by 16 (22% increase)</td>
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<td>• The % of reviews in date has increased by 0.5% from August to September</td>
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<td>• Proportion of spot placements being made out of area – maintained</td>
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No of PHB packages has increased by 2 in month.
Packages over 100K have increased by 0.43% an increase in 8 package over 100K in September. The Average weekly cost has decreased on average by £5.63 per case between August and September.

Chair sought clarity around the action plans the CCG have in place with regards to the monitoring of performance against the trajectories. LQ explained that this will be addressed at the joint committee and a report brought back to the QPF committee.

**Action - LQ to bring an updated report to the next QP committee,**

**ECIP Report – Emergency Care Improvement Programme**

LQ presented the ECIP report and highlighted the following identified recommendations:

- Clarification of the governance structure to support staff making decisions
- Further focused work with care homes to develop pathways that ensure only those patients with a real clinical need are transferred to ED
- SPA referral needs to be as easy as referral to ED for primary care
- Increased use of booked morning slots to ensure frail patients attend secondary care earlier in the day (thus giving the greatest chance of same day discharge)
- Clarification of the definition of intermediate care
- Development of outcome measures – how will you know this service is successful?

AW sought clarity around how the SAFER project is moving forward and whether the CCG is confident and assured that it will deliver what has been agreed and LQ explained that assurance has been given and that the project will be implemented by winter 2016.

SW highlighted how the social media movement has further developed positive engagement and communications with all patients, staff and stakeholders and members went on to briefly discuss a system approach to offer alternative communications on a wider scale.

MT sought clarity around whether ‘length of stay’ reviews are being carried by WUTH and LQ advised that this being reviewed by the urgent care board.

**Action - It was agreed that NH bring to the next committee progress against the recommendations that have been highlighted within the report.**

LQ asked members to note and acknowledge that due to non-achievement pf national targets, assurance regarding the quality and safety of services remained paramount. The following measures are in place:

- All patients are immediately logged onto the system
- Clinical Support workers undertake observations to monitor patients conditions
- Senior Nurse and Consultant available to review patients.

when there are times of high pressure and demand in A&E and if standards fell below 80% in a week then an action plan to maintain patient safety is be require d by the CCG.

**IAPT/Advocacy**
LQ provide the committee with an overview of the current IAPT position as of September 2016 which highlighted the following:

- **Access**: 0.75% target not met (monthly target 1.25%) The 15% access rate is an annual target and is not anticipated it will be met by the end of 2016/17; the CCG are forecasting to meet 11%. Due to the extended waiting times in the service.;
- **6 week waiting time**: 66.51% target not met (75%). this is largely due to an inherited backlog of patients working their way through the system. Local data shows that the standard is being met for those entering treatment. Additional meetings are being held with the provider to establish complex demand and responsive action planning; a revised trajectory is required. The Intensive Support Team will visit the service and provide recommendations to improve service waiting times as a whole
- **18 week waiting time**: 98.17% target met (95%)
- **Recovery**: 44.71% target not met (50%) this continues to be scrutinised in order to achieve the year-end target.

Members discussed the performance issues and it was agreed NH would bring back a report to the QPF committee detailing the actions that are being undertaken to achieve the targets taking into account the impact of the closure of advocacy in Wirral services

**Action –NH to bring a report and action summary of the plans that are in place to achieve the standards.**

LQ advised that the CCG continues to work with the provider and NHS England to achieve national standards, and improve service quality. The CCG uses all contract levers available to improve performance against constitutional targets.

Other areas of focus included:

- Reporting structures-members were asked to note, these is subject to change dependent upon the outcome of December’s GB.
- RTT- non achievement against the constitutional standard and STF requirement. Pressure due to increase demand in dermatology, trauma and orthopaedics.
- Diagnostics achievement against the national standard
- Mixed Sex accommodation. A contract performance notice has been issued, and a meeting held. The CCG is waiting for the action plan in order to monitor progress against the plan in the contract meetings
- Cancer performance – SW highlighted her disappointment with regards to the in month t cancer figures. SS explained that this is monitored monthly at the contract meetings, however achievement against performance is quarterly

### 2.3 Aggregated Report

SS and LW provided an update on the following areas:

**Serious Incidents**

SS advised that within the period of 1st April 2016 to 30th September 2016, 153 Wirral-wide Serious Incidents were reported compared to 169 for the same time period in 2015 - a reduction of approximate 8%.
**Never Events**

SS reported that there were 3 never events reported within this reporting period and advised the committee of the lessons learnt and the recommendations put forward to ensure processes are standardised across all directorates and followed by staff.

**Pressure Ulcers**

SS reported that during discussions with WCFT, it was agreed that they would develop an overarching action plan for pressure ulcers which would support wider learning and actions instead of separate action plans for all incidents identified. This is enabled via the WCFT Pressure Ulcer Multi-disciplinary Review (PUMDR) meetings.

SS informed the committee of the following key findings and explained the actions which are now in progress:

- Lack of holistic care planning and assessment of risk.
- Insufficient sharing of information between the multi-disciplinary team to support the delivery of holistic care.
- Missed collaborative opportunities across the patient care pathway to deliver shared care

**MRSA Bacteraemia or bloodstream infections (BSI)**

SS advised that there is zero tolerance to MRSA however there have been three cases of MRSA bacteremia or bloodstream infection (BSI) identified within the current year to date (Apr 2016 - present) all of which assigned to Wirral CCG (community).

SS highlighted that the first identified MRSA (BSI) was in April and the remaining two within a week of each other in July. A Post Infection Review (PIR) is undertaken for all cases of MRSA BSI, and a panel formed with the purpose to identify how a case occurred and the actions that will prevent reoccurrence in future.

Themes identified:

Themes and learning outcomes from the three cases so far this year have highlighted the following issues:

- Inappropriate prescribing
- Use of long term catheters
- Training and ongoing management of invasive devices
- The need for standardised IPC Training and regular reviewing of arrangements for continence and device training for WUTH, WCT and ‘other’ providers
- Review of policies and practices within ‘other’ local care providers i.e. Wirral Hospice St Johns to provide IPC peer support and promote cross organisation learning
- Clearer communications required between all agencies, particularly around previous MRSA statuses
- Timely recognition of sepsis development by healthcare professionals

**Complaints and MP Enquiries**

LW advised that within the reporting period of 1st April 2016 to 30th September 2016, there were 101 complaints made to NHS Wirral Clinical Commissioning Group and that
the majority of complaints received during this period related to the following:

- Continuing Healthcare (CHC), examples include: concerns raised in relation to CHC Retrospective review delays appeal of the decisions in relation to patient’s current eligibility for CHC funding.

- GP practices – These complaints were redirected to either the practice direct or NHS England for their investigation and response, following consent from the patient / complainant, in line with the CCG’s Complaints Policy.

- Access to service – The majority of these complaints related to concerns raised with issues regarding the changes to the Phlebotomy service.

LW went on to advise that there were 99 complaints closed within this reporting period, some of which had been received prior to 1st April 2016.

**MP Enquiries**

Within this reporting period, there were 22 MP enquires received and LW advised that the majority of these enquiries related to: CHC (Continuing Health Care) concerns, waiting times and access to services commissioned by the CCG including phlebotomy and care and treatment received by patients in relating to services commissioned by the CCG including Inclusion Matters.

LW went on to report that 22 MP enquires were closed during the same period and that all responses with the exception of 2 whereby extensions of time were agreed with the MPs office, were investigated and responded to within the CCGs target Key Performance Indicator of 20 working days.

**PALS – Patient Advice and Liaison Service**

LW advised that within the period of 1st April to 30th September there were 154 enquires received and that the highest number of enquiries received related to GPs and GP practices.

Other areas highlighted included:

- Claims
- Freedom of Information requests (FOIs)

Members sought assurance around how never events are being monitored and LQ advised that she would be presenting a report to the Governing Body detailing this.

The QPF committee noted the aggregated report presented at today’s meeting.

**2.4 HR Report Update**

Chair welcomed GJ to the meeting who presented a report for the quarter July to September 2016 and advised on the following key areas:

**Cumulative Turnover Rate**

- The cumulative turnover rate remained high during the period in question, with it being 18.23% as at September 2016. This is higher than a number of other CCGs. The trend has been a steady increase in the cumulative turnover rate over
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- It is recommended that the CCG reviews any information that exists from Exit Interviews to understand the reasons for staff leaving, and then agree actions to address these, where appropriate.

**Sickness Absence Rates**

- The monthly sickness absence fluctuated above and below the 2.00% target during the period in question, with it being 1.82% as at September 2016. This is one of the lowest monthly sickness rates that the CCG has had in the previous 12 months, though is to be partly expected, given that sickness rates tend to be lower during the summer months.

- The rolling sickness absence rate was above the 2.00% target during the period in question, with it being 2.62% as at September 2016. This includes previous months where sickness rates have been higher.

- It is recommended that the CCG checks that line managers are aware of the key provisions in its Attendance Management Policy, and that appropriate support and sickness management is being provided to staff.

**Statutory & Mandatory Training Compliance**

- The overall compliance rate remained above the 85.00% target during the period, with it being 91.10% as at September 2016.

- The only training below target as at September 2016 was Fire Safety, which had an 84.00% compliance rate.

- It is recommended that the CCG continues to monitor when training for individual members of staff is due to expire, and ensure that they have the opportunity to complete the appropriate refresher training ahead of the expiry dates. Particular attention should be given to Fire Safety training, in the first instance.

**Personal Development Review (PDR) Compliance**

- The overall compliance rate for the previous 12 month period was 37.20% as at September 2016, with only 14.30% having completed and submitted learning plans. Although a specific target is not stated, the CCG should be aiming for 100% of staff to have had a PDR, with a learning plan in place.

- It is recommended that the CCG makes this an immediate priority, and tasks line managers with having to complete PDRs and learning plans for their staff by a particular deadline. Line managers can be offered appropriate support ahead of them undertaking this.

Members discussed the culture of the CCG and how this impacts on the development of staff and the organisation. Further discussions took place around PDRs and members highlighted that the current documentation is not user friendly and requested that these are developed further.
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<th>Ref No.</th>
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<tr>
<td>AW welcomed the mandatory training results and suggested that the achievement target is increased to 90% which members agreed. Members noted the HR performance report.</td>
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<td><strong>3.0 Items for Approval</strong></td>
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<td><strong>3.1 Policies for Approval</strong></td>
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<td><strong>Self-Care Policy</strong></td>
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<td>MT introduced SM to the meeting who provided an overview of the amendments required to be approved by the QPF in relation to the Wirral Self Care and the gluten free food policy. The self-care policy has been previously approved at Novembers QPF, however there have been some suggested amendments which include malaria treatment following discussion these amendments where approved.</td>
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<td><strong>Gluten free Policy</strong></td>
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<td>Following the decision at GB to further restrict the gluten free products a task and finish group has met to draw up the gluten free policy which was presented by SM. Following discussion some further amendments where agreed :</td>
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<td>• the inclusion of Pizza’s in relation to the gluten free food policy is removed as not to encourage unhealthy eating.</td>
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<td>• the sentence is also removed: ‘Clinicians will be required to consider whether the benefit of prescribing a treatment for an individual justifies the expense to the NHS.</td>
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<td>• The letter is approved by the CCG’s head of Communications and Engagement</td>
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<td>SW highlighted the confusion around the communications that have been sent out in relation to these policies and it was agreed that a more updated version would be sent out to practices with a clear communication script.</td>
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<td>The QPF committee agreed and accepted the proposed amendments. Heads of Communications and Engagement to approve the letter to patients</td>
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<td><strong>4.0 Items for Information</strong></td>
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<td><strong>4.1 Other Committee Minutes</strong></td>
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<td>• Serious Incidents Review Group of 5th October 2016.</td>
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<td>Members of the QPF committee noted the minutes from the above committee.</td>
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<td><strong>5.0 Risk Register</strong></td>
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<td><strong>5.1 Risk Register</strong></td>
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<td>LW requested that there is increased enhanced surveillance in relation to never events recorded on the risk register and LW is to update the register to reflect this.</td>
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<td><strong>6.0 Any other items of Business</strong></td>
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<td><strong>6.1 AOB</strong></td>
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Minutes of the WCCG QPF Meeting – 29.11.2016 Page 8 of 9
MT gave a brief overview of the discussion that took place in Finance Committee which was held earlier in the morning. MT will be reporting on the current financial position at the next Governing Body and reported that the recent check point meetings with NHSE have gone well and advised that contracts negotiations are still taking place with WUTH, CWP and WCT.

Members noted the finance update.

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<th>Date and Time of next meeting</th>
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<td>The date and time of the next QPF meeting is scheduled for:</td>
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<td><strong>Tuesday 20th December at 1pm in Room 539 OMH</strong></td>
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<td>Please forward any apologies to <a href="mailto:Allison.hayes@nhs.net">Allison.hayes@nhs.net</a></td>
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The meeting ended at 15:50pm:
Clinical Senate Meeting

Tuesday 9th August 3.00pm
Duncan Room, Old Market House

**Present:**
- Sue Wells (SW) Medical Director WCCG
- Lax Ariaraj (LA) Planned Care Lead
- Simon Delaney (SD) Primary Care Lead
- Sian Stokes (SS) Lead for Long Term Conditions
- Amanda Bennett (AB) Consultant Pediatrician and Designated Dr for Safeguarding Children
- Lorna Quigley (LQ) Director of Quality and Patient Safety
- Melanie Carroll (MC) Community Pharmacy Cheshire and Wirral
- Evan Moore (EM) Medical Director WUTH
- Chelsea Worthington (CW) Corporate Support Admin Assistant
- Elspeth Anwar (EA) Public Health Consultant
- Sandra Christie (SC) Director of Nursing and Performance
- Ewen Sim (ES) Medical Director Community Trust
- Clare Pratt (CP) Deputy Director of Nursing

**In Attendance:**
- Andy Moran (AM) Wirral Care Record Project Lead

**Apologies:**
- Fiona Johnstone (FJ) Director of Public Heath
- Paula Cowan (PC) Lead for Urgent Care
- Catherine Hayle (CH) Wirral Hospice
- Richard Lattern (RL) Wirral Hospice
- Fawad Ahmed (FA) Wirral Hospice
- Mark Lipton (ML) Deputy Medical Director WUTH
- Lesley Doherty (LD) Registered Nurse at WCCG Governing Body
- Gaynor Westray (GW) Director of Nursing and Midwifery/Director of Infection Prevention and Control

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<th>Item No.</th>
<th>Agenda Items</th>
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<tr>
<td>1.1</td>
<td><strong>Welcome and introductions:</strong></td>
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<td>SW welcomed each member to the group.</td>
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<td>As AM was in attendance to give a Wirral Care Record update he introduced himself to the group.</td>
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<td>1.2</td>
<td><strong>Conflicts of Interest</strong></td>
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<td></td>
<td>There were no conflicts of interest</td>
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<th><strong>Minutes and Actions from Previous meeting</strong></th>
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<td>The minutes of the previous meeting held on 14th June 2016 were agreed as a true and accurate record. SS raised that both herself and Sue Smith have the same initials on the July set of minutes. CW to amend to establish and differentiate Sian Stokes and Sue Smith.</td>
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<th>1.4</th>
<th><strong>Matters Arising:</strong></th>
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<td>There were no matters arising</td>
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<th><strong>ITEMS FOR APPROVAL</strong></th>
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<th>2.1</th>
<th><strong>Registry Update</strong></th>
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<td>AM advised the group that the Wirral Care Record and Registries will be ready for testing at the end of August followed by training mid-September.</td>
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<td>There are currently 42 out of 54 practices signed up to ISA which covers 276,000 people and is 83% of the Wirral population. 24 out of 35 are activated data sharing.</td>
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<td>Currently there has been 695 people opt out of the Wirral Care Record with the main reason being that they are concerned about data security. When looking at the ‘opt out’ age range there seems to be an increase from age 50+.</td>
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<td>The registry view in the Wirral Care Record shows if clinically agreed measures have been completed/met for patients across Health and Social Care. If not then the issue can be addressed quickly.</td>
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<td>Cerner have agreed to the CCG having a total of 11 registries to be decided by 2020. Currently the registries are:</td>
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|     | • Asthma (adults and children’s)  
|     | • COPD  
|     | • Adult Diabetes  
|     | • Children’s diabetes |
|     | Included in the pack presented by AM is a diagram of registries linked to the rightcare work which is currently being undertaken by WCCG with support of Carl Marsh. |
|     | AM advised the group of the timelines for the Community Trust, CWP and DASS. ES expressed his concerns of the unknown date for DASS which AM will pick up with Cerner along with the exact date for the Community Trust. |
SS discussed letters that have recently been printed in the papers about the Wirral Care Record, SW advised that after recent discussions with Mike Chantler the CCG’s Head of Comms and Engagement it was felt the most effective response would be to continue with positive messages and information.

SC advised the group that the Community Trust has their AGM meeting next month and it would be really useful to know if patients ask regarding the Wirral Care Record if there was a place to direct them. SW advised that the website seems most popular if they wish to be directed there.

There is further discussion to take place regarding secondary use of data in line with the report from Dame Caldicott which has recently been published.

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<th>2.2</th>
<th>Diabetes and Respiratory Update</th>
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<td>EA advised the group of the new reporting system of a monthly report to the Healthy Wirral Partners Board (HWPB) which is a one page update of the progress, next steps and any asks or risks for escalation.</td>
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<td>There is a business case, more of a service development plan for what services will look like which is due to go the September’s HWPB meeting of the 2 phases. Phase one will be work from April 17- September 17 and then phase two will be a three year plan. Currently there is no financial support for this past April 2017. ES is in favor of the development of this for the patients of Wirral.</td>
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<td>CP mentioned that EA should look at the Knowsley model as they have recently just done some work that could benefit the development for Wirral.</td>
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<td>There has been a roll out of the diabetes plan and discussions have taken place with staff at workshops.</td>
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<td>LA raised a query with regards to the item within the risks for escalation section regarding a delay in progress of care home outcomes due to the lack of quality assurance officer’s input for nursing home visits. EA advised that June Walsh is the manager and wanted to get into all of the care homes to help with improvement on diabetes, as this wasn’t going at the right speed, an issue was raised which EA can confirm has now been resolved.</td>
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<td>EA to bring monthly updates to the Clinical Senate Meeting.</td>
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<th>2.3</th>
<th>Rightcare Detailed Packs</th>
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<tr>
<td>SW was hoping to bring all three detailed packs from Rightcare to the meeting but unfortunately they are not ready. These will be brought to the September meeting.</td>
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<tr>
<td>LA touched on that Wirral CCG spend more on epilepsy with worst outcomes, SW advised that the CCG will be looking at such things in more detail.</td>
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</table>
Members noted the Rightcare packed provided.

SW split the group into two, for separate discussions on what other registries the Senate would like to recommend to be developed and clinical discussions regarding the STP/LDSP. The two groups then reported back to the whole group for further discussion.

### 2.4 Other Registries

Members discussed which registries they thought would be most beneficial for patients on the Wirral.

It was agreed the following areas would be recommended for consideration:
- Frailty
- Adult wellness including sexual health
- Children’s wellness
- Cardiovascular

Once these have been worked on, discussions can always then take place to produce the further registries. Cerner have allowed us to develop these until 2020.

Mental Health was suggested which the group had a lengthy discussion regarding and decided that a tile would be included for depression in adult wellness.

**Action** - SW will consult with the MD of CWP regarding the potential of a Mental Health Registry.

Cerner already have an adult wellness registry developed in the USA, maybe this is something that can used as a starting point to build on.

Learning Disabilities was discussed.

SC asked if there were clear outcomes to come from the new registries that have been discussed?

Like diabetes and respiratory these will go to a workshop as this is about getting the right people involved to discuss and develop.

If a tile is red on a registry it is not the job of someone who doesn’t deal with that issue to do, for things such as ‘flu jab’ or ‘bloods’ but to flag with the patient that this is still outstanding and to direct them to the relevant person.

Group are in agreement for the 4 registries discussed.

Group also welcomed the splitting into smaller groups for in depth discussion.

### 2.5 Clinical Discussion regarding STP/LDSP

The other half of the table had a clinical discussion regarding the STP/LDSP document regarding care closer to home.

ES asked if anyone was aware if the time in minutes on the page was for the patient to reach the services by walking or ambulance etc? This is something that needs to be established.

Can tele care/medicine been removed from the 15 minutes column as this is
received over the phone.

**Action** – add Critical care

EM advised the group that this may not be the best use of time. There needs to be more than just this page for in depth discussion. There needs to be a clear process set up with evidence. National evidence is required as we will need this for any public consultation. When this document is shared with patients there needs to be clarity regarding the purpose of the change suggested.

Process → evidence → narrative → consultation

It was felt the 15 and 30 minute categories should be amalgamated as an 'out of hospital offer'.

We need to look at the places where we spend the most money which is the 60 minute category. The CCG spends ¾’s of its money on hospital services. We need a focus on three areas to focus on and weigh up. Group suggested Emergency Departments, Acute Medical Treatment and Elective Surgery.

SW advised the group that the next clinical congress meeting is scheduled for the 7th September where further discussions will take place. Wirral needs to be well represented at this meeting.

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<th>ITEMS FOR NOTING</th>
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<th>ANY OTHER BUSINESS</th>
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<th>DATE AND TIME OF NEXT MEETING</th>
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<td>The next meeting will be held on:</td>
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**13th September 2016, 3pm – 5pm, Room Duncan, Old Market House.**

Please forward apologies / agenda papers to chelsea.worthington@nhs.net ALL
Clinical Senate Meeting

Tuesday 13th September 3.00pm
Duncan Room, Old Market House

Present:
Lorna Quigley (LQ) Director of Quality and Patient Safety (chair) Wirral CCG
Lax Ariaraj (LA) Planned Care Clinical Lead Wirral CCG
Sian Stokes (SS) Lead for Long Term Conditions Clinical Lead Wirral CCG
Melanie Carroll (MC) Community Pharmacy Cheshire and Wirral
Chelsea Worthington (CW) Corporate Support Admin Assistant Wirral CCG
Elspeth Anwar (EA) Public Health Consultant Wirral Local Authority
Sandra Christie (SC) Director of Nursing and Performance Wirral CT
Paula Cowan (PC) Clinical Lead for Urgent Care Wirral CCG
Mark Lipton (ML) Deputy Medical Director WUTH
Faouzi Alam (FA) Medical Director CWP
Avril Delaney (AD) Director of Nursing, Therapies and Patient Partnership CWP
Clare Pratt (CP) Deputy Director of Nursing WUTH
Lesley Hodgson (LH) Clinical Lead for Diabetes
Nikki Stevenson (NS) Clinical Service Lead for Respiratory Medicine WUTH
Kathy Fegan (KF) Clinical Lead for Respiratory

In Attendance:
Laura Middleton (LM) PWC- in an observational capacity

Apologies:
Lesley Doherty (LD) Registered Nurse WCCG Governing Body
Gaynor Westray (GW) Director of Nursing and Midwifery/Director of Infection Prevention and Control-WUTH
Ewen Sim (ES) Medical Director WCT
Sue Wells (SW) Medical Director/Acting Chair WCCG
Amanda Bennett (AB) Designated Doctor WUTH
Simon Delaney (SD) Primary Care Lead Wirral CCG

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<th>Item No.</th>
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<tr>
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<td>LQ welcomed each member to the group.</td>
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<td>Members introduced themselves and their job role.</td>
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<td>1.2</td>
<td>Conflicts of Interest</td>
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There were no conflicts of interest declared pertaining to the agenda.

1.3 Minutes and Actions from Previous meeting

The minutes of the previous meeting held on 9th August 2016 were agreed as a true and accurate record.

1.4 Matters Arising:

SW has contacted FA regarding the potential for a Mental Health Registry. FW is happy to coordinate this work and lead this group

Action- LQ to get an update from Jon Develing to ensure that critical care was added to the STP/LDSP document.

ITEMS FOR APPROVAL

2.1 Person Centred Framework

AD presented the Person Centred Framework
A workshop was held on the 21st June where staff members, carers and service users from all localities from within CWP met with the aim to develop the first set of principles for Person Centred Framework.

Listed below are the principles which come from the workshop:

1. We are all unique, with our own strengths, needs and aspirations. We know that everyone has different abilities and that we all have something to offer. We will respect and nurture different experiences and viewpoints.
2. We are both willing to learn and are glad to support everyone to live full lives
3. We believe that mental health and physical health are as important as each other. We will work together to make life the best it can be, remaining positive and hopeful, treating each other fairly and consistently.
4. We will celebrate our achievements and learn from everything we do, and we will have the courage to speak up and voice our views we will always try to improve things to make a lasting difference.
5. We will be honest, realistic and clear about our roles, using language that we all understand.
6. We believe it is important for us to know what matters to each person we meet. We will be adaptable in our approach, working in partnership to provide care which, as far as possible takes into account each person’s preferences.
7. We will encourage and support informed decision-making, giving everyone the choice of when to invite others to act on their behalf. We will empower people to express their preferences and provide support and advice on the different options available, allowing people to make meaningful choices.
8. We will work with everyone’s strengths, abilities and those things we
may not be so good at, to work together to achieve our goals, taking
time to celebrate the good things we do.

The principles have been brought to Clinical Senate in order to receive some
feedback before these are due to be launched in February 2017.
FA advised that CWP have adapted the 6 C’s in every aspect of what they do
and that’s how they would want these principles to be adopted

LA raised regarding principle number 7 although he is not saying this should
be removed it would be useful to consider that the option may not always be
available.

EA advised that within the next agenda item, there are patient centred
outcomes which have come from workshops that may be able to link in with
the work from CWP.

As part of AD’s job role at CWP there is a strategy that they have for Mental
Health that they wish to adapt right across the services.
CWP would also like to develop recovery colleges to help with patients with
their self-care.

Clinical senate members are in agreement with the principles presented and
where asked to share with wider colleagues within their organisations for
feedback. Comments are to be back with AD before the workshop which is
being held on 19th October. Once agreed these will be going to CWP board in
December.

2.2 Diabetes & Respiratory Business Case

EA and AR introduced the proposed business case to the senate. The
purpose for this was for clinical input prior to the submission of the business
case to the Healthy Wirral Partners Board scheduled on 22nd September. The
following models have been developed with health and social care staff and
patients, informed by data intelligence and national evidence base over a 6
month period.

These models will be presented as proposals by clinical leads to the Healthy
Wirral Partners Board on 22nd September.

It was noted that when looking at the 5 year vision for Long Term Conditions,
it has been found that there is an overlap on work for both Diabetes and
Respiratory.

The attached (attach it) was presented to the group which outlined the future
Long Term Conditions model which included a one stop shop. This has been
developed following a workshop that has recently been undertaken. The
vision is to have a number of services in the one place to encourage
attendance from patients and to encourage a consistent approach in the
review of management plans and upskilling the wider workforce

The 6 person centred points from a patient living with Long Term Conditions
in Wirral are:

• Support from the whole of the healthcare team (including specialist)
• Confidence in monitoring and self-managing my condition
• Getting the right medication and treatment for me
• Impact on everyday life (including working life)
• Keeping fit and mobile; getting out and about (including transport)
• And the last one to be specific domain for the condition

Nikki Stevenson presented the slides for respiratory proposal for implementation over the next 2 years. Members noted that pilots have been started and 4 clinics are underway in different locations.

Key points: Primary and Community Care
• Majority of patients with asthma and COPD are managed in Primary Care
• All new patients to be referred to intermediate services for 1 stop education and management plan (conformation and written plans of diagnosis)
• Increase community pharmacy medicine optimisation reviews
• Upskilling for nurses, care homes and pharmacists via Nurse Educator role provided by intermediate service

Key points: Intermediate Service

There would be 4 satellites (including consultant/GPwSI/Respiratory nurses/psychology/COPD, PR (not sure what this is) and oxygen team team) to continue and build on existing pilots to:
• Develop reassurance/support helpline 8-8 7 days a week
• See patients with moderate/severe asthma and COPD patients whose spirometry doesn’t match symptoms
• See all new asthma patients 1 stop education and written management plan and referral to PR
• Expand rehabilitation class to all patients with fixed airflow obstruction
• Increase capacity of specialist respiratory physiotherapy for patients with asthma

Key Points: Early Support Discharge
• Continue COPD ESD team working 7 days a week linked to Rapid Community Service.
• This is currently 5 days a week but will have an extension from December 16

Acute Hospital – Complex Specialist & Inpatient Care
• See complex patients

Lesley Hodgson CCG GP lead for Diabetes presented the proposed service for Diabetes for the next 2 years

Members noted the spoke clinic’s started in November 15 and then in April 16. Input from patients has been very useful to use in developing the service description.

Key Points: Primary and Community Care
- Majority of patients with diabetes are managed in primary care
- Upskilling for nurses, care homes and pharmacists via Nurse Educator role provided by intermediate service
- Increase community pharmacy medicine optimisation reviews

**Key Points: Intermediate service**

Build up capacity and breadth of MDT including dietician, diabetes specialist nurses, psychologist within 4 ‘satellites’ including:
- One triage service for all referrals, the majority of patients seen the intermediate service
- Education programme for patients and staff optimized and implemented within different community settings
- More complex patients to be reviewed in the intermediate service as appropriate
- Care homes intervention (multidisciplinary)

**Key points: Acute Hospital ‘hub’ complex specialists**

- Continue development of MDT complex foot clinic
- Appliances element of podiatry including total contact casting and orthotics
- See complex patients

Following the presentations, the Clinical Senate were requested to answer the 3 following questions:
1. What do you like about the models?
2. What will help us implement the models
3. What could you do to help this go faster/be more effective?

During discussion, it was agreed:

**Question 1** – the models are integrated, they have a great direction of travel, the patients journey is made a lot easier, they enhance care and patients will be able to have the knowledge of their condition.

**Question 2** – More mental health involvement, work on early intervention, get 3rd sector organisations involved i.e the fire service, same language used right across Wirral, have flexibility on when being pro-active, get the best from the Wirral Care Record

**Question 3** – Equip staff for training, communication to everyone.
LA suggested an animated YouTube video for a patient’s journey.

AD suggested thinking about peer support; this will help patients and would be useful to have in places such as the one stop shop.

LA likes how both Respiratory and Diabetes link together so much. Has there been any thought about similar pathways for the 2? There seems to be one for Respiratory but not diabetes, LH advised that this is because Primary Care are good at what they do in the initial stages. LA also advised how good it would be to upskill staff.

Patients will be allowed to have a plan which suits them, whether they carry it around or have it accessible on their phone etc. This will also be accessible to
both Primary and Secondary care.

**Action** – AR and EA to feedback to the Clinical Senate at the next meeting regarding a Business Case update.

Senate members expressed their gratitude to LH, AR, EA, NS & KF for all their hard work over the past 6 months.

### 2.3 Redesign of Clinical Pathways (attached the slides)

AR presented a proposed process for redesign of clinical pathways. This has recently come from event that has taken place on the 19th August with a proposed model to go to the Healthy Wirral Partners board meeting on 22nd September.

Senate was asked to note that this process is designed for large service transformation. And therefore the cycle should take 6 months.

LA advised the group of how time consuming redesigning a pathway can be. He has recently been involved in the redesign of the MSK pathway which still seems to be a long way off.

LA asked if there are any short cuts of lessons learnt from previous pathways that could potentially help shorten the process.

EA advised that they may be able to hurry things through but this will not give the pathway re-design the attention it needs, the CCG wish to make sure that everything is done properly, no matter of the time.

The principles and resources required throughout the process will be:

- Executive sponsorship
- Clinical engagement
- Clinical leads
- Management support
- Financial input/modelling
- Business intelligence input

Group agreed the process and principles for the redesign on clinical pathways.

### 2.4 EOL Feedback

Community Trust on behalf of all partners has submitted a bid to NHSI for a Transformational Change through System Leadership which has been successful. This will commence in October until December with participants having to complete at least 2 hours week per week throughout the programme for the virtual elements. The area of transformation which will team will focus on will be end of Life Care.

There will be a further updates and progress will be reported through senate.

### 2.5 Quality Impact Assessment

LQ suggested to the group about bringing Quality Impact Assessments to the
meeting for a clinical discussion not to undermine the process that is established within organisations, but as a way of considering the impact and how by working together these can be mitigated against.

Agreement was given in principle, however. There needs to be a balance of what comes to the meeting.

Group agreed for some draft principles to be drawn up to for consideration.

### ITEMS FOR NOTING

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<tr>
<th>3.1</th>
<th>IFR Annual Report</th>
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<tr>
<td></td>
<td>Members noted the IFR Annual Report.</td>
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<td>AD expressed some inaccuracies within regard to the report relating to mental health. It was agreed to discuss these outside of the meeting.</td>
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<th>3.2</th>
<th>Wirral Care Record Clinical Safety Case/ Clinical Hazard Log.</th>
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<td>Members noted the risk register</td>
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<th>Clinical Senate Dates</th>
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<td>Members noted the future Clinical Senate dates for 2017</td>
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<th>Papers from Clinical Groups</th>
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<td>Members noted the draft minutes and papers from other clinical groups</td>
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<td>PC advised that the SRG group meeting has now become the A&amp;E delivery group meeting to be chaired by David Allison CEO WUTH</td>
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### ANY OTHER BUSINESS

| 4.1 | SC brought to the committee’s attention that recent publication of the Kingsfund report for district nursing. Senate agreed that this would be useful to be agended for the next meeting |

### DATE AND TIME OF NEXT MEETING

The next meeting will be held on:

**11th October 2016, 3pm – 5pm, Room Nightingale, Old Market House.**

Please forward apologies / agenda papers to [chelsea.worthington@nhs.net](mailto:chelsea.worthington@nhs.net) ALL
Clinical Senate Meeting

Tuesday 11th October 3.00pm
Duncan Room, Old Market House

**Present:**

Sue Wells (SW) Medical Director/ Chair WCCG  
Lorna Quigley (LQ) Director of Quality and Patient Safety Wirral CCG  
Lax Ariaraj (LA) Planned Care Clinical Lead Wirral CCG  
Sian Stokes (SS) Lead for Long Term Conditions Clinical Lead Wirral CCG  
Chelsea Worthington (CW) Corporate Support Admin Assistant Wirral CCG  
Sandra Christie (SC) Director of Nursing and Performance Wirral CT  
Paula Cowan (PC) Clinical Lead for Urgent Care Wirral CCG  
Mark Lipton (ML) Interim Medical Director WUTH  
Faouzi Alam (FA) Medical Director CWP  
Simon Delaney (SD) Primary Care Lead  
Ewen Sim (ES) Medical Director CT

**In Attendance:**

Susan Maire (SM) Senior Medicines Optimisation Lead  
Rachael Pugh (RP) Practice Pharmacist  
Jess Davey (JD) GP shadowing Sian Stokes

**Apologies:**

Lesley Doherty (LD) Registered Nurse WCCG Governing Body  
Gaynor Westray (GW) Director of Nursing and Midwifery/Director of Infection Prevention and Control-WUTH  
Amanda Bennett (AB) Designated Doctor WUTH  
Elspeth Anwar (EA) Public Health

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<td><strong>PRELIMINARY BUSINESS</strong></td>
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<td>1.1</td>
<td>Welcome and introductions:</td>
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<td>Wirral CCG have updated their policy regarding Conflicts of Interest in line</td>
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with new guidance. This will be addressed at each meeting and a declaration must be made by anyone who has an 'individual' conflict of interest with an agenda item in the meeting. The chair will then make a ruling as to the action to take in light of the significance of that conflict.

SW reminded committee members of their obligation to declare any interest they may have on any issues arising within the meeting as an individual. LA advised the group that he works at WUTH doing Endoscopy, SW advised LA that he could remain in the room and take part in the discussion regarding gastroenterology but not be part of the decision making regarding recommendation from the committee for this item.

1.3 Minutes and Actions from Previous meeting

The minutes of the previous meeting held on 13th September 2016 were agreed as a true and accurate record.
SC asked for additional wording to be added to the first sentence of the EOL feedback. This will now read that the Community Trust on behalf of all partners submitted the bid.

1.4 Matters Arising:

SW asked LQ for an update from Jon Develing to update members on whether critical care was added to the STP/LDSP. LQ ensures members this has now been done.

It was suggested on the back of talks at the last meeting that Quality impact assessments for service review/ additional PLCP items should come to a Clinical Senate meeting.

Members noted that the Wirral Care Record clinical case/hazard log which came to the September meeting, will be sent out again to all members to advise on any risks or hazards members might feel have been omitted.

There is an action for LQ and Avril from CWP to meet outside of the meeting to discuss IFR panel, which LQ confirms has been done.

ITEMS FOR APPROVAL

2.1 Rightcare Packs

SH delivered a presentation regarding the cardiovascular Right Care work for members to view and discuss any further key areas they wish for the next stage of the Right Care programme to consider in further detail.

This approach has been put together to focus on some of the key areas.

Each focus pack provides detailed information on opportunities to improve in the highest spending programmes, which include a wider range of measures and information on the most common procedures and diagnosis for the condition in question.
By using information, together with local intelligence and reports, the CCG will be able to ensure its plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities.

Included in the presentation was data reported regarding Hypertension. Members noted that this is key.

The data presented is up to 2 years old, but SH advised she will look into getting a more up to date data pack to compare figures. BI can access both the hospitals and practices data, so they would be able to do a comparison with both and look to see if there was any coding errors which could link in with why WCCG are currently the lowest performing CCG for Hypertension. The group also discussed if the CCG could link in with the fire brigade and CWP who also do health checks.

The CCG also needs to speak to St Helens CCG who are currently the top performing CCG for Hypertension to see if there is something they are doing different we could learn from. SH is happy to give them a call to see if they can relay some of their work.

Members also looked at data for:
- Mortality
- Coronary heart disease
- Stroke or TIA
- AF
- AF patients with stroke risk

SH presented the top 10 diagnosis codes by cost and activity for non-elective admissions in 15/16 and group agreed that this information would benefit to have some clinical input as some of these headings could be grouped together.

The next steps for CVD are a workshop with all CVD clinical group members to redesign and transform pathway work, communication and engagement and improve outcomes and efficiency.

Also included in the papers were also packs for:
- Gastrointestinal
- Respiratory
- Neurology

As shown in the above packs, the CCG are performing well in some areas and not so well in other areas. The Clinical Senate needs to decide the next best key areas that will make a change in figures.

SH presented to the group a spreadsheet for a patient’s journey for AF which included primary and secondary diagnosis and length of stay for each patient.

Due to the large total, SH has had discussions with John Halliday at the hospital who looks at this sort of information and coding, he has advised that
the person who inputs the data is currently off on maternity but there are
other people within her team continuing the work, the only way to get to the
bottom of the coding issues may be to do a clinical audit.
We need to look to see if the primary diagnosis is really what these patients
are coming in with.

After consideration Clinical senate recommended further work regarding
Hypertension, AF and Heart Failure

Gastroenterology
CCG members met with Carl Marsh from Rightcare on the 10th October
regarding Gastro and looked at the data presented which showed that Wirral
CCG where the 2nd highest in this section. SW advised the group of some key
issues which come out of the meeting.
After discussion Senate recommended further work regarding Gastritis,
hepatobiliary ( alcohol) NEL diverticular disease and constipation

Respiratory
A huge amount of work has taken place across a number of providers.
Group discussed Clinical Senate should consider consistent leaflets for all
providers to have the same information.

Members noted that it is self-care week In November that providers could
supply a big push on.
Respiratory work would continue via the Healthy Wirral respiratory work
which is ongoing

Neurology
Medicines Management have recently been in discussions to switch a current
epilepsy drug which could reduce monies.

After discussion Senate recommended further work around Epilepsy (medication and NEL), pain, headache (including migraine)

Many items discussed regarding the Right Care packs could be affected by
the Wirral alcohol consumption problem. SW to have a separate conversation
with Elspeth from Public Health.

SH to attend the January Clinical Senate to give an update.

2.2 Kingsfund-Quality Framework for District Nursing

ES declared an interest as Medical Director of WCT.

The Kings Fund report 2016 is based on research and surveys into what
good district nursing care looks like, it was found that activity has increased
significantly in the last few years, complexity of care has increased and
nationally the workforce, particular senior nurses has declined in the same
period.

All members are aware of the pressure to deliver a good community nurse
system nationally. The pressure has seen:
- Increased task focused approach
- Staff rushed
• Reductions in preventative care
• Lack of continuity to care
• Impact on staff wellbeing: increased absences, burn out, difficultly recruiting and staff leaving/retiring
• Lack of national quality metrics
• Lack of sustainable staffing model

What it looks like as a local picture on Wirral:
• Struggling to recruit but some success with quarterly recruitment events
• Retirements of senior nursing staff
• Increased activity and acuity
• The service recorded its highest level of activity yet in August, just short of 30,000 contracts in month and 1,300 contracts above plan
• Additional activity in block contract e.g. average of 400 nursing hours per month on IV antibiotic administration.

There is currently a traffic light system being used to identify local pressures across the 12 community nursing teams.
SC presented to the group a table which included the amount of each coloured days for visits for the 12 community nursing teams for the months (excluding weekends) July, August and September.

As system leaders we need to start recognising the importance of district nursing, in realising our ambitions of Healthy Wirral and STP and be aware of when these are under pressure.
We need to develop a sustainable, resourced community nursing workforce to deal with capacity and demand.
We also need to manage demand on the service - central triage, E-rostering and E Allocation, nursing home support work.

These issues were discussed by members

2.3 Six priority clinical areas

LQ brought this paper to the Clinical Senate meeting to highlight the priority areas which have come from the 5 year forward review in October 2014. The planning guidance sets out national ambitions for transformation in six vital clinical priorities: Cancer, Dementia, Diabetes, Learning Disabilities, Maternity and Mental Health.

For year end the CCG will receive an overall rating for each of the six clinical priority areas on a four point scale.
• Top performing
• Performing well
• Needs improvement and
• Greatest needs for improvement

The overall rating is arrived at by looking at the scores of CCGs on individual indicators from the CCG Improvement and Assessment Framework. For 16/17 year-end ratings which will be published in June 2017, CCGs will receive a CQC style rating.
Presented to the group was Annex B – A baseline assessment of six clinical priority areas which included the name of the clinical area, the overall rating and the indicator rating. Ratings are measured quarterly against the indicators nationally set.

Members noted there is a vacancy for the Cancer Clinical Lead as Jane Fletcher has officially left at the end of September. Members discussed each heading and the ratings given; SW identified that LA and SS to pick up the areas outside of the meeting. LA advised that he will speak to Peter Arthur regarding mental health.

Maternity is showing that it is performing really well, whereas diabetes shows great need for improvement – poor participation in the audit measured. Members particularly talked about the indicator rating for diabetes which states that only 7.3% of GP practices participated in the National Diabetes Audit. Members advised that some practices are not aware of this audit, but this needs to be highlighted. ES advised that he will raise this at the next PLT meeting.

### 2.4 Diabetes and Respiratory update

Members noted the one page Diabetes and Respiratory update sent from HealthyWirral.

SW gave feedback for the business case which was presented to the Healthy Wirral Partners Board. The group was very supportive and have advised to write to Sam Jones to see if there is any further resource available. There is still some further work to be done to work out what part of the system savings would be made for. The Healthy Wirral team will be coming back to the next Healthy Wirral Partners Board to give an update.

ES gave feedback to senate from the Healthy Wirral Information Governance meeting about lack of progress following key personnel leaving for other jobs. ES is asking for Senate to give the support to the Healthy Wirral Partners Board meeting.

SW asked if the group if they would be happy if SW took this to Healthy Wirral Partners Board support from the Clinical Senate that replacement for this post (project manager for Wirral care|record), Group agreed.

### ITEMS FOR NOTING

#### 3.1 Papers from Clinical Groups

Members noted the draft minutes and papers from other clinical groups

#### 3.2 Conflicts of Interest policy

Members are asked to review and note the updated policy and appendices. Section 13 of the policy also details the process for managing conflicts of interest at meetings and the decision making processes. A template for recording any interests during meetings is also included within appendix f.

#### 3.3 Medicines Management Terms of Reference
Members noted the Medicines Management Terms of Reference. Group agreed they are happy to receive minutes from this meeting going forward to both note and agree. Both a GP lead and Medicines Management lead sits on the both the Medicines Management Committee and Drugs Therapeutic meeting. Currently looking at this being commissioner led and to tie in with all the current STP work.

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<th>ANY OTHER BUSINESS</th>
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4.1 LQ advised the group that PWC have made some recommendations for the Clinical Senate. When the report has been publically published, LQ will bring to the meeting for members to review.

SW advised members that she has recently been appointed as Chair of the CCG, she will continue to chair the senate meetings until a Medical Director has been elected in post. Group congratulated SW on her new job role.

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<th>DATE AND TIME OF NEXT MEETING</th>
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The next meeting will be held on:

8th November 2016, 3pm – 5pm, Room Nightingale, Old Market House. Please forward apologies / agenda papers to chelsea.worthington@nhs.net

ALL
Present:

Lesley Doherty (LD)  Registered Nurse Lay Member (Chair)
Alan Whittle (AW)  Lay Member
Mike Treharne (MT)  Chief Finance Officer
Dr Susan Wells (SW)  Medical Director
Mike Cunningham (MC)  Deputy Chief Financial Officer
Wendy Farrington-Chadd (WFC)  Recovery Director
Graeme Hancock (GH)  Business Intelligence Manager
Tricia Clitheroe (TC)  Head of Contracts and Delivery

Note Taker:
Chelsea Worthington (CW)  Corporate Support

In Attendance:
Vic Horton (VH)  Reporting Accountant

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<td>WCCG/Finance Committee /29.11.2016</td>
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Apologies for absence

Apologies were received from: Nesta Hawker

Declarations of Interest:
Chair reminded the Finance Committee members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Wirral Clinical Commissioning Group.

Declarations declared by members of the Finance Committee are listed in the CCGs Register of Interests. The Register is available either via the secretary to the Governing Body or the CCG website at the following link: https://www.wirralccg.nhs.uk/Downloads/AboutUs/WhosWho/Register%20of%20Interests%20Version%20Updated%20June%202016.pdf

There were no declarations of interest received at today's meeting.

Notes & Actions for the last meeting

The minutes from the meeting held on 25th October 2016 were agreed as a true and accurate reflection notwithstanding typo and grammatical errors.

Matters Arising

PMO Update
MT confirmed that Jim McKenna has now started to sit along side the PMO function to strengthen the team. He is currently working 2 days a week which will be reviewed with extension if needed.
**AMG Update**
WFC provided the committee with an update from the Activity Management group meetings.
WFC advised that at the last meeting it was agreed that a director would be in attendance at each meeting to give support and help in the key areas. WFC observed and confirmed that the group are focussing on the right areas. The group needs to revisit the Terms of Reference and the current chair arrangements. It is also essential that the group has clinicians in attendance for their input in decisions. Directors have agreed they should attend the AMG meeting in rotation and feedback for consistency will go to the directors meeting.

**Financial Report Month 7**
MT presented the finance report which reviews the headline financial position for NHS Wirral CCG as at the end of October (month 7), and highlighted the following headlines:

- £8.319m YTD deficit against Rescource Limit
- Year-end forecast remains at £9.028m deficit, and assumes £3.6m targeted recovery measures moved from QIPP reserve to operational budgets for forecast outturn at month 7 will be achieved
- Remaining balance on QIPP reserve of £0.7m- schemes need to be identified
- £2m of risk is attached to forecast. This could equate to outturn of £11.028m
- Worst case deficit £12.6m (if none of the £3.6m recovery measures were achieved)

As at the end of October, The CCG has reported a deficit of £8.319m.

Presented to the group was table of all expenditure areas with 3 different columns for M7 indicating the budget holder view, M7 pre management actions and M7 after management actions to give the group a better understading of the expenditure.

The Liverpool Heart and Chest Hospital contract is also over performing by £164k as at month 7 predominantly due to £66k related to day cases including an invenricular pacemaker, percutaneous interventions and perc complex ablations. Members noted that there has been meetings set up with both Countess of Chester and Liverpool Heart and Chest to look at 16/17s Finance and Activity.

There is a concerted management effort to continue to manage risks for QIPP including reserves and contingency. M8 will give the committee a firmer view on year end outturn. If the CCG hit the £9m deficit at year end, there is a debate to use the 1% surplus which would reduce to £4.1m which is a similar figure to last year.

AW advised there is a lot of good work going on which is offset by underachievement of QIPP, and should be the CCGs main focus and making the PMO function work is critical.

**Prescribing**
The month 7 financial position for prescribing has been informed by August’s data. This shows a year to date position of £942k underspent, of which relates to good performance in practice prescribing. The figures presented are before any repeat prescribing has come into play.
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| **Continuing Healthcare**  
As at the end of October, Joint/Fully funded and Childrens packages are overspent by £2.6m. This is an adverse movement of £352k when compared to the month 6 position. Of this, approximately £158k is the result of the FNC rate increase approved by the DH. The remaining pressure has been caused by a number of new packages and existing package price increase.  
AW asked if the FNC payment has been funded or is an in year pressure. MT confirmed a £1.8m FYE overspend will be due to the FNC payment, AW suggested this point is worth highlighting at a public GB meeting.  
The group supported MT speaking to NHS England to discuss the amend the year end deficit figure. |
| **CCG Expenditure/CCG Run Rate Presentation**  
MT presented graphs that supported the table for budget holder forecast agreement and run rates. There is currently a gap of £3.6m of where the CCG needs to be by the end of the financial year. MT asked for the group to take the table away to review and if there are any amends to the table to email him.  
Members agreed that the run rate will be a standing monthly agenda item for the Finance Committee. This will allow members to discuss what the financial figure needs to be, where it is currently at and what actions need to be undertaken.  
As advised there are meetings arranged for the CCG to meet with both Liverpool Heart and Chest and also the Countess of Chester to have discussions regarding activity for this year. WUTH as main providers are on a block contract, with a significant underspend this year, MT explained the process for the contract performance review meetings and the negotiations that are taking place for next years contract.  
It was noted that last year the finance agreement was signed before a MOU was put into place, this is a lesson learnt that will not be repeated. The contracting approach will be different. The CCG’s Governing Body and NHS England support this decision. |
| **Recovery Plan/Improvement Plan**  
WFC advised members of the main points in the financial recovery plan  
• Challenging charging issues  
• Work going on to help the 17/18 contracts to be done differently  
• Activity management has more focus and linking collectively with finance  
• CHC/FNC is a main focus area (Lorna Quigley taking exec lead on this)  
• Prioritised QIPP plan to focus teams on the big areas  
• Prescribing is going well  
• 17/18 Financial Plan has been agreed in draft at the last GB meeting, an updated version will available the next meeting  
• There are updates on contracts  
• NHSE need to see the CCG’s Improvement plan involving the recommendations from PWC’s review  
As this was a verbal update LED indicated to members her concern that providing assurance to the GB from the Finance Committee is difficult to demonstrate scrutiny. |
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<td>SW felt that in this case as the next GB meeting is private, it would be appropriate that the GB have the first sight to ensure the wider GB debate and discussion but agreed that at any formal GB meeting the Finance Committee would have the papers to meet the scrutiny and oversight remit.</td>
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<td><strong>Comparison of CHC/JFP/FNC Figures</strong></td>
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<td>VH attended the Finance Committee to give members an overview of the CHC/JFP/FNC figures.</td>
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<td><strong>CHC:</strong> Wirral CCG are currently ranked at 173/209 in England for the number of CHC packages with 343 patients who are eligible year to date. The national average is 90 people per 50,000 population and the CCGs average is 64 people eligible per 50,000 population, which is 37% below the national average. The total CCG year to date spend is £444k.</td>
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<td><strong>Joint Funded Packages:</strong> Wirral CCG is ranked at 1/209 in England for the number of joint funded packages and the number of people eligible year to date is 478. The national average is 12 people per 50,000 and the CCGs average is 90 people eligible per 50,000 that’s a 350% difference above national average. The CCGs year to date spend is £417k.</td>
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<td><strong>FNC:</strong> Wirral CCG is ranked at 32/209 for FNC packages and the number of people eligible year to date is 866 people. The national average is 107 people per 50,000 population and Wirral CCG has an average of 162 people eligible. The FNC weekly rate is set nationally, therefore any variations to spend per 50,000 is solely due to the number of eligible patients.</td>
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<td>This data is national and readily accessible. There seems to be an argument that although we are high on JFP the number is less for CHC. Baseline spend shared clearly highlights the issue of Adult Joint Funding and that the CCG is an outlier. VH explained that there are a lot of historic packages which date back to 2008. The priority for the CCG patients and carers care and experience. There are some concerns that have been raised about the lack of reviews that are delayed and noted this is under review.</td>
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<td><strong>Personalised budgets are included in the figures, the CCG needs to get 312 over the next few years. There are some domiciliary packages already in place that we could use towards the requirement.</strong></td>
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<td><strong>Impact of HRG4+ Impact</strong> MT has drafted a letter regarding the national payment system for 17/18 and 18/19. The CCG will object to the introduction of HRG4+ and in particular the methodology used to arrive at the proposed set of national prices. The committee agreed to the letter being sent and for the GB to be informed. Consultation closes on the 6th December and the tariff will then be released on the 21st December if there is no challenge. It was noted that if 66% of the CCG’s reject this notice, then NHS England will have to review.</td>
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<td><strong>Contracting Update</strong> In line with the latest planning and contracting guidance the CCG has</td>
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commenced contract negotiations with main providers. All contracts are required to be signed by both parties before the 23rd December.

The local timetable for signing off all other contracts (wave2) is January 2017. This is a challenging timescale and is contingent upon all parties agreeing and completing the required contract documentation.

WUTH, WCT and CWP were issued contract offers by the CCG on the 4th November 2016, and all providers issued their responses to the CCG by the 11th November in line with national guidance.

Provider responses have been reviewed by the CCGs finance, BI, commissioning and contracting teams and all have been discussed with providers in weekly contract negotiation meetings, scheduled to take place until December 2016.

As agreed the Spire contract is part of wave 2 and will be signed by the end of January 2017 after contract negotiations are completed with WUTH. The overperformance of Spire is a major issue for the CCG and there has been discussions for them to become a sub-contractor.

WUTH has rejected the CCGs offer of £214.260m on the basis of a fixed envelope and has sought a number of areas of clarification on assumptions made by the CCG. The trust’s counter offer to the CCG is £231.364 excluding cost per case contracts, growth, RRT compliance and any HRG4+ adjustments following the published tariff. The trust’s counter offer is to deliver a control total surplus for 17/18 of £6.13m. Given the considerable difference between contract expectations it is unlikely that contracts will be signed by 23rd December and highly likely that mediation will be required. NHSE are aware of this and an escalation meeting will be taking place this 2nd Dec.

The CCG and CT are in discussions regarding £700k of the CCGs assumptions relating to GPOOH and Propco charges. It is expected that these areas will be resolved through negotiation and contracts will be signed by 23rd December.

Contracting negotiations are progressing with CWP with no material issues of dispute. Contracts are expected to be signed by 23rd December 2016.

**Update from NHSE Checkpoint meeting 23/11/2016**

MT and WFC provided the group with an update from the NHS England Check Point Meeting.

- The CCGs Forecast Position £9m overspend against resource limit+ £2m risk (excluding 1% headroom)
- Month 7 overall position £8.319m overspend (excluding 1% headroom) against key areas. Members noted the breakdown of figures

The main conversation was about where the CCG need to be to meet this forecast position. For the CCG to change their year end financial position would be a timing issue and would need to consult with NHS England.

The month 12 forecast position shown against the key areas shows the achieving control total, risk position and budget holder view.

**AOB**

Terms of Reference
Include oversight of recovery plan and improvement plan. MT and LD to review and send to SW to check before taking to GB.
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**Date & Time of Next Meeting**

*Tuesday 20th December 2016*

*10am in room 539*

*Please send apologies to Chelsea.worthington@nhs.net*