Wirral Clinical Commissioning Group

**Wirral Clinical Commissioning Group**

**Extra-Ordinary Governing Body Board Meeting – A meeting in public**

**Tuesday 20th November 2012**
**0900 – 1200**
**Albert Lodge, Victoria Health Centre, Wallasey**

## AGENDA

| Ref No | Time | No | Item | | Papers |
|---|---|---|---|---|---|
| | **0900** | **1.** | **PRELIMINARY BUSINESS** | | |
| GB12-13/091 | | | **1.1** | **Apologies for Absence**<br>• **Susan Wells**<br>• **Abhi Mantgani** | |
| GB12-13/092 | | | **1.2** | **Chair's Announcements** | |
| GB12-13/093 | | | **1.3** | **Declarations of Interest** | |
| GB12-13/094 | | | **1.4** | **Comments/questions from members of the public** | |
| GB12-13/095 | | | **1.5**<br><br><br><br>**1.6** | **Minutes of previous meetings:**<br>• **Meeting held on 30th October 2012**<br><br>**Matters Arising** | Final Ratified minutes of Public Extra Ordina |
| | **0930** | **2.** | **ITEMS FOR APPROVAL** | | |
| GB12-13/096 | | | **2.1** | **Organisational Development Plan (Lorna Quigley)** | Organisational Development Plancov<br>OD Plan v4.docx |

| | | | | | |
|---|---|---|---|---|---|
| GB12-13/097 | | | **2.2** | **BME Plan**<br>**(Lorna Quigley)** |  WEHAG cover sheet.rtf  amended wehag strategy final.pdf |
| | **1030** | **3.** | **ITEMS FOR INFORMATION** | | |
| GB12-13/098 | | | **3.1** | **Community Mental Health Team Consultation**<br>**(Val McGee)** | Presentation to follow |
| | **10.50** | **4.** | **RISK REGISTER** | | |
| GB12-13/099 | | | **4.1** | **Items to be included onto the Risk Register**<br>**(Mark Bakewell)** |  Copy of RiskRegister V3-0 update 7th Nove |
| | **1110** | **5.** | **ANY OTHER BUSINESS** | | |
| | | | | | |
| | | **6.** | **DATE AND TIME OF NEXT MEETING** | | |
| | | | Tuesday 4th December 2012, 1.00 – 3.00pm, Nightingale Meeting Room, Old Market House.<br><br>Please forward apologies to: Julie.stamper@wirral.nhs.uk | | |

**Wirral Clinical Commissioning Group**
**Extra Ordinary Governing Body Meeting**

**Minutes of Public Meeting Held on**

**Tuesday 30th October 2012 at 1230**
**Albert Lodge, Wallasey**

**Present:**

| | |
|---|---|
| Dr P Jennings (PJ) | Designated Chairman WCCG |
| Dr A Mantgani (AM) | Designated Accountable Officer WCCG |
| Lorna Quigley (LQ) | Corporate Chief Officer WCCG |
| James Kay (JK) | Lay Advisor (Audit & Governance) |
| Dr S Wells (SW) | GP Executive Wirral Health Consortium |
| Mark Bakewell (MB) | Designated Chief Finance Officer WCCG |
| Fiona Johnstone (FJ) | Director of Public Health |
| Christine Campbell (CC) | Acting Chief Officer Wirral GP Consortium |
| Simon Wagener (SW) | Lay Advisor (Patient Champion) |
| Iain Stewart (IS) | Chief Officer Wirral Alliance Consortium |
| Dr A Ali (AA) | GP Executive Wirral GP Consortium |
| Dr J Oates (JO) | Chair Wirral GP Consortium |

**In attendance**:

| | |
|---|---|
| Julie Stamper (JS) | Board Support Assistant (taking minutes) |
| Mr A Dalgarno (AD) | NHS CWW |

**Apologies**:

| | |
|---|---|
| Dr A Smethurst (AS) | Secondary Care Doctor |
| Graham Hodkinson (GH) | Director of Adult Services |
| Andrew Cooper (AC) | Chief Officer Wirral Health Consortium |
| Dr P Naylor (PN) | Chair Wirral Health Consortium |

| REF NO | MINUTE | ACTION |
|---|---|---|
| **1.** | **PRELIMINARY BUSINESS** | |
| GB12-13/057 | Apologies for absence were noted above. | |
| GB12-13/058 | **Chair's Announcements**:<br>• PJ introduced the new members of the team (Alex Dalgarno and Simon Wagener). | |

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| | • PJ explained that as this was an extra-ordinary meeting of the Governing Body Board there were no previous minutes to review. The extra-ordinary meeting was called in order to support the authorisation site visit scheduled for 13th December. | |
| GB12-13/059 | **Declarations of Interest**: There were no declarations of interest declared at today's meeting. | |
| GB12-13/060 | **Comments/questions from members of the public**: There were no members of the public in attendance today. | |
| **2.** | **ITEMS FOR APPROVAL** | |
| GB12-13/061 | **Information Governance Strategy**: MB presented the Information Governance (IG) paper and explained that IG is a crucial aspect of delivery going forward. The CCG has a statutory obligation to be compliant with all of the standards within the IG Tool Kit. Level 2 compliance needs to be achieved by 21st March 2013.<br><br>The IG Governance Lead for the CSU are supporting the CCG in achieving compliance and the action plan and work required is being discussed at the Quality, Performance & Finance Committee on 31st October. Presenting papers for approval can then go through as part of the workstream process.<br><br>The IG Strategy paper was presented. This focuses around risks to the organisation, which are managed through the QFP Committee agenda. The role of the Audit Committee in relation to IG is to ensure processes are in place in order to deliver the requirements necessary. The Caldicott Guardian (Shanila Roohi) is an important part of this process. There will be implications for the whole of the CCG ensuring we are compliant. This covers confidentiality, patient records etc. Suzanne Crutchley and Mark Bakewell will be leading the work on this. The draft plan will get us to Level 1 by the end of December and Level 2 by the end of March. The CSU are being asked to perform this and will be continually monitored through the Quality, Performance & Finance Committee.<br><br>Board approval was given. | |
| GB12-13/062 | **Information Governance Policy**: Approval is sought from the Governing Body Board to adopt the Information Governance Policy. MB gave a brief overview of the IG Policy and discussion followed.<br><br>AM suggested contacting Dr Roohi, Caldicott Guardian who is very knowledgeable on information governance and asked that she represents us on the Clinical Strategy Group. Dr Roohi is not a direct member of the Quality, Performance & Finance Committee but she will be asked to attend regarding information governance.<br><br>LQ asked for certain clarity ie 4.5 staff contracts. MB confirmed that the | |

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| | internal policies will be concentrated primarily on members of staff first and foremost. MB advised that there will need to be further training for the Governing Body Board members.<br><br>MB confirmed that core staff will be a significant part of the plan which should be implemented by the end of March 2013.<br><br>CC asked about the CCG having a responsibility for making reference to providers in the policy and if we need to ensure our providers follow our policies. AD advised that we need reasonable assurance for contracts but full assurance for in-house responsibilities. The organisation would be liable for ensuring training and to ensure that it is all kept up to date and carried out on a regular basis.<br><br>FJ questioned the appropriateness of sharing information and if there is a clear protocol for sharing information in place. She feels it should be recognised under the Health & Social Care Act that appropriate governance is in place surrounding patients etc.<br><br>JK asked if we should put IG on the Risk Register now as there may be the risk of not getting to Level 2 by end of March 2013. We need to show that we can get this risk under control.<br><br>MB informed us that there will be routine spot checks carried out by members of the Information Governance Team checking that staff have locked their computer screens when they are away from their desks, put away confidential information in a locked drawer or cabinet etc. On-line training will be available to all members of staff and this will then ensure that a policy is in place and adhered to.<br><br>PJ informed the members that we will be taking JK's recommendation to put IG on the risk register.<br><br>This policy was adopted by the members and will be taken forward as agreed. | |
| GB12-13/063 | **Mission Vision and Values**: LQ gave an overview of the process that had been undertaken by the Governing Body in relation to the development of the Mission, Vision and Values. In order to achieve these, the Governing Body had been supported with some external evaluation for two ½ day sessions. During the first session the mission had been formulated, and a set of statements developed for the vision. This was then tested by stakeholders for their views which were collated. The second session agreed the vision and the values based on the feedback received.<br><br>The agreed mission vision and values are:<br><br>**Mission** – Your partner in a healthier future.<br><br>**Vision** - Wirral CCG commits to improve health and reduce disease, by working with patients, public and partners, tackling health inequalities and helping people to take care for themselves.<br><br>**Values** – Caring, fair and responsible. Safe and trusted. Person centred. | |

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| | PJ thanked the Governing Body members for their support and input into the process.<br><br>The Missions Values paper received full approval from the Board. | |
| GB12-13/064 | **<u>Equality & Diversity Strategy</u>**: This paper was deferred until the November Extra-ordinary Board meeting. | **LQ** |
| GB12-13/065 | **<u>Comms and Engagement Strategy</u>**: LQ presented the Patient Experience, Communications and Engagement Strategy paper for approval. It was therefore decided to adjourn the meeting for 5 minutes for the members of the Governing Body to read through so it can be approved.<br><br>It was acknowledged that this strategy relates to other strategies, including Equality & Diversity Strategy. The aim of the strategy is to ensure we have a robust system in place for communications and engagement. Recommendations have been received. A Stakeholder analysis has been carried out. CC is looking at how we are bringing all this together following a workshop she recently attended.<br><br>The following comments where received:<br><br>Version control references should be inserted.<br>Clatterbridge Cancer Centre is missing from stakeholder matrix.<br><br>It was agreed by the members of the Board to take the paper away to read and for approval at the meeting of 6th November. | |
| GB12-13/066 | **<u>Safeguarding Policy for Children & Adults</u>**: LQ presented 3 papers regarding safeguarding:-<br><br>**<u>Safeguarding Children Policy</u>**: It was acknowledged that the author of this paper was Anne Eccles (Designated Safeguarding Nurse) who is leaving her post in the near future. Debbie Hammersley will be fulfilling the role of Safeguarding Nurse on 12th November. As a CCG and NHS body there is a statutory duty to ensure we are looking after the welfare of children. Systems need to be in place. Support is available to staff to ensure they are trained correctly.<br><br>It is the responsibility of the Governing Body to ensure everyone is accountable. GP's need to be trained at Level 1 and Level 2. The policy is a way of ensuring that the correct processes are in place for safeguarding. The policy dovetails into Local Authority Policy for which we will be active members of the Children's Safeguarding Board.<br><br>LQ asked the Board for comments and is seeking approval.<br><br>AM is the Accountable Officer for validation and ensuring that all GP's meet requirements. | |

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| | JK advised that there is a risk on the cover document which needs to emphasise that the risk is the people in the population, that we are safeguarding vulnerable members of the society. Felt that equality was not clear for screening on the quality impact assessment (it says it needs to be done).<br><br>PJ advised that it should read the Accountable Officer not the Chair. LQ to amend.<br><br>**Safeguarding Adults Policy**: LQ advised that further guidance will be given regarding Adult Safeguarding, in the absence of this the CCG would adopt the same model for children. It was reiterated that this policy is also aligned with the Local Authority Safeguarding Policy. The Chair of Local Safeguarding Children's Board is also the Chair of the Local Safeguarding Adults Board. As a CCG there is a seat on both Boards and LQ is the nominated person for that. The CCG clinician who will be a member of the Children's Board is Shanila Roohi.<br><br>The CCG have appointed a Safeguarding Nurse (Val Tarbath) who is responsible for safeguarding adults and for dealing with issues relating to the Mental Capacity Act. She will be assessing the quality in nursing homes and looking at safeguarding issues if there are concerns. She will also be working closely with the Local Authority. Serious case reviews will be taking place as and when concerns arise.<br><br>**Governance Policy**: Roles and responsibilities of members of staff have been put into the policy. The Chief Clinical Officer will be the Accountable Officer in relation to safeguarding.<br><br>SW asked if all staff will be involved in the training processes for safeguarding etc. AM reassured him that we are adding this as part of staff development.<br><br>It was acknowledged that the appendices need to have Cheshire removed and replaced with Wirral information.<br><br>The Board adopted both policies subject to amendments being made. | **LQ** |
| **3.** | **ITEMS FOR INFORMATION** | |
| GB12-13/067 | **Annual Status Review (ASR)**: LQ presented for information the ASR which has been produced by the CSU. This provides information to the CCG relating to population and gives us an opportunity to look at the local health economy.<br><br>FJ advised that various sources of information is available and need to be taken into account when looking at population trends and analysis, and this needs to be brought together to enable our Governing Body to show our line of sight and what we will be deciding to commission.<br><br>MB emphasised that this is a really exciting time for the CCG with fresh finances, end of the PCT era and moving forward with our own strategic | |

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| | planning. This will give us time to reassess our allocations etc. Further guidance is expected by mid-December.<br><br>FJ mentioned the Health & Well-being Board meetings. We are focusing on our priorities in December, but we need to ensure that a Health and Well-Being Strategy is developed by April 2013 onwards which is important to us as a CCG. | |
| GB12-13/068 | **Process for FOI's, Complaints & Handling**: LQ presented the process which has been produced by the CSU in handling for FOI's requests, and complaints. This work has been undertaken which has been supported by AD and the Team at the Cluster. This outlines the roles and responsibilities during the transition period.<br><br>The Chief Clinical Officer, is responsible for the signing of CGG solely responses, and is accountable and therefore must be assured that processes have been adhered to.<br><br>It was agreed that this is a robust document, especially dealing with complaints regarding practices, GP's, hospitals etc. in recent weeks the CCG had received some complaints that required investigation and resolution. A fortnightly complaints meeting has been commenced within the CCG to keep updated regarding complaints.<br><br>FJ asked for a description of how a complaint was dealt with in relation to a Senior Individual from an organisation?<br><br>AD assured that there is statutory procedure in place now which will differ the procedure we will in place from 1st April 2013, and reiterated that this is an interim procedure (1st October to 31st March 2013).<br><br>These processes where noted by the Board. | |
| **4.** | **RISK REGISTER** | |
| GB12-13/069 | **Risk Register**: MB presented the Risk Register and noted the existing risks which were discussed at the previous Governing Body Board meeting, ie the Child Health System and also one 1:1. There has been an added risk around IAP waiting times.<br><br>This information is for noting only and a more informed discussion will take place at the next Governing Body meeting on 6th November. | **MB** |
| **5.** | **ANY OTHER BUSINESS** | |
| | No other business to discuss. | |

| 6. | **DATE AND TIME OF NEXT MEETING** | |
|---|---|---|
| | The next Extra-ordinary Meeting of the Governing Body Board will take place on **Tuesday 20th November 2012, 9.00am to 12.00noon**. Albert Lodge, Victoria Health Centre, Wallasey.<br><br>The next scheduled meetings are:<br><br>6th November 2012, 1.00-3.00pm, Nightingale Meeting Room, OMH<br>4th December 2012, 1.00-3.00pm, Nightingale Meeting Room, OMH<br><br>Please email apologies to: Julie.stamper@wirral.nhs.uk | |

Wirral Clinical Commissioning Group

# Organisational Development Plan

| | | | |
|---|---|---|---|
| **Agenda Item:** | 2.1 | **Reference:** | GB12-13/096 |
| **Report to:** | Governing Body | **Meeting Date:** | |
| **Lead Officer:** | Lorna Quigley | | |
| **Contributors:** | CWW CSU<br>North West Leadership Academy. | | |
| **Governance:** | **Link to Commissioning Strategy** | | |
| | **Link to current governing body Objectives** | | |

**Summary:**


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All new organisations need a plan for their own development, this is important for Wirral Clinical Commissioning Group.

This plan sets out the first phase of development for the CCG Governing Body as they work within a federated structure focusing on the strengths and areas required for development.

During the diagnostic work that has been undertaken, areas of competence have been defined, in addition to areas that require development. These need to be worked on in order for the organisation to fully mature.

These include:

Strategic intentions
Development of objectives
A governance assurance framework
A set of objectives

The CCG is still undertaking the recruitment of some posts, it is anticipated that as a result of this, there will be changes to the plan.

The governing body is asked to:

- to approve phase one of the organisational development plan
- Support and participate in the work required to undertake phase two

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| **Recommendation:** | **To Approve** | | x |
| | **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 approved A project plan will be developed for phase two of the OD plan | | |

*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** | What is the financial impact of the proposal/item on the PCT? Is it covered in a budget, has funding been agreed? Cost of not taking action?Actual figures should be covered in the main paper. |
| **Value For Money** | Does the proposal/item represent value for money (cf. New Investment Form). |
| **Risk** | What is the level of risk in the Board taking the recommended decision? What is the level of risk in the Board not taking the recommended decision? What has been done to mitigate that risk? |
| **Legal** | Are there any legal implications in what is recommended? If there are, has legal advice been obtained? Is legal opinion required before the Board takes the decision ie. the Board couldn't take the recommended decision without knowing the legal position. |
| **Workforce** | What impact would there be on PCT or other NHS staff if the Board takes the recommended decision? Is this positive or negative? What is being done to address the implications?Are there implications for staff engagement? |
| **Equality & Human Rights** | Have equality and human rights issues been taken into account in the proposal? What is the evidence to support this? Has an impact assessment been undertaken (see below). |
| **Patient and Public Involvement (PPI)** | Have patients and public been involved in the proposal? How would the recommended decision of the Board affect their involvement? |
| **Partnership Working** | Does the proposal evidence partnership working? Has it been considered whether the proposed course of action affects partners – positively or negatively? What has been done to ensure partners are involved in or advised of the decision? |
| **Performance Indicators** | Is there a relevant performance indicator for this item? If so, how will the proposed course of action affect the agreed activity/objectives against that performance indicator? |
| **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.

NHS

Wirral Clinical Commissioning Group

# Organisational Development Plan

# 2012-2014

# September 2012

**Translations available on request**

Vietnamese:
Baûn vaên phieân dòch luoân coù saün khi coù söï yeâu caàu.

Arabic: الترجمة متوفرة عند الطلب.

Bengali: অনুরোধ জানালে অনুবাদ পাওয়া যাবে।

Chinese: 如有需要，我們可提供中文譯本。

Hindi: मांगने पर तरजमा मिल सकता है।

Urdu: درخواست کرنے پر ترجمہ فراہم کیا جائے گا۔

This plan will be made available following approval from the Governing Body and will be found at:

www.wirralccg.nhs.uk

Paper copies of the plan are available to members of the public free of charge and copies of this document in other formats can be made available on request. If you require a copy in large print, audio cassette or in another language, please contact:

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# 1 INTRODUCTION AND BACKGROUND

## 1.1 Purpose of this Document

Organisational development is the process through which an organisation develops its systems, processes, structures capacity and capability to be the best that it can be, to deliver its strategy and to sustain itself over the long term. At the heart of an organisation is a vision and core set of values. That vision and those values help shape the organisation's future form. An organisation's effectiveness depends on a shared understanding of, and commitment to, the vision and values. Organisational development plans will continue to be developed by the business in order to underpin the organisational strategy.

Our Organisational development activities are sponsored from Governing body level to ensure they reach across all areas of the business and take the organisation forward in a systematic way, making sure the organisation has the right 'fit for the future' workforce to achieve its strategic ambitions.

The purpose of the Organisational Development Plan (OD Plan) is twofold, firstly to set out the principles, vision and decisions required to deliver an effective and sustainable GP Commissioning system via a single consortium. Secondly, it outlines the underpinning interventions required to further develop our organisational capabilities in order to support our aspiration to achieve full statutory & regulatory status by April 2013.

The OD Plan performs the following functions:

- Identifies organisational strengths and areas for organisational improvement where development is required.
- Identifies key organisational development priorities
- Underpins the organisational strategy in delivery the vision and objectives
- Identifies the culture/behavioural changes required to achieve the necessary transformation required to delivering our strategic objectives.
- Incorporates the development needs identified from the self assessment for authorisation against the 6 domains

## 1.2 Foreword

Reform across the NHS is occurring within the new structures and roles set out in National, Regional and Local strategic direction, introduced as part of the implementation of the NHS White Paper (July 2010) and the accompanying NHS Operating Framework (Dec 2010). This means more than just structural change and is as much about behavioural and cultural change. It requires a greater emphasis on knowledge systems, local clinical leadership and empowerment, and new clinical programme management solutions, which deliver maximum benefit from available resources, workforce, finance, knowledge and skills for local patient benefit.

Whilst there are numerous guides and well-grounded theory to support the work of the Clinical Commissioning Group, there is no prescriptive way of reforming local NHS systems and services. The opportunity exists therefore for Clinical Commissioning Group's to lead the process for re-engineering the shape of local commissioning reform and the way in which local services are developed and clinical programmes are re-engineered over the next 3 years. With this in mind, system reform activities will give consideration to the following:

- Address the key areas of challenge / areas of significant risk
- Ensure that strategies & actions are focussed; patient centred and subject to best value scrutiny.
- Ensure they complement & align with existing local / strategic plans of health and social care partners.
- Should be challenging, radical & transformational.
- Take account of Health Improvement and Health Equity knowledge.
- Take account of any applicable DH planning guidance.
- Have clear objectives and a clear plan of QIPP based delivery
- Frequency for reviewing the plan itself to take account of any national / local changes and how actions will be reviewed locally.
- Assess the workforce development required to deliver and sustain real reform.
- How to effectively engage the local population and communicate key messages to stakeholder groups.

## 2 MISSION, VISION AND VALUES

Our mission, vision and value are at the heart of our Clinical Commissioning Group. To ensure we enabled all our staff and stakeholders to be involved in creating and agreeing these we undertook a lengthy engagement process. This included focused sessions with the Governing Body, consultation with member practices, local community groups, other professional stakeholders and with the CCG team.

As a result of this engagement work, the current mission, vision and values and strategic are shown below. They are an integral part of developing and delivering the strategy and the organisational development plan for the Wirral Clinical Commissioning Group.

### 2.1 Our Vision

Your partner in a healthier future for all

### 2.2 Our Values

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

### 2.3 Our Strategic Objectives

Organisational values encapsulate the beliefs that are shared among the stakeholders of an organisation. These will drive the culture and priorities and provide a moral framework in which decisions are made. Our values are shown in figure 1.

| Our Core Values |
| --- |
| Caring, fair and responsible |
| Safe and trusted |
| Person-centred |

**Figure 1: Our values**

### 2.3 Our values

These newly developed values are integral to driving the cultural and behavioural changes required to deliver our overarching strategic aims and objectives. We will focus on integrating these values in a way which brings coherence to our actions, behaviours, processes and culture.

## 3. STRATEGIC CONTEXT

### 3.1 Context

NHS reforms challenges Clinical Commissioning Group's to transform themselves into very different organisations to what has been before. The Clinical Commissioning Group will be expected to promote innovation whilst maintaining continuity of services. We will need to work in collaboration with all key stakeholders to support an integrated and joined-up system of health and social care, while simultaneously stimulating competition and innovation. We will also need to demonstrate improvements in long term health outcomes, while maintaining progress on our day to day delivery. Finally we will need to demonstrate value for money, while meeting demands for wider access and choice, and wider patient and public involvement.

The Clinical Commissioning Group strategy and therefore the organisational development plan has to reflect the environment in which it operates. In terms of gearing up Clinical Commissioning Group for the challenges ahead, some further environmental analysis will be required as a continuous process and feed all aspects of planning for Clinical Commissioning Group's organisational development. The Clinical Commissioning Group organisational environment is made up of:

- **The internal environment** e.g. staff and management , technology required to support clinical commissioning activities, operational resources and finance
- **The micro-environment** e.g. our external customers, our local population, Clinical Commissioning Group membership and local referring GP practices, healthcare suppliers, our strategic partners particularly the Local Authority as our joint commissioning and health and wellbeing corporate partner

- **The macro-environment** e.g. Political and legal, Economic, Socio-cultural, and Technological Factors. These are known as PEST Factors. In order to gear up our collective understanding of the new commissioning environment we would need to consider these factors when developing the clinical change programmes.

## 3.2 PEST (Political and legal, Economic, Socio-cultural, and Technological Factors)

### Political factors

The political arena has a huge influence upon the regulation of our local health care system, the Money available and the priorities for disease management. We will need to consider issues such as:

- political pressure as a consequence of changing health care threshold issues
- current and future legislative requirements
- healthcare market
- international (EU) legislation
- regulatory bodies and processes (changes to Care Quality Commission)
- government policies & operational expectations
- government term and the risk of change within strategic planning timescales

### Economic factors

The Clinical Commissioning Group will need to consider a number of economic drivers when developing the design of their local healthcare system the continuous development of the clinical QIPP (Quality, Innovation, Productivity and Prevention) programme will be a critical feature within the transition period and beyond 2013 when Clinical Commissioning Group will hold corporate accountability for the economic stability of the local healthcare system.

### Socio-Cultural factors

Understanding the diversity of needs within a given population and planning health improvement products (i.e. services that provide advice, support, intervention and support wellbeing) is a fundamental aspect of health system commissioning. Aligning clinical commissioning programmes with the defined understanding and therefore needs of our local population, based on socio cultural factors will be an important aspect of Clinical Commissioning Group activities. The new clinical commissioning model will require programmes that enable, over time, to build

organisational capability and drive the Clinical Commissioning Group to become a true market driven commissioner. By this we mean, driven by the needs of our people and delivered by the capabilities specifically engineered into our economy through a network of highly regulated suppliers.

**Technological factors**

The Clinical Commissioning Group has been working with the PCT to consider many technological innovative tools and techniques each designed to provide the answers to questions around future. Demand, economic and health impact assessment. In terms of technological influences the Clinical Commissioning Group will consider further requirements to best meet the needs of both the Clinical Commissioning Group as an emerging organisation and the commissioning competencies it would need to develop.

## 3.3 SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis

For the purposes of Clinical Commissioning Group strategy and organisational development a SWOT analysis has been undertaken. The identification of organisational strengths, weaknesses, opportunities and threats is based on insight and history and will therefore need to be re-examined as our Clinical Commissioning Group develops.

It is recognised that environmental analysis is essentially a management and strategic planning discipline, therefore, it is an essential component for establishing new organisational systems. It is clear that the reform and policy agenda presents many interesting and challenging issues that need to be worked through. It is also fair to say that the ability to face complex challenges, engage key stakeholders, generate innovative solutions and translate into productive action has been a relative strength historically within the PCT and now within our Clinical Commissioning Group.

| Strengths | Weaknesses |
|---|---|
| • Leadership capabilities (clinical and managerial)<br>• Effective engagement processes<br>• Clear views on strategic choice & vision<br>• Cohesive partnerships & relationships<br>• Experienced & established clinical challenge<br>• Public health infrastructure<br>• System management understanding<br>• Service development experience | • Performance improvement systems across the system<br>• Knowledge management systems<br>• Sufficient 'hands on' support<br>• Capacity planning<br>• Workforce Flexibility<br>• Internal & external reporting systems<br>• Breadth of commissioning competence across the whole system<br>• Knowledge and skills gaps |
| **Opportunities** | **Threats** |
| • Achieve significant improvement (patients and systems)<br>• Develop local clinical workforce & leadership<br>• Re-investment into community services<br>• Significantly reduce health inequalities<br>• Improve productivity & best value<br>• Policy delivery & fit for purpose<br>• Innovative patient centred services | • Breadth of policy agenda<br>• Speed & consistency of change<br>• Financially driven developments<br>• Workforce & capability retention during changes<br>• Competitive environment will intensify<br>• New commissioning systems require robust governance frameworks<br>• Significant organisational change<br>• Operating costs for new systems |

**Figure 2: SWOT analysis**

### 3.4 Management Structure

The Clinical Commissioning Group is responsible for commissioning health services on behalf of the population and our budget for 2012/13 is £ 209 million. Our management structure has been developed to ensure strategic alignment between the commissioning agenda, our objectives and vision whilst delivering strategic alignment and effective delivery of national and local targets.

### 3.5 Building a new health commissioning service

New commissioning models have to break new ground and be transformational to deliver better outcomes, be closer to the clients it serves; and be less expensive to operate, with less bureaucracy, and control health care spending. With this in mind, it stands to reason that marginal changes to systems and structures will not suffice and a fundamental shift in thinking is required. Clinical Commissioning Group's with the leadership of local GPs and support from the local commissioning support organisations are developing a new healthcare system which is more patient centred, efficient and effective.

## 4 METHODOLOGY AND IDENTIFYING ORGANISATIONAL DEVELOPMENT PRIORITIES

### 4.1 Methodology

In order to support the CCG in identifying their organisational development priorities the NHS northwest Leadership academy has developed a clinical commissioning group governing body framework (figure 3).


**Figure 3: North West CCG governing body development framework**

The purpose of this tool is to help members of CCG governing bodies to evaluate the capability of their CCG for the purpose that is had responsibility for.

The development framework outlines a series of good practice statements that describe the processes, structures, capabilities and skills that a high performing, fully authorised CCG governing body will have to display.

In order to achieve the CCG's purpose it must deliver on the three core duties:

1. **Effectiveness and Efficiency -** CCG functions must be provided effectively, efficiently and economically (within relevant financial parameters).

2. **Quality of Services** - CCGs must continuously improve the quality (i.e. effectiveness, safety and patient experience) of services provided, particularly in relation to the outcomes achieved as a result of that care.

3. **Reducing Inequalities and Promoting Patient and Public Involvement** - CCG functions must be exercised with regard to reducing access and outcome inequalities across the healthcare system and involving patients, carers and the public in the decisions in relation to the commissioning and provision of care.

The CCG's ability to perform well against these duties will be a result of a number of skills, capabilities, structures and arrangements (outlined on the outer ring of the North West CCG Governing Body Development Framework).

**Diagnostics and the self assessment process**

The CCG Governing Body undertook a two part diagnostics workshop. This commissioned by the North West Leadership Academy

**The process was undertaken in 2 parts:**

Part 1 Roles and composition questionnaire

The roles and composition questionnaire is designed to facilitate understanding of the current roles and composition of the governing body and the readiness for engagement in the development process. This questionnaire was distributed to all members of the governing body.

Part 2 Facilitated Development day

Once part one had been completed all members of the governing body where invited to attend the facilitated study day. The aims of this were:

- Review the context of change and the authorisation process
- Discuss roles, responsibilities, authority and accountability of members of CCGGB
- Receive feedback on Board Development Framework
- Identify 'gaps' to be addressed
- Agree an action plan, to build on strengths and address challenges

## 5 ORGANISATIONAL DEVELOPMENT PRIORITIES

### 5.1 Identified organisational development priorities

The diagnostic work undertaken has identified key priorities which have been mapped against 6 domains:

- Commissioning
- Partnership and Collaborative working
- Change leadership Performance
- Performance
- Regulating and discharging duties
- Performance monitoring and evaluation

An overview of these is detailed in Table 1. The full details of the priorities, are detailed in the Organisational development Implementation plan (Appendix 1). Following the facilitated development day an action plan was devised by members of the governing body based on the issues raised from the questionnaire.

| Domain | Key priorities |
|---|---|
| **1. Commissioning** | • Develop prioritisation methodology<br>• Agree process to undertake future JSNA to ensure full engagement across the Clinical Commissioning Group area.<br>• Gaining knowledge/skills to manage and develop the local market more effectively |

| | |
|---|---|
| | • Identify key contracting clinical leads and support them to gain the level of knowledge required to fully engage in this work<br>• Build skills to improve analysis performance information from local providers to identify when services are not delivering.<br>• Develop further capabilities in procurement.<br>• Ensure that there are contract management and negotiation skills within the CCG. |
| **2. Partnership and Collaborative working** | • Ensure communications and engagement strategy is in place for commissioning that ensures we reach all our stakeholders.<br>• To identify and work with other consortia to develop objectives for co-ordinated commissioning.<br>• Work more closely with Public Health and Local Authority to ensure robust Health Needs Assessment process in place Process to identify and involve key stakeholders appropriately |
| **3. Change Leadership** | • Skills to undertake excellent strategic planning<br>• Process to robustly prioritise objectives<br>• Develop and strengthen relationship management skills<br>• A clear plan to set out how GP Practices will be supported in the change required to deliver the key objectives of the CCG<br>• Develop our expertise in a range of change management techniques |
| **4. Performance** | • Appropriate constituted management infrastructure arrangements in place.<br>• A robust strategic planning process<br>• Development of processes and policies for change / programme management.<br>• Development of processes and policies for continuous improvement.<br>• Scheme of delegation<br>• Ensure robust systems and processes are in place to enable scrutiny of decisions as to how funding is spent<br>• Capacity to undertake robust contract management of provider services<br>• Increase analytical expertise and capacity within the Clinical Commissioning Group |

| | |
|---|---|
| **5. Regulations and discharging duties** | • Stakeholder management processes to identify prioritisation of relationship in context of consortium delivery priorities.<br>• Ensure consistent stakeholder management process and clarification of objective and priorities.<br>• CCG has plans in place to train staff in the recognising and reporting of safeguarding issues. |
| **6. Performance Monitoring and evaluation** | • Continue to develop members of the governing body as strategic leaders via Board development programme to support strategic alignment and enhanced effectiveness<br>• Work with the NW leadership Academy to develop specific and generic development plans for the teams<br>• Develop talent management and succession planning processes.<br>• Develop senior leaders to role model shared values and behaviours in order to influence organisational and cultural change.<br>• Increase clinical leadership capacity and capability across the CCG.<br>• Develop formal mechanism to identify new talent<br>• Develop formal mechanism for succession planning |

**Table 1: An overview of key priorities**

## 6 DELIVERY

### 6.1 Governance

The role of the CCG Governing body is to provide strategic direction of the organisations business and to ensure that performance is of the highest possible standard. Given the wide ranging and complex agenda that the NHS as a whole is facing the governing body has a governance structure through the development of an integrated assurance framework.

To ensure robust performance management a number of committees have been developed with clear Terms of Reference ensuring ultimate accountability. The committees of the governing body report to the CCG on a monthly basis or as outlined in their terms of reference. The committee structure is described in the constitution and outlined in Figure 4.

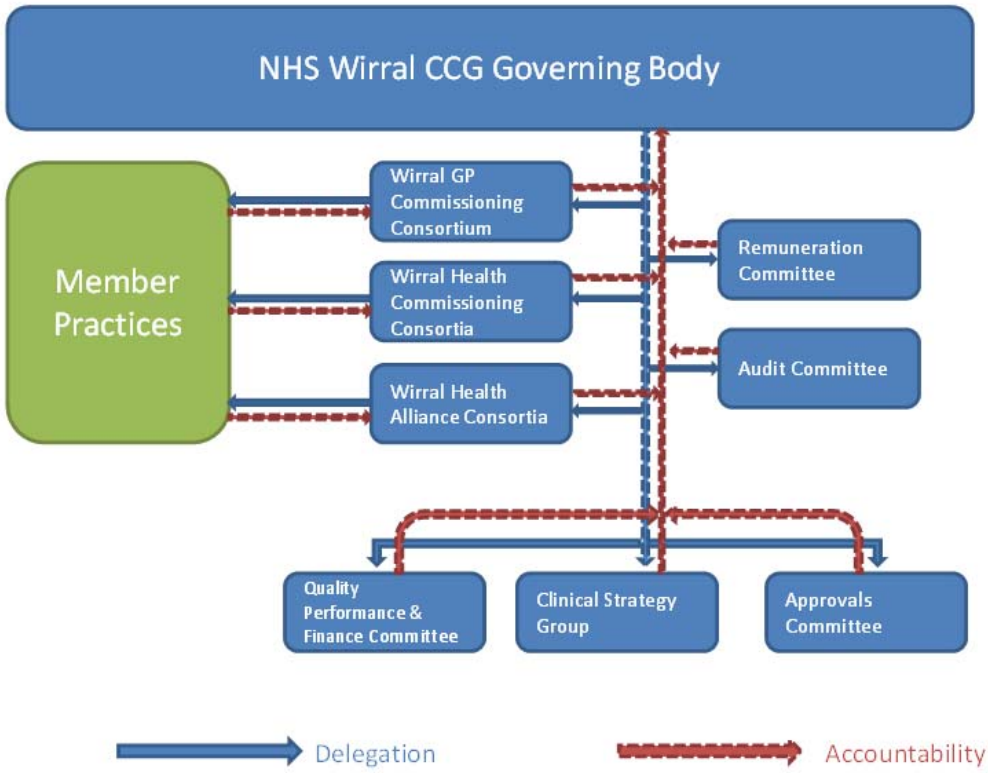



**Figure 4: NHS Wirral CCG committee structure**

In order to ensure risks associated with the delivery of this Organisational Development Plan are monitored the CCG governing body will retain overall responsibility and accountability for implementation and compliance.

## 6.2 Risk Analysis

A risk analysis has been undertaken. A summary of the key risks and the mitigation strategies is shown in Table 2.

| Risk | Description | Mitigation |
|---|---|---|
| **Capacity and capability** | Risk of "hands on" support within the CCG to support the Agenda | Ongoing review of capacity within the CCG through risk management framework.<br>CCG to prioritise commissioning intentions to enable achievement. |
| **Pace / complexity of reform** | Risk of CCG (member practices/CCG staff) being informed of changes. | Maintain the robust relationships with LAT and neighbouring CCG's.<br>Maintain internal and external communications and engagement with member practices and CCG staff. |
| **Financial targets** | CCG unaware of their allocation or the formula being used for the forthcoming year | Planning assumptions to be based on different scenarios.<br>Risk sharing arrangements to implemented |
| **QIPP challenge** | CCG maybe unable to achieve its QIPP targets | Robust QIPP plan with to include monitoring mechanism.<br>Development of the clinical QIPP teams. |
| **Ensuring appropriate commissioning support** | Risk of CSS dilution with the establishment across a larger foot print. | Robust SLA with CSS, ensuring KPI's are delivered. |

**Table 2: Risk analysis summary**

## 7 SUMMARY

This organisational development plan has identified the overarching areas that the CCG wishes to progress in order to achieve its ambition to become a successful and sustainable organisation that commissions services based on population need. The rapidly developing and changing environment means that we will need to continually monitor and review our approach to organisational development as a whole.

Through the implementation of this Organisational Development Plan we will seek to impact on the culture and development of approach which will be values driven, demonstrating a commitment to learning and continual adaptation. We will use the 7S model in all organisational development activity in order to improve the organisation's business performance. This will include focusing on 'hard S' elements (Systems, Structure and Strategy) and the 'softer' elements around Shared Values, Style, Staff, and Skills.

Areas will include,

- developing a culture of collaboration and integration,
- partnership working with the community and stakeholders,
- developing the capability and capacity of the local workforce,
- leadership development
- building knowledge, intelligence, analysis and data resources.
- Clinical engagement, developing
- Developing our ability to manage a complex market and health system of appropriate providers,
- Developing a culture of innovation and utilising efficiencies are also essential.

Ultimately, the shape of our organisation and its culture will be influenced by the implementation of this organisational development plan and its supporting Implementation plan. Our organisational development plan supports the achievement of authorisation by aligning our vision, values and objectives set within our priority healthcare initiatives. It does this by looking at where we are on our journey to authorisation, assessing the gaps in our organisation against where we want to be and by a specific review of our capability and capacity to deliver our vision for the local population we serve.

**APPENDIX - A LEADERSHIP ACADEMY REPORT**

NHS NORTH WEST

LEADERSHIP ACADEMY

**THE NORTH WEST CLINICAL COMMISSIONING GROUP**

**GOVERNING BODY DEVELOPMENT FRAMEWORK**

# OUTCOMES REPORT

## NHS WIRRAL CCG

This report has been produced by NHS North West Leadership Academy.

If you have any queries please contact Amy Brockbank, Programme Manager on 0161 625 7318 (07747474341) or by email on amy.brockbank@nwacademy.nhs.uk

## INTRODUCTION

- This report presents outcomes from Part Two of the Clinical Commissioning Group Governing Body Development Framework (CCGGBDF).
- In total, **10** responses were received from the CCG Governing Body (CCG GB).
- Responses from each Governing Body member will be collated for the Governing Body as a whole (individual response will not be identifiable).
- The report will feed into the Facilitated Development Day organised for your CCGGB.
- The Facilitator will use this information at the Facilitated Development Day which will enable the Governing Body to target the most important areas of development and create an action plan for development.

## HOW THE OUTCOMES WILL BE PRESENTED:

Thank you for completing Part Two of the CCGGBDF which consisted of six questionnaire sections (listed below).

| **Questionnaire Sections:** |
|---|
| 1. Commissioning* |
| 2. Partnership & Collaborative Working* |
| 3. Change Leadership |
| 4. Performance* |
| 5. Regulating & Discharging Duties |
| 6. Performance Monitoring & Evaluation* |

*Sections which include 'subsections'.

Within each section/subsection, you were asked to rate items according to the following Response Scale. Each response is then related to a numerical value and a colour ('rag') rating development indicator:

| Response Scale | Assigned Numerical Value** | | 'Rag' Rating | Development Indicator |
|---|---|---|---|---|
| Strongly Disagree | 1 | | | Areas with highest development need |
| Disagree | 2 | | | |
| Neither Agree/Disagree | 3 | | | Areas with some development need |
| Agree | **4** | | | Strengths/Areas with least development need |
| Strongly Agree | 5 | | | |
| Not Applicable | | | | For NWLA review |

** The numerical value represents its associated response (e.g. Strongly Agree = 5) for each graph presented in the Outcomes Sections below (Graphs 1 to 6).

The Outcomes for each Questionnaire Section (1 – 6) comprise the remainder of the report. Outcomes will be presented in the following order:

- Section Overview (overall section development indicator)
- Subsection Outcomes (Mean response per subsection)
- Item Outcomes (Range of outcomes per rag rating)

# 1. COMMISSIONING

**Section Development Indicator:**

The Commissioning Section comprises 4 sub-sections and 33 items relating to commissioning for the locality, commissioning within policy, making sound investments and managing contracts.

## SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members **Agree** to statements aligned to commissioning activity. This indicates that 'Commissioning' is seen to be an area of **strength** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **limited development need.** To further explore perceptions of commissioning performance, Section 1.2 displays the total average response per 'subsection' whilst Section 1.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are **green**, Section 1.3 will highlight areas you may wish to discuss/develop further.

## COMMISSIONING SUBSECTION OUTCOMES

**Chart 1: Commissioning Subsection Outcomes**

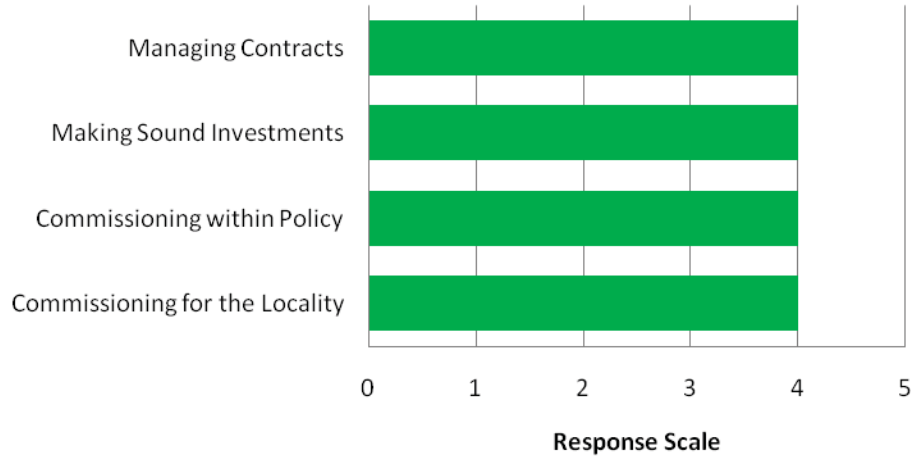


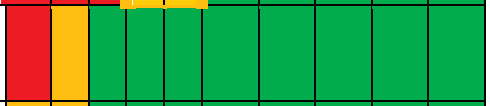
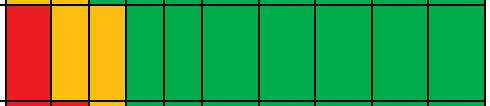
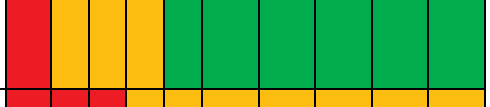

Chart 1 gives an overview of Governing Body Members responses to each sub-section of Commissioning. For each sub-section the Mean response was 'Agree'.

## COMMISSIONING ITEM OUTCOMES

The range of responses within each subsection against each item can be seen in Table 1 below:

**Table 1: Commissioning - Responses per Item**

| Section | **Item** ['As I CCG Group Leader, I…'] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Commissioning for the Locality | Have evidence of assurance that the CCGGB bases commissioning decisions on the needs of the local health economy. | | | | | | | | | | |
| | Have evidence of assurance that the CCGB has a comprehensive understanding and up-to-date needs assessment of the entire locality population, at any one time. | | | | | | | | | | |
| | Have evidence of assurance that information received into the CCG in relation to locality healthcare needs is holistic, accurate and reliable. | | | | | | | | | | |
| | Have evidence of assurance that the CCGB as a whole has the capability to comprehensively interpret statistical data in relation to the locality and make reasonable inferences from the data. | | | | | | | | | | |
| | Have evidence of assurance that patients and citizens are actively engaged and integral to commissioning decisions and care pathway design, through relevant LINks, Local Health Watch committees and internal patient / citizen engagement groups. | | | | | | | | | | |
| | Have evidence of assurance that commissioning decisions are led by the patient 'voice' for care provision (i.e. making patients central to how and what services are delivered). | | | | | | | | | | |
| | Have evidence of assurance that commissioning decisions and care pathways are regularly evaluated through gathering and using patient feedback. | | | | | | | | | | |
| | Can demonstrate using local patient experience and citizen feedback (i.e. Through LINks, Healthwatch and Patient Survey results) to improve services and change services throughout the care pathway. | | | | | | | | | | |
| | Can explain the difference between local healthcare needs and wants (e.g. citizens may want specialised secondary care treatment, but preventative measures could improve the health of the locality more) and ensure this is addressed in commissioning decisions. | | | | | | | | | | |

| | | |
|---|---|---|
| | Have evidence of assurance that commissioned services have the capacity to cope with fluctuations in demand in the locality (e.g. flu outbreaks). |  |
| Commissioning within Policy | Can demonstrate an up to date knowledge of key national and local strategy and policy drivers and understand how these impact services which need to be commissioned or de-commissioned. |  |
| | Can demonstrate commissioning decision are taken in line with key strategic and policy drivers (e.g. with regard to reducing health inequalities within a CCG's locality and a focus on preventative and public health initiatives). |  |
| | Demonstrate that I ensure commissioning decisions are made with reference to the 'Joint Strategic Needs Assessment;' driven by the Local Authority (encompassing health, community and social services). |  |
| | Can explain the complexities of competing legislative and strategic requirements and translate these into commissioning plans (e.g. Commissioning for what patients want and ensuring the health of the locality improves generally). |  |
| | Can demonstrate that clinicians are actively engaged and integral in making commissioning decisions and shaping care pathways. |  |
| | Can demonstrate any service re-design is clinician led and evidence based. |  |
| Making Sound Investments | Can describe and explain the services that the CCG commissions together with the costs of these services. |  |
| | Can describe and explain the likely healthcare demand levels across specialties & localities. |  |
| | Can describe the local and national demographic trends and changes in disease profiles. |  |
| | Can describe how the full social and economic impact of commissioning decisions are considered. |  |
| | Can demonstrate an in-depth understanding of the whole healthcare system. |  |

| | | |
|---|---|---|
| | Can explain the CCG's position within the health economy and how it is likely to evolve. | |
| | Have evidence of assurance that the CCG makes commissioning decisions with regard to the financial implications of contracts and how a contract impacts on a CCG's performance against its allocated commissioning budget. | |
| | Can describe what the future of commissioning will 'look like' in terms of the healthcare needs of the locality and the key strategic and policies that will affect the CCG, and seek to commission services in anticipation of these changes. | |
| | Can demonstrate commissioning decisions that enhance the CCG's performance against the NHS Commissioning Board criteria for performance related payments. | |
| Managing Contracts | Can demonstrate that service specifications in relation to provider activity and quality are integral within contracts (e.g. CQUIN payments and outcome indicators aligned to the NHS Outcomes Framework). | |
| | Can explain the needs and motivations of partnering organisations and use these in negotiations. | |
| | Remain principled in contract negotiations (i.e. ensure providing organisations receive a fair value for the services that they provide). | |
| | Can demonstrate that I think strategically about the CCG's own market value and at the same time identifying key opportunities to leverage maximum value. | |
| | Have evidence that the CCG continually monitors the utilisation of established contracts and re-negotiate contracts taking into account patient experience, should they be either under or over used. | |
| | Can demonstrate that I effectively manage demand levels for services in a locality, encouraging patients to use certain services through Patient Choice should this be beneficial. | |
| | Can demonstrate that payment to providers is only made once performance against contracted service delivery has been validated. | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Can describe and explain whether contract management services should be out sourced or shared across CCGs, taking into consideration the skills and systems necessary to perform this function effectively and the most economical way to achieve this. | | | | | | | | | | |

## 2. PARTNERSHIP AND COLLABORATIVE WORKING

**Section Development Indicator:**

The Partnership and Collaborative Working Section of the CCGGBDF comprises 4 subsections and 23 items relating to working within the CCG ('internal and member'), across CCGs, with Non-NHS Organisations and with a Whole Systems Approach.

### SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members either **Agree** or **do not have a strong preference to agree or disagree** to statements aligned to partnership and collaborative working. This indicates that 'Partnership and Collaborative Working' is seen to be an area of **strength** but with certain areas holding **potential for some further discussion/development** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **limited/isolated development need.** To further explore perceptions of partnership and collaborative working, Section 2.2 displays the total average response per 'subsection' whilst Section 2.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are either **green** or **amber**, Section 2.3 will highlight areas of strength as well as areas you may wish to discuss/develop further.

### PARTNERSHIP& COLLABORATIVE WORKING SUBSECTION OUTCOMES

**Chart 2: Partnership & Collaboration Subsection Outcomes**

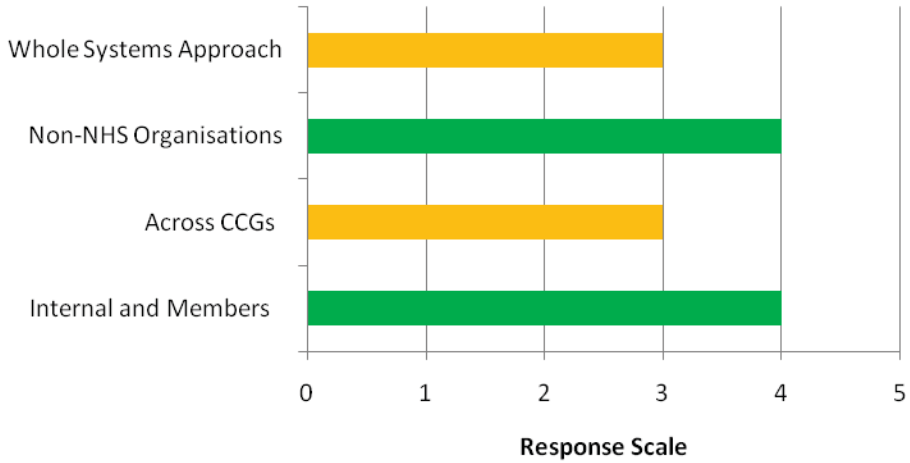



Chart 2 gives an overview of Governing Body Members responses to each sub-section of Partnership & Collaborative Working. For the subsections relating to working within the CCGGB ('internal and member') and 'Non-NHS Organisations' the Mean response was 'Agree'. For working 'Across CCGs' and considering a 'Whole Systems Approach' the Mean response was 'Neither Agree or Disagree'

### PARTNERSHIP& COLLABORATIVE WORKING ITEM

## OUTCOMES

The range of responses within each subsection against each item can be seen in the Table 2 below:

**Table 2: Partnership and Collaborative Working - Responses per Item**

| Subsection | Item ['As a CCG Group Leader, I…'] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Internal & members | Feel comfortable and able to openly say what I am thinking and feeling, express doubts or uncertainties or a lack of understanding or an issue at CCGB meetings. | | | | | | | | | | |
| | Feel involved at a sufficiently early stage of issues, projects and strategic developments in order to be able to make a meaningful contribution to the work of the CCG. | | | | | | | | | | |
| | Seek and value the opinion of colleagues, both clinical and non-clinical, when necessary (e.g. Finance or HR). | | | | | | | | | | |
| | Spend sufficient informal time with the CCGB group, allowing me to get to know them and enhance team working and collaboration. | | | | | | | | | | |
| | Promote an open, inclusive and honest culture, engaging clinical CCG members and CCG staff at all levels. | | | | | | | | | | |
| | Promote a culture where individual differences and talents are recognised and everyone can participate, thrive and contribute (i.e. diversity). | | | | | | | | | | |
| Across CCGs | Can demonstrate effective inter-CCG partnership working arrangements in order to enable the most appropriate and comprehensive service offering to patients. | | | | | | | | | | |
| | Can demonstrate significant knowledge of health economics in neighbouring areas and the services that CCGs in these areas commission. | | | | | | | | | | |
| | Seek to establish across CCG collaboration agreements to commission less demanded services efficiently. | | | | | | | | | | |

| | | |
|---|---|---|
| | Can demonstrate that I support service improvement co-working between speciality leads across CCG in order to promote better patient safety, patient experience and quality patient care. | |
| Non-NHS Organisations | Adapt my language and communication style to engage non-clinical individuals and organisations (such as Local Authorities). | |
| | Can describe and explain the strategic priorities of non clinical organisations (such as Local Authorities) and how these align to the objectives of the CCG. | |
| Whole Systems Approach | Have evidence of effective, collaborative partnership arrangements across professional, organisational and sector boundaries to secure optimal and integrated whole healthcare system outcomes and pathways. | |
| | Am regularly briefed as part of the CCGB team on the appropriateness and effectiveness of the CCG's various partnership arrangements. | |
| | Have evidence of assurance the CCG actively and effectively communicates and engages with all relevant stakeholders (e.g. patients, Local Authorities, citizens, Providers) in order to define the best and most appropriate investment in service delivery. | |
| | Can demonstrate effective existing working relationships between primary and secondary care and ensure this continues for new commissioning and provider contractual performance requirements. | |
| | Seek to align stakeholders' (e.g. Local Authorities) objectives with the objectives of the CCG. | |
| | Am well known and respected for integrity and honesty in all dealings with partnering organisations and stakeholders (including patients and citizens). | |
| | Am well known for upholding the value of commissioning quality patient care first and foremost, in an increasingly competitive and financially demanding environment. | |
| | Can demonstrate that I effectively adapt communication and language to engage with different partnering organisations and stakeholders with different agendas and perspectives. | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Can describe the partnership wide and whole healthcare system impact of national and local agendas. | | | | | | | | | | | |
| | Can describe and explain the impact of strategic decisions across the whole healthcare system (i.e. Patients, citizens, CCG, CCG members, NHS and non NHS providing organisations, Local Authorities and other partnering organisations). | | | | | | | | | | | |
| | Can demonstrate that I balance conflicting interests across the health care system and make appropriate commissioning decisions and judgments. | | | | | | | | | | | |

## 3. CHANGE LEADERSHIP

**Section Development Indicator:**

The Change Leadership Section of the CCGGBDF comprises 12 items relating to Leading Change.

### SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members **Agree** to statements aligned to leading change. This indicates that 'Change Leadership' is seen to be an area of **strength** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **limited development need.** To further explore perceptions of leading, Section 3.2 displays the total average response for the section (there are no 'subsections') whilst Section 3.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are **green**, Section 3.3 will highlight areas you may wish to discuss/develop further.

### CHANGE LEADERSHIP SECTION OUTCOMES

**Chart 3: Change Leadership Section Outcome**

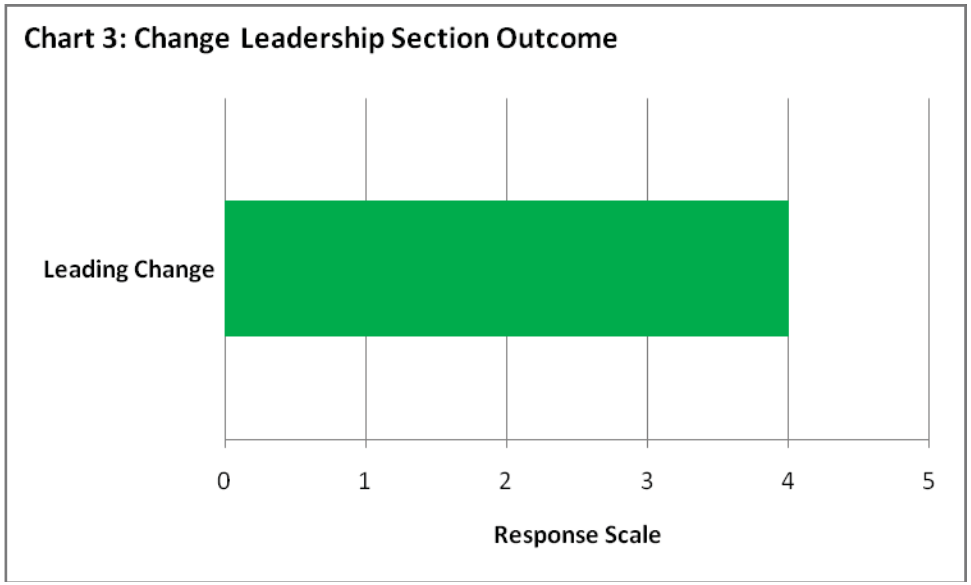



Chart 3 gives an overview of Governing Body Members responses to each sub-section of Change Leadership. For each sub-section the Mean response was 'Agree'.

## CHANGE LEADERSHIP ITEM OUTCOMES

The range of responses against each item can be seen in the Table 3 below:

**Table 3: Change Leadership - Responses per Item**

| Subsection | Item ['As I CCG Group Leader, I…'] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Leading Change | Am an effective ambassador of new ways of working and can demonstrate that I 'role model' desired ways of working on a daily basis, both in non clinical and clinical practice. | | | | | | | | | | |
| | Can evidence that the CCG ensures that change is 'done with' a workforce and across a healthcare system, as opposed to being 'done to' them | | | | | | | | | | |
| | Can demonstrate that I collaborate with others to contribute to and navigate changes (e.g. CCG staff, CCG members, patients, citizens, partnering and providing organisations). | | | | | | | | | | |
| | Can evidence that the CCG supports effective internal two way communication processes with CCG staff (e.g. Create a staff COMPACT agreement), | | | | | | | | | | |
| | Can demonstrate that the CCG regulates the pace and scale of change in a CCG effectively, within CCG member practices and across the whole health system. | | | | | | | | | | |
| | Can explain what the 'future' of the CCG and whole healthcare system will look like and the steps needed to get there for the CCG, the CCG member practices and across the whole health system. | | | | | | | | | | |
| | Can evidence that I engage successfully with employees at all levels in the CCG, within CCG member practices and across the whole health system through creating an inspiring vision and, ultimately, putting the vision into practice. | | | | | | | | | | |
| | Can demonstrate that my leadership style adapts to meet challenge - according to the strategic nature of change. | | | | | | | | | | |
| | Can evidence that I engage and communicate with internal and external stakeholders from different backgrounds (e.g. both clinical and management support roles). | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Can demonstrate that I lead and support decisions, positively and publically even though they may not reflect my personal views. | | | | | | | | | | |
| | Can evidence that I am well known and respected for integrity and honesty in all dealings, both internally within the CCG and externally across the whole healthcare system. | | | | | | | | | | |
| | Can evidence that I am well known for upholding the values of commissioning quality patient care, as a priority | | | | | | | | | | |

## 4. PERFORMANCE

**Section Development Indicator:**

The Performance Section of the CCGGBDF comprises 2 subsections and 20 items relating to being held to account and holding others to account and CCG Performance.

### SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members **Agree** to statements aligned to the section 'Performance'. This indicates that 'Performance' is seen to be an area of **strength** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **limited development need.** To further explore perceptions of performance, Section 4.2 displays the total average response per 'subsection' whilst Section 4.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are **green**, Section 4.3 will highlight areas you may wish to discuss/develop further.

### PERFORMANCE SUBSECTION OUTCOMES

**Chart 4: Performance Subsection Outcomes**

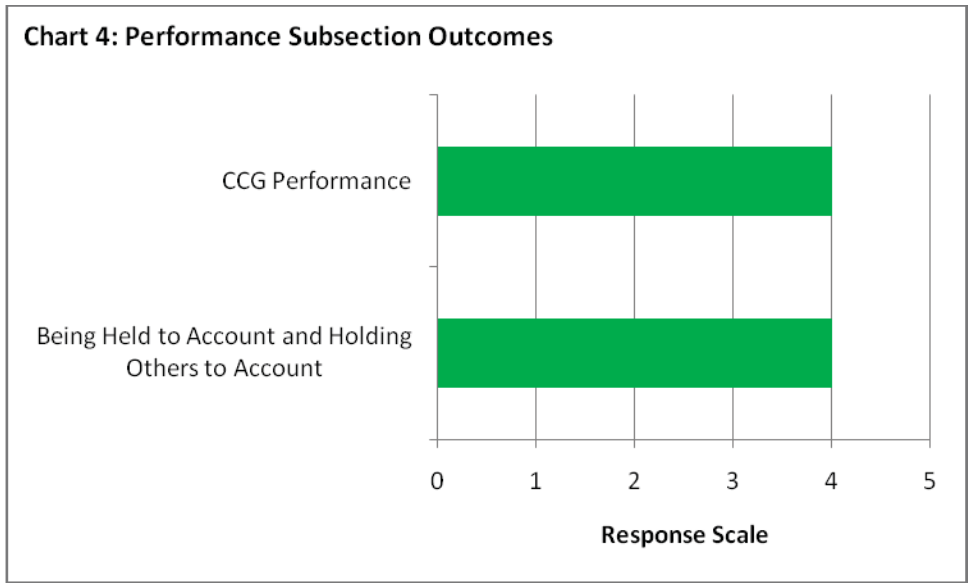



Chart 4 gives an overview of Governing Body Members responses to each sub-section of Performance. For each sub-section the Mean response was 'Agree'.

## PERFORMANCE ITEM OUTCOMES

The range of responses against each item can be seen in the Table 4 below:

**Table 4: Performance - Responses per Item**

| Subsection | Item ['As I CCG Group Leader, I…'] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Being Held to Account and Holding Others to Account | Can demonstrate that I challenge clinical and non-clinical peers in a manner appropriate for the situation or context (e.g. in a business meeting). | | | | | | | | | | |
| | Can evidence that I welcome, and respond positively, to challenge from others regarding my reasoning, decisions and actions. | | | | | | | | | | |
| | Can demonstrate that the CCGB maintains the right balance between supporting and challenging one another. | | | | | | | | | | |
| | Can demonstrate support for an open and constructive performance management culture throughout the CCG and its members, where performance is discussed and addressed honestly (e.g. Internal and external 360 degree feedback). | | | | | | | | | | |
| | Can evidence that clinical colleagues in member practices are held to account for performance against practice and individual performance indicators, designed to align performance with CCG targets (e.g. referral and prescription rates). | | | | | | | | | | |
| | Can evidence that contracted providing organisations are held to account for delivery of quality patient care within agreed contracted outcomes (e.g. CQUIN standards). | | | | | | | | | | |
| | Can evidence that staff within the CCG and member practices demonstrate performance against key national and local key performance indicators regularly. | | | | | | | | | | |
| | Can evidence that I ensure clinical colleagues hold providing organisations or member practices to account, for the delivery of healthcare to agreed outcomes. | | | | | | | | | | |
| | Can demonstrate that I understand my corporate accountability for commissioning quality patient care, as part of a CCGGB. | | | | | | | | | | |

| | | |
|---|---|---|
| | Accept my accountability for commissioning quality patient care within the commissioning budget set by the NHS Commissioning Board. | |
| | Can demonstrate that I understand the CCG will be held to account by the NHS Commissioning Board to break even against their commissioning budget. | |
| | Can demonstrate that I understand I am accountable for the accuracy of the organisation's performance information provided to public (e.g. Quality Report, performance measures to be included in the Quality Outcomes Framework). | |
| CCG Performance | Can demonstrate that I understand the budgets that have been allocated to the CCG from the NHS Commissioning Board and how these budgets can be spent. | |
| | Can demonstrate that I understand the CCG's performance position against NHS Commissioning Board allocated budgets at any one time. | |
| | Can demonstrate that I understand how, when and why quality premium payments from the NHS Commissioning Board to the CCG and its member practices are paid. | |
| | Can evidence that the CCG can be counted on to achieve or exceed relevant local quality outcomes (Commissioning Outcomes Framework) and national quality outcomes (The NHS Outcomes Framework). | |
| | Can evidence that the CCG advocates the controlled transition from activity based to outcome focused performance measurement, in readiness for the Quality Outcomes Framework. | |
| | Can evidence that the CCG will achieve or exceed relevant quality and efficiency targets such as QIPP, whilst maintaining high quality care standards (e.g. continue to support reduced waiting times). | |
| | Can evidence that the CCG continually leads the best use of resources within budget and workforce capacity and aligns activity to outcomes. | |
| | Can evidence that the services commissioned by the CCG address local health inequalities and promote equality in health outcomes. | |

## 5. REGULATING FUNCTIONS AND DISCHARGING DUTIES

**Section Development Indicator:**

The Regulating Functions and Discharging Duties Section of the CCGGBDF comprises 10 items relating to governance and assurance arrangements.

### SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members **Agree** to statements aligned to the section 'Regulating Functions & Discharging Duties'. This indicates that this section is seen to be an area of **strength** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **limited development need.** To further explore perceptions of performance, Section 5.2 displays the total average response per section (there are no 'subsections') whilst Section 5.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are **green**, Section 5.3 will highlight areas you may wish to discuss/develop further.

### REGULATING FUNCTIONS & DISCHARGING DUTIES SUBSECTION OUTCOMES

**Chart 5: Regulating Functions & Discharging Duties Section Outcomes**

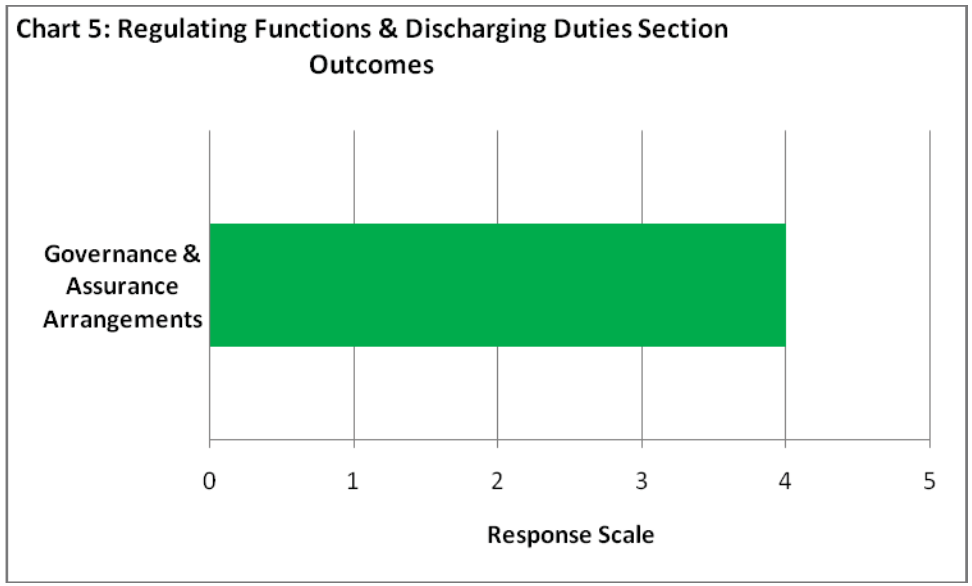



Chart 5 gives an overview of Governing Body Members responses for the section 'Regulating Functions & Discharging Duties'. For this section the Mean response was 'Agree'.

## REGULATING FUNCTIONS & DISCHARGING DUTIES ITEM OUTCOMES

The range of responses against each item can be seen in the Table 5 below:

**Table 5: Regulating Functions and Discharging Duties - Responses per Item**

| Subsection | Item [Good Practice Statements] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Governance and Assurance Arrangements | The governance structure is designed to achieve the strategic objectives of the CCG and includes committees and sub committees to be able to achieve this. | | | | | | | | | | |
| | Assurance arrangements are based on an assessment of the risks faced by the CCG and are designed to mitigate and manage these risks effectively. | | | | | | | | | | |
| | Assurance arrangements ensure that risks are escalated to CCGB level and members of the CCGB feel assured that risks are escalated when necessary. | | | | | | | | | | |
| | The CCG governance structures and assurance arrangements build upon and utilise relevant good practice from PCT and PBC governance arrangements and new innovative practice. | | | | | | | | | | |
| | Assurance arrangements are in place to manage any conflicts of interest and ensure probity in all decisions made by the CCGB. | | | | | | | | | | |
| | The governance structure is scaled to the CCG's locality size and what is necessary to service the needs of that locality (e.g. it is likely that a smaller locality will require a leaner governance structure). | | | | | | | | | | |
| | The governance structure committees and sub-committees each have clear and documented terms of reference outlining accountabilities and thresholds for escalating issues or risks to the CCGB. | | | | | | | | | | |
| | The governance structure and assurance arrangements are reviewed regularly and there is a formal timetable in place to do this. | | | | | | | | | | |

| | | |
|---|---|---|
| | The governance structure includes sub-committee(s) responsible for discharging the statutory duties of the CCG (e.g. effectiveness and efficiency, quality of service and reducing access to service and outcome inequalities and promoting patient and public involvement). |  |
| | Assurance arrangements provide assurance to the CCGB that the statutory duties of the CCG (e.g. effectiveness and efficiency, quality of service and reducing access to service and outcome inequalities and promoting patient and public involvement), are discharged effectively. |  |

## 6. PERFORMANCE MONITORING AND EVALUATION

**Section Development Indicator:**

The Performance Monitoring and Evaluation Section of the CCGGBDF comprises 2 subsections and 9 items relating to CCG Governing Body performance and CCG Staff performance.

### SECTION OVERVIEW

Overall, responses indicate that 'as CCG leaders', the majority of governing body members **do not have a strong preference to either agree or disagree** to statements aligned to the section 'Performance Monitoring & Evaluation'. This indicates that this section is seen to be an area **to be discussed further** by governing body members. This outcome will be explored further in the Facilitated Development Day but overall indicates an area of **potential development need.** To further explore perceptions of performance monitoring and evaluation, Section 6.2 displays the total average response per 'subsection' whilst Section 6.3 displays the range of responses per 'item'. You may note that although overall the responses to this section are **amber**, Section 6.3 will highlight areas of strength as well as the areas you may wish to discuss/develop further.

### PERFORMANCE MONITORING & EVALUATION SUBSECTION OUTCOMES

**Chart 6: Performance Monitoring & Evaluation Subsection Outcomes**

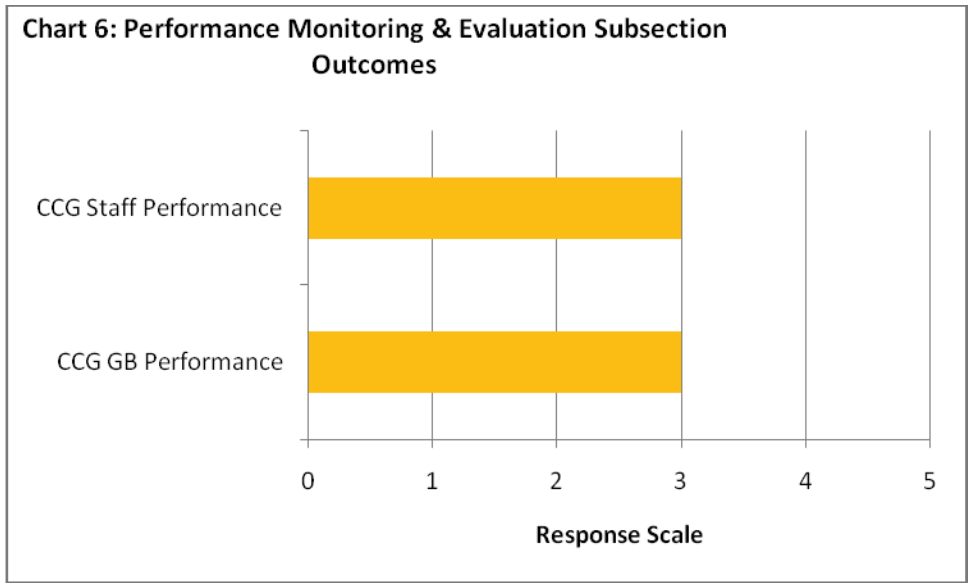



Chart 6 gives an overview of Governing Body Members responses for the subsections 'CCG GB Performance' & 'CCG Staff Performance'. For each subsection the Mean response was 'Neither Agree or Disagree'.

### PERFORMANCE MONITORING & EVALUATION ITEM OUTCOMES

The range of responses against each item can be seen in the Table 6 below:

## Table 6: Performance Monitoring and Evaluation - Responses per Item

| Section | **Item** [Good Practice Statements] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CCGB Performance | Performance of CCGB members is regularly reviewed, at least bi annually throughout the transitioning period and when the Consortia are newly established. | | | | | | | | | | |
| | The performance evaluation system effectively considers information sources external to the CCG (e.g. Providing organisations, member practices or Citizens). | | | | | | | | | | |
| | Individual CCGB member development or training opportunities are identified and actioned as a result of a performance evaluation. | | | | | | | | | | |
| | Individual CCGB members have a personal development plans in place at all times. | | | | | | | | | | |
| CCG Staff Performance | CCG key performance indicators are regularly reviewed and updated for changes in strategic objectives. | | | | | | | | | | |
| | All CCG staff receive yearly performance appraisals. | | | | | | | | | | |
| | Development objectives and personal development plans for CCG staff are linked to performance metrics (which are aligned to strategic objectives). | | | | | | | | | | |
| | Development opportunities for CCG staff are identified and actioned, based on their performance evaluation. | | | | | | | | | | |
| | The appraisal process is clearly understood and transparent for all staff within the CCG. | | | | | | | | | | |

## SUMMARY:

The outcomes for NHS Wirral from the CCGGBDF are positive and largely highlight the perceived strengths of the CCG GB. Certain sections did indicate that governing body members did not have a strong preference for selecting either agree or disagree. These sections may highlight areas which warrant further discussion or development. Within each section there were indicators of specific items with 'high development need'. These items were not in the majority for each section but may need to be looked at further in the Facilitated Development Day. The outcomes are intended to inform discussion in the Facilitated Development Day and the development of a focused action plan for CCG GB development. The overall aim of participating in the CCG GB development process is to assist the CCG in developing processes, structures, capabilities and skills that a high performing CCG Governing Body will display.

If you would like to discuss this report or CCG GB development further, please contact: Amy Brockbank, Programme Manager on 0161 625 7318 (07747474341)
or by email on amy.brockbank@nwacademy.nhs.uk

## APPENDIX B IMPACT ASSESSMENT SCREENING TOOL

### 1. Initial Screening Process

| |
|---|
| 1.1 Title of the policy/procedure/function/service<br><br>Organisational Development Plan |
| 1.2 Directorate/Department<br><br>Governing Body |
| 1.3 Name of the person responsible for this Equality Impact Assessment<br><br>Helen Jones |
| 1.4 Date of Completion<br><br>October 2012 |
| 1.5 Aims and Purpose of this policy/procedure/function/service<br><br>The purpose of the Organisational Development Plan (OD Plan) is twofold, firstly to set out the principles, vision and decisions required to deliver an effective and sustainable GP Commissioning system via a single consortium. Secondly, it outlines the underpinning interventions required to further develop our organisational capabilities in order to support our aspiration to achieve full statutory & regulatory status by April 2013.<br><br>. |
| 1.6 Is this a new or existing policy/procedure/function/service<br><br>New |
| 1.7 Examination of Available Evidence – Tick evidence used |

| | |
|---|---|
| *Census Data for UK* | _ |
| *Census Data for London* | _ |
| *Census Data for Local Authority Area* | _ |
| *Trust Workforce Data* | _ |
| *Trust Patient Data* | _ |
| *National Patients Survey* | _ |
| *Trust Patients Survey* | _ |
| *Complaints Summaries* | _ |
| *Other Internal Research/Survey/Consultation/Audit (please list)* | |

*Other External Research/Survey/Consultation/Audit (please list)*

What is the summary of the available evidence?

Reform across the NHS is occurring within the new structures and roles set out in National, Regional and Local strategic direction, introduced as part of the implementation of the NHS White Paper (July 2010) and the accompanying NHS Operating Framework (Dec 2010). This means more than just structural change and is as much about behavioural and cultural change. It requires a greater emphasis on knowledge systems, local clinical leadership and empowerment, and new clinical programme management solutions, which deliver maximum benefit from available resources, workforce, finance, knowledge and skills for local patient benefit.

1.8 Does the evidence indicate that there is, or is the potential to be any significant impact on anyone or any group in relation to the following equality strands?

No

| **Strand** | **Yes/No/Insufficient Data** | **Justified Yes/No** |
|---|---|---|
| Ethnicity/Race | No | N/A |
| Disability | No | N/A |
| Gender/Sex | No | N/A |
| Religion/Belief | No | N/A |
| Sexual Orientation | No | N/A |
| Age | No | N/A |
| Human Rights | No | N/A |

If further evidence is required to complete this section, take steps to obtain to **before** proceeding with the assessment. If the review of evidence indicates that there is a significant unjustified impact, a Full Equality Impact Assessment must be carried out.

| | |
|---|---|
| 1.9 No further evidence Required. Skip to Section 5. | √ |
| 1.10 Full Equality Impact Assessment required. | No |

## APPENDIX C DISSEMINATION AND TRAINING PLAN

To be completed with the corporate document when submitted to the appropriate committee for consideration, approval and ratification.

The status column must be given a **Red**, **Amber** or **Green** rating with evidence to demonstrate an action has been completed.

### DISSEMINATION PLAN

| **Title of document:** | **Date finalised:** | | | | |
|---|---|---|---|---|---|
| **Dissemination Lead: (print name and contact details)** | Lo rna Quigley<br>0151 651 0011 ext 1053 | | | | |
| **Proposed action to retrieve out-of-date copies of the document.** | New plan | | | | |
| **To be disseminated to:** | **Disseminated by whom?** | **Timescale** | **Status R A G** | **Paper or Electronic** | **Comments** |
| Website ☒<br><br>Other (give details) ☒<br><br>Training Sessions (give details below) | Lorna Quigley<br><br>Chief Officers of CCs | 1 month<br><br>1 month | G<br><br>G | Electronic<br><br>Electronic | |

### IMPLEMENTATION PLAN

| **Training** | **Timescale** | **Owner** | **Status** |
|---|---|---|---|
| Training Event | | | |
| Training Plan Lead | | | |
| **Compliance monitoring** | **Timescale** | **Owner** | **Status** |
| Methodology to be used for monitoring/audit purposes | | | |
| Responsibilities for conducting monitoring/audit | | | |
| Frequency of monitoring/audit (e.g. annually, half yearly) | | | |
| Process for reviewing/reporting results | | | |

Wirral Clinical Commissioning Group

# Wirral Ethnic Health Advisory Group Workshop Report and Development Plan

| | | | |
|---|---|---|---|
| **Agenda Item:** | 2.2 | **Reference:** | GB12-13/097 |
| **Report to:** | Governing Body | **Meeting Date:** | 20th November 2012 |
| **Lead Officer:** | Lorna Quigley | | |
| **Contributors:** | Wirral Ethnic Health advisory Group | | |
| **Governance:** | **Link to Commissioning Strategy** | | |
| | **Link to current governing body Objectives** | | |

**Summary:**


This report presents the background, findings and recommendations of a BME Community Engagement workshop which was jointly hosted by The Wirral Ethnic Health Advisory Group (WEHAG) and NHS Wirral In March 2012.

The workshop, which was attended by health and social care experts and BME community leaders from the voluntary and community sector, set out to consider the major health and social care challenges facing BME communities on Wirral and to collectively seek solutions to addressing some of the service barriers experienced by those communities.

The event provided an important opportunity for all those present to consider NHS plans to address equality and diversity in delivering health care and in driving service improvements; and just as importantly, to understand the implications of the new Equality Act 2010. The Act is an important consideration as it will underpin the statutory duty placed on all NHS bodies including Clinical Commissioning Groups (CCGS) and health service providers to deliver equality eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act.

A series of key recommendations for service improvements arising from subsequent discussions are included in this report. It is proposed that these recommendations form the basis of a longer-term BME health Improvement Strategy (BMEHIS) and service model for the Wirral and that this will in turn inform future commissioning intentions of CCGs, CSOs and their partners. The report contains recommendations as to how this could be achieved.

The board is asked to :

- Note the report
- Support the development of a BME strategy which will inform the development of the CCG Equality and Diversity Strategy

| | | | |
|---|---|---|---|
| **Recommendation:** | **To Approve** | | X |
| | **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:** | | | |

*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** | What is the financial impact of the proposal/item on the PCT? Is it covered in a budget, has funding been agreed? Cost of not taking action?Actual figures should be covered in the main paper. |
| **Value For Money** | Does the proposal/item represent value for money (cf. New Investment Form). |
| **Risk** | What is the level of risk in the Board taking the recommended decision? What is the level of risk in the Board not taking the recommended decision? What has been done to mitigate that risk? |
| **Legal** | Are there any legal implications in what is recommended? If there are, has legal advice been obtained? Is legal opinion required before the Board takes the decision ie. the Board couldn't take the recommended decision without knowing the legal position. |
| **Workforce** | What impact would there be on PCT or other NHS staff if the Board takes the recommended decision? Is this positive or negative? What is being done to address the implications?Are there implications for staff engagement? |
| **Equality & Human Rights** | Have equality and human rights issues been taken into account in the proposal? What is the evidence to support this? Has an impact assessment been undertaken (see below). |
| **Patient and Public Involvement (PPI)** | Have patients and public been involved in the proposal? How would the recommended decision of the Board affect their involvement? |
| **Partnership Working** | Does the proposal evidence partnership working? Has it been considered whether the proposed course of action affects partners – positively or negatively? What has been done to ensure partners are involved in or advised of the decision? |
| **Performance Indicators** | Is there a relevant performance indicator for this item? If so, how will the proposed course of action affect the agreed activity/objectives against that performance indicator? |
| **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.

# Meeting the Health and Social Care Needs of BME Communities in Wirral

## Wirral Ethnic Health Advisory Group (WEHAG) Workshop Report and Strategic Development Plan 2012 -2015.

## DRAFT

## Table of Contents

**Meeting the Health and Social Care Needs of Black and Minority Ethnic (BME) Communities in Wirral**

**Acknowledgements**

**The following individuals are thanked for their valuable contribution to the workshop, its findings and recommendations, and the production of this report.**

**Workshop Host and Speakers 13 March 2012**

| | | |
|---|---|---|
| Kathy Doran | Chief Executive | NHS Cheshire, Warrington and Wirral |
| Dr. Shyamal Mukherjee MBE | Medical Director | NHS Cheshire, Warrington and Wirral/ Wirral Ethnic Health Advisory Group |
| Dr. Phil Jennings | Chair | Wirral Clinical Commissioning Group |
| Dr Abhi Mantgani | Medical Director/NHS Wirral Clinical Lead for CVD/CKD/Diabetes | Wirral Clinical Commissioning Group |
| Teresa Owen | Deputy Director of Public Health, NHS Wirral | |
| Rick O'Brien | Head of Branch – Personal Assessment and Planning, Department of Adult Social Services | |
| John South | Interim Chief Executive, Wirral Community NHS Trust | |
| Tina Long | Director, Wirral University Teaching Hospital NHS Foundation Trust | |
| Andy Mills | Head of Involvement and Patient Experience, NHS Wirral. | |

**Members of the BME Community for their attendance**

**Staff from Wirral Change for hosting the event**

**Meeting the Health and Social care Needs of Black and Minority Ethnic (BME) Communities in Wirral**
**WEHAG Workshop Report and Recommendations for Strategic Development Plan**

## SECTION ONE – BACKGROUND AND INTRODUCTION WEHAG WORKSHOP REPORT

### Introduction

This report presents the background, findings and recommendations of a BME Community Engagement workshop which was jointly hosted by The Wirral Ethnic Health Advisory Group (WEHAG) and NHS Wirral In March 2012. The workshop, which was attended by senior health and social care experts and BME community leaders from the voluntary and community sector, set out to consider the major health and social care challenges facing BME communities on Wirral and to collectively seek solutions to addressing some of the service barriers experienced by those communities. The event provided an important opportunity for all those present to consider NHS plans to address equality and diversity in delivering health care and in driving service improvements; and just as importantly, to understand the implications of the new Equality Act 2010. The Act is an important consideration as it will underpin the statutory duty placed on all NHS bodies including Clinical Commissioning Groups (CCGS) and health service providers to deliver equality eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act.

During the workshop, delegates received and discussed a series of key presentations on the major health impacts areas for BME populations on Wirral including; coronary heart disease, diabetes & renal disease, stroke, mental health and issues affecting older people. A series of key recommendations for service improvements arising from subsequent discussions are included in this report. It is proposed that these recommendations form the basis of a longer-term BME health Improvement Strategy (BMEHIS) and service model for the Wirral and that this will in turn inform future commissioning intentions of CCGs, CSOs and their partners. The report contains recommendations as to how this could be achieved.

### Background

#### Wirral Ethnic Health Advisory Group

WEHAG is the Wirral's advisory forum for information exchange, focusing on ethnicity and health. It is a key driver for change, actively contributing towards a reduction in health inequalities, accountable to local people and committed to delivering actual results. Its aims are;

- To develop a common health strategy which addresses health issues and unmet needs of all BME communities.
- To help promote a common corporate strategy to address the requirements of different BME groups and feedback progress.
- To identify and develop specific health agendas (e.g. Mental health, diabetes, cardio-vascular disease, cancer, drugs, alcohol, and social isolation) relating to all BME groups.

## WEHAG workshop 12/3/12

In hosting the recent workshop WEHAG aimed to provide a forum for sharing views between BME community leaders, practitioners, service users; and the health and social care professionals who commission and provide local health services.

Delegates who attended were drawn from all major local stakeholder organisations including; BME Community and Voluntary sector providers, community elders and activists, service users, GPs and CCG representatives, Commissioning Support Organisation, (CSO) Wirral Hospital Trust representatives, NHS Wirral, Public Health specialist, Department of Adult Social Services and health and social care practitioners.

The event comprised a series of presentations from the NHS Wirral Chief Executive, and CCG clinical leads, public health specialists and senior officers from Wirral University Teaching Hospital and Wirral Council and these were followed by question and answer sessions and workshop discussions. Key recommendations from the workshops are recorded in this report.

## Responding To The Health Needs Of BME Communities – The National Context

The NHS Constitution is very clear: "everyone counts" be they patients or staff. This means the NHS needs to consider the outcomes that different people experience: taking different or extra steps to improve access and design services so that their health outcomes and experience are equitable. These ideas of fairness and equity are intrinsic to the new NHS that has emerged as a result of the Health and Social Care Act 2012, and sets out the aim of patient-centered care, to involve patients, carers, local communities and staff in improving the NHS. For staff, the NHS needs to build working environments where all staff are confident in their skills, thriving in workplaces that are fair and free of discrimination.
Health inequalities can be addressed by providing quality prevention services and better-targeted public health promotions, such as smoking cessation, screening programmes, cardiac rehabilitation, and self- management of diabetes. Some people with protected characteristics, including people from BME communities, need extra resources to enable them to access or use prevention and other services, so that they do not add to the productivity challenge. Below are some clear examples of exclusions from services:

A review for the Department of Health [1]suggests BME patients find it more difficult to access GP services due to four inter-related factors:

- Substantial communication problems caused by language and culture
- A greater disease burden experienced by BME patients, who tend to have a
- Poorer health status variable quality of GP practices, the expectations of BME patients are different
- Language barriers have been shown to be a significant case of communication difficulties between BME patients and GPs; BME patients are less likely than the general population to feel they have had sufficient time with their GP and as such may need longer appointment times.
- They are also more likely to say they feel unable to complain about Primary care services, do not understand how the local structures of the NHS work or the role of the commissioner and to be frightened of being taken off their GP's list.

[1] Lakhani, M. (2008) No Patient Left Behind: how can we ensure world-class primary care for Black and minority ethnic people? Dept. Of Health

### Public Sector Equality Duty – The Equality Act 2010

The new Public Sector Equality Duty came into force on 5th April 2011. The Equality Duty replaces the three previous duties on race, disability and gender, bringing them together into a single duty, and extends it to cover all 'protected characteristics' including age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. The new Equality Duty requires public bodies including Commissioning Support Organisations (CSOs), CCGs, and health service providers to have due regard to the need to eliminate discrimination, advance equality of opportunity and to foster good relationships in developing policies and services. Health services will need to ensure they consider the needs of all individuals in their day-to-day work, in delivering services and also to their employees.

## Wirral Health Plans and Responses

### NHS Wirral Single Equality Scheme 2010 -13 and Action Plan (SES)

NHS Wirral's Single Equality Scheme 2010 -2013 and Action Plan [2] sets out the basis on how NHS Wirral and CCGs will continue to meet the general duties of current equality legislation in compliance with The New Equality Bill 2010.

Priorities outlined in the Wirral SES which are fully supported by CCGS are to:

- To Involve and empower people
- To target Inequalities thought effective partnerships
- To ensure excellence in health services
- To become a high performing, high reputation organisation

### Cheshire, Warrington and Wirral PCT Cluster Equality Objectives 2012– 2013

Cheshire, Warrington and Wirral PCT Cluster have agreed a set of equality objectives for 2012 -2013 which will help to drive CCG and cluster wide commissioning and service development plans. The following objectives are supported by a number of actions to be achieved by March 231st 2013. summarised overleaf:

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- Objective 1: To ensure accessibility to services and information specifically;
- Objective 2: To develop joint consultation and engagement
- Objective 3: To ensure the equality of opportunity in employment and training provision
- Objective 4: To improve understanding community needs through information sharing

[2] http://www.wirral.nhs.uk

**Wirral BME Population Changes and Health Needs**

- [3]Wirral BME population is estimated to constitute up to 10% of Wirral's demographic (Census 2011 estimates). This is double that of estimates from the 2001 Census. This estimate is supported by planning data from NHS Wirral.
- There is an Increasing and diverse BME community in Wirral.
- The fastest growing ethnic groups in Wirral are Eastern European, Ian Black African and Pakistan (WEHAG Workshop Health and Social Needs of BME Community Wirral- March 2012)
- Higher percentage of BME in (Birkenhead, Tranmere, Rock Ferry) (Neighbourhood Profile 2011: Birkenhead Tranmere and Rock Ferry Ward).
- Experience from Community and Voluntary sector has revealed stark health inequalities affecting a wide range of BME communities, particularly Asian, European, African and Irish communities. Barriers identified include language and culture, which impact on service user awareness or understanding of a service.
- The NHS has recognised BME health inequalities on a local and national level agreeing that 'people from BME communities within this country have worse outcomes than the general population' (NHS Wirral BME Needs Assessment 2010).
- BME communities identified as a priority group across Wirral (Wirral Council 2025 Sustainable Community Strategy)

## Health and Social Care Needs of BME Communities in Wirral

NHS Wirral Joint Strategic Needs Assessment 2011 (JSNA) states that there is a lack of robust data on the population prevalence of BME groups which makes assessing levels of access to services particularly difficult. The current methods, both nationally and locally of capturing data around ethnicity and migration are not fit for purpose as population change is happening faster than it has in the past.

[3] Business Case for BME Community Development and Training Provision Pilot (NHS Wirral April 2012)

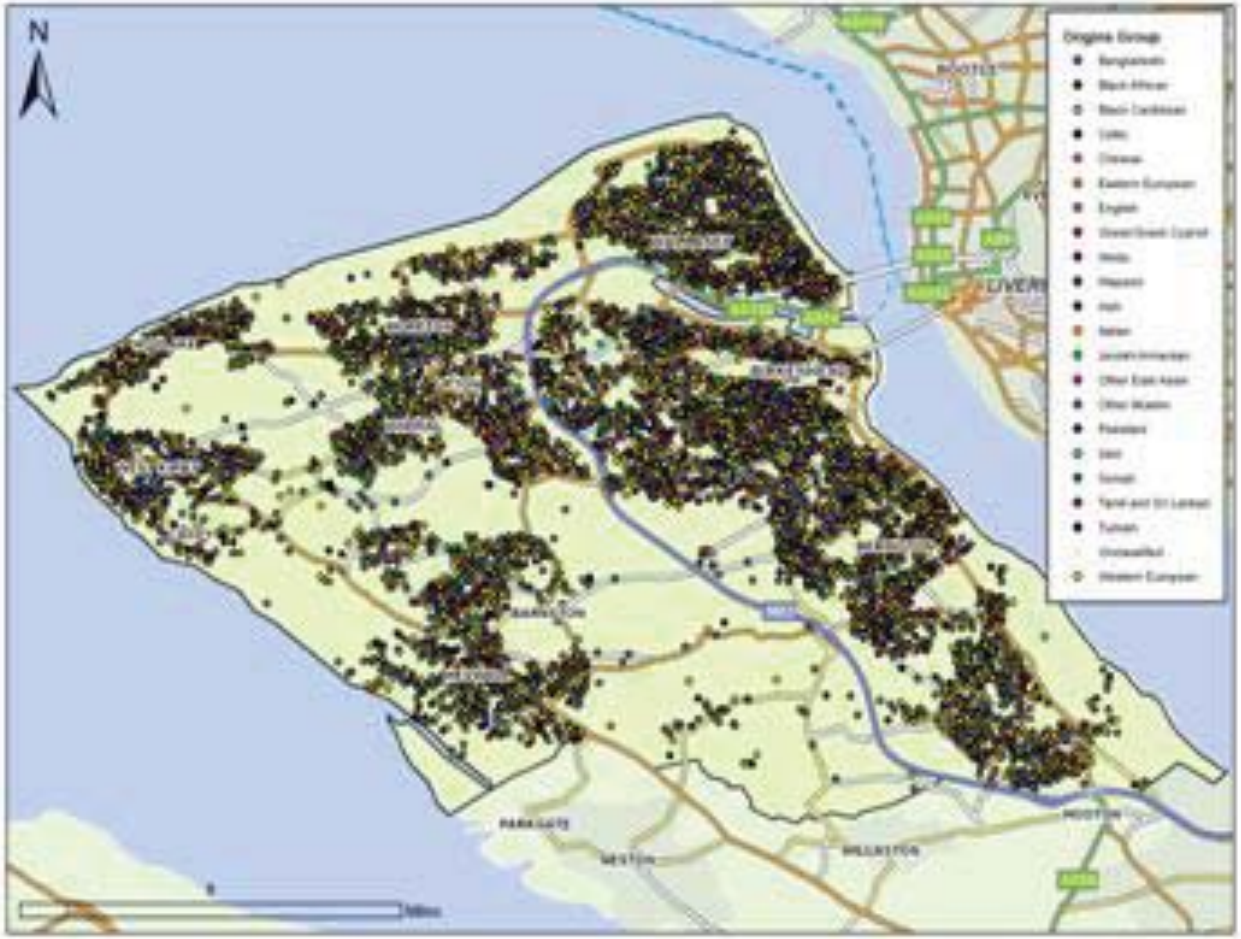
Recent clinical service data from NHS Wirral [4]however *suggests* that people BME communities living in Wirral are **more likely to be living with a number of chronic diseases that the general population**. The data indicates that;

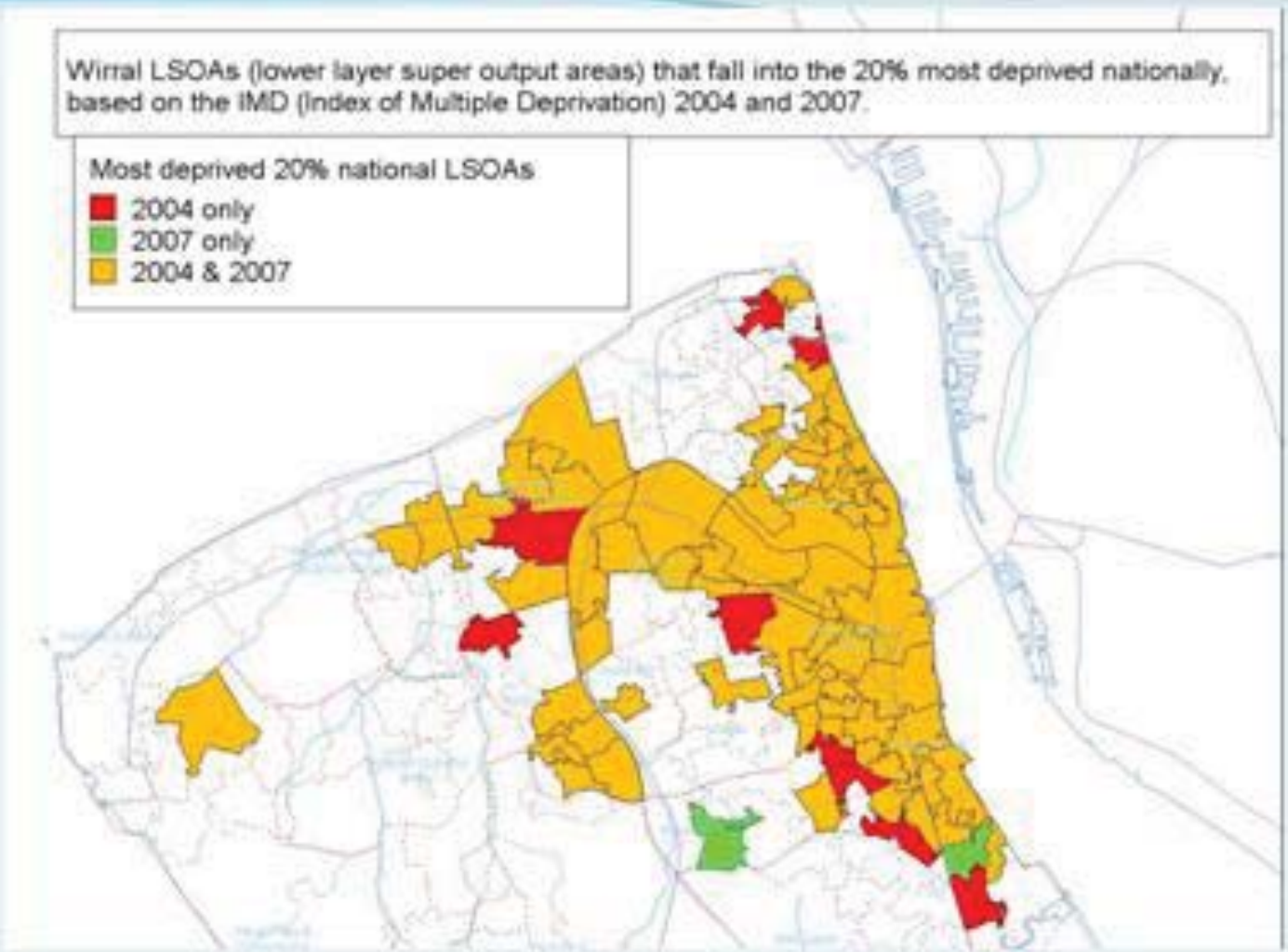
- There is a rising incidence of lung cancer and people from BME communities are more likely to die from all cancers
- There are higher levels of people with depression
- Higher risk of emergency admissions (including uncontrolled diabetes)
- Far higher levels of risky health behaviours
- Lower levels of breast feeding, healthy eating, physical activity
- Less access to health services
- Very low uptake of bowel screening amongst the Muslim community

[4] *WEHAG Presentation March 2012- Health and Social needs of BME Communities Wirral Dr SM Mukherjee*

NHS Wirral

# Map showing dominant non-English Origins group




Wirral LSOAs (lower layer super output areas) that fall into the 20% most deprived nationally, based on the IMD (Index of Multiple Deprivation) 2004 and 2007.
Most deprived 20% national LSOAs
2004 only
2007 only
2004 & 2007

## Examples of Key health impact for fastest growing ethnic groups in Wirral.

Vascular disease is a major cause of illness and death amongst Wirral populations and can have serious health effects in terms of long term or permanent disability including; loss of mobility, amputations, blindness, kidney failure, mental Health Problems.

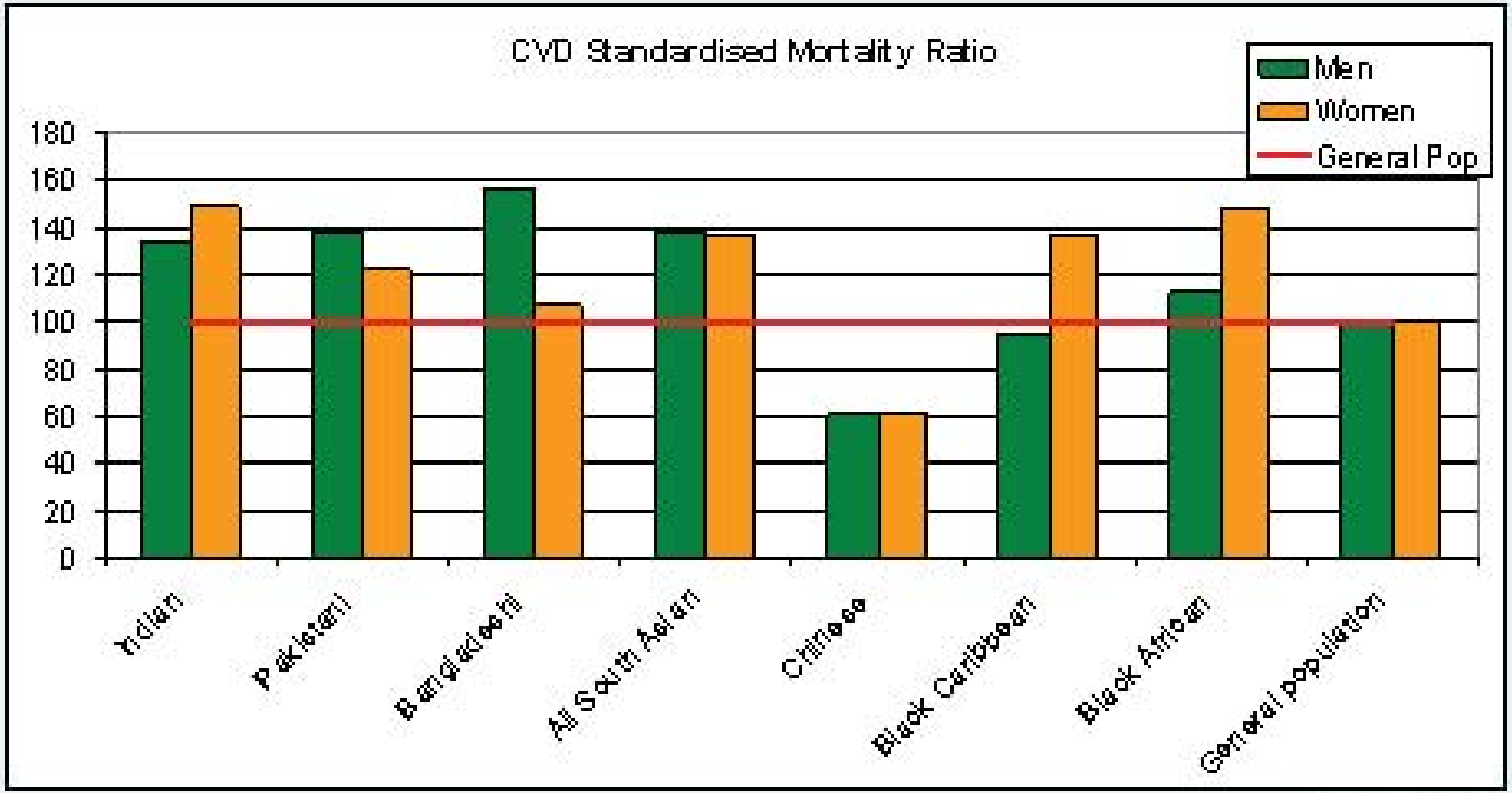
Smoking

- This is the biggest single cause of preventable illness and premature death
- COPD mortality has shown a downward trend in males but an upward trend in females. This is probably due to the pattern of smoking in the past. Much worse in deprived areas.
- Significantly higher deaths from lung cancer in Wirral compared to national
- 26% smoking during pregnancy in Seacombe (19% Wirral, range 3-42%)
- Little data available for Eastern Europeans though we know smoking prevalence is high.
- For Indian people there is high CVD prevalence and mortality in men.
- These are high rates of BMI and high CVD mortality in Black African women.
- This is high BMI in Pakistani women High and CVD prevalence and mortality in Pakistan men and women.

BME Elders

- Pakistani and Indian elders significantly higher hospital admission rates than average
- Higher rates of admission for mental illness (Black Caribbean and Bangladeshi elders)
- Main age related health conditions concerning African Caribbean, South Asian and Chinese and Vietnamese elders in the UK are: Eyesight, High Blood Pressure, Hypertension, Dental problems, Hearing problems, Sleep difficulties, Kidney/urinary Tract Disorders

# CVD Mortality Ratio (from national data)



**OVERVIEW OF PREVALENCE AND HEALTH IMPACT ON BME COMMUNITIES FOR PRIORITY DISEASE AREAS (Summary of WEHAG workshop presentation slides 12/3/12 including reference to National and Local Data)**

| CORONARY HEART DISEASE[5] | DIABETES AND RENAL DISEASE[6] |
|---|---|
| • South Asians groups have a moderately higher incidence of CHD that the general population<br>• Scottish and Irish people in England and Wales have higher levels of CHD than the general population<br>• South Asians living in the UK have a 50% greater risk of dying prematurely from CHD than the general population<br>• Modeling estimates of Wirral CHD prevalence shows 83% (n 14,739) people with CHD are currently undiagnosed | • South Asian and Caribbean groups have a much higher rate of non insulin dependent diabetes<br>• Mortality from related conditions is 3.5 times higher among South Asians and Caribbean men, and 6 times higher for Caribbean women.<br>• Non-insulin dependent diabetes remains undiagnosed in up to 40% of Asian diabetics<br>• Diabetes is three to five times more common among people of African-Caribbean and Asian origin living in the UK. In these groups it tends to develop at a younger age |
| **STROKE[7]** | **MENTAL HEALTH/ DRUGS AND ALCOHOL[8]** |

[5] [7] [8] WEHAG Workshop Presentation (March 2012) Dr Abhi Mantgani NHS Wirral Lead CVD/CKD/Diabetes Vascular Disease in Wirral BME Community.

| | |
|---|---|
| • Stroke is more common in Black African and Black Caribbean populations, but also relatively high in Chinese and South Asian groups and Scottish and Irish groups<br>• Black Caribbean men have the highest self-reported incidence of stroke<br>• For women aged 55 and over the highest incidence of stroke is amongst Bangladeshi and Pakistani women<br>• High blood pressure is the major known risk factor<br>• Diabetes and the incidence of sickle cell disease are additional factors linked to an increased risk of stroke | • NHS Wirral BME Community Development Workers (CDW) made over 8000 contacts between 2009 -2012.<br>• CWD data indicates that 42% of people may have a mental health problem (evidenced through PHQ2 9 2 questions, which may indicate mental health problems.<br>• Suicide rates and incidence of mental health can be higher in certain ethnic groups |

| **Older People**[9] | **Improving BME Service Experience** |
|---|---|
| • Rate of Stroke is high in some South Asian groups and Caribbean Elders<br>• Diabetes is high in Caribbean, African, Asian and Middle Eastern elders<br>• Cancer appears low in most groups (exception of Irish elders)<br>• Main age related health conditions concerning African Caribbean, South Asian and Chinese and Vietnamese elders in the UK are: Eyesight, High Blood Pressure, Hypertension, Dental problems, Hearing problems, Sleep difficulties, Kidney/urinary Tract Disorders.<br>• Very low uptake of bowel screening amongst the Muslim community | • There is generally a lower uptake of health screening for all major disease areas<br>• Poor knowledge, underlying health and cultural beliefs, attitudes, language and attitudes of health professionals have been reported by BME communities as important barriers to people accessing heath services<br>• Low uptake of health promotion: and service information is not routinely produced or made available in non- English language formats<br>• Social Marketing campaigns do not adequately take into account the needs and preferences of BME groups<br>• Lack of multi-lingual signage in health services also remains a problem, adding to the problem of lower access in general<br>Heath assessments do not routinely cover questions relating to patients ethnicity, culture, heritage or communication needs – relevant information is not routinely passed on with subsequent referral<br>• general lack of awareness as to what preventative services are available and a lack of understanding of how the health services and systems work different experiences in country of birth can create confusion, resulting in lower levels of take up of services<br>• There is a general lack of local information and data on the health needs of BME communities and this makes it difficult to plan |

[8] WEHAG Workshop Presentation March (2012) Dr Phil Jennings Chair of Wirral Clinical Commissioning Group – Health Challenges & Solutions incorporating Delivering Race Equality in Mental Health.
[9] WEHAG Workshop Presentation (March 2012) Meeting The Needs Of The Elderly, Teresa Owen Deputy Director of Public Health NHS Wirral

**Patient Experience - BME Needs Assessment Findings (2010)**

The following issues were highlighted in earlier research commissioned by NHS Wirral in 2010.[10]

The feedback provides some interesting insight into patient experience, service issues and preferences in terms of future health delivery models. Suggestions include;

- Language barriers, especially where appointments need to be made by phone
- Lack of synergy between mainstream health services and traditional cultural
- Models of health care
- BME elders preferred to use traditional remedies e.g. Chinese elders reported being less likely to access preventative services preferring Chinese traditional medicines
- Cultural differences: The Chinese elders and Asian women's groups felt that some preventative health measures such as healthy eating initiatives were not relevant to them e.g. they did not take account of traditional foods such as rice and noodles rather than potatoes
- There is a perceived lack of culturally appropriate and flexible care provision for BME elders, including dementia sufferers and the absence of practical support for BME carers.

**Workshop Findings And Recommendations**

**Identified Gaps Highlighted By Workshop Participants**

Participants attending the WEHAG workshops were asked to identify perceived service gaps and what they considered needed to be done to improve the patient experience and health outcomes for BME communities. Comments are summarised below:

*Indicates the one issue/task the group felt would make the biggest difference to health experience of BME communities
A full list of suggested gaps and issues are given in the following table.

[10] WPCT: BME Health Needs Assessment - Icarus February 2010

**Summary Of Views From Workshops Discussion**

| TOPIC | WORKSHOP DISCUSSION |
|---|---|
| Involvement/engagement with BME communities | • Better and improved Communication<br>• Translation and interpretation (cultural sensitivity)<br>• Professionals understand services and can match to needs<br>• Accessibility of services to be improved Information about services to be provided to BME individuals<br>• Build trust and confidence<br>• Engagement with communities (especially with hard to reach)<br>• Framework? Use Partnership Hub for translation services* |
| Mental Health/Drugs and Alcohol | • How do we tackle cultural sensitivity around these issues?<br>• Is enough info available?<br>• Are we focused on the right things i.e. gambling?<br>• Are we focused on wider context effect on M. Health (housing, literacy? Crime)?<br>• Do we understand enough about drug/alcohol abuse in BME communities?<br>• Focus on broader needs of BME individuals including, housing, welfare benefits employment – that effect health |
| Older People | • Can people slip through assessment processes?<br>• Are local care home contracts sensitive enough?<br>• Self-funders may experience system differently.<br>• Assessment/support planning to be more sensitive to BME communities |
| CVD | • What about those not accessing services i.e. screening diabetes/vascular uptake rates in BME*<br>• Do we always ask about ethnicity/heritage?<br>• Do we do enough to explain what services are available?<br>• What happens after screening re info back to patients?<br>• Do we tie-in community assets/services with NHS E and D work? |
| Improving Service Experience | • Different methods of involvement and better communication channels.<br>• Mapping exercise &Community skill audit<br>• Going out into the communities*<br>• Identify local businesses and services<br>• Build capacity and capability in small BME organisations<br>• Raising awareness with health service staff to improve Patient centered care<br>• Capturing patient experience at point of delivery<br>• Different ways of advertising and promotion |

## SECTION TWO – DEVELOPING A STRATEGIC PLAN TO MEET THE HEALTH AND SOCIAL CARE NEEDS OF BME COMMNUNITES IN WIRRAL 2012-2015

### A Strategic Approach To Improving The Health Of BME Communities

The findings and recommendations contained in this report should provide an important focus for discussion in terms of developing the range of health services that will adequately meet the needs of BME communities on Wirral. It is proposed that the development and delivery of a **BME Health Improvement Model (BHIM)** (see annex 1) based on the above recommendations would ensure that locally identified needs are being addressed particularly in terms of the major health impact areas as described earlier. The model and suggested performance framework detailed in the EDS would support further development of integrated patient pathways for BME populations focusing on a tiered model of intervention which would as a minimum would deliver the key recommendations relating to the following six strategic work areas

1. Engagement activity
2. Health promotion and primary prevention services
3. Detection and management in primary care
4. Referral and access to acute care
5. Community aftercare
6. Isolated and ageing communities

### Final Recommendations

The following six recommendations (and corresponding supporting actions) are proposed and these should to form the basis of future strategic development and service improvement:

1. **Increase engagement activity to ensure newly arrived communities are included in mainstream services**

- Increase access (earlier and timely) amongst BME communities to health and health promotion services to help reduce illness, mortality and subsequent impact on families and services.
- Improve staff competence, confidence and levels of knowledge, underlying health and cultural beliefs, attitudes and language by ensuring that all health care staff have access to training and ongoing support to deliver services that meet the cultural needs and preferences of BME communities.
- Increase engagement and communication with BME groups to understand and respond to service needs and choices explore the role of established community leaders, practitioners, and services and of community elders in connecting people with services.
- Reach out and encourage lifestyle changes and improved health regimes amongst local BME communities and work with them to develop make relevant and target social marketing and health promotion campaigns relating to; Vascular Disease, Coronary Heart Disease, Renal Disease/Diabetes, Stroke Prevention, Smoking, Cancer prevention, Mental Health , Alcohol

2. **Ensure effective provision and access to health promotion and primary prevention services including a comprehensive translation and interpretation service**

- Increase health protection measures and particularly vaccinations uptake amongst vulnerable groups
- Work closely with HAA teams to support vulnerable patients to access prevention services and achieve healthier lifestyles by receiving health checks and referral to health trainers.
- It is recommended that a local Communications and Advocacy Support Hub be established to deliver the majority of the Language and Communications Support services needed by Primary Care services on the Wirral. The Hub should:

    - provide locally based communication and advocacy that addresses need through local partnership / community ownership
    - ensure BME and Vulnerable members of the community have the support they need to access health services through better Language, Communication and Advocacy support
    - provide advice and support to Health Professionals and the health sector with regards to the communication needs of Vulnerable and BME people

    - address Health inequities with regards to access and the provision of services for BME and Vulnerable people.

3. **Ensure effective detection and management of identified conditions in primary care (as close to home as possible**

- Reduce levels of CVD in the under 75's BME populations by improving screening uptake
- Increase take up of cancer screening programme for BME communities particularly Bowel and Cervical screening.
- Develop more specific support for people with long-term conditions including skilling up existing health care professionals to respond to the cultural and religious needs of patients; whilst ensuring that there is effective liaison with other BME practitioners as part of delivering interagency support packages.
- Reduce levels of smoking and alcohol-related problems by improving access to Identification and brief advice and support programmes

4. **Ensure swift referral and access to acute care**

- Ensure that a range of effective translation, interpretation and communication support services (T&ICS) are provided routinely as part of core service provision as part of integrated support pathway (primary and secondary care). This should include telephone, face to face, written translation, interpretation and communication support.

5. **Ensure comprehensive aftercare and follow-up in the community**

- Ensure continuity of care for people who are discarded from hospital to prevent unplanned hospital admissions and to provide onward interagency liaison and support.

6. **Address population movement challenges presented by an ageing and increasingly isolated BME community and incoming BME workforce**

i. Improve the quality of data collection and analysis and Increase understanding of the 'make-up' of practice population and use social marketing techniques to reach them
ii. Co- produce, develop and deliver specific patient experience programmes for BME communities to ensure that services meet identified needs.

It is important to note that the model should not seek to establish separate services for BME communities as this would be counterproductive and not sustainable (or desirable). The Programme will need to become fully integrated with existing health care systems and services and not developed simply as an add on. It is however reasonable to expect that in the short term reconfiguring and transforming existing services, some additional specialist service elements may need to be established (i.e. bespoke screening services or additional translation and interpretation services) to accelerate progress and to enhance the capacity and functioning of some existing health services.

The (Draft) Model is highlighted in Annex 1 Introduction of the model forms part of the recommendations for commissioners in terms of making a sea-change in BME community health experience over the next three to five years.

The Model suggests that it would be beneficial to recruit BME Primary and care liaison workers, and co-locate them in the community and within in GP Surgeries working along side health practitioners and Community organisations with the remit of supporting local BME patients and health care professionals to access appropriate prevention treatment and aftercare services. This service would seek to compliment existing BME health services and would focus on delivering support in line with the six work areas highlighted above. The workers would provide advice and support, interpretation and translation services to those whose first language is not English and those with communication difficulties. Such support would enable greater understanding of health care services and increase access to screening, detection and management of key conditions. The service could also facilitate increased access to acute care and after care services. Consideration should also be given to how the service would be operationalised and managed. Establishment of a team leader post may be an option.

**Measuring Performance - NHS Wirral Equality Delivery System**

The Equality Delivery System (EDS) is a performance-monitoring tool developed by the Department of Health to help drive service improvement. EDS has been introduced to ensure all NHS organisations including PCTs, CCGs and provider services are meeting the Public Sector Equality Duty to ensure that Equality is embedded into all the work of NHS organisations. In the context of this report and in developing local heath services for BME populations the EDS tool can provide a useful framework to help NHS commissioners and providers to drive improvements by delivering better outcomes for patients and communities and better working environments for staff. The EDS can also help the NHS to
Deliver on the NHS Outcomes Framework and the NHS Constitution; and providers meet the Care Quality Commission's "Essential Standards of Quality and Safety."

The tool comprises a series of benchmark measures relating to four key goals;

- Better health outcomes for all.
- Improved patient access and experience.
- Empowered engagement and included staff.
- Inclusive leadership at all levels.

The DH proposes that Health Watch and 3rd Sector organisations are involved in monitoring and verification processes.

NHS Wirral carried out its first verification process at the end of April 2012 and this information can be used as a baseline for developing further services. In this first assessment NHS Wirral reported that it had made progress against all four of the above goals and this was verified by partners. The full assessment and verification is available at www.wirral.nhs.uk/equalityanddiversity

The EDS supports local organisations to have a structured way of measuring the four goals mentioned above, a clear way of setting outcomes for the year ahead and engage effectively with staff, patients and local communities when grading their performance and setting new and objectives.
NHS EDS guidance [11] sets out a number of benefits that can be accrued by NHS services meeting their equality duties including:

- Reducing spending in the acute sector by improving the early access of marginalised groups to primary care services.
- Supporting registration drives; for example, at primary care level with BME communities often lead to reduced costs down the line. Equalities work can also substantially help to reduce 'do not attend' rates.
- Early intervention and preventive health programmes among marginalised groups demonstrably reduces both the incidence and costs of, for example, heart disease, stroke, cancers and diabetes.
- Ensuring equalities spending should face similar levels of VFM testing to other health work. Sometimes, high levels of evidence are required for commissioning services for BME people, while many "mainstream" services are commissioned on the basis of relatively scant evidence.
- Commissioning small-scale community providers can often be highly cost-effective in achieving better outcomes than mainstream providers.

It is recommended that the EDS outcome is used a key framework to monitor performance of the strategy and the proposed service model.

[11] Statement *On Cost And Benefits – Regulatory Impact Assessment For Public Sector Equality Duty* (DH 2012)

**Next steps**

- Further consultation with communities, commissioners and partners
- Integrate within Joint Strategic Needs Assessment/the work of the Health and Wellbeing Board
- Formal adoption of Strategy on 30/10
- Undertake an Equality Analysis on this strattegy!
- Facilitate consortia/co-production/Joint commissioning of solutions

## References


Feedback, notes and presentations from WEHAG Away 22nd March 2012.

Race for Health Tackling Health Inequalities in the New NHS Recommendations for Action March 2011. (Race for Health is an NHS membership organisation sponsored by the Department of Health and hosted by Liverpool PCT.)
http://www.raceforhealth.org/

Wirral Black And Minority Ethnic Health Needs Assessment (Consultation) Report –WPCT: BME Health Needs Assessment Icarus February 2010

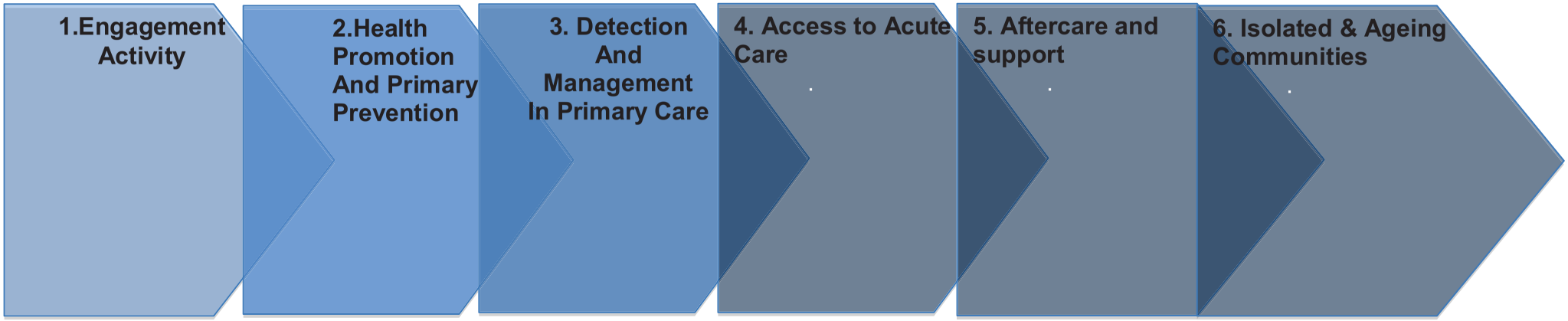
Business Case for BME Community Development and Training Provision Pilot NHS Wirral April 2012

NHS Wirral Joint Strategic Needs Assessment (JSNA) Update 2011N
NHS Wirral Single Equality Scheme 2010 -2013
http://www.wirral.nhs.uk
Lakhani, M. (2008) No Patient Left Behind: how can we ensure world class primary care for Black and minority ethnic people? Dept. Of Health

**BME Health Improvement Program (BHIP) Model**

**Health Impact Areas**


**Model of Care Based on Six Key Development Areas**




**BME Public and Patient profiling, engagement and involvement integral to planning, delivery and service review**

**Cultural Awareness and Religious Sensitivity Training for all Health and Social Care Professionals**

**Improved access to Translation and Interpretation Services**

**D H Equality Delivery System – performance tool to drive**

**RISK REGISTER - Master**

| Risk ID | Date | Source | Risk Description | Strategic 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 | Jul-12 | On-going |
| 2 | Ongoing | CSS | Reduction in local expertise and organisational memory due to PCT staff leaving | | 2 | 4 | 8.00 | 8.00 | | | | 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 | Nov-11 | On-going |
| 3 | 24.07.12 / 28.08.12 / 27.09.12 | Gov Body / QPF / WHCC | Overperformance on WUTH Contract | Financial Management | 3 | 5 | 15.00 | 15.00 | | | | 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 Contigency Funds / Planned Slippage to offset | Ability to influence behaviour | Review performance areas, initiate action plan to address performance issues | Divisions | Nov-12 | Nov-12 | 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, | AC / TK | Nov-12 | Aug-12 | 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 | 2 | 5 | 10.00 | 10.00 | | | | 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 | Continue workstream on progression of NHS 111 Service with NHS Direct and contract negotiations with Community Trust | AC | Nov-12 | Sep-12 | On-Going |
| 6 | 27.09.12 | QPF | Child Health Information System (CHIS) - Imminent Risk of Crashing | Provision of relevant Information System supporting appropriate statutory requirements | 4 | 3 | 12.00 | 12.00 | | | | 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 | Ascertain Project plan, responsible Officer, Contigency Plan / Backup Scenario | Rosemary Curtis ? | Nov-12 | Sep-12 | On-Going |
| 7 | 24.10.12 | WGPCC | WGPCC will fail to meet IAPT waiting time targets due to performance of one provider | | 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 | Nov-12 | Oct-12 | On-Going |
| 8 | 06.11.12 | Gov Body | Commissioned Out of Hospital Budgets, increase in package costs, Restitution Cases | Achieve Financial Balance | 3 | 4 | 12.00 | 0.00 | | | New Item | 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 | Dec-12 | Nov-12 | On-going |
| 9 | | | | | | | 0.00 | 0.00 | | | | | | | | | | | | |
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| CSS |

Completed
On-going
Outstanding

| **Impact Values** | |
|---|---|
| Negligible | 1 |
| Minor | 2 |
| Moderate | 3 |
| Major | 4 |
| Catastrophic | 5 |

| **Probability Values** | |
|---|---|
| Rare | 1 |
| Unlikely | 2 |
| Possible | 3 |
| Likely | 4 |
| Almost Certain | 5 |

| **Green/Yellow/Red Threshold Values** | |
|---|---|
| Green - maximum score | 4 |
| Yellow - minimum score | 5 |
| Yellow - maximum score | 12 |
| Red - minimum score | 15 |