Wirral Clinical Commissioning Group

Governing Body Meeting – A meeting in public

Tuesday 2nd April 2013
1300 - 1700
Albert Lodge, Victoria Central Health Centre,
Mill Lane, Wallasey

PUBLIC AGENDA

Ref No	Time	No	Papers	
	1300	**1.**	**PRELIMINARY BUSINESS**	
GB13-14/001		**1.1**	**Apologies for Absence:** • **Andrew Smethurst** • **John Oates** • **Lorna Quigley**	
		1.2	**Chair's Announcements**	
		1.3	**Declarations of Interest**	
		1.4	**Comments/questions from members of the public**	
		1.5 **1.6**	**Minutes of previous meetings:** • **Held on 5th March 2013** **Matters Arising/Actions Points:** • **Held on 5th March 2013**	Draft minutes of Public GB meeting 5th Draft Action Points from PUBLIC GB Meet

	1315	**2.**	**ITEMS FOR APPROVAL**	
GB13-14/002		**2.1**	**Community Equipment Tender** **(Laura Thompson)**	Community Equipment Tender co Community Equipment Tender 3 c
		2.2	**BME** **(Laura Thompson)**	BME cover sheet.doc BME Investing in Health Workers Gove
		2.3	**PALS Service** **(Philip Jennings)**	PALs cover sheet.doc Pals paper.doc
	1415		**ITEMS FOR INFORMATION AND NOTING**	
GB13-14/003		**3.1**	**Finance & Performance Report** **(Mark Bakewell)**	GB M11 Finance Cover Sheet 2nd Apr GB Wirral CCG Finance Report- Mont
		3.2	**Pre-Implantation Genetic Diagnosis (PIGD)** **(Sheena Hennell/Shanila Roohi)**	Cover sheet PIGD paper.doc Wiiral PGD Paper March 13.doc Policy PGD March 13.doc
		3.3	**Minutes for Noting** • Wirral GP Commissioning Consortium of 12th February 2013. • Wirral Health Commissioning Consortium of 20th February 2013 **(Draft)**. • Wirral Alliance Commissioning Consortium of 7th February 2013. • Quality, Performance & Finance Committee of 31st January 2013.	WGPCC Executive Board Minutes 12.02. Draft WHCC Executive Board Minu WACC Executive Board Meeting -FINAl Final minutes of QPF 31st January 2013 v1

	1530	**4.**	**RISK REGISTER**	
GB13-14/004		**4.1**	**Items to be included onto the Risk Register (All)**	Copy of RiskRegister V3-0 update 20th Mai
	1545	**5.**	**ANY OTHER BUSINESS**	
GB13-14/005				
		6.	**DATE AND TIME OF NEXT MEETING**	
			The date of the next Governing Board meeting is: Tuesday 7th May 2013, 1300 - 1700 Nightingale Meeting Room, Ground Floor, Old Market House Please forward apologies to: Julie.stamper@nhs.net	

Wirral Clinical Commissioning Group

Governing Body Meeting

Minutes of Public Meeting

Tuesday 5th March 2013

Nightingale Meeting Room, Old Market House

Present:

Dr P Jennings (PJ)	Chairman WCCG
Dr A Mantgani (AM)	Clinical Chief Officer WCCG
Lorna Quigley (LQ)	Chief Officer WCCG
Mark Bakewell (MB)	Chief Financial Officer WCCG
Dr P Naylor (PN)	Chair WHCC
Dr S Wells (SWells)	GP Executive WHCC
Dr J Oates (JO)	Chair WGPCC
Dr M Green (MG)	Chair WACC
Dr A Ali (AA)	GP Executive WGPCC
Andrew Cooper (AC)	Chief Officer WGCC
James Kay (JK)	Lay Advisor (Audit & Governance)
Graham Hodkinson (GH)	Director of Social Services
Dr A Smethurst (AS)	Secondary Care Doctor
Christine Campbell (CC)	Acting Chief Officer WGPCC
Fiona Johnstone (FJ)	Director of Public Health

In attendance:

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

Apologies:

Simon Wagener (SW)	Lay Advisor (Patient Champion)
Iain Stewart (IS)	Chief Officer WACC
Mr A Dalgarno (AD)	NHS CWW

REF NO	MINUTE	
1.	**PRELIMINARY BUSINESS**	
GB12-13/175	Apologies for absence were noted as above.	
	Chair's Announcements: To discuss procurement legislation in any other business.	
	Declarations of Interest: There were no declarations of interest declared.	

Signed: Chair

	Comments/questions from members of the public: None present.	
	Minutes of previous meetings: **29th January 2013**: Amend page 3, remove fourth paragraph beginning "Process steps……". Not relevant to the item. The rest of the minutes were agreed as an accurate record. **5th February 2013**: Agreed as an accurate record. **Action Points of previous meetings**: **29th January 2013**: • GB12-13/145 – The OD plan was circulated and uploaded on to the website. **5th February 2013**: • GB12-13/110: PJ and FJ to re-articulate minutes related to consortia linking in with Public Health – this is on-going. • GB12-13/122: AC advised that Mr Cook has now had a final response regarding actions taken. • GB12-13/158 and 160: MB to bring back final papers once contracts are signed off. Will come back in April once contracted values have been detailed. • GB12-13/161: Development sessions with management team and Governing Body as a whole. Workshops to be attended over the coming months. • GB12-13/164: CSU SLA - amendments were made and circulated. Indicated to CSU that we are likely to be signing. All comments were received and duly noted. We will ask the new Head of Corporate Affairs to bring a report to the Governing Body for an update.	**JS** **PJ/FJ** **MB** **ALL** **MB/LQ**
2.	**ITEMS FOR APPROVAL**	
GB12-13/176	**2.1** **IG Policies x6**: MB presented the 6 Information Governance policies today. The purpose of the report is to update the CCG with IG performance, and to demonstrate that the correct support and programmes of work are underway to meet the Information Governance Toolkit requirements by 31st March 2013. All the policies have been agreed in principle through the Quality, Performance & Finance Committee and are at Governing Body for ratification. To be uploaded on the website tomorrow. All staff must have completed their IG training by 31st March. MB working on log-in details for e-learning etc with Andrea Lewis.	

Signed: Chair

		LQ asked the Governing Body to note that the CCG will use the DH 2013/14 NHS Standard Contract Section E Core Legal Clauses and Definitions, section 60 (Data Protection, Freedom of Information, and Transparency) for all contracts issued. The Governing Body was asked to approve the policies and to commit to complete the outstanding actions in support of the IG Toolkit.	
3.		**ITEMS FOR INFORMATION AND NOTING**	
GB12-13/177	**3.1**	**Finance & Performance Report**: MB gave an update on the year to date financial situation performance. The report sets out the financial position for NHS Wirral CCG as at the end of January (Month 10) within the 2012/13 financial year. As at the end of January (Month 10) the year to date position for Wirral CCG is an over spend of £0.5m with over performance against commissioning expenditure of £1.1m offset by an under performance against running costs of £0.6m. The year to date variance position between Governing Body and the combined consortia is an overspend at divisional level of £5.45m with the Governing Body underspent by £4.99m. The overall CCG performance position in relation to NHS contracts shows an overspend at month 10 of £8.6m (previous month £8.1m) primarily being due to over performance on the WUTH contract of £7.64m (previous month £7.39m) at divisional level. The year to date position is based on actual activity as at month 9, £6.97m over performance with a pro-rata adjustment to equate to the month 10 position and application of estimated contract adjustments for re-admissions/out-patient follow-up ratios as appropriate, (again, based on the month 9 actual activity position). Prescribing expenditure is currently providing the CCG with a year to date underspend of £3.4m (previous month £2.96m). There is an under performance of those budgets managed at Governing Body level of £377k and underperformance at divisional level of £3.02m. The performance position is based on 8 months actual data with 2 months estimated costs for December and January. Commissioned "out of hospital" budgets are £1.54m overspent at month 10, an adverse in month movement of £114k. The main drivers for the continued over performance remain within the Continuing Healthcare section with Older People (£244k), Mental Health (£347k) and Physical Disabilities (£275k), and all Joint Funded packages (£899k). These overspends are being partially offset by underperformance on Funded Registered Nursing Care (FRNC) of (-£295k).	

Signed: Chair

		Reserves are underspent by £5.76m at month 10 which is due to the release of the contingency element and a number of earmarked reserves which are available for release. There is a year to date underspend of £632k in relation to running costs at month 10, an adverse in month movement of £64k. This is primarily due to the movement in under performance on the CSU costs at Governing Body level of £421k (previous month £445k). Clinical backfill reported at consortia level continues to underperform year to date (£297k). A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position. Based on the information received as at month 10 within the 2012/13 financial year (January), the position for the CCG remains on track to achieve a balanced position against its delegated budget. From an overall perspective, the PCT is still in a position to achieve its overall control total. The Governing Body was asked to note the financial position as at the end of January 2012 and the forecast outturn position for 2012/13.	
	3.2	**<u>Minutes for noting</u>**: • Wirral GPCC of 15th January – noted • Wirral HCC of 16th January – noted • Wirral ACC of 10th January – noted • Approvals Committee of 16th November – noted	
4.	**RISK REGISTER**		
GB12-13/178	**<u>Items to be included on the Risk Register</u>**: MB presented the Risk Register, advising that it has been updated following recent meetings across the Board. Primary Care Mental Health budget under some pressure. Need to plan for next year for extra resources. WACC have issues around the implementation of the 111 project. Jennifer Shaw to provide an update today. Contract variations and 111. Increased from a likelihood score of 4 to a 5. Assumed increased cost exposure in terms of the new service. Discussions with CT. MB asked the committee to note the Risk Register today.		

Signed: Chair

5.	**ANY OTHER BUSINESS**	
GB12-13/179	AS asked the Governing Body to consider our position regarding information being circulated about Section 75 of the Healthcare & Social Report. In terms of commissioning, we as a CCG are keen to use any qualified provider (AQP) in terms of caring for our patients. Fine detail legislation which is currently up with the House of Lords – terminology within section 75 has caused concern. AM advised that the policy all 3 consortia have adopted is that we will use the AQP when appropriate and we feel beneficial to the patient. Re-enforce it is the policy of the CCG to be selective. AQP is not compulsory at the moment. It was felt by the majority that there may be a financial risk to us potentially, if we have to put every contract out to tender. Everyone needs to be made aware of this and the implications. LQ will ensure the minutes accurately reflect our position. We need to put out a position statement on the website, preferably before the minutes go live. We should say that we will use AQP when it is appropriate and we will assess the impact and choice of service best suited for the patient. Nobody has raised objections today. PJ is happy with this route at present and feels no intervention is necessary.	**LQ**
6.	**DATE AND TIME OF NEXT MEETING**	
	The next Governing Body meeting will be an informal meeting on:- Thursday 21st March 2013, 1300-1500 Beveridge Meeting Room, Old Market House. Please forward apologies to: Julie.Stamper@wirral.nhs.uk	

Signed: Chair

Wirral Clinical Commissioning Group

Governing Body Meeting

Held on Tuesday 5th March 2013

Action Points – Public Meeting

Item Number	Action Points	Responsibility	Due Date
	PUBLIC MEETING		
GB12-13/175	Previous minutes of 29th January. Amend page 3, remove fourth paragraph beginning "Process steps……". Not relevant to the item.	Julie Stamper	ASAP
GB12-13/110	PJ and FJ to re-articulate minutes related to consortia linking in with Public Health – this is on-going.	Phil Jennings/ Fiona Johnstone	ASAP
GB12-13/158 & 160	MB to bring back final papers once contracts are signed off. Will come back in April once contracted values have been detailed.	Mark Bakewell	April
GB12-13/161	Development sessions with management team and Governing Body as a whole. Workshops to be attended over the coming months.	ALL	March/ April
GB12-13/164	CSU SLA - amendments were made and circulated. Indicated to CSU that we are likely to be signing. All comments were received and duly noted. We will ask the new Head of Corporate Affairs to bring a report to the Governing Body for an update.	Mark Bakewell/ Lorna Quigley	April/May
GB12-13/179	Putting a position statement on the website.	Lorna Quigley	March

Wirral Clinical Commissioning Group

Community Equipment Tender

Agenda Item:	2.1	**Reference:**	GB13-14/002
Report to:	Governing Body Board	**Meeting Date:**	21st March 2013
Lead Officer:	Andrew Cooper		
Contributors:	Neil Lynch and Laura Thompson		
Governance:	**Link to Commissioning Strategy**	This proposal links to Wirral CCG priority areas surrounding planned medical initiatives and long term conditions objectives	
	Link to current governing body Objectives	This proposal links to Wirral CCG QIPP plan and the CCG Strategic Objectives.	
Summary:	This report intends to update the CCG on the procurement options available to commission a Community Appliance Service.		
Recommendation:	**To Approve**		✓
	To Note		
	Comments	The Governing Body is asked to review options A – C outlined in the update and decide on which option to proceed with.	
Next Steps:	Once a decision on procurement has been made proceed with implementing the option.		

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

What are the implications for the following (please state if not applicable):	
Financial	The financial implications of moving to a cost per case have been highlighted throughout this process.
Value For Money	Moving to a cost per case may increase costs but the new service specification enables patients to be assessed and fitted with appliances in a timely manner which should reduce the need for them to access other health services.
Risk	The risk of not procuring a new Community Appliance Service is patients will continue to wait a long time to be assessed and treated and dissatisfaction will

	remain. The risks and benefits of each procurement option is outlined within the paper.
Legal	Advice regarding EU Procurement Regulations has been sought from Wirral NHS/CSU Procurement & Contracting team.
Workforce	No impact on work force has been raised whilst exploring possible procurement options with the Procurement & Contracting Team.
Equality & Human Rights	Equality & Human rights have been considered throughout this process.
Patient and Public Involvement (PPI)	Patients and the public have been involved whilst the service specification was being developed.
Partnership Working	Throughout this process partners have been included and communicated with to ensure all involved are aware of decisions being made.
Performance Indicators	N/A
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

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

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Community Appliance Service		Operational Group	Feb 13	Options Paper to Governing Body
Community Appliance Service		Operational Group	September 2012	Decision to AQP Community Appliance Service
Community Appliance Service		CAG	April 12	Allow WUTH six months to implement the specification.

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be

submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

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

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

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

Governing Body: Update on available procurement options for Community Appliance Service.

Introduction

1. Following the Operational Group decision to procure the Appliance Service through an AQP route, further discussion with the contract & procurement team has taken place. They initially advised that based on the workings supplied and developed with finance as the appliances (i.e. consumables/goods) are worth over fifty percent of the contract value 59% (£431,951 - total value of the contract £722,585.0) this technically means they would be breaching EU procurement regulations if they proceeded with an AQP process.

2. However due to the marginal nine percent split between the cost of appliances (59%) and the services (41%) along with the lack of robust data supplied to us around the amount and costs of appliances it is thought a challenge to any breach would be unlikely.

3. The point was stressed to the procurement team the ability to provide a patient with a choice of providers is important to Wirral CCG.

4. The commissioner and procurement team are suggesting three options for the Operational Group to now consider:

   Option A – Tender

5. An Open tender processes to be undertaken for the whole contract the goods and services and this would need to be advertised via the Official Journal of European Union as a Part A procurement and as a framework agreement. The whole process would take at least 6-9 months.

6. The CCG would need to provide resource in the form of an evaluation panel to evaluate the tender bids.

7. The CCG would be able to appoint more than one provider to a framework agreement contract which will give patient choice. However potential providers would need to demonstrate their capacity, capability and quality arrangements to meet service delivery requirements within the published tariff. As the tender process is more detailed and lengthy this may impact on the number of potential providers applying due to resources required compared to the contract value and the fact that there is no commitment from the CCG to the level of any guaranteed activity.

8. Tariffs could remain as in the agreed specification allowing providers to source their own appliances submitting monthly invoices to finance and data to commissioners.

9. Alternately tariffs for each level could be recalculated to identify a tariff for the patient episode and for the appliance. The specification would need to be changed to detail that the successful provider(s) would need to purchase appliances through NHS supply chain which may deliver efficiencies. Currently only 60 percent of suppliers supplying goods for Community Appliance Service are on NHS supply chain.

10. NHS Supply Chain has agreed to look into options of these suppliers supplying via one of the distributers on their current framework. Alternatively the CCG could enter into local agreements with these suppliers until such time as NHS Supply Chain retender this area.

11. This option would also involve the CCG either being responsible for the process of purchasing appliances or they could for a fixed cost contract the purchasing of appliances out to NHS Supply Chain.

Option B – AQP for service element & purchase appliances via NHS Supply Chain

12. An AQP process is carried out for only the services element of the contract. The tariffs for each level would need to be recalculated to identify a tariff for the patient episode and for the appliance. The CCG would appoint as many providers as qualify through the bidding process and this would lead to patient choice.

13. The specification would need to be changed to detail that appliances provided to patients would be purchased by the CCG via NHS Supply Chain. This option would again involve the CCG either being responsible for the process of purchasing appliances or they could for a fixed cost contract the purchasing of appliances out to NHS Supply Chain. It could furthermore lengthen the patient pathway.

14. As only 60% of appliances, product suppliers are available through NHS Supply chain. Any current supplier not on NHS Supply Chain would not be able to supply directly via NHS Supply Chain. NHS Supply Chain has agreed to look into options of these suppliers supplying via one of the distributers on their current framework. Alternatively the CCG could enter into local agreements with these suppliers until such time as NHS Supply Chain retender this area.

15. Alternately the AQP service providers could order via Wirral's NHS Supply Chain order portal with the orders being placed via the procurement department at an agreed cost, this may deliver an efficient payment and order monitoring process, with one invoice per month being submitted to the CCG.

16. All service providers would then be mandated in the service specification to source all appliances via NHS Supply Chain. It will be the responsibility of the Provider to undertake stock control, ordering of stock and consignment stocking for frequently used items (this would be where the Provider buys in the stock and it is kept at the Provider's premises).

Option C – Original decision AQP whole service.

17. This option would be for the full provision of the service via AQP. This would technically breach EU procurement Regulations, however due to the marginal nine percent split between medical service costs and the cost of appliances in the current service, along with the lack of robust data supplied to us around the cost/s of individual appliances the CCG may decide that a challenge would be unlikely and that there is sufficient rationale that supports this approach to allow more robust management information to be collated and the robust contract management arrangements within the specification would help shape the future service model and commissioning intentions .

18. If the CCG were to favour this option, in order to minimise potential for challenge the CCG could consider implementing control measures such as awarding a 2 year contract with a planned 12 month review of management information data.

19. Also the stringent data capturing performance indicators within the new specification would ensure that providers submit robust service activity and true financial information that would also inform future commissioning and procurement options for the service.

20. The AQP procurement process for the whole service element will take approximately 3 to 4 months.

Options the Governing Body are asked to consider:

Options A - C	**Risks/Disadvantages**	**Benefits/Advantages**
A- Open tender which would allow multiple providers to be appointed to a framework.	Tender route involves a longer procurement process 6-9 months. Tender process may put potential providers off applying as no income guaranteed. CCG would need to provide resource in the form of an evaluation panel to evaluate bids.	Wirral CCG would not be in breach of EU procurement regulations. The tender route would enable the agreed specification to be implemented.
B**-** AQP for service element & purchase appliances via NHS Supply Chain	Tariffs would need to be recalculated paying providers for the service element only. Wirral CCG would be responsible for purchasing the appliances or they could (for a cost) contract this out to NHS Supply Chain). Currently only 60% of appliances are available through NHS Supply Chain. Sourcing the other 40% of goods would need to be considered and managed by the CCG. Alternately the AQP service providers could order through NHS Supply Chain Wirral portal which would need to be managed by the CCG. The patient pathway would remain fragmented and untimely as the specification developed and agreed could not effectively be implemented. Patient outcomes may not improve and patient dissatisfaction may remain.	No breach of EU procurement regulations.
C – Original decision AQP whole service	Potentially Wirral CCG would be breaching EU procurement regulations and their decision to use the AQP route could be	As the data is not robust a challenge may be unlikely.

	challenged	In order to minimise the risk of a potential challenge the procurement team suggested implementing the following measure: Award a two year contract with a planned 12 month review of data, this would give the CCG an accurate picture of the cost of goods v services and inform future commissioning and procurement decisions

Recommendations

21. The Governing Body is asked to consider Options A to C and decide on the option they wish to proceed with.

L J Thompson

WHCC Commissioning Support Manager

Wirral Clinical Commissioning Group

Pilot – Investing in Health Workers to support black minority ethnic populations access and integrate into health & social care services across Wirral.				
Agenda Item:	2.2		**Reference:**	GB13-14/002
Report to:	Governing Body		**Meeting Date:**	
Lead Officer:	Andrew Cooper			
Contributors:	Laura Thompson			
Governance:	**Link to Commissioning Strategy**	This proposal links to the CCG vision – To improve health and reduce disease tackling inequalities and helping people take care of themselves.		
	Link to current governing body Objectives	• Enhance the quality of life for people with long term conditions. • Ensure people have a positive experience of care.		
Summary:	This proposal outlines a one year pilot project aimed at investing in Health Workers to support black minority ethnic populations access and integrate into health & social care services across Wirral.			
Recommendation:	**To Approve**			✓
	To Note			
	Comments	Further information on the recommendation if necessary ie. if there are specific items to approve/note in addition to the report itself		
Next Steps:	If this proposal is approved proceed with implementation of the pilot project and six month review.			

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

What are the implications for the following (please state if not applicable):	
Financial	The financial implication of this pilot project is £92,625.00 over a twelve month period. It is being funded through non-recurrent spend and this pilot has been agreed at the Operational Group.
Value For Money	The aim of this pilot project is to engage BME communities to access health care and relevant services in a timely manner further more providing support to isolated BME community members to access appropriate health services.
Risk	The risk of not supporting black minority and ethnic populations accessing and integrating into health care services across Wirral could result in a continued increase in non-elective emergency admissions and populations not accessing healthcare in a timely manner.
Legal	None highlighted.
Workforce	No NHS staff would be impacted on in relation to this pilot project.
Equality & Human Rights	This pilot has been developed with stakeholders and links to the Wirral Ethnic Health Advisory group Workshop Report and Strategic Development Plan 2012-2015
Patient and Public Involvement (PPI)	This pilot project has been developed using feedback from reports undertaken in conjunction with local BME populations, and away days.
Partnership Working	Partners have been included throughout the development of this pilot and kept up to date as decisions have been made.
Performance Indicators	Key performance indicators have been developed to ensure the pilot project is meeting the service outcomes these will be monitored monthly.
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

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

Report History/Development Path

Report Name	Reference	Submitted to	Date	Brief Summary of Outcome
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step
Pilot – Investing in Health Link Workers to support BME populations access and integrate into health & social care services across Wirral		Operational Group	March 13	Agreed – Take to Governing Body for approval
Investing in Health Link Workers to support BME populations access health & social care services across Wirral		Operational Group	February 13	Revise & merge with engagement paper
Improving Engagement in BME Populations across Wirral Health Economy		Operational Group	November 12	Discussed

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Wirral Clinical Commissioning Group

Pilot – Investing in Health Workers to support black minority ethnic populations access and integrate into health & social care services across Wirral.

Introduction

1. Further to the feedback from Operational Group February 2013 this paper sets out a proposal to combine the key elements of the previously approved "Improving Engagement in black minority ethnic populations across Wirral" and the "Investing in Health Workers to access and integrate health & social care services and replace both previous proposals.

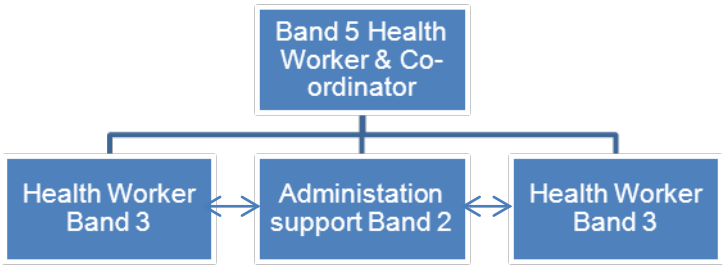
Proposal to consider

2. Wirral CCG is asked to consider funding Health Workers and administration support as a pilot for a one year period, at six months a review will be undertaken to ensure the service specification is being delivered and key performance indicators are being met. The findings will than form the basis for a decision to be made on the future commissioning and procurement route for this service.

3. The Health Workers would provide the following key services to BME communities across Wirral:

    a. Support primary care with engagement of BME communities to detect & enable GPs to manage key disease areas
    b. Provide support and education in accessing acute care services
    c. Provide after care and support to BME community members
    d. Target isolated & ageing BME community members in accessing through to engaging with existing healthcare services

Staffing Model



Finance

4. The cost for Wirral CCG to support this project is illustrated below:

Staff member	**Cost for one year**
Health Worker Co-ordinator band 5 1WTE	£29,486.25 band 5 mid-point including on costs-Health Worker – Co-ordinator
Health Workers 2 WTE band 3	2 x WTE Health Workers band 3 mid-point including 25% on costs £22,020.0 x 2 = £44,040.00
Administration 1 WTE band 2	1 x WTE band 2 Administrator mid-point £19,098.75
Total Cost per Year	£92,625.00

5. This proposal is in total £21,810.96 cheaper than the combined cost of the two separate proposals previously presented at the Operational Group.

6. If funding for the pilot was agreed for this project it would be on condition that the provider delivers the proposal and submits the monthly score card reporting which will be reviewed monthly and evaluated at six months.

Recommendations

7. Governing Body are asked to consider and agree to the following:

a.) Agree to a one year investment of £92,625.00 per year to fund Health Workers to support black minority ethnic populations access and integrate into health & social care services across Wirral.

L J Thompson

Commissioning Support Manager WHCC

Appendix 1

Pilot - Investing in Health Workers* to support black minority ethnic populations access health & social care services.

***Previously Known as Health Link Workers

Introduction

2. Health Link workers have provided health related support to black minority ethnic (BME) populations across Wirral over the last fifteen years. Historically Health Link workers have been commissioned by Public Health and employed by Wirral Multicultural Organisation (WMO). They have engaged and supported the black minority ethnic population across Wirral in accessing health & social care services. In March 2013 Public Health are decommissioning this service.

3. It is believed Public Health and the Drugs & Alcohol Service are to jointly commission an outcome based service based around health promotion and primary prevention of disease targeting BME communities.

4. Wirral has seen a significant increase in the (BME) population since the 2001 census which presented a figure of 3.56% compared to a total in 2010 of 5.83% n=18,291[1].

5. There is lack of robust data on the population prevalence of the BME population, current methods nationally and locally of capturing data around ethnicity are not fit for purpose. One reason for this is population change is happening faster than it has in the past. An estimate of people in Wirral from BME groups is estimated to be anywhere between 5%-16.4%[2].

6. Local intelligence informs us it is not possible to produce a statistically reliable estimate of the ethnic composition of Wirral's BME population, data available does however inform us that after White British the largest ethnic grouping is Asian/Asian British group which is estimated to have increased from 100 people in 2001 to 900 people in 2009 an 800% increase followed by White other background, then White Irish, Eastern European & Chinese[3].

Background

7. Health Link Workers are currently based at WMO and provide satellite sessions in local GP surgeries closest to where there seems to be larger numbers of BME communities. They provide a wealth of support services to people from the BME communities examples of which include[4]:

    a. One to one and group support to people from BME communities to encourage health-enhancing attitudes and behaviour and help improve their lifestyle and wellbeing i.e. smoking cessation, chair based exercises.

[1] Wirral PCT BME Health Needs Assessment/Icarus February 2010.
[2] JSNA consultation document September 2008
[3] JSNA Population document October 2011
[4] Service Level Agreement Wirral PCT & WMO 2009.

b. Proactively promote and support activities available to BME communities and encourage uptake of health services, raise awareness of mental health illness and availability of screening programmes. Engage with hard to reach groups that do not access WMO or health and social care services, in partnership with other relevant agencies.

c. Signpost service users to other appropriate organisations to meet their health needs and to support individuals signposted from other organisations.

d. Provide translation and interpretation support to vulnerable people as part of on-going engagement and support package to improve patient health literacy and to ensure they continue to engage and maintain contact with health and social care services.

e. Provide communication support to health and social care professionals across both primary and secondary and tertiary care to ensure patient's cultural and religious needs are met, particularly targeting those individuals with distinct health needs and long term conditions.

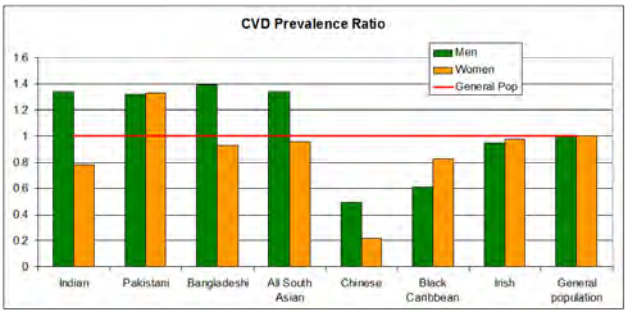
8. In addition to the core duties listed above and owing to the nature of their work support workers also contribute in a non-direct way to local initiatives such as admission prevention.
Through relations workers have developed within local BME communities patients who become unwell often contact WMO who directly liaise with GP surgery's and in a separate number of case studies reported by WMO admission to hospital has been prevented.

9. BME communities largely share the same health concerns as the population in general and include Type 2 diabetes, obesity, kidney failure, ischaemic heart disease, smoking, cancer and poor psychosocial health. However people of certain ethnic groups experience a disproportionately greater burden of CVD including coronary heart disease (CHD) and stroke and tend not to engage in immunisation and screening programmes[5][6][7].

10. An example of national data for CVD prevalence ratio across BME communities is illustrated below.

Table 1 illustrates national data for CVD prevalence ratio amongst BME communities.

[5] WEHAG Workshop Presentation (March 2012) Dr Abhi Mantgani NHS Wirral Lead CVD/CKD/Diabetes Vascular Disease in Wirral BME Community.
[6] WEHAG Workshop Presentation March (2012) Dr Phil Jennings Chair of Wirral Clinical Commissioning Group – Health Challenges & Solutions incorporating Delivering Race Equality in Mental Health.
[7] WEHAG Presentation March 2012- Health and Social needs of BME Communities Wirral Dr SM Mukherjee



11. Evidence highlights that individuals from BME communities need extra resources to enable them to access and or use health services so they do not add to the current productivity challenge that lies ahead.

Current financial spend

12. During 2011-12 patients from BME populations admitted to Wirral University Teaching Hospital (WUTH) cost Wirral CCG an estimated £1,363,139.0 (calculations based on deducting actual costs in table 2 of British, any other white background & not stated ethnic category costs).

13. This is a conservative estimate of non-elective admission costs as a portion of the "Z not stated ethnic category" has not been apportioned to the calculation in point 11.

Table 2 illustrates Wirral Non-Elective Admissions by Ethnic Group at WUTH 2011-12

Wirral Non-Elective Admissions by Ethnic Group at WUTH - 2011-12

ETHNIC_ORIGIN	EthnicCategory	Year	Activity	Price_Actual	POD Category
NULL	NULL	2011/12	44	£ 56,498	Non-Elective Admissions
0	NULL	2011/12	18	£ 14,812	Non-Elective Admissions
A	British	2011/12	43812	£ 66,070,322	Non-Elective Admissions
B	Irish	2011/12	164	£ 238,946	Non-Elective Admissions
C	Any other White background	2011/12	479	£ 710,397	Non-Elective Admissions
D	White and Black Caribbean	2011/12	53	£ 55,793	Non-Elective Admissions
E	White and Black African	2011/12	42	£ 39,295	Non-Elective Admissions
F	White and Asian	2011/12	24	£ 22,118	Non-Elective Admissions
G	Any other mixed background	2011/12	91	£ 93,361	Non-Elective Admissions
H	Indian	2011/12	124	£ 137,717	Non-Elective Admissions
J	Pakistani	2011/12	28	£ 32,014	Non-Elective Admissions
K	Bangladeshi	2011/12	104	£ 100,581	Non-Elective Admissions
L	Any other Asian background	2011/12	174	£ 203,966	Non-Elective Admissions
M	Caribbean	2011/12	12	£ 14,682	Non-Elective Admissions
N	African	2011/12	57	£ 61,214	Non-Elective Admissions
P	Any other Black background	2011/12	33	£ 35,312	Non-Elective Admissions
R	Chinese	2011/12	138	£ 196,846	Non-Elective Admissions
S	Any other ethnic group	2011/12	59	£ 59,985	Non-Elective Admissions
Z	Not stated	2011/12	1166	£ 1,242,368	Non-Elective Admissions

Data reliant on data accuracy at point of input

14. The total contract value set for the Health Link Workers per annum from 2009-2012 was £51,000.0 which was funded by NHS Wirral and commissioned by Public Health.

National & local perspective

15. In light of The Equality Act 2010 and the Public sector Equality Duty which came into force across Great Britain on 5th April 2011 requiring public bodies i.e. Clinical Commissioning Groups (CCG) "to consider all individuals when carrying out their day to day work - in shaping policy and delivering services", it furthermore requires public bodies "to have due regard to the need to eliminate discrimination and advance equality of opportunity". NHS Wirral and latterly Wirral CCG have outlined NHS Wirral Single Equality Scheme 2010-2013[8] which aims to "Involve and empower people, target inequalities through effective partnerships, ensure excellence in health services & become a high performing, high reputation organisation".

16. The Wirral Ethnic Health Advisory Group (WEHAG) Workshop report March 2012 and Strategic Development Plan 2012 – 2015 that followed highlights Cheshire, Warrington and Wirral PCT's cluster wide equality objectives which have been set out in order to drive CCG commissioning and service development plans. The objectives are as follows:
    a. To ensure accessibility for Wirral's BME population to services and information specifically.
    b. To develop joint consultation & engagement.
    c. To ensure the equality of opportunity in employment and training provision.
    d. To improve understanding of community needs through information sharing.

17. Clinical service data from NHS Wirral indicates that people from BME communities are more likely to be living with a number of chronic diseases than the general population. BME communities are more likely to die from all cancers, they suffer higher levels of depression, have a higher risk of emergency admissions. The uptake of breast feeding, health eating and physical activity along with accessing health services and for example bowel screening in the Muslim community is very low and needs to be addressed in an attempt to prevent further financial spend[9].

Proposal to consider

18. Wirral CCG is asked to consider funding the Health Workers (previously known as Health Link workers) for a further three years.

19. The Health Support Workers would provide the following key services to BME communities across Wirral:

    a. Support primary care with detection & management of key disease areas
    b. Provide support and education in accessing acute care services
    c. Provide after care and support to BME community members
    d. Target isolated & ageing BME community members in accessing through to engaging with existing healthcare services.

20. During the life of the contract being decommissioned Public Health added reporting requirements. WMO have tried with the limited resources available to respond and submit required data. As a result of KPIs an increased need to provide educational leaflets, flyers and information in a number of languages has been requested this

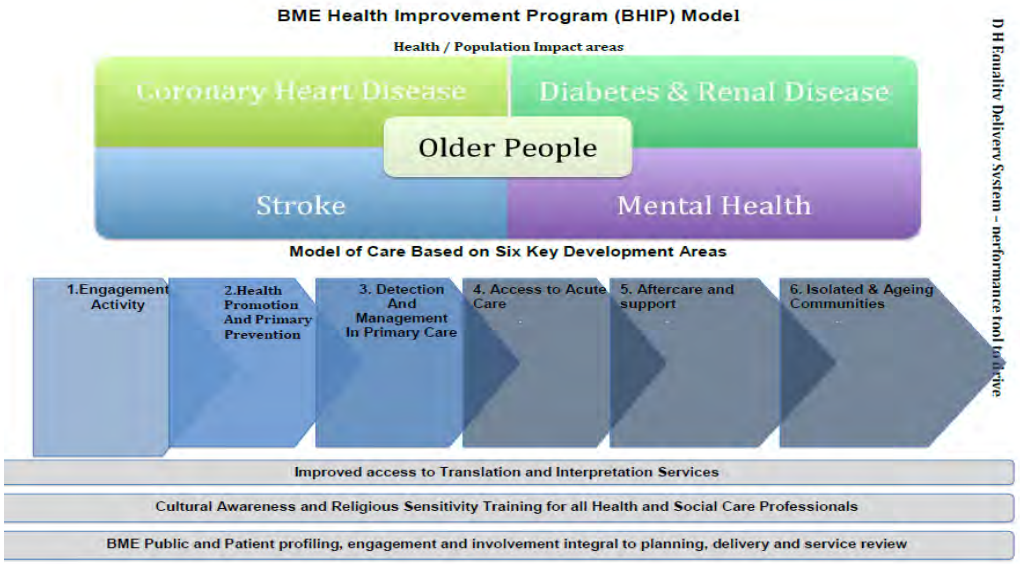
[8] http://www.wirral.nhs.uk
[9] Wirral PCT BME Health Needs Assessment/Icarus February 2010.

proposal also asks Wirral CCG to consider funding these additional elements. The scorecard inserted below illustrates WMO progress to date on achieving KPIs.

Scorecard WMO Oct 12.pdf

21. The recommendations that have formed the basis of a longer term BME Health Improvement Strategy illustrated below will help inform future commissioning intentions of CCGs enabling them to meet current gaps in service provision for BME communities.

Table 3 illustrates BME Health Improvement Program (BHIP) Model



22. This proposal would support all of the key development areas listed above and links to other pieces of work recently submitted to Wirral CCG i.e. “Improving Engagement in BME populations across Wirral Health Economy”, “Provision of Interpretation & Translation Services for BME populations across Wirral Health Economy”. Supporting this proposal would mean Wirral CCG would have virtually met all of the objectives laid down in the Wirral Single Equality Scheme Action Plan 2010-2013 along with PCT cluster Equality Objectives.

Finance

23. The cost for Wirral CCG to support this proposal for a three year period is illustrated below:

Option A		
Costs yearly		
Staff @ 3 WTE band 3 incl. 25% on costs		
£19077.00 x 3		71,538.00
Data collection and evaluation @ .5 WTE Band 2		10,470.63
Marketing, promotion and training *		9,000.00
		91,008.63
£91,008.63 x 3 years	**£273,025.89**	

Option B

Costs yearly		
Staff @ 3 x 0.6 WTE band 3 incl. 25% on costs		
£ 14307.6 x 3		42922.8
Data collection and evaluation @ .5 WTE Band 2		10,470.63
Marketing, promotion and Training *		9,000.00
		62393.43
£62,393.43 x 3 years	**£187,180.29**	

*Funding would be used to enable generic health leaflets to be translated into different languages, keep website material current & fund core training for staff.

24. As previously mentioned the total contract value set for the Health Link Workers per annum from 2009-2012 was £51,000.0 which was funded by NHS Wirral and commissioned by Public Health.

Potential savings & evaluation

25. If funding was granted for the three year period evidence available (submitted from Health Link worker balanced scorecard) suggests s the service as it stands now would continue to be ahead/on target in meeting its current performance indicators.

26. If funding of these posts was to be continued, robust evaluation and performance indicators could be added or reviewed in relation to the priority disease areas affecting BME communities as laid out in the example illustrated in table 4 below. There would be the potential for cost saving to be realised within Wirral CCG and additional disease areas could be targeted.

Quality Requirements	Frequency of reporting	Format of reporting
Older people. Number of individual patients engaged with and signposting to existing primary care services i.e. over 75 health checks, cancer screening programmes i.e. bowel screening.	Monthly	Provider monthly returns
Number of those individual patients who attend GP for service or who WMO assist in arranging appointment	Monthly	Provider monthly returns
Coronary Heart Disease (CHD) & Stroke		
Number of individual patients engaged with and directed to existing primary care services for CHD screening.		
Numbers of those individual patients who attend GP for screening or who WMO assist in arranging appointment.	Monthly	Provider monthly returns
Diabetes & Renal Disease		
Number of patients with diabetes who have been offered relevant health education promotion in relation to diet & lifestyle.	Monthly	Provider monthly returns
Number of patients who have been targeted and directed to attend primary care for diabetes review.	Monthly	Provider monthly returns
Number of those individual patients who attend primary care	Monthly	Provider monthly returns

for a diabetes review.		

Risks

27. The risks of not continuing to commission health support workers to support BME communities across Wirral include leaving a large gap in current service provision at a time when the BME population across Wirral is rising. In the longer term leaving these vulnerable communities without support could lead poor health outcomes.

Benefits

28. Based on the Wirral Non-Elective Admissions by Ethnic Group at WUTH 2011-12 data provided to the CCG recorded activity for non-elective admissions for BME individuals was 2,269 contacts which equates to an estimate of £1,105.18 per admission equalling £2,507,653.42. If through implementation of this proposal Wirral CCG aimed to reduce non-elective admissions by 10 percent a cost saving of £250,765.30 could be realised.

Recommendations

In light of the Public Health decision to decommission Health Link workers Wirral CCG is asked to consider and agree one of the following:

29. Agree to an investment of either

    a. Option A £273,025.89 to fund 3 WTE Primary Care BME support workers, data collection and enable generic education & advice materials to be translated for a three year period. To assist Wirral CCG in meeting current equality legislation in complying with The Equality Bill, Cluster PCT objectives and NHS Wirral's Single Equality Scheme and action plan 2010-13.

    b. Option B £187,180.29 to fund 3 x 0.6 WTE Primary Care BME support workers, data collection and enable generic education & advice materials to be translated for a three year period. To assist Wirral CCG in meeting current equality legislation in complying with The Equality Bill, Cluster PCT objectives and NHS Wirral's Single Equality Scheme and action plan 2010-13.

L J Thompson Commissioning Support Manager

December 2012

Pilot Project - Improving Engagement in Black Minority Ethnic Populations across Wirral Health Economy.

Introduction

1. Wirral has seen a significant increase in the black and minority ethnic population (BME) since the 2001 census which presented a figure of 3.56% compared to a total in 2010 of 5.83% n=18,291[10].

2. There is a lack of robust data on the population prevalence of the BME population, current methods nationally and locally of capturing data around ethnicity are not fit for purpose one reason for this is population change is happening faster than it has in the past.[11] An estimate of people in Wirral from BME groups is estimated to be anywhere between 5% - 16.4%.

3. Local intelligence informs us it is not possible to produce a statistically reliable estimate of the ethnic composition of Wirral's BME population, data available does however inform us that after White British the largest ethnic grouping is Asian/Asian British group which is estimated to have increased from 100 people in 2001 to 900 people in 2009 which is an 800% increase followed by White other background, then White Irish, Eastern European & Chinese[12].

Background

4. A recent Wirral Ethnic Health Advisory Group (WEHAG) away day highlighted a number of areas that need to be addressed to build on previous implemented initiatives aimed at improving current health inequalities that exist across the Wirral BME population.

5. One of the urgencies highlighted by task groups at the WEHAG away day attendees felt would make the biggest difference to the health experience of BME populations within Wirral was to go out into communities and inspire the BME population to engage with and appropriately use Primary Care Health Services across Wirral Health Economy.

6. Key health and wellbeing issues facing BME communities largely share the same health concerns as the population in general and include Type 2 diabetes, obesity, kidney failure, ischaemic heart disease, smoking, cancer, poor psychosocial health[13] . However people of certain ethnic groups experience a disproportionately greater burden of CVD including coronary heart disease (CHD) and stroke and tend not to engage in immunisation and screening programmes[14].

Current management & financial spend

7. During 2011-12 patients from BME population admitted to Wirral University Teaching Hospital (WUTH) cost Wirral CCG an estimated £1,363,139.0 (calculations based on

[10] Wirral PCT BME Health Needs Assessment/Icarus February 2010.
[11] JSNA consultation document September 2008
[12] JSNA Population document October 2011
[13] Aspinall J, Jacobson B Ethnic disparities in health and health care: A focused review of the evidence and selected examples of good practice London Public Health Observatory 2004.
[14] Wirral PCT BME Health Needs Assessment/Icarus February 2010.

deducting actual costs in table 1 of British, any other white background & not stated ethnic category costs).

8. This is a conservative estimate of non-elective admission costs as a portion of the "Z not stated ethnic category" has not been apportioned to the calculation in point 7.

Table 1 illustrates Wirral Non-Elective Admissions by Ethnic Group at WUTH 2011-12

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Z	Not stated	2011/12	1166	£ 1,242,368	Non-Elective Admissions

**** Data reliant on data accuracy at point of input***

Proposal to consider

9. Wirral Clinical Commissioning Group (CCG) proposes to pilot a Wirral wide rapid response service to encourage and improve engagement of the BME population accessing Primary Care GP practice services in a timely manner.

10. The JSNA consultation document 2008 highlighted a major problem in that BME communities had a lack of knowledge on where to get help and advice accessing appropriate health care services.
11. In order to improve engagement with the vast array of existing primary care health services s available to all residents on Wirral, if this proposal was approved GPs across Wirral CCG would have direct access to staff that would provide a rapid response encouraging the BME population to engage with general practice services.

12. GP practice would forward a referral via phone or fax to Wirral Multicultural Organisation (WMO) outlining the assistance required.

13. WMO would contact the patient within 48 working hours of receiving the referral arrange an appointment within 14 working days to meet with the patient and agree an action plan. The agreed plan would be faxed back to the GP practice and implemented with the assistance of WMO services and staff.

14. Wirral GP practices individually or as divisions may also contact WMO to assist them in targeting specific BME communities to increase uptake in for example screening, immunisation and or enhanced service programmes that may be beneficial to the

BME population that are currently not being accessed. In particular members of the BME community who are known to be hard to reach would be targeted by WMO using a variety of methods including WMO attending known BME community activities, lunches or centres to encourage engagement.

15. Outlined below is an example of how WMO could assist GP practice (if required) to further reduce cardiovascular disease mortality in the under 75 BME population. If practices felt Quality Outcomes Framework (QoF) outcomes could be improved within individual practices or across divisions WMO could use existing community links as well as establishing new links to encourage uptake of primary care management of vascular disease.

16. This proposal would support NICE 2008 Community Engagement Public Health recommendations by encouraging local people to be involved in commissioning, design and delivery of services[15]

Finance

17. The cost for WMO to provide timely support to all GP practices and to further engage BME communities in existing health care services for a two year period is outlined in the table below:

	Staff Costs **based on staff estimator 2010/11**
2012 -2013	£24,141 band 5 inc on costs – Engagement Officer bottom of banding
	£11,000 band 3 inc on costs – Administration Support midpoint of banding
2013-2014	As Above
Total	£70,282.0

18. This proposal would be funded using a block contract model, practices could utilise the service provided by WMO as frequently or infrequently as required during the funded period.

Potential benefits & savings

19. If funding was granted for a two year period evidence suggests that by encouraging local skilled professionals to facilitate with the engagement of BME population communities will be further empowered and confident in accessing appropriate healthcare services for future generations to follow. A local example of this was the community development workers commissioned by Wirral PCT and links developed through Citizens Advice Bureau & Advocacy Wirral[16].

[15] NICE 2008 Community Engagement Public Health

[16] BME Positive Practice Guide Improving Access to Psychological Therapies 2009

20. If implementation of this proposal was successful and 10% of non-elective admissions to WUTH were prevented Wirral CCG would realise cost savings of £136,313.90 in year one.

21. Potential benefits of such a proposal also include the potential for QoF achievements to rise benefiting practices as well as the long term health outcomes of practice populations.

Evaluation

22. In order to ensure thorough evaluation of this project WMO will from the outset record and submit monthly quality and Key Performance Indicators (KPIs) which would be defined by Wirral CCG but an example is illustrated below.

Quality Requirements	Frequency of reporting	Format of reporting
Number of new referrals to service by GP practice.	Monthly	Provider monthly returns
Number of new referrals contacted within 48 working hours.	Monthly	Provider monthly returns
Number of patients offered an appointment with WMO services within 14 working days.	Monthly	Provider monthly returns
Number of action plans developed and faxed to patients GP within 48 hours of assessment appointment.	Monthly	Provider monthly returns
Number of patients at follow up who have engaged with recommendations of the action plan.	Monthly	Provider monthly returns
Number of patients at follow up who have not engaged with recommendations of the action plan.	Monthly	Provider monthly returns
Improving productivity & DNA rates with WMO.	Monthly	Provider monthly returns
Improving productivity cancellation rates	Monthly	Provider monthly returns
Outcomes	An audit i.e. of action plans developed and implemented quarterly and outcomes for patients since implementation.	By nine months

23. Key service performance indicators would include:

Performance Indicators	
Patients reporting improved knowledge on how to access appropriate health services.	Patient questionnaires at initial assessment and follow up.
Number of patients engaged with who go on to develop an action plan.	Monthly reporting
Number of patients (at follow up) who have engaged/implemented action point/s from action plan (at least one point from plan).	Monthly reporting

24. After the service has been offered for one year review of non-elective admissions to WUTH could also be compared against 2011/12 data taking into account flaws in data recording.

Recommendations

Wirral CCG board are asked to consider and agree to the following:

25. Agree to an investment of £70,282.0 to fund WMO to provide rapid and timely assistance to aid engagement of the BME population in health care services highlighted by Wirral GP practices.
26. Agree to the WMO staff providing a rapid response to general practice requests encouraging the BME population to engage with general practice services in a timely manner, through contacting and working with patients to develop and implement action plans.

27. Agree to an evaluation reporting process to ensure this proposal delivers and improves engagement of BME population with existing health care services across Wirral.

L J Thompson

September 2012

Wirral Clinical Commissioning Group

Patient Advice and Liaison Service

Agenda Item:	2.3	**Reference:**	GB13-14/002
Report to:	Governing Body	**Meeting Date:**	2nd April 2013.
Lead Officer:	Phil Jennings		
Contributors:	Lorna Quigley		
Governance:	**Link to Commissioning Strategy**	Ensuring people have a positive experience of care. Embracing the NHS constitution in all we provide and commission	
	Link to current governing body Objectives	Improve the health of all Wirral residents. Promote maximum self care by involving abs including our patients in all decision made about them.	
Summary:	The Patient Advice and Liaison Service is a core service provided by all primary and secondary care NHS Trusts. PALS act as a facilitator to handle the concerns of patients, family and carers, with the power to negotiate immediate solutions when possible to do so. The CCG's within Cheshire and Warrington have recognised the need for a PALs service which they are purchasing through the Commissioning Support Organisation. The model that Wirral have adopted is different but, is comparable to other PALs services run by statuary organisations. The PALS service is provided by Wired, the service and commenced in November 201. This service is due to expire on 31st March 2013 at a cost of £34k for the full year. The governing body is asked to approve the continuation of the contract for the PALS service which is managed by Wired.		
Recommendation:	**To Approve**		x
	To Note		
	Comments		
Next Steps:	Once approved the Provider to be informed and a performance monitoring framework to be developed.		

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

What are the implications for the following (please state if not applicable):	
Financial	The full year cost of the proposal is £34,000
Value For Money	This service demonstrates value for money which was assessed during the procurement of the service
Risk	The risk of not having a PALs service would not give patients/public rights under the NHS constitution.
Legal	N/A
Workforce	If not approved, there will be redundancy costs associated with the service.
Equality & Human Rights	This service promotes the services users rights to complain under the NHS constitution, the service supports users/patients would not always be comfortable in complaining or voicing concerns
Patient and Public Involvement (PPI)	This service is designed for specifically for all service users and has been designed nationally using patient groups.
Partnership Working	This proposal involves the CCG working in partnership with the 3rd sector and the commissioning support unit
Performance Indicators	There are performance indicators within the service specification; these will be strengthened in the new contract.
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

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

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

Private Business

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

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

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

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

Wirral Clinical Commissioning Group

Review of the Patient Advice and Liaison Service (PALS) service (March 2013)

1. Introduction

The NHS Plan, 2000 set out the Government's ambitions to create a patient centred NHS, giving patients a greater say in their care and the way in which the NHS works.

Consultation on the NHS Plan demonstrated that while patients wanted support after things had gone wrong, they also really wanted help while things were going wrong, to sort things out on the spot.

By April 2002, every NHS Trust was required to establish a Patient Advice and Liaison Service (10.17, The NHS Plan), that would provide an "identifiable person [the patient] can turn to if they have a problem or need information while they are using hospital and other NHS services" (10.8 The NHS Plan).

PALS also have a role in delivering Section 242 and 244 of the NHS Act 2006, Involving Public and Patients in Healthcare, through its direct contact with Patients concerns and quality control in improving service delivery.

The Patient Advice and Liaison Service is a core service provided by all primary and secondary care NHS Trusts. PALS act as a facilitator to handle the concerns of patients, family and carers, with the power to negotiate immediate solutions when possible to do so.

PALS also provide feedback on common themes and concerns, which patients, their carers and families bring to their attention and be a catalyst for improvements and change.

2. The Aim of Patient Advice and Liaison Service (PALS)

The key aims for PALS are;

- To continually improve the patient experience of health care services.
- To effect change and improve quality.
- To ensure that concerns are handled thoroughly without delay with the aim of satisfying the patient whilst being fair and open with all those involved.

3. Background

The PALs service was run by NHS Wirral and was based in the centre of Birkenhead. Feedback was received that this was this not convenient for all Wirral citizens and so other communication methods including have your say and in touch.

Due to the changes brought about by the health bill, the service was unable to operate in its current format. The community element of the service was transferred to the Community Trust in order for them to manage and support their organisation. This gave the PCT an opportunity to review the current provision and revise the service. Once the model was agreed and the service specification written, a procurement process was undertaken. Wired where the successful organisation in securing the contract.

4. Current Position

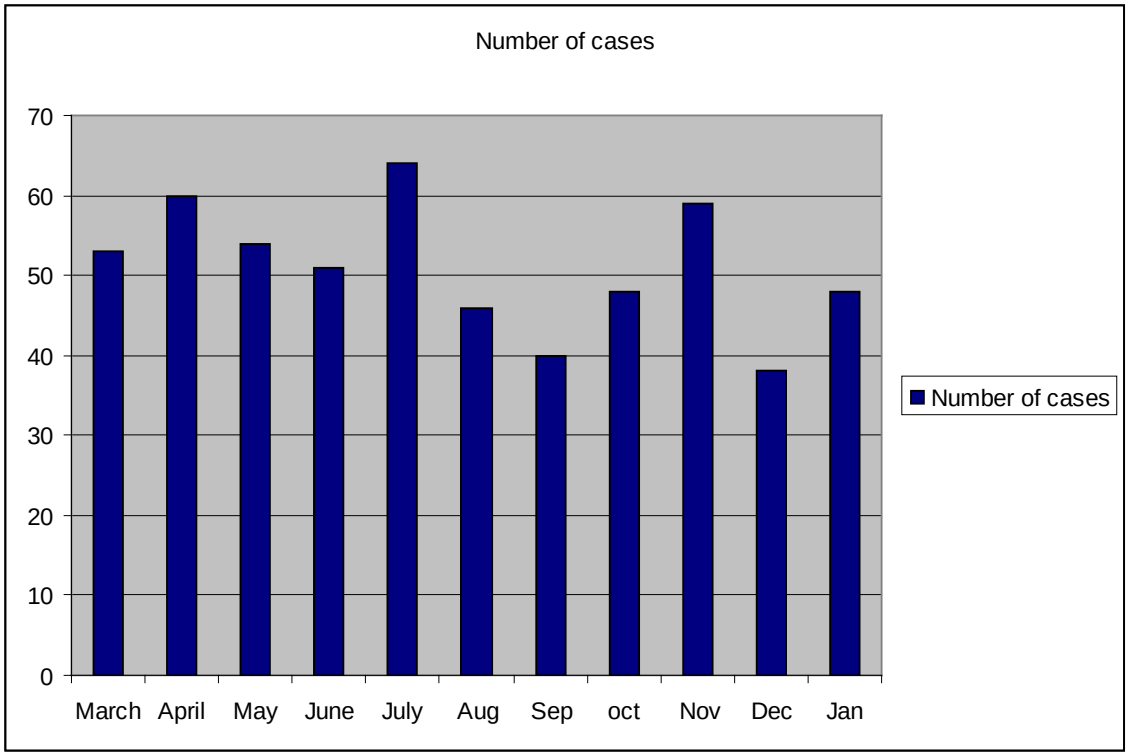
The PALS service is provided by Wired, the service and commenced in November 201. This service is due to expire on 31st March 2013 at a cost of £34k for the full year.

.

The CCG's within Cheshire and Warrington have recognised the need for a PALs service which they are purchasing through the Commissioning Support Organisation. The model that Wirral have adopted is different but, is comparable to other PALs services run by statuary organisations.

5. Performance against specification

Monthly monitoring reports have been received from Wired as per contract, based on the service specification;



Narrative is provided by Wired in relation to specific cases which is feedback to providers.

Data is provided on response times and the number of cases, closed and transferred each month.

6. Recommendations

There is a need for the CCG to have PAL's service, as a means of receiving patient/user feedback. The model of using a third sector organisation is innovative, but has proved successful and has the ability to compliment statuary organisations.

Wired have provided an effective PALs service on behalf of the CCG since 2011.

The recommendation is that the Governing Body supports the continuation of the PALs service hosted by Wired for a further 12 months, and the development of a robust monitoring framework.

Phil Jennings
Lorna Quigley

Wirral Clinical Commissioning Group

Finance Report Month 11 – February, 2012/13 Financial Year				
Agenda Item:	3.1		**Reference:**	GB13-14/003
Report to:	Governing Body Board meeting		**Meeting Date:**	2nd April 2013
Lead Officer:	Mark Bakewell			
Contributors:				
Governance:	**Link to Commissioning Strategy**	Sound financial control is essential to the CCG strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year.		
	Link to current governing body Objectives	To achieve financial control total with sound financial management.		
Summary:	This report updates the CCG on the financial performance against budgeted allocation for 2012/13 as at Month 11 (February) 2013			
Recommendation:	**To Approve**			
	To Note			✓
	Comments			
Next Steps:	Continuation of performance monitoring through the remainder of the financial year			

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

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

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

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

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Financial Plan		Governing Body	8th May 2012	

Private Business

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

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

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

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

Wirral Clinical Commissioning Group

NHS Wirral Clinical Commissioning Group

Finance Report for the period 1st April 2012 to 28th February 2013

Introduction

1. This report sets out the financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of February (Month 11) within the 2012/13 financial year.

Resources

2. The total budget allocated to Wirral CCG for the year is £468 million from within the overall PCT baseline of £660 million. Based on the federated model approach a number of budgets are aligned to the Governing Body (£136m) to be managed on an economy wide basis and the remaining budgets devolved to the combined consortia (£332m). This is usually where practice level information is available and performance is based on actual activity (using GP Registration for individual patients).

Financial performance

3. As at the end of February (Month 11) the year to date position for Wirral CCG is an under spend of (£22k) with over performance against commissioning expenditure of £461k offset by an under performance against running costs of (£483k).

4. This compares to the January Month 10 position of £0.5m overspend, with the overall favourable movement of £0.5m being mainly due to further under spends on prescribing budgets, continued release of contingency reserves and further release of earmarked reserves offsetting over performance on the Wirral University Teaching Hospitals FT contract (WUTH).

5. The year to date variance position between Governing Body and the combined consortia is a overspend at divisional level of £5.8m with the Governing Body underspent by (£5.83m).

6. A year to date overall Financial Summary for Wirral CCG is available in Appendix 1. The table below shows the performance variances at month 11:

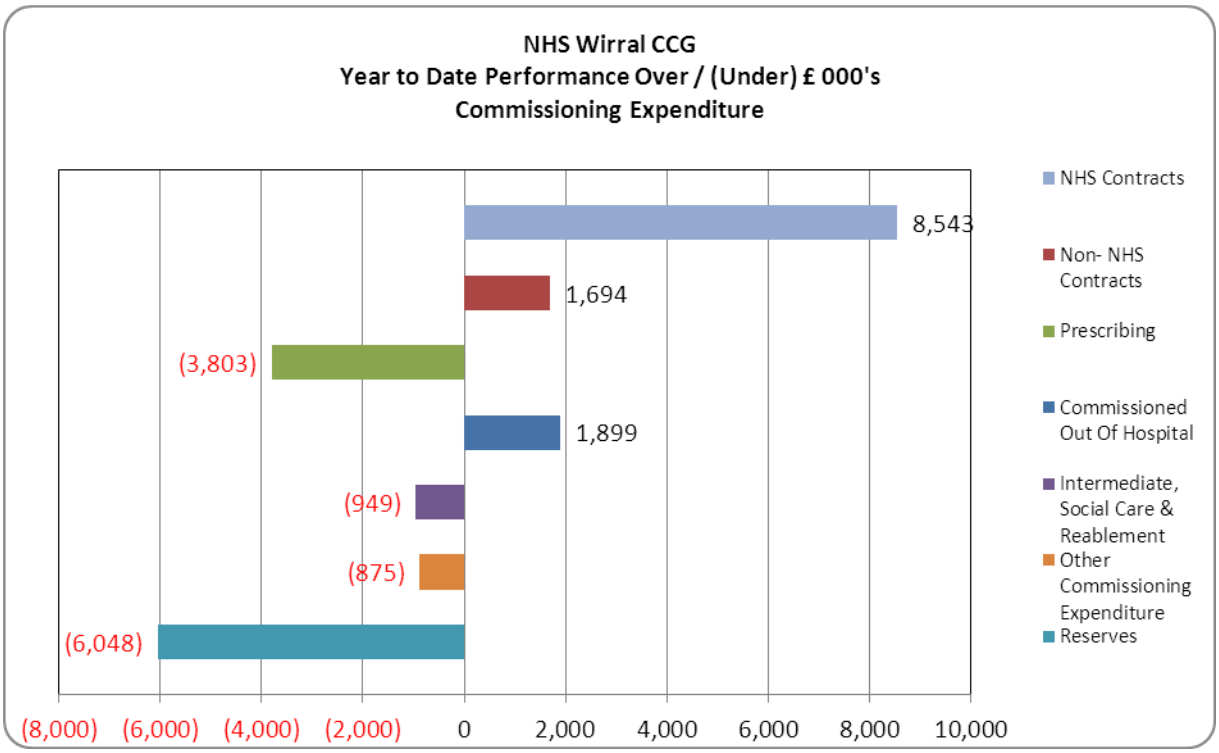
YTD variance	Combined Consortia £ 000	Governing Body £ 000	Total Wirral CCG £000
Commissioning Expenditure	6,201	(5,740)	461
Running costs	(392)	(92)	(483)
TOTAL	**5,809**	**(5,831)**	**(22)**

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

YTD variance	WGPCC £ 000	WHCC £ 000	WACC £ 000	Total Wirral CCG £000
Commissioning Expenditure	(766)	7,267	(243)	6,201
Running costs	(228)	(100)	(64)	(392)
TOTAL	**(993)**	**7,167**	**(307)**	**5,809**

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

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



NHS Contracts

10. The overall CCG performance position in relation to NHS contracts shows an overspend at month 11 of £8.5m (previous month £8.6m) primarily being due to over performance on the Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) contract of £8.49m (previous month £7.6m) at divisional level.

11. The year to date position is based on actual activity as at Month 10 (as per table below) £7.2m over performance with a pro-rata adjustment to equate to month 11 position and application of estimated contract adjustments for re-admissions / outpatient follow-up ratios as appropriate (again based on the month 10 actual activity position).

WUTH Point of Delivery	YTD Actual Performance as at M7 Oct 2012 Over / (Under) £ 000's	YTD Actual Performance as at M8 Nov 2012 Over / (Under) £ 000's	YTD Actual Performance as at M9 Dec 2012 Over / (Under) £ 000's	YTD Actual Performance as at M10 Jan 2012 Over / (Under) £ 000's
Elective	1,223	1,446	1,698	1,302
Non-Elective	2,044	2,449	2,727	2,840
Outpatient Attendances	1,084	1,156	1,151	1,276
Outpatient Procedures	696	802	865	975
A&E	(13)	34	62	139
PbR Total	**5,034**	**5,887**	**6,503**	**6,532**
Non-PbR Total	550	772	471	692
POD Total	**5,584**	**6,659**	**6,974**	**7,224**

12. The point of delivery above shows over performance across the majority of areas. Non-elective performance has been fixed at an agreed outturn level and pro-rata is in line with year to date position, elective point of delivery over performance has increased which was expected due to the referral trends from earlier in the year.

13. There has been a reduction in the run rate of the in-month overspend between months 9 and 10 which would support the view that work streams led by the CCG are beginning to have some positive effects (practice visits / referral pattern etc). Non elective activity is also above the fixed contract position.

14. Performance on other NHS contracts shows a combined overspend of £51k year to date (previous month £929k). The favourable £876k movement was due to the Royal Liverpool and Broad green University Hospital contract of £261k movement due to HCD incorrectly charged on top of fixed outturn position, CCO £222k movement, year end settlement better than expected and £399k favourable movement with Wirral CT contract due to resolution of outstanding physio issues.

15. There is also over performance year to date on the North West Ambulance Service contract £186k, Warrington & Halton Hospital £55k, Countess of Chester £93k and Christie Hospital £75k.

Non-NHS Contracts

16. At month 11 Non NHS Contracts are over spent to date by £1.69m (previous month £1.46m).

17. Firstly the backlog of patients transferring to “Spire” due to 18 week RTT targets from earlier in the financial year of £194k.

18. Over performance against planned levels of activity also exist and continue against the Independent Midwifery One to One provider £413k for ante / post natal care, Spa Medica (Ophthalmology Cataracts) £343k, and the “Spire” contract for patient choice referrals (non RTT Backlog patients) £254k.

19. Under performance continues on the Assura Ophthalmology contract £106k year to date and also in Primary Care Mental Health contracts £277k year to date.

20. With the utilisation of the two AQP’s radiology and physiotherapy, it is anticipated that under performance will be seen in other areas to compensate the reported expenditure. Other existing performance factors are outlined below.

Prescribing

21. Prescribing expenditure is currently providing the CCG with a year to date underspend of £3.8m (previous month £3.4m). There is an under performance of those budgets managed at Governing Body level of £663k and underperformance at divisional level of £3.14m. The performance position is based on nine month’s actual data with two months estimated costs for January and February.

22. The year to date divisional underspend is primarily due to cost growth, a substantial drop in generic drug prices and the delay in the transfer of prescribing dementia drugs to primary care and underperformance in respect of planned drug developments as per the original financial plan. Further detailed information is to be presented to the QPF committee by the medicines management team.

Commissioned Out of Hospital

23. Commissioned "out of hospital" budgets are £1.9m overspent at month 11, an adverse in month movement of £358k. The main drivers for the continued over performance remain within the Continuing Healthcare expenditure in relation to Older People (£274k), Mental Health (£338k) and Physical Disabilities (£298k), and all Joint Funded packages (£973k) These overspends are being partially offset by underperformance on Funded Registered Nursing Care (FRNC) of £319k.

Reserves

24. Reserves are underspent by £6m at Month 11 which is due to the release of the contingency element and a number of earmarked reserves which have been released due to changes in the expenditure plans.

Running Costs

25. There is a year to date underspend of £483k in relation to running costs at month 11, an adverse in month movement of £149k. This is primarily due to the movement in under performance on the Commissioning Support Unit (CSU) costs at Governing Body level £259k (previous month £374k). Clinical backfill reported at consortia level continues to underperform year to date (£323k). A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position.

Forecast Outturn

26. Based on the information received as at month 11 within the 2012/13 financial year (February), the position for the CCG remains on track to deliver at least a balanced position against it delegated budget and from an overall perspective the PCT is still in a position to achieve its overall control total, the actual forecast position is £290k underspend at month 11.

27. One of the key performance drivers to the financial performance position remains around the WUTH contract and intelligence regarding contract performance using the month 10 position resulted in a stable forecast outturn position to the value of £9.0m with indications that it may be slightly lower.

28. There have been some movements in the NHS contract position in relation to the areas highlighted previously and prescribing continues to provide a material underperformance against planned expenditure (£4.3m)

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

NHS Wirral Clinical Commissioning Group Financial Summary - 2012/13			
Month 11	**Annual Budget**	**Forecast Variance M11**	**Forecast Variance M10**
Clinical Commissioning Groups(CCG)	£'000	£'000	£'000
NHS Contracts	331,418	8,957	10,080
Non-NHS Contracts	12,517	2,123	1,806
Prescribing	59,815	(4,376)	(4,378)
Commissioned Out of Hospital	29,293	2,134	1,842
Intermediate, Social Care & Reablement	8,900	(1,038)	(902)
Other Commissioning Expenditure	8,629	(832)	(720)
Reserves	7,704	(6,682)	(7,006)
Cost Improvement Programme	0	0	0
Total CCG Commissioning Expenditure	**458,274**	**286**	**723**
Running Costs	**9,829**	(576)	(723)
Overall CCG	**468,103**	**(290)**	0

Financial Risk

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

Original Risk Identified	Potential Risk Value	Degree of Forecast Risk	Current Forecast Performance	Degree of Forecast Risk
Commissioned Out of Hospital	£1.0 million		£1.9m	
Performance on Secondary Care Contracts (WUTH)	£3.0 million		£9.0m	
Prescribing	£1.2 million		(£4.3m)	
Cost Efficiencies	£6.2 million		Linked to other risks as embedded within contracts but managed via contingency	

Degree of Forecast Risk – Assessed as

Red Over performance > 2%
Amber Over performance > 1% or risk of delivery

Green Minimal Risk (Forecast Underperformance or low value)

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

Conclusion

32. Wirral CCG's Quality, Performance and Finance Committee is asked to note:

    - the financial position as at the end of February 2012
    - the forecast outturn position for 2012/13

Mark Bakewell
Chief Financial Officer
NHS Wirral Clinical Commissioning Group

20th March 2013

Wirral Clinical Commissioning Group

Pre- Implantation Genetic Diagnosis (PIGD)

Agenda Item:	3.2	**Reference:**	GB13-14/003
Report to:	Governing Body Board	**Meeting Date:**	2nd April 2013
Lead Officer:	Shanila Roohi		
Contributors:	Sheena Hennell		
Governance:	**Link to Commissioning Strategy**	This proposal links to Wirral CCG priority areas surrounding planned initiatives and CSG terms of reference.	
	Link to current governing body Objectives	This proposal links to CCG Strategic Objectives.	
Summary:	. This paper asks the Governing body to note the protocol for PIGD that has been approved at Clinical Strategy Group (Dec 2012)		
Recommendation:	**To Approve**		
	To Note		✔
	Comments		
Next Steps:	Advise Complex case team and Shanila Roohi of outcome		

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What are the implications for the following (please state if not applicable):	
Financial	N/A
Value For Money	N/A
Risk	The risk of not noting at a Governing Body level, is that individual requests will continue to be analysed separately and not matched against an agreed protocol
Legal	Advice has been taken from CCG Solicitor
Workforce	N/A
Equality & Human Rights	Equality & Human rights have been considered throughout this process
Patient and Public Involvement (PPI)	PPI has been part of all processes
Partnership Working	Throughout this process relevant partners have been included
Performance Indicators	N/A
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

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

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Wirral Clinical Commissioning Group

Wirral CCG Governing Body Meeting

Pre-Implantation Genetic Diagnosis (PIGD)

Introduction

1. PIGD refers to procedures that are performed on embryos prior to implantation or oocytes prior to fertilisation. This enables early identification of certain genetic disorders or chromosomal abnormalities. It can also be used to determine the sex of the embryo where there is risk of X linked disorders.

2. Couples would undergo a standard IVF or Intracytoplasmic insemination procedure (ICSI) with PIGD being performed on the resulting embryos. This would allow only UNAFFECTED embryos to be transferred back to the woman's uterus.

3. PIGD can only be offered to couples where the genetic changes responsible for the disease can be identified.

Current Procedures

4. The health treatment panel (Individual Funding requests panel) deals with requests for PIGD on a case by case basis at present.

5. There is no National guidance or consensus of managing these requests in English PCT's. Locally we have used a draft policy with plans to have this formally ratified as soon as possible,(appendix 1 Draft policy).

6. The numbers of cases coming through to the complex case team and panel are variable and listed in appendix 2.

7. One of the previous cases was shared with the legal team for their input and advice due to its complex nature (appendix 3).

8. The summarisation of the legal advice was that the policy was acceptable in its current form BUT would need to go through a formal ratification process as soon as possible so it is no longer a draft policy and to reduce organisational risks from possible legal challenges.

9. The panel has explored national variations and information from NHS Scotland with the Scottish PIGD and screening Service was considered to be robust and thorough and would be useful to take into consideration. (appendix 4)

10. Appendix 5 is the summary of PIGD that was previously raised for discussion at the Clinical Advisory Group- the precursor to the CSG.

Considerations

11. The panel would like to suggest the CSG consider the current draft PIGD policy, the lack of current National guidance and the recent need for legal opinion, together with the legal advice suggesting a ratified policy is in place as soon as possible.

12. There are currently great variations in the criteria applied in decision making processes for individuals requesting PIGD.

13. The panel currently use the draft policy as the foundation for decision making.

Debate Points

14. Dr Jane Wright and Dr Shanila Roohi have advised that the main debate points are

    - Adopt the policy versus disregard
    - If disregard then stick with a case by case decision and consider the issue of children
    - Adopt and formally ratify the policy, keeping it in line with current IVF policy for BMI
    - Look to see what others areas have adopted

15. It is not known if the CSU/ specialised commissioning services will take over requests for PIGD or IVF in the future but the current draft policy is an organisational risk until ratified.

Recommendations

16. The CSG should consider formal ratification of this policy if they are comfortable with its current criteria.

17. The CSG should consider a future formal review and update of the PIGD criteria for future cases if this is a service to be under the auspices of the CCGs.

CSG Outcome

18. CSG approved protocol with 2 minor alterations, now actioned

19. A formal review once protocol in use to be planned

Shanila Roohi

21.12.12

NHS
Wirral Clinical Commissioning Group

Wirral CCG Governing Body Meeting
Policy Position 'NHS Wirral' May 2012

Mandatory criteria	• Both partners are registered with a Wirral GP Practice • Couples must have no living unaffected children from the present relationship. • Patients will be eligible for one complete cycle of IVF treatment as part of the PGD process; in compliance with the CMSSCT fertility policy. • Women must be aged between 23 and 39 years old (and not over 40 at the time of treatment). • Women's BMI must be between 19- 29 before treatment. • Couples to have received genetic counselling from an appropriate genetic counsellor-A health professional who has undergone further approved training in this field, holds registration with the appropriate association and has experience and knowledge of the genetic conditions appropriate for PGD. • The PGD clinic must be licensed by the HFEA to carry out a test for the relevant condition and the test must be included in the list of UKGTN approved tests. • The centre must have a HFEA licence to provide PGD for the condition being considered. • Consideration must be given to the welfare of the child, in accordance with the criteria outlined in the Commissioning Policy for IVF/ICSI within CMSSCT Fertility Policy.

Pre-implementation Genetic Diagnosis

Adapted from:

East Midlands Specialised Commissioning Group, Commissioning Policy for Pre-implantation Genetic Diagnosis, EMSCGP013V1, June 2009

NHS Dudley, Commissioning Policy for Pre-implantation Genetic Diagnosis (PGD), Version 3.0 – May 2010

Wirral GP Commissioning Consortium

NHS
Wirral Clinical Commissioning Group

WIRRAL GP COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Tuesday 12th February 2013, 7pm
Nightingale Room, Old Market House

Present:

Dr Navaid Alam	(NA)	GP Lead
John Callcott	(JC)	Non Executive Advisor
Christine Campbell	(CC)	Chief Officer (Acting)
Chandra Dodgson	(CDo)	Finance Lead
Dr Andy Lee	(AL)	GP Lead
Dr Hannah McKay	(HM)	GP Lead
Dr John Oates	(JO)	Chair
Ann Riley	(AR)	Nurse Member
Eddy Shallcross	(ES)	Patient Council Chair
Dr Pankaj Srivastava	(PS)	GP Lead

In attendance:

Carol Diamond	(CD)	Commissioning Support Manager
Anita Fletcher	(AF)	WGPCC Administrator
Kerry Hogan	(KH)	Commissioning & Engagement Support Manager
Paul McGovern	(PM)	Commissioning Support Manager
Emma Shanks	(ESh)	Senior Consortia Accountant

Ref No.	Minute
WGPCC/EB/ 12-13/0075	**1.1 Apologies for absence** Apologies were received from Dr Akhtar Ali, Karen Hornby and Dr Abhi Mantgani.
	1.2 Declarations of interest Interest was declared in item 2.3 as it affects all GP members. JO also declared an interest in items 2.4, 3.1 and 3.2. Due to this fact, JC would Chair the meeting for these items and present the corresponding papers.
	1.3 Public Comments/Questions There were no members of the public present.
	1.4 Minutes and Action Points of the last meeting The minutes from the last meeting were agreed to be a true record of the meeting. <u>Matters Arising</u> **Any Other Business: Commissioning Priorities for 2013/14** – Members were informed that CD, KH and PM had put together a list of issues and priority areas to look at for next year. This list will be presented at the next Clinical Leads' meeting on Tuesday 5th March 2013 and will then be proposed as priorities for the Consortium for 2013/14.

Ref No.	Minute
	Action Points **Additional Patient Representation** – This had been raised at the Patient Council meeting and members were invited to contact CC or KH with their interest; none had been received to date. It was agreed that this would be raised at the next couple of meetings and if unsuccessful, a different route would be followed with contact being made to patients in writing. A suggestion was made for GPs to approach patients they feel would fit the position. **Project Scorecard** – KPI's had been set up and populated with data. A number of reviews of KPI's had taken place with the intention for this to be live at the start of the next financial year. Key areas that the Executive Board feel should be focused on will be sought. **Terms of Reference** – A meeting is due to take place with the Chief Officers within the other Consortia to ensure consistency in Terms of Reference. An update will be provided at the next Executive Board meeting on 19th March 2013 with a copy being sent to the Executive Board members for comment prior to that date. **Nurse Training Plan** – Members were advised that the slow uptake of some sessions was raising concern. Nurses had been reminded of the training plan at the Protected Learning Time event. If uptake is still low, this will be raised at the next Practice Members' Forum and Clinical Leads' meeting. AR explained that staff have advised that they are not being released from practice to undertake training. A reminder may need to be highlighted to practices that backfill is available from individual practice training budgets. This will be raised again at the next Practice Managers' Forum. **Foundation Years Trust Pilot Project** – CD informed members that she had met with Jill Quayle to discuss evaluation. A template had been created and quarterly reports will be provided. An email will be issued to practices advising them that contact will be made by the Trust if their practice falls within the target group set. The Foundation Years Trust is currently recruiting volunteers. The pathway has been set up to start on 1st April 2013 and feedback will be shared in August/September 2013. Members were advised that funding for the project will be from next year's budget.
	1.5 Minutes for Noting Executive Board Members noted the minutes of the Wirral Clinical Commissioning Group Governing Body meeting which was held on 8th January 2013. Members were informed that the meeting mainly concentrated on amendments to the Constitution. The deadline for practices to return the sign-up page for the Constitution had been the end of January 2013. Sign-up is crucial to the CCG authorisation process. As at 12th February, 32 signed sheets out of 61 have been returned. Reminders have been issued to all outstanding practices.
WGPCC/EB/ 12-13/0076	**2.1 Update on Interface Forms** Members were advised that interface forms had been in circulation for two years and have enabled the Consortium to influence areas of concern to practices, such as hospital discharge letters. Forms were still being received but numbers had reduced over the past quarter which may be the result of the introduction of the redesigned hospital discharge letter. This is a positive step as it demonstrates that the changes made have been useful. Practices are now looking elsewhere for areas to raise queries on. Trends on these queries will be analysed to see if anything can be done differently. The interface form is being rolled out to all Wirral GP practices mid February 2013 and the issues raised will be recorded on an electronic database. Most issues raised to date have been indicative of a trend (such as discharge letters), rather

Ref No.	Minute
	than isolated incidents. A request was made for an additional box to be included on the interface form for 111. Members were advised that a discussion had taken place at the Operational Group meeting around highlighting issues to service providers, and providing feedback to the practices. It was agreed that further work was needed on how feedback is provided Wirral-wide.
	2.2 Savings and Commissioning Allocations Report Members were advised that the paper provides a position statement of the savings / commissioning proposals submitted and invoices outstanding by practices as at 31st January 2013. As practices are constantly being reminded of the deadline to submit proposals and invoices, the situation changes on a daily basis. Practices have been requested to only submit invoices during this financial year if they have incurred costs during 2012/13. Practices have been advised that they should not submit invoices for approved bids for equipment or staff that have not or will not be purchased or required during the remaining months of this financial year 2012/13. Resources that will be released through this process will be made available again in the new financial year and made available to practices from the end of April 2013. This has been guaranteed to practices. Members were advised that as at 12th February 2013 all uncommitted savings and invoices were as follows: **Uncommitted Savings / Commissioning 2011/12** Uncommitted Savings £648.92 Uncommitted Commissioning £16,572.28 Total Uncommitted **£17,221.20** **Invoices Outstanding 2011/12** Savings Invoices £666,172 Commissioning Invoices £190,425 Total Invoices Outstanding **£856,597** **Invoices Outstanding 2010/11** Total Invoices Outstanding **£51,892** Following discussion, the Executive Board agreed that the final deadline for submission of savings and commissioning allocations invoices, relating to the years before 201/12, would be Friday 15th February 2013. Any invoices submitted after this point would not be honoured.
	2.3 Chronic Obstructive Pulmonary Disease Update Members were advised that a Chronic Obstructive Pulmonary Disease Local Enhanced Service (COPD LES) has been in place since July 2011 and is due to end 31st March 2013. COPD

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	continues to be one of the top reasons for hospital attendances/admissions to secondary care for WGPCC. The purpose of the paper is to update the Executive Board of the investment and support offered to Wirral GP Commissioning Consortium practices to improve the management of patients with COPD within primary care and to consider the impact the COPD LES has had on hospital readmissions. The Executive Board is requested to note the contents of the paper and to review the COPD schemes in place in 2012/13 to inform commissioning in 2013/14. Members were advised that it is difficult to review this LES to see what its impact has been. A review of the data available indicates a slight reduction in admissions due to COPD, although it is unknown which of the measures implemented during 2012/13 has contributed to this. Data received from the Primary Care team shows that only a few practices have provided data and because of this it is unknown as to whether a practice has implemented the LES. It was felt that practices were relying on discharge letters and remembering to pass them on to be looked at. A search must be undertaken every two weeks. Executive members felt that this work has become submerged with everything else that practice staff had to do. A suggestion was made that undertaking this work through a LES may not be right approach and that the Oxygen Service could possibly help. It was felt that there was not enough information available to determine the successful impact of the LES and therefore to recommission this in 2013/14. It was agreed that WGPCC COPD group would need to take stock of all COPD support available, and good practice that is taking place across the Wirral, and come up with an action plan to support COPD management in 2013/14.
	2.4 Primary Care Mental Health Progress Update Due to interest declared in this proposal by the Chair, the item was chaired by JC. Members were advised that since the last Executive Board meeting, guidance had been provided from the IAPT North West Regional Team confirming that the maximum waiting time from referral to first regular therapy appointment (including assessment and triage) should be no longer than 56 calendar days. Figures have improved significantly since the last meeting with the average waiting time from referral to assessment being seven days and 41 days from referral to first regular therapy appointment. For Step 3, Peninsula has put a number of steps in place which is starting to be reflected in the figures. Executive Members agreed that the figures for average waiting times were positive but figures for the longest waiting patients are high. Members were advised that a review meeting with IAPT would be taking place on 14th February 2013. Their thoughts and strategies on how to tackle these issues would be sought at the meeting. Hopefully, they will have some suggestions for the service provider. Each Primary Care Mental Health provider will be represented at the meeting. This will be a good opportunity with having everyone together to discuss issues occurring Wirral wide. The suggestion was made that DNA guidance from IAPT could be sought.

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	A suggestion was given that the Consortium may want to review the contract in time for the third year of the contract, starting in November 2013. DNA rates are extremely high, equating to up to 25% or 1 in 4 patients. In was agreed that the contract should be reviewed urgently, as currently there is no incentive for the provider to reduce its DNA rate. The Board members agreed unanimously that only clinical appointments should be paid for, and that DNA appointments should not be funded. Members were advised that the total budget allocated to the Consortium Primary Care Mental Health contract during Year 1 was £1,706,242. This included the recurrent base budget of £1,021,639 (which was based on historic referral activity) and non-recurrent additional funding of £685,603 (to take into account projected future need). During Year 1, Peninsula's activity has increased steadily on a month by month basis, with the highest number of contacts reported in October 2012. Peninsula anticipates activity to continue to increase and has forecast the total number of sessions to be delivered during Year 2 to be approximately 6,768 compared with 3,843 sessions delivered throughout Year 1, with expenditure estimated as £1,638,809. With regards to 2013-14, £1,021,639 has been set aside recurrently against the Consortium Primary Care Mental Health budget (Peninsula's share is proportional to the list size of the 21 practices that use their service). Based on Peninsula's forecast above, there are concerns that there is likely to be a shortfall in funding during Year 2 of the contract. The Commissioning Support Unit is currently looking at these figures. Members felt that the allocation for each provider should be capped at the value of the first contract year and payments should not be made for DNAs. Members were advised that referral rates are the same for each of the providers, and so it is not clear why one provider is having such difficulty in managing its waiting list in comparison to the others. Executive Board members agreed for the funding to be capped at year one contract levels, and that payments should not be made for DNAs. Suggested revisions to the Primary Care Mental Health contract waiting time KPI were discussed, and based on IAPT guidance it is recommended that the KPI be changed to the following: • Patients to be offered an assessment appointment within 10 working days of date of referral • Patients to be offered first regular therapeutic appointment within 20 working days of assessment It was agreed that patient's expectation is important. The wording of letters to patients needs to be looked at to ensure that patients understand the potential waiting times, and also that the person who undertakes an assessment may be different from the person who undertakes the first clinical appointment. Members were advised that the tariffs per session applied by the Primary Care Mental Health providers vary. The average contacts per case per step also vary significantly. Therefore, the Board is asked to consider whether there are any merits in reviewing both the tariffs in place and guidance regarding contacts per case prior to the commencement of Year 3 of the contract The Board members noted the performance of Peninsula to date and were happy with the recommendations above, and the following actions were agreed: • KH to explore payment terms within the contract and how to implement the Board's decision

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	regarding non-payment of DNAs • KH to revise the waiting time KPI • KH to review the sessional tariffs and average contacts per case
WGPCC/EB/ 12-13/0077	**3.1 Admissions Prevention Service** Members were reminded that this service had begun as a pilot scheme by Wirral GP Commissioning Consortium in March 2011. The service has shown a steady increase in demand. The two other Wirral Consortia have come on board and now commission the service to meet their population needs. The service has been set Key Performance Indicators in terms of achieving 90% of referrals to be assessed within 2 working days of receipt; at the end of quarter three the service was achieving 98% of referrals within 2 working days. All 27 member practices have used the service at least once during the current financial year. In the first three quarters the best recorded outcome was for 40% of referrals to result in an avoided admission. The service is funded by Wirral GP Commissioning Consortium up to 31st March 2013, therefore it is now critical to decide on the future of the service beyond this point, identify the relevant financial resources needed to support its continuation, and determine any changes that will need to be made to the service specification based on the commissioning intentions of the Consortium. Even at the most conservative estimate, data indicates that the service will have saved at least £50k (taking away the cost of the service) through avoided admissions in this financial year, just for this Consortium. A case study evaluation of the service has been commissioned through the Applied Health and Wellbeing Partnership with Liverpool John Moores University (LJMU) to review the experiences of Health Professionals who have referred their patients into the service. The feedback has been extremely positive. The outcome of the evaluation will be circulated to Board members at a later date. With regards to risks to the Consortium of not continuing the service, there is likely to be a negative impact on hospital admissions. Members were advised that partnership working and protocols in place are good. The roles and relationships have strengthened through involvement with the local Rapid Access Multi-Disciplinary Teams. Looking forward, there are opportunities to develop the service and these were highlighted in the paper and discussed. It was agreed that there is the need to focus more on facilitating discharge. To date the service has been commissioned on a block contract basis, and significant investment has been made during the initial two years to support the development of the service infrastructure. However, now that the service is fully operational and established, and also now receives funding from the other Wirral Consortia, it is timely to review if the existing block payment arrangements, and payment rates, remain the most appropriate. The following options are presented for consideration, should it be decided to continue to continue to commission this service: a) The service continues as a divisional project for 2013/14 at the same rate as the current level of investment as 2012/13 b) Wirral GP Commissioning Consortium continues to fund a service alongside separate arrangements for the other Wirral Clinical Divisions based on a ‘fair share’ type model, with

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	contract management and reporting remaining at individual divisional levels c) A cost per case tariff model is established based on a three part process with payments claimed against: o Initial referral receiving full nursing assessment o Case management of care episode o Final payment related to discharge and completion of case within agreed target times (up to 14 days, 14-28 days) Members were advised that the paper recommends the following:: • Wirral GP Commissioning Consortium Executive Board supports the commissioning of an Admission Prevention and Facilitated Discharge Service in 2013-14, up to a maximum cost of £170,000. This will be on the basis that the service specification and KPIs are reviewed, revised and a new version that meets the requirements of the Consortium is agreed between commissioner and provider. • The paper further recommends formal monthly activity reviews and quarterly contract reviews for negotiation and agreement to establish a suitable point to transfer from block payment to activity payment. Board members felt it was a proactive and pragmatic service and would like to commission a service where this continued. Seeing patients in a timely manner is the absolute essence of the service. The facilitated discharge figures were highlighted as they were felt to be disappointing. It was agreed that the facilitated discharge part of the service did need to be looked at. The Executive Board agreed that the Consortium should continue to commission an Admissions Prevention and Discharge Facilitation service, that the service specification should be reviewed, and also asked for a cost per case tariff to be looked at.
	3.2 Podiatry Service Extension Members were advised that the paper sets out a proposal to extend the Peninsula Health LLP practice based podiatry service from April to June 2013. The procurement process for a Community Podiatry and Orthotics AQP Service is now underway and the projected start date for the service is 1st July 2013. Wirral GP Commissioning Consortium has commissioned Peninsula to deliver additional sessions until 31st March 2013. As the new AQP service is not due to start until July 2013, it is proposed that the Consortium extends the contract with Peninsula for a further three months up until the end of June 2013. This will ensure that waiting times from referral to assessment to podiatry services are not compromised for patients registered with a Wirral GP Commissioning Consortium member practice. An additional resource of £23,067 is required to continue to commission additional sessions of podiatry over this three month period. Members were advised that there would be a risk involved from a patient access and experience if the service were to be stopped. Members were informed that payment is only received by Peninsula for patients who attend the service; payment is not made for DNAs. The Board approved the proposal to invest a maximum commitment of £23,067 to commission additional sessions of podiatry from Peninsula for a three month period from 1st April to 30th June 2013.
WGPCC/EB/ 12-13/0078	**4.1 Financial Budget 2012/13**

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	Executive Board Members were advised that as at the end of December 2012 (Month 9) the Consortium was underspent by £296,000 which is an improvement in the position on the previous month. This is mainly due to the reduction in the over performance on NHS and Non-NHS Contract expenditure. Members were informed that the Wirral Hospital contract is still overspent and is forecasting an overspend at year end. Members were advised that the month 10 position had just closed and was showing an improvement. At month 9, the year to date position for Wirral CCG is an overspend of £1,054k with a forecast variance of £675,000 overspend by year end. In previous months a break even position had been forecast for the whole CCG however, this has been revised this month on the basis of the continuing over performance on WUTH and the position with packages of care. Based on an action point raised at the last meeting, a spreadsheet showing an analysis of activity undertaken under Locally Commissioned Services for the Consortium was tabled at the meeting. The specialities analysed were ENT, Rheumatology, Orthopaedics, Dermatology and Ophthalmology and members were advised that each one showed a saving should the same activity have been carried out at WUTH. Two areas not listed were Audiology and Oral Surgery and members were advised that information in these areas would hopefully be available for the next meeting. Practice based budgets were due to be sent out to practices at the end of the following week. Emma Shanks was introduced as the new Finance representative on the Executive Board for Wirral GP Commissioning Consortium and would be replacing CDo. CDo was thanked for all the work she has undertaken for the Consortium.
	4.2 Patient Council and Engagement Update Members were informed that the Deputy Chief Executive of Wirral Hospital Trust attended the meeting on 22nd January 2013 to answer patients' questions, which included waiting times, car parking charges, and hospital food. The meeting had been a lively one and was well supported although the Chair of the Patient Council would like to see younger people attending. The last Patient Council Executive Board meeting was held on 5th February 2013; the commissioning and engagement strategies were discussed at the meeting. Younger members would also like to be seen at this meeting. A suggestion was made for GPs to approach younger patients to try and recruit them to these groups. When Numed is installed in GP practices, the Patient Council meetings could be highlighted on this to encourage patients to become involved. A further suggestion was for a copy of the meeting agenda to be displayed in practice waiting rooms, this may encourage people to attend if there was a topic that was of interest to them. **Action:** KH to take forward these suggestions.
	4.3 Executive Nurse Update Members were advised that the Nurse Training Programme had been issued to all relevant people. The aims and outcomes set are included in the training programmes. KH and AR are due to meet to address comments received so far. Nursing issues that were

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	raised at the Protected Learning Time Event on 5th February 2013 have been forwarded to KH. During this session, email addresses and any particular interests nurses have were sought.
	4.4 Practice Manager Update No update was available as KH and LM were not present at the meeting.
	4.5 Items for Risk Register The Primary Care Mental Health budget and waiting times were highlighted as being a significant risk to the Consortium and Members agreed that this should be added to the risk register.
WGPCC/EB/ 12-13/0079	**5. Any Other Business** There was no other business discussed.
WGPCC/EB/ 12-13/0080	**6. Private Business** There was no private business discussed.
	7. Date and Time of Next Meeting The date and time of the next meeting is Tuesday 19th March 2013, 7.00pm in the Nightingale Room, Old Market House, Birkenhead. Please send any apologies to Anita Fletcher on anita.fletcher@wirral.nhs.uk

The meeting finished at 9.00 pm

WIRRAL HEALTH COMMISSIONING CONSORTIUM
EXECUTIVE COMMITTEE
Minutes of Meeting

Wednesday 20th February 2013
Albert Lodge - Victoria Central Health Centre

Present:	Dr Pete Naylor (Chair)	Chair
	Mr Andrew Cooper	Chief Officer
	Dr David Jones	GP Executive Lead
	Dr Sue Kidd	GP Executive Lead
	Dr Sean Magennis	GP Executive Lead
	Dr Sue Wells	GP Executive Lead
	Cllr Phil Davies	Non Executive Director
	Emma Shanks	Finance Lead
	Brian Knight	Patient Forum Representative

In Attendance:

Sheena Hennell	Commissioning Manager
Grace Price - Jones	Executive Assistant

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WHCC/EB/ 12-13/0104	**1.1 Apologies for Absence** Apologies were received from Dr Shyamal Mukherjee, Dr Paula Cowan, Graham Hodkinson, Carol Heath and Anita Swift.
WHCC/EB/ 12-13/0105	**1.2 Declarations of Interest** Declarations of interest were made for all GP Executive Leads as the committee will be discussing enhanced services. Clllr Phil Davies declared an interest in item 2.1 Interpretation and Translation Services as he is a Board Member for the Wirral Multicultural Organisation.
WHCC/EB/ 12-13/0106	**1.3 Public Comments/Questions** One member of the public was in attendance during the meeting.
WHCC/EB/ 12-13/0107	**1.4 Minutes from the last meeting** The minutes from the previous meeting were reviewed and accepted as an accurate record. <u>Matters Arising</u> No matters arising were discussed by the committee.

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	Actions Contacting Brimstage Manor – the Commissioning Support Manager contacted Brimstage Manor; however, due to work capacity, they are unable to send any members of staff to support the Dementia workshop. There are currently 73 members of staff attending the workshop. Phlebotomy Specification Review – Dr David Jones put himself forward to be involved in the task and finish groups relating to this review. ***Action:*** *the Executive Members were asked to identify at Cluster whether any members would be interested in getting involved in the QIPP teams and forward their name to the Executive Team.*
WHCC/EB/ 12-13/0108	**2.1 Interpretation and Translation Service** The proposal was presented to the Executive Committee as the service will be funded at consortium level. Health Link and Wirral Multicultural Organisation are providing this service until 31 March 2013. The service provides face-to-face translation for healthcare interactions. The service also has additional scope outside of the medical consultation, for example, attending the pharmacist with the patient to collect and explain instructions relating to prescribed medication. The costing of the service is on a case by case basis and depends on the demand for the service within the consortium. The Board discussed the possibility of using dual handsets to facilitate the use of other phone based translation services. The committee agreed to fund this service for a further twelve month period.
WHCC/EB/ 12-13/0109	**3.1 Service Review** The committee reviewed the services that have been commissioned by WHCC during the past 12 months. The board members agreed to review the services commissioned. The following services were discussed: Admissions Prevention Service – there was some feedback regarding patients being admitted to nursing homes for respite and being registered with local GP practices as temporary residents – this has an impact on GP practices that have a high density of nursing homes in their geographical area. It was agreed that this issue will need to be reviewed if the service is re-commissioned. The board agreed that this service had excellent feedback from practices and has benefitted many patients. The board agreed to extend this scheme. Calm and Create – the service are planning to expand. There have been significant changes in patients PHQ and GAD scoring. There is only a small change in the amount of referrals but it was agreed that this service fills a gap for patients. The board felt that there may be other community services and signposting other services may be required. It was agreed to extend the service for another six months.

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	Dermatology – Dr Coombs is going to provide an evaluation presentation at the GP Members meeting. The service is very useful; however, it can be difficult to book appointments due to the high demand. The referrals from the service into the hospital are very low. The board agreed to continue this service but review the appointment system. MSK Upskilling – Wirral Community Trust have been providing this service, there is currently limited information available regarding service provision, patient numbers etc. and the intermediate service does not appear to have been fully launched. SH advised that she will be meeting with the service lead and will be undertaking a full service review. It was agreed that this service will be rolled over on a month by month basis whilst the review takes place. Falls Pick Up Service – nineteen patients have now fallen and thirteen managed to stay at home. There has still been a number of savings made by the service. The board agreed to continue this service. COPD and Practice Nurse Upskilling – The COPD admissions have fallen following the implementation of this service. The practice nurses felt very engaged. It was requested that an evaluation of the service be brought to the next meeting. Telehealth – Wirral GP Commissioning Consortium have now also agreed to jointly commission this service and are funding further equipment. The board agreed to continue with this service. ***Action:*** *Calm and Create Evaluation to be distributed to the board.* ***Action:*** *Review of the referral data from the Dermatology Upskilling service into Peninsula ENT.* ***Action:*** *Letter to advise GP's that the Dermatology Upskilling service is to be used as a training tool not a referral service.* ***Action:*** *Eldercare Evaluation on the Falls Pick Up Service to be sent out to practices.* ***Action:*** *Evaluation of the COPD and Practice Nurse Upskilling service to be brought to the next meeting.* ***Action:*** *SH agree the finance terms with Wirral GP Commissioning Group continuing with the Telehealth service.*
WHCC/EB/ 12-13/0110	**4.1 Lymphoedema Maintenance Service** The board were informed that the community Lymphoedema clinics have now been arranged and will be based at Victoria Central Health Centre (VCHC). There was a bariatric couch already available at VCHC so this service redesign has been undertaken without additional cost to the consortium.
WHCC/EB/ 12-13/0111	**4.2 Finance Update** The committee were informed that the consortia are currently £6.3 million overspent at month 9. The position this month has worsened by £693k. A full report was provided by the Consortium Finance Lead.

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WHCC/EB/ 12-13/0112	**4.3 Items for Risk Log** No items were identified.
WHCC/EB/ 12-13/0112	**4.4 Risk Register** The committee reviewed the revised risk register and agreed the amendments made.
WHCC/EB/ 12-13/0113	**5.1 Subgroup Minutes for Noting** The minutes from the November meetings of the sub-committees were noted.
WHCC/EB/ 12-13/0114	**6. Summary of Actions** Please refer to action points attached.
WHCC/EB/ 12-13/0115	**7. Summary of Financial Approvals** Translation services costs to be added to summary sheet. ***Action:*** *Add translation services onto the financial approvals summary sheet.*
WHCC/EB/ 12-13/0116	**8. Any Other Business** The committee discussed that the Annual General Meeting being cancelled. The committee felt that the end of year meeting / end of year report would be useful to share with the members and various consortium fora. ***Action:*** *Speak to the GP Members Chair regarding an end of year report / presentation at the next meeting.*
	Date and Time of Next Meeting The date and time of the next meeting is Wednesday 20th March 2013, 1.00pm at Albert Lodge, Victoria Central Health Centre. Please send any apologies to Wendy Holmes on wendy.holmes@wirral.nhs.uk

WIRRAL ALLIANCE COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Thursday 7th February 2013
Civic Medical Centre, Bebington

Present:

Dr Mark Green (Chair)	St Hilary Group Practice
Dr Helen Downs	Civic Medical Centre
Dr Richard Williams	Riverside Surgery
Dr Bryan Conlan	The Orchard Surgery
Iain Stewart	Chief Officer
Michael Roach	Non-Executive Advisor

In Attendance:

Allison Hayes	Executive Assistant
Sheena Wood	Commissioning Manager
Matt Gilmore	Strategic Information Analyst, CWW CSU
Emma Shanks	Finance Link, CWW CSU
Allan Stewart	Practice Manager Member
Julie Webster	Deputy Head of Public Health
Debbie Marsden	Practice Nurse Member
Mark Bakewell	Chief Finance Officer, CCG

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WACC/EB/ 12-13/0042	**Preliminary Business** **1.1 Apologies for absence** Apologies were received from Dr G Francis, Dr M Salahuddin, Dr I Camphor and Paul Wormald.
	1.2 Declarations of interest There were no declarations of interest declared. **1.3 Minutes and Action Points of Previous Meeting/Matters Arising** Practice Manager Member asked for his point on iPad applications to be entered under Any Other Business. Subject to this amendment the minutes from the previous meeting held on 10th January 2013 were agreed as a true record of the meeting and were proposed by Dr Downs and seconded by Dr Green. Grammatical errors were corrected. **Action Points** – Please refer to the attached sheet. **1.4 Chair Report** **Governing Body Update** The Chair reminded members that with effect from April 2013, the consortium Executive board meetings will be held in public and members agreed to apply the best practice board etiquette previously distributed. An update on the Governing Body constitution was provided to members with regards to the recent amendments that had been agreed/not agreed by the CCG Governing body. Chair advised that currently 18 member practices across Wirral had signed and returned the constitution to the CCG. Chair asked for member practices to consider signing and returning the

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	constitution in due course. Discussions occurred on how constituent member practices can transfer between other consortia. Chief Officer informed members that final discussions between the 3 consortia are concluding shortly on how best to manage entrants and leavers from respective consortia – it is likely that practice movement between consortia would only happen at the start of each financial year (and not within the financial year). Chair informed the group that the draft CCG Strategic Plan will shortly be made available to the general public and stakeholder organisations. Chair requested practices to emphasis to patients the opportunity to get involved in practice and Alliance patient groups by the use of the 'Your GP needs you' cards now available in practices. Chair informed the group that the Military Veterans enhanced service posters are now displayed within each practice.
WACC/EB/ 12-13/0043	**Items for Discussion** **2.1 Finance Presentation** Mark Bakewell gave a presentation to Board members with regards to the financial planning assumptions for 2013-2014 and the strategic plan work streams. **2.2 QIPP Commitments** Chief Officer gave an overview of the QIPP commitments. Members requested details on the agreed priorities of the CCG Clinical Strategy Group with regards to future QIPP teams work programmes. – Chair to progress.
WACC/EB/ 12-13/0044	**Items for Approval** **3.1 Admissions Prevention Service** Chief Officer declared an interest in this item. Commissioning Manager presented the Board with the details of the service and the review of the pilot that has recently been undertaken. Members were asked to determine the preferred direction from the following options: • Renew the pilot service for 2013/14 • OR serve notice to the service Members agreed to continue with the pilot service for 2013/14 and commented how the service has made a positive impact for patients and clinicians. – **Action: Commissioning Manager to progress with securing service for a further year**. **3.2 Budget Review 2012/13** Chief Officer provided the group with an overview of the current financial budget position. Members were asked to consider approving the commitment of £200,000 to the CCG financial position as at 31st March 2013. Board members agreed. Action: Chief Officer to advise CCG Chief Financial Officer.
WACC/EB/ 12-13/0045	**Items for Information** **4.1 Quality, Performance and Finance** Strategic Information Analyst provided an update to the Board with regards to activity performance by member practices to Wirral University Teaching Hospitals NHS Trust (WUTH). Key areas to note are Outpatient Procedures. Members agreed to direct this to the Clinical Working Group for further analysis.

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	Members requested further data on the highest referral specialities. ***Action - Strategic Information Analyst to provide more information on referrals*** **Finance** Finance support member provided the group with a report that set out the financial position for Wirral Alliance Commissioning Consortium (WACC) as at the end of December (Month 9) within the 2012/13 financial year. The Executive Board is asked to note: • the financial position as at the end of December 2012 • the forecast outturn position for 2012/13 financial year (however noting the possible variation between year to date position and forecast position) • the potential risks identified for 2012/13 financial performance Members requested more information on the WUTH year-to-date variance position for the consortium, by practice level. ***Action – Finance Link to provide information around WUTH year to date variance positions.*** Further discussions took place on the underspend forecast on prescribing for the consortium. **4.2 Risk Register** Members discussed the current risks recorded. Risks to be included are: • Overspend within WUTH – impact on practices • Capacity with regards to up skilling and meeting attendances Risks mitigated are: • Investment in agreed projects being concluded by end March 2013 • Forecast overspend as at end March 2013
WACC/EB/ 12-13/0046	**5.0 Minutes for noting** The minutes from the following committees meetings were noted: - Consortium Practice Manager Forum - Consortium Clinical Working Group - CCG Governing Body - Consortium Patient Engagement Group
	6.0 Summary of Actions Please refer to action points attached
	7.0 Any other Business Chief Officer tabled a proposal to include the consortium practices into the service agreement that provides a Falls pick up service to patients registered with the other two consortia. Members agreed to the pick-up service but did not want the associated telehealth service. ***Action - Chief Officer to clarify if the service agreement enables the selection of the pick-up service only and update at the next meeting.***

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	Practice Manager representative sought advice with regards to implementation of dual screens for clinicians and the benefit they provide. Members requested that the IT GP Lead seek a response from the CWW CSU Informatics service – **Action: Dr Salahuddin to raise matter with appropriate person.** Members requested information on the approval of kiosks within practices and also the future of the Informatics service contract. ***Action – Chief Officer to provide feedback at the next meeting.***
	Private Business Private business minutes recorded separately
	8.0 Date and Time of Next Meeting The date and time of the next meeting is ***Thursday 7th March 2013, 3pm at Civic Medical Centre, Bebington.*** Please send any apologies to Allison Hayes on allison.hayes@wirral.nhs.uk

16:46pm meeting closed and Non-Board members left.

Wirral Clinical Commissioning Group

Quality, Performance & Finance Committee

Minutes of Meeting Held on Thursday 31st January 2013
9.00 – 12.00noon
Room 539, Old Market House

Present:

Phil Jennings (PJ)	Chair, Wirral CCG
Mark Bakewell (MB)	Chief Finance Officer, Wirral CCG
Pete Naylor (PN)	Chair, WHCC
James Kay (JK)	Lay Member (Audit & Governance)
John Oates (JO)	Chair, WGPCC
Lorna Quigley (LQ)	Chief Operating Officer, Wirral CCG
Iain Stewart (IS)	Chief Officer, WACC
Simon Wagener (SW)	Lay Member (Patient Champion)

In attendance:

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

Ref No	ITEM	ACTION
QPF12-13/045	**PRELIMINARY BUSINESS**	
45.1	**Apologies for Absence**: Apologies were received from:- Paul Arnold, Deputy Director of HR, NHS Warrington Abhi Mantgani, Accountable Officer, Wirral CCG Christine Campbell, Chief Officer, WGPCC Andrew Cooper, Chief Officer, WHCC Shanila Roohi, Medical Director/Caldicott Guardian	
45.2	**Declarations of Interest**: There were no declarations of interest today.	
45.3	**Minutes of Previous Meeting**: Minutes of 29th November 2012 were agreed as a true record with the amendment of the paragraph regarding the Risk Register (page 9). There has not been a change in policy. MB to re-write with JS.	**MB/JS**

	Actions List from Previous Meeting: 36.1 Bariatric surgery. JK recently received an update via email from PN. MB added that bariatric surgery will fall into specialist commissioning as from April due to standardisation across the board. This matter has now been closed. 40.3 Intensive Support Visit - on today's agenda. 41.1 LQ re: Quality CWP – on today's agenda. 41.7 Serious incidents – on today's agenda. 42.1 Local Authority budget cuts. IS to draft a formal response to meet today's deadline.	**IS**
QPF12-13/046	**ITEMS FOR APPROVAL**	
46.1	**Quality, Performance & Finance – Terms of Reference**: The draft terms of reference were brought to the committee today following queries regarding voting. It was decided to delete the 2nd paragraph completely and replace with the draft circulated by JK. With regards to exceptional circumstances and decision making, it was decided that the Chair, Chief Officer, Chief Financial Officer and the Chief Clinical Officer should be able to make a decision and for it then to be ratified at a further meeting. This should also be included in the SORD. JK to discuss with AD to decide on the correct wording. Typographical errors need to be amended within the terms of reference. In the absence of the Chair the meeting would need to be chaired by a clinician not a lay member. It was agreed today that Chief Officers are not to vote. The terms of reference will be re-drafted and brought back to the next QPF meeting in February.	**PJ**
QPF12-13/047	**ITEMS FOR DISCUSSION**	
47.1	**Information Governance Report Update**: SC attended the meeting today to give an update on the CCG's position in relation to Information Governance. SC presented updated policies relating to ICT and CSU (Confidentiality and Data Protection Policy and Corporate Records Retention Policy). There will be training for all employees over the next 8 weeks which should take an average of 2 hours to complete. Staffing lists are being refreshed and should be finalised this week.	

	MB informed the members that the information asset registers are to be finalised. SC to feedback to the ICT service regarding local ipad policies relating to the use of Apps. A short page of do's and don't's was requested so they are user friendly.	**SC**
47.2	**Performance Reports**: LQ talked us through the reports. Issue raised that we are not receiving the reports we should be. The WUTH contract monitoring report from December 2012 shows there is still an over performance year to date across all reports, having seen a slight dip in December. GP referrals have decreased from October, November and December, but still up against plan. There has been a slight improvement. There has been a small decrease across specialties. Two specialties have seen an increase; paediatric cardiology from 1-2 referrals, have increased to 20 referrals in December. There has been an over performance in endocrinology. In December there was an additional 229 referrals on top of the usual number of referrals. Other referrals ie consultant to consultant referrals, dentists referring to maxillofacial etc. A decrease was seen in November, which decreased further in December. Women and children specialties have increased their referrals to 941 in one month. WHCC 11,375, 11,332, 10,761, 11,032. PN is going to pick up with contracts the reason why consultant to consultant figures have not dropped. Kent House had closed to admissions therefore patients were moved to Eastway on the Countess of Chester site. We had not been informed of this. Concerns have been raised with CWP. The Learning Disabilities has gone out to consultation which includes the closure of Kent House. CWP talked us through their proposals and we have grave concerns. AM recently wrote to Sheena Cumiskey detailing our concerns and a response is required by mid-February. PJ, AM and CC are due to visit Kent House on 7th March. **Actions to be taken**: • Escalate correspondence to a more formal step relating to issues with plans and reporting received. Disappointed with progress so far, detail our expectations, quality issues relating to amber, red and green flags being incorrect. • To invite a business intelligence representative to this meeting now that Tony Kinsella no longer attends.	**PJ/AM/CC** **LQ**
47.3	**Intensive Support Visit Update**: PJ updated the Committee regarding the Intensive Support Visit prepared by David Jones. The results are similar to the other visits previously carried out.	

	There are still 3 more visits to carry out. It was felt that we need to make a statement regarding what we will do in the future regarding this issue. It would be useful to understand the Wirral wide issues regarding coding etc. It was agreed to carry on with the intensive support visits. PJ will write to the consortia chairs regarding the outstanding practices and arrange a meeting with them and PN, MB and LQ to discuss.	**PJ** **PN/MB/LQ**
47.4	**<u>Finance Update</u>**: MB gave an update on the year to date financial situation performance. The report sets out the financial position for Wirral CCG as at the end of Month 9 (December 2012) within the 2012/13 financial year. As at the end of December (Month 9), the year to date position for Wirral CCG is an over spend of £1.05m with over performance against commissioning expenditure of £1.75m offset by an under performance against running costs of £0.7m. The year to date variance position between Governing Body and the combined consortia is an over spend at divisional level of £5.86m with the Governing Body under spent by £4.81m. The overall CCG performance position in relation to NHS contracts shows an over spend at Month 9 of £8.1m (previous month £6.9m) primarily being due to over performance on the WUTH contract of £7.39m (previous month £6.53m) at divisional level. The year to date position is based on actual activity as at Month 8, £6.66m over performance with a pro-rata adjustment to equate to the month 9 position and application of estimated contract adjustments for re-admissions/out-patient follow up ratios as appropriate (again, based on the month 8 actual activity position). Prescribing expenditure is currently providing the CCG with a year to date underspend of £2.96m (previous month £1.92m). There is an under performance of those budgets managed at Governing Body level of £363k and under performance at divisional level of £2.6m. The performance position is based on 7 months actual data with 2 months estimated costs for November and December. MB has asked Judith Green to attend our next meeting to give an update on prescribing expenditure. Commissioned “out of hospital” budgets are £1.43m over spent at month 9, an adverse in month movement of £264k. The main drivers for the continued over performance remain within the Continuing Healthcare section with Older People (£228k), Mental Health (£284k) and Physical Disabilities (£242k), and all Joint Funded packages (£791k) being offset by underperformance on Funded Registered Nursing Care (FRNC) of £189k. Reserves are under spent by £5.36m at Month 9 which is due to the release of the contingency element and a number of earmarked reserves	

	which are available for release. There is a year to date underspend of £696k in relation to running costs at Month 9, an adverse in month movement of £19k. This is primarily due to the movement in under performance on the Commissioning Support Unit costs at Governing Body level of £421k (previous month £445k). Clinical backfill reported at consortia level continues to underperform year to date (£297k). A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the position. The forecast expenditure outturn position for the CCG was higher than the resource allocated from within the PCT baseline. It is important to note that the overall PCT position remained in financial balance due to management of non-recurrent resources and over/under performance in other areas and therefore still in line with its control total with the Strategic Health Authority. The CCG's financial plans identified the main areas of financial risk in terms of performance for the year and an overall CCG risk with regards to financial performance. Risks will be subject to constant review as more information becomes available regarding performance against planned levels of expenditure. MB thanked the divisions for the urgent work carried out and for identifying the areas of risk. MB will continue to look at the risks over the coming months and will set time aside with colleagues to discuss the outstanding issues. PN asked for a formal plan of what the next steps are. It was therefore decided the plan can go to Quality, Performance & Finance meeting in April, to Governing Body meeting in June for ratification and then can go out to all practices in June. MB asked the Committee to note the position as at the end of December and agree decisions taken.	**MB** **MB**
47.5	**<u>QIPP Update</u>**: MB gave an update on the QIPP Report. The report sets out the QIPP position for the NHS Wirral CCG as at the end of December (Month 9) within the 2012/13 financial year. The current assessment of risk of delivery is made up of a number of factors including year to date contract performance, intelligence from commissioning managers on scheme progression and monitoring of scheme performance at a detailed level. An assessment of all existing CIP schemes has taken place since the last Quality, Performance & Finance meeting which have led to amendments to the CIP values and risk of delivery as appropriate. However, as per requirements the overall CIP requirements have remained the same. In conclusion, the Committee was asked to note the progress to date on the QIPP Programme and the current assessment of delivery of risk around the QIPP Programme.	

QPF12-13/048	ITEMS FOR INFORMATION	
	Contracting Issues:	
48.1	**CWP**: Deferred.	
48.2	**CT**: Deferred.	
48.3	**WUTH**: Contract negotiation meetings are up and running. WUTH are disappointed with our stance in some areas. When we apply the National Rules and re-admissions there will be issues. As a team it is important to discuss this as a priority. No formal offers have been made yet. This will be discussed further at an Operational Team meeting.	
48.4	**CCC**: IS advised that formal contract offers have been made with Clatterbridge and agreement should be reached around mid-Feb.	
48.5	**Serious Incidents – December**: For noting. There were a total of 9 serious incidents reported on StEIS in December. There were no never events reported during this period.	
48.6	**Serious Incidents – January**: Within the period of 11th December 2012 to 14th January 2013, Wirral had 11 new incidents reported on the StEIS being investigated and performance managed. Concerns were raised regarding the reporting of serious incidents from CWP. Procedures don't appear to be being followed correctly regarding timescales etc. LQ has received around 4 requests on the same cases requesting time extensions. WUTH reported a never event in the summer of 2012 regarding a wrong type of lens being placed in an eye. We have now had reports of 2 never events in consecutive months. It was agreed that this needs to be investigated as human error is not acceptable. LQ and PN to get together and go through all these queries to satisfy ourselves as a CCG so that they can be signed off. LQ to email out for interest to set up monthly meetings. The Root Cause Analysis Reports and Action Plans for the incidents listed today will be received and reviewed at a future QPF meeting. The Action Plans will be monitored until the group are satisfied that all actions have been managed appropriately and agreed that the incident can be closed. It was suggested a meeting be set up with CWP to discuss concerns across the patch. Approval was given for LQ to arrange a meeting as a matter of urgency and will feed back at the next meeting.	**LQ/PN** **LQ** **LQ**

48.7 48.8	**Quality Handover Assembly**: LQ reported on the closure of the PCT. She will be representing the CCG on 15th February, attending a Quality Handover Assembly on 15th February which will be attended by various providers, including voluntary and statutory organisation. **Quality Surveillance Group**: LQ reported that each area team will have a quality surveillance group. It is prescriptive of who sits on it and which providers attend. There is a QSG planned for the end of March covering all CCG's. Monthly meetings will be planned and updates will follow.	**LQ**
QPF12-13/049	**RISK REGISTER**	
49.1	**Risk Register**: LQ presented the Risk Register, advising that it has been updated following recent meetings across the Board, including the most recent Governing Body meeting held on 29th January. There were 4 new risks added for the attention of the Quality, Performance & Finance committee today. Business intelligence to be added to the Risk Register for QPF which will encourage a change in decision making. It was generally felt that the Risk Register doesn't reflect the high level culture we as a CCG are aspiring to. Felt that it needs to be bigger and show how we are managing the risks in a clearer way. LQ will update the Risk Register for circulation at the next Governing Body meeting on 5th February 2013.	**LQ** **LQ**
QPF12-13/050	**ANY OTHER BUSINESS**	
50.1	No other business was discussed today.	
QPF12-13/051	**DATE AND TIME OF NEXT MEETING**	
	The next meeting is scheduled for: Thursday 28th February 2013, 1.30 – 5.00pm, Room 539, Old Market House. Lunch will be available from 1.00pm in Room 539. Apologies/agenda items to: Julie.stamper@wirral.nhs.uk	

RISK REGISTER - Master

Risk ID	Date	Source	Risk Description	Organisational Objectives (reference to detail)	Impact	Likelihood	Current Matrix Score	Previous Matrix Score	Trend	Driver for Change in Trend	Rationale	Key Control Established	Key Gaps in Control (reference to evidence)	Assurance on Controls (reference to evidence)	Gaps in Assurance (reference to evidence)	Action	Owner	Date of next review	Date of last review	Status
1	3.07.2012	Gov Body	Increase in activity for GP's as a result of the introduction of NHS111		3	3	9.00	9.00	⬌			Current provision of primary care / urgent care services - ability to absord additional activity	Unknown impact of 111 Service Impact	Monitoring of Primary Care/ urgent care activity and performace of NHS111 through information flows	Timely impact on monitoring of primary care activity	Monitor Information regarding implemention of 111	Governing Body	As further information becomes available	Mar-13	On-going
2	Ongoing	CSS	Reduction in local expertise and organisational memory due to PCT staff leaving		2	3	6.00	6.00	⬌			CSS / CCG Transitional Arrangements, Procedure Notes, CSS SLA, Legacy Documentation, Appropriate Handover	Individuals leaving before handover process is complete	CSS SLA Arrangements ensuring continuity, locality link involved in CSS Operational Group Meetings	SLA still in infancy	Continue development of SLA, transitional arrangements, clarity of responsibilities	Chief Officers	As further information becomes available	Mar-13	On-going
3	24.07.12 / 28.08.12 / 27.09.12	Gov Body / QPF / WHCC	Overperformance on WUTH Contract	Financial Management	4	5	20.00	20.00	⬌			Financial / Activity Reporting through QPF / Gov Body. Divisional Reporting / Practice Level Reviews - Action Plans	Ability to influence contract performance - Implementation of Action Plans	Regular Monitoring through committee / gov body structure, Use of Contingency Funds / Planned Slippage to offset	Ability to influence behaviour	Review performance areas, initiate action plan to address performance issues	Divisions	Apr-13	Mar-13	On-Going
4	28.08.12	QPF	Inability to monitor CT contract performance / outcome measures due to unavailability of information	Quality / Financial Management on Cost Per Case / Impact on Future Commissioning Intentions	2	4	8.00	8.00	⬌			CT Contract Monitoring / (Contract Query raised), Refinement of KPI's	Ability to influence provider behaviour	Regular Monitoring through contract monitoring process and subsequenty committee / gov body structure with ability to withold payment for non-provision of information as required	Ability to influence behaviour	Review contract query outcome, monitor action plan, Mersey Internal Audit Report - Data Quality Assurance Review	AC	Apr-13	Mar-13	On-Going
5	27.09.12	QPF	Contract Variation to Wirral NHS Community Trust Contract regarding implementation of NHS 111 to NHS Direct	Future Commissioning Arrangement regarding 111 service provision	0	5	0.00	15.00	⬇	Contract Variation Signed		CT Contract Monitoring / (Contract Query raised), Part of NHS 111 Steering Group	Ability to influence implementation of NHS 111 Service, financial assumptions made with NHS 111 project	Urgent Care Meetings, Feedback from NHS 111 Workstream , Regular Monitoring through contract monitoring / negotiation process and subsequenty committee / gov body structure	Ability to influence implementation of NHS 111 Service	Contract Variation Signed, 2013/14 Contract Monitoring	AC	Apr-13	Mar-13	Completed
6	27.09.12	QPF	Child Health Information System (CHIS) - Imminent Risk of Crashing	Provision of relevant Information System supporting appropriate statutory requirements	4	2	8.00	8.00	⬌			CT Contract Monitoring, CHIS Replacement Project via WHIS/ CICT	Lack of clarity regarding Responsible Officer / Availability of Project Plan	Regular Monitoring through committee / gov body structure, also raised via Public health Governance Group	Ability to prevent system failure	Project Plan in Place for CHIS system replacement (PARIS) - Discussed with Rose Curtis - Ongoing Project Plan	Rosemary Curtis ?	Apr-13	Mar-13	On-Going
7	24.10.12	WGPCC	WGPCC will fail to meet IAPT waiting time targets due to performance of one provider	Quality / Patient Access	2	5	10.00	10.00	⬌			Action plan agreed with provider, including weekly submission of data and bi-weekly monitoring meetings	Provider dealing with old waiting list as well as new patients referred	Action plan dealing with both groups of patients will be monitored and reviewed by board on a monthly basis	Demand continues to rise for this service	Action plan agreed with Provider	Christine Campbell / Dr Oates	Apr-13	Mar-13	On-Going
8	31.10.12	QPF	Non-Compliance with Information Governance Standards by March 2013	Statutory Responsibility	2	2	4.00	8.00	⬇	IG Toolkit Evidence		IG Toolkit Assessment Work Programme to ensure compliance with required level by March 2013	Development of IG Policies / Procedures and implementation within CCG	Regular Monitoring through QPF and Audit Committee Meetings & Information Governance Manager work Programme through CSU SLA	Ensure Implementation of required standards	IG Toolkit Monitoring Programme	SIRO (CFO)	Apr-13	Mar-13	On-Going
9	06.11.12	Gov Body	Commissioned Out of Hospital Budgets, increase in package costs, Restitution Cases	Achieve Financial Balance	3	4	12.00	12.00	⬌			Financial / Activity Reporting through QPF / Gov Body. CSU SLA Monitoring Process	Time lag in information recieved, external stakeholders pursuing restitution cases	Regular Monitoring meetings with CSU, Top 10 package reviews, pro-active approach to new cases	Ability to influence behaviour	Review performance areas, initiate action plan to address performance issues	Governing Body	Apr-13	Mar-13	On-going
10	20.10.12	Gov Body	Impact of Local Authority Budgets Cuts	Financial Management / Service impact across Economy	3	5	15.00	15.00	⬌			Impact Assessment of Chief Executive Options Appraisal on NHS Budgets	Quantify Impact	Financial Planning and Budget Setting Process	Ability to manage impact of cuts	Action Plan for impact assessment	Governing Body	Apr-13	Mar-13	On-going
13	06.12.12	WACC	CCG Constitution - refusal to sign agreement by some member practices	CCG Authorisation	0	3	0.00	9.00	⬇	CCG Authorised		Provision of up to -date information on progress of authorisation	Clarity on signed requirement for authorisation	Regular updates to Governing Body	Ability to influence behaviour	Identify key outstanding / unresolved issues	Dr Mark Green	Apr-13	Mar-13	On-going
14	06.12.12	WACC	Impact of NHS 111 on patient safety and demand shift to practices	Urgent Care Strategy	3	3	9.00	9.00	⬌			GP membership of QIPP Team to influence implementation	Centralised aspects of service that cannot be influenced	Regular updates to 111 Steering Group /QIPP Workstream & Governing Body	Ability to influence behaviour and implement robust service model	Continue workstream on progression of NHS 111 Service with NHS Direct and contract negotiations with Community Trust	Dr Bryan Conlan	Apr-13	Mar-13	On-going
15	06.12.12	WACC	Forecast overspend as at end March 2013	Financial duty to balance	1	3	3.00	3.00	⬌			Demand management initiatives in place	Time-lag for initiatives impacting on outcomes	Reviewed by WA Board / QPF committee on regular basis	Increased Activity continues to rise / demand mgt schemes have little / no effect	Review over performance areas, initiate action plan to address performance issues	Iain Stewart	Apr-13	Mar-13	On-going
16	31.01.13	QPF	Lack of demand data/activity plans to forward plan future needs due to unavailbility of business intellegence	Quality / Financial Management on Cost Per Case / Impact on Future Commissioning Intentions	3	3	9.00	12.00	⬇	CSU BI Provision		SLA meeting with CSU/ buisness Intellgence team	Ability to lead contract negotiations. Ability to provide accurate national returns	Regular monitroing through CSU/SLA meetings. Escalation to CSU MD. Monitoring through QPF committee	Abilty to influence behaviour. Ability to plan	Programme of work defined with CSU. Additional technical support in place	LQ/MB	Apr-13	Mar-13	On- going
17	31.01.13	QPF	Late reporting and undertaking of root cuase analysis followino SI by CWP	Quality/ contracting issue	3	4	12.00	12.00	⬌			Quality Leads meeting/ CWP contract meeting/QPF	Ability to monitor provider performace	Regular montioring via CWP quality. CWW quality leads meeting	Ability to monitor a safe service is being delivered. Ability to assess if lessons have been learnt	Quality leads summit with provider. CCG quality committee	LQ	Apr-13	Mar-13	On-going
18	07.02.13	WACC	GP capacity to attend key meetings	GP Engagement / Redesign Agenda	2	3	6.00	6.00	⬌			Considering different model for clinical backfill	Time-lag to establishing model	Discussion at Alliance Board Meetings / Clinical Strategy group	Abilty to create capacity		Iain Stewart	Apr-13	Mar-13	On-going
19	13.02.13	WGPCC	Primary Care Mental health budget pressure due to overperformance and high DNA rate	Financial duty to balance	3	3	9.00	9.00	⬌			Regular contract monitoring meeting with provider, and with CCG finance and CSU contracting leads, to manage capacity and demand within available resources	Not a block contract so alternative means of managing demand within available resources need to be found	Working with contracting team to determine amendments that can be made to pathway in order to manage demand	Increase in demand and referrals	Review referral rates per practice; explore use of step 2 within contract with a view to reducing reliance upon the more advanced and	CC	Apr-13	Mar-13	Ongoing
20	21.03.13	GB	Contract Sign off Process with Providers	Contract Agreement in Place for Commissioning Arrangements	4	3	12.00	0.00	⬆	New Item		Contract Negotiation Process between CCG & WUTH	Abilty to enforce Contract Sign off by Provider	Regular Dialogue with provider and Communication with AT on negotiation process	Ability to enforce Contract Sign off by Provider	Continue Negotiation Process, Elevate to GB as appropriate	LQ / MB	Apr-13	Mar-13	Ongoing

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