NHS
Wigan Borough Clinical Commissioning Group

MEETING: Governing Body **Item Number:** 10.1

DATE: 24 January 2017

REPORT TITLE:	**Healthier Together Joint Committee minutes from a meeting held on the 21 September 2016.**
CORPORATE OBJECTIVE ADDRESSED:	**All corporate objectives are met.**
REPORT AUTHOR:	**Phil Watson CBE, Chairman HT Joint Committee**
PRESENTED BY:	**Dr Tim Dalton**
RECOMMENDATIONS/DECISION REQUIRED:	**Receive.**
EXECUTIVE SUMMARY **The Governing Body are asked to receive the minutes of the Healthier Together Joint Committee meeting held on the 21 September 2016 for information.**	
FURTHER ACTION REQUIRED:	**None.**
EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Shared Minutes of the Healthier Together Joint Committee Meeting held in Public

Date of meeting: 21st of September 2016

Date of paper:	
Subject:	Healthier Together Joint Committee
Decision / Opinion Required:	For approval
Author of paper and contact details:	Nathalie.delahaye@nhs.net
Purpose of paper: For record of the Shared Minutes of the Healthier Together Joint Committee meeting on 21st September 2016. Papers for the meeting can be viewed here - Joint Committee Meeting Papers 2016	
The item has been discussed previously at these meetings:	n/a

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Title	**Minutes taken at the meeting of the Healthier Together Joint Committee**
Author	Nathalie Delahaye
Version	0.1
Target Audience	**Healthier Together Joint Committee**
Date Created	27 September 2016
Date of Issue	
To be Agreed	
Document Status (Draft/Final)	DRAFT
Description	Greater Manchester CCGs Healthier Together Joint Committee minutes of meeting 27/09/16

Document History:

Date	Version	Author	Notes
27/09/16	0.1	N Delahaye	Draft minutes created
20/10/2016	0.2	M Wright	Updated with comments
Approved:			
Signature:			**Phil Watson CBE, Chairman**

Greater Manchester CCGs Healthier Together Joint Committee

SHARED MINUTES OF MEETING
Wednesday 21st September 2016
Mersey A, 4th Floor, 3 Piccadilly Place, Manchester, M1 3BN
Chair – Phil Watson

ATTENDANCE

Meeting of the 12 committees of:
Bolton CCG
Bury CCG
Central Manchester CCG
Heywood, Middleton & Rochdale CCG
North Manchester CCG
Oldham CCG
Salford CCG
South Manchester CCG
Stockport CCG
Tameside & Glossop CCG
Trafford CCG
Wigan Borough CCG

Other organisations in attendance:
Central Manchester NHS Foundation Trust
East Lancashire CCG
Healthwatch
NHS North Derbyshire CCG
Transformation Unit

Voting members in attendance:			
Alan	Dow	Chair	NHS Tameside and Glossop CCG
Kiran	Patel	Chair	NHS Bury CCG
Michael	Eeckelaers	Chair	NHS Central Manchester CCG
Chris	Duffy	Chair	NHS Heywood, Middleton and Rochdale CCG
Frank	Costello	Deputy to Tim Dalton	NHS Wigan Borough CCG
Joe	McGuigan	Deputy to Nigel Guest	NHS Trafford CCG
Julie	Daines	Deputy to Ian Wilkinson	NHS Oldham CCG
Paul	Bishop	Neighbourhood Clinical Lead	NHS Salford CCG
Ranjit	Gill	Clinical Accountable Officer	NHS Stockport CCG
Martin	Whiting	Clinical Accountable Officer	NHS North Manchester CCG

Other attendees:			
Phil	Watson	Independent Chair	
Debbie	Austin	Governing Body GP	NHS North Derbyshire CCG
Steve	Jones	Clinical Champion HT representing A&E	Central Manchester NHS Foundation

Phil	Watson	Independent chair	
Ed	Dyson	Healthier Together SRO	NHS Central Manchester CCG
Jane	Eddleston	Healthier Together Chief Medical Advisor	Central Manchester NHS Foundation Trust
Jack	Firth	Healthwatch representative	Healthwatch
Julie	Flaherty	Clinical Champion HT Nursing	HT SRFT
Dan	Nethercott	Clinical Champion HT Critical Care & Anaesthetics	HT NHS Bolton
Roger	Laitt	Clinical Champion HT Radiology	HT SRFT
Nick	Lees	Clinical Champion HT Surgical	HT SRFT
Mark	Holland	Clinical Champion HT Acute	HT UHSM
Fleur	Blakeman	Strategy & Transformation Director	NHS Eastern Cheshire CCG
Steven	Pleasant	Lead Local Authority Chief Executive for Health (AGMA)	Tameside Metropolitan Borough Council
Matthew	Wright	Assistant Director	Transformation Unit
Sophie	Hargreaves	Healthier Together Programme Director	Transformation Unit
Paul	Wood	Interim Director of Transformation	Transformation Unit

Apologies:			
Tim	Dalton	Chair	NHS Bolton CCG
Wirin	Bhatiani	Chair	NHS Wigan Borough CCG
Joanne	Downs	Head of Finance	NHS North Manchester CCG
Jerry	Hawker	Chief Officer	NHS Eastern Cheshire CCG
Moneeza	Iqbal	Programme Director	NHS North Manchester CCG
Su	Long	Clinical Accountable Officer	NHS Bolton CCG
Gaynor	Mullins	Chief Operating Officer	NHS Stockport CCG
Nigel	Guest	Clinical Accountable Officer	NHS Trafford CCG

Members of the public in attendance:			
Beverley	Hoyle	Member of the public	Transport for Sick Childrean
Alistair	McDonald	Member of the public	Visiting MD from Australia

Quorate requirements:
The meeting was quorate

1.0	**Welcome and Introductions**

Apologies for Absence

The Chair, Phil Watson (PW), welcomed everyone to the meeting and read the list of apologies. Deputies Frank Costello was sent in place of Tim Dalton, Joe McGuigan for Nigel Guest and Julie Daines for Ian Wilkinson.

Quorum Confirmation

PW confirmed that the meeting was quorate. PW updated that there would be a category two decision and this is permitted.

Declaration of Interests

PW asked for any declarations of interest; none were given.

Confirmation of Minutes (June 2016)

PW asked the group to go through the minutes of the previous meeting page by page and raise any amendments. The minutes were approved and signed off by PW.

Review of actions

PW stated that all listed actions would be covered by the meeting agenda.

ID	Type	Risk / Issue / Action / Decision / Outcome Description	Owner
1	Decision	Approval - Minutes of meeting on 15th June 2016	HTJC
2	Decision	Meeting was Quorate	HTJC

2.0 Programme update

2.1 Commissioning intention on high risk elective

Ed Dyson (ED) explained that HT have passed integrated primary leadership and oversight care over to the HTJC board and an update on what is theme 2. Theme 2 transforming community based care, delivers the public consultation commitment around primary and integrated care. It focuses on local care organisations, built around populations of 50,000 and in all areas this is being progressed well. There is increased joint working to share best practice and increased arrangements with social care. The primary care strategy and standards are being developed and will be approved in the September period. Also the other key development, is seeking to secure the funding to mainstream primary care access with NHS England. The commissioning intentions have been agreed and will be sent out to the CCG's.

2.2 Programme Overview

Sophie Hargreaves (SH) gave a brief presentation of the overview of the programme. Sectors have 7 stages to pass through during implementation. Currently sectors are at stage 2b designing the medical models of care and all sectors have started stage 3; their business cases. The Transformation Unit are supporting sectors in these stages, with assistance from the clinical champions.

Every sector has detailed project plans and are reporting against them at the HT programme board.

Item 2 2016 09 21
HT Programme Overv

ID	Type	Risk / Issue / Action / Decision / Outcome Description	Owner
3	Risk	Sectors Completing the Business cases within desired timeframe	HTJC

3. Sector updates

3.1 Manchester and Trafford Sector (MaTs)

ED gave the update - key progress on the ownership and clinical engagement involvement and mobilising towards implementation. In terms of implementation, the risks that apply to the programme around workforce and capital are challenges within the sector also. MaT sector is working through finalising the clinical model of care and the implication of that on the business case development. Pleased with progress so far.

Joe McGuigan (JM) asked what the number of emergency surgical patients were as this will help develop the business cases across GM not just MaTs. Jane Eddelston (JE) added that after the event Healthier Together had on the 18th August, it was recognised that the number is similar across the sectors, for each non hub site there are about between 250-300 high risk elective surgeries and between 650-700 high risk emergencies; of these 2/3rds to 3/4's are people who are having conservative surgeries, so it's not entirely clear what their clinical path will consist of. Regardless if they need to go to surgery, they do need to be under a surgical team so they can access appropriate diagnostics. When we get on to the champions update we can go into this in more

details.	
3.2	**North East Sector**

Julie Daines (JD) fed back on the North East sector where the CCG has had some key achievements to report. The clinical lead has now been identified as Dr Ian Wilkinson and the sector is in the process of appointing a HT Director. 2a assurance review has been completed, and a model was presented at the HT sharing meeting. We have a meeting with HT to establish a Patient Participation Group (PPG). The business case pro forma has been submitted and we are working on our business case for submission in December. Overall, Good progress across NE sector, better than anticipated due to challenges within Pennine. The Pennine Acute Transformation Unit is being set up to help support wider programmes as well as HT, all CCGs are actively involved.

3.3	**North West Sector**

Frank Costello (FC) represented the NW Sector Summary of issues; uncertainties of capital funding and the capacity of Salford to accommodate any high risk elective transfers. FC commented that the later agenda item associated with commissioning intentions and the consequent inability of NWs, to facilitate the same changes by April 2017 due to capacity not being available at that time will be discussed and the intentions will reflect this. All other areas are progressing well in terms of HR development and establishment of appropriate governance across the trust. Generally a positive picture of progress.

3.4	**South East Sector**

Ranjit Gill (RG) represented the SE Sector. Good progress on surgeons working collaboratively and the model of care emerging. One area of uncertainty for the sector is if there is a need for an on call surgeon on non-hub sites for day case patients who have to stay in overnight due to complications. Sector considering an audit of the cases to understand any issues. The business case is going well and stage 2b assurance meeting has been set. RG still awaiting Tameside's commitment to the Memo of Understanding (MoU) on the HT standards. JD added that supplementary to the model of general surgery, we need to work through the knock on effect to A&E support in a hub and non-specialist units.

ED enquired why the MoU's which progressed reasonably easily at all other sites, why was there an issue in the SE sector? RG replied that the strategic partnership board minutes record and show commitment from Tameside to the complete commitment of HT, we are just awaiting the signature. They want to understand what a single service model for ED looks like before committing; the conversation will be followed up at Programme Board next Friday.

3.5	**Assurance update**

SH explained that an assurance framework has been implemented and is progressing well. The detail of the surgical model of all sectors is progressing well. At the Sharing Event attended by over 80 delegates from across the sectors models were shared and discussed. The central team is supporting sectors in the medical model assurance (stage 2b). In terms of stage 3, the business cases are required by the end of November and are critical given the risk on capital, this has been marked as a risk. Good progress around the activity modelling which is feeding in to the business case. Work on financial modelling has also commenced, but there are still some concerns around completion of the business cases in time. SH and ED are discussing if there is anything further we can do centrally to improve that.

JE added that we are expanding on the medical model and reviewing what is in the medical pathfinder. The medical model hones down the acutely ill patients, and the pathfinder had a number of features which can lead to a hub site, obvious things like GI bleeding., This work needs to be based on the NWAS findings.

3.6	**Decision on Commissioning intentions**

ED led on this and introduced the paper to agree on. At the last committee meeting, one of the areas of feedback from the committee was to increase pace with implementation and movement of high risk elective surgery and asking our Heads of Commissioning to start developing intentions so it can be part of the hospital contracts. The central team have put words together that can be included within our intentions communications. As the 12 CCGs and stakeholders we need to send a unified message, that we want to see this shift of high risk elective patients and joined up working. It's feasible in 3 of the 4 sectors, but we need to set

that challenge, and raise the urgency. High risk elective cases (HR elect), ambulatory care services and MDTs were included because they are feasible and sectors have started to progress the workforce OD changes and brought teams together. They are a good basis from which to build the more risky elements of the model and they are quite symbolic to help with businesses cases and benefits to patients in terms of lives saved. There will be different elements in different sectors, variations and tests of feasibility but, we need to put forward a common message of what we want to happen in the coming financial year.

There is a need for the Committee to approve this narrative so we can develop contracts to reflect these changes. So I am seeking your support with this.

FC stated Bolton and Wigan will continue to do general surgery until Salford's' issues are resolved regarding capital builds as well as operational things that need to be in place. JD asked about the reference in appendix 1 and whether it meant all aspects had to be in place and when will be monitoring on these. SH explained that there are two things to consider firstly, there is a variation with CCGs in how services are commissioned, some have a view of high level outcomes, i.e. mortality for the whole population, others are looking at more specific things around mortality, specific cohorts. So we've given a range of metrics to work with supporting how you commission. The second point, is the work on standards and the development of sector dashboards which the clinical champions will go into detail later in the meeting.

Michael Eeckelaers (ME) commented that the detail is important and something we should support, this is the first decision which signals to the providers across GM that we really want to roll out the changes. We are embarking on our own commissioning intentions meetings which need to be signed off by the end of this calendar year. As a committee we should support these proposals.

RG expressed support for the paragraph, but wondered if we can change the words 'implement elements', to 'implement the first stage of' so as to make it clear that we are intending to implement all of HT, in that same vein say something about not just the surgical services but also intensive care changes to support that first stage move. So we make sure everything is done and ready for patients to be transferred.

AD said he thought it good paragraph across the board, and wouldn't put in stage 1, as it doesn't stop after that. FC agreed and said we are expanding the assurances; it doesn't stop at stage 1.

PW asked if we supported RG's suggested change? This was not agreed.

CD stated that in terms of the Heads of Commissioning, they have seen these intentions and agreed them in principle, so I think it's good to go.

PW understood and asked if we agreed that it stays at it is and we will minute Ranjit's point.

JD replied that the next meeting is in the middle of November and we recognise this needs to be done before then, as we will be in the middle of our contracts. It will mean different things to different providers, but the intent is there.

ED said the important thing from the HTJC is we can each as individual organisations write our own commissioning intentions without anyone else, but here we have a core value we have agreed, we can trust that as long as it doesn't materially change and come back for a further review, we can get into the processes we need to. We will progress with each provider and we'll keep our coordinating role and link it to the Clinical Alliance so these KPIs are valid and meaningful. There will be emphasis on this not being the only part of Healthier Together. We will need to work collaboratively with the Heads of Commissioning to issue this, and we will ask CCGs to add these to their letters. They will do that and we will continue to work between Heads of Commissioning and the Clinical Alliance to revise this. I'm asking for the approval to this and approval to progress this without coming back for further decision making.

PW asked the group if they had approval for this as a vote, voting members unanimously agreed.

ID	Type	Risk / Issue / Action / Decision / Outcome Description	Owner
4	Decision	Category 2 Decision on commissioning intentions letter	HTJC
5	Action	Single service model for ED medicine to be discussed at Programme Board to firm up Tameside's understanding and signature on MoU	HTJC
6	Risk	Business cases to be supported so they are complete in December	HTJC
7	Risk	Medical models to be completed	HTJC

4	GM updates
4.1	Clinical Update

JE showed us the attached presentation and facilitated discussion.

Item 5 1 Clinical Update V0 5.ppt

Roger Laitt updated on radiology; AD enquired about the time to scan and report, and whether we can assume that scans have been looked at if they are on the system. RL explained that it varies in terms of cost and quality, it's not a perfect system and I'm not sure it's safe to assume anything, some CCGs outsource this, others have teams of varying quality.

AD asked whether in the 2 months there is any assessment on the scans. RL explained that there is an informal one, as it is seen by radiographers who see scan coming off the system but there are no regulations or rules around this, we are reliant on good quality radiographers to red flag things. There is massive variation in the system that needs addressing

PW thanked Jane and colleagues for their presentation

4.2	Finance Update

Paul Wood (PWo) updated the group on the stock take at the end of August, there's still a lot to be done on Revenue Implications and Clinical Models before we have a clear picture across GM. Jon Rouse agrees we need to pick this pace up and we now have a central team to pull it together with the sectors.

JMc explained that this has been ongoing and that we need to do it across GM and move forward. He suggested that the market is positive and people are prepared to lend money, so we may need to get money from elsewhere.

Michael Eeckelaers (ME) expressed the need for this to happen, of taking control and doing things differently. As we are working together can we finance this together, equally and in doing so move forward?

PB if you can borrow the money cheaper elsewhere and not use NHS central it would be preferential.

JD added; the bureaucracy of the NHS is really difficult to manoeuvre.

PWo Jon Rouse has tasked the partnership estate team and he is happy to lobby for this. However, the Strategic business case will go through existing bureaucracy, to ask for money or to get the permission to get money from elsewhere. JM felt we should support Paul to get this done and put paperwork together.

ME Would we basically get a robust business case and do we agree to this effective way to get capital?

PW asked the board if they agreed and the decision was unanimous.

RL if we contribute money together, can we do so in the spirit that we will spend it where it is needed and not

just on own sectors.

Alan Dow (AD) we do need more understanding but think we can agree this in principle.

4.3	HR Update

SH explained that the HR groups have been making good progress on what we can do GM wide on recruitment, especially A&E consultants, they have developed a GM wide recruitment campaign and facilitating conversations to the DGOs. Principles governing recruitment and conversations at Programme Board and HR group have been agreed. Locums or preferential money deals are to be standardised and has been taken to the Programme Board these principles have been agreed. These are key strategic issues for GM and key to HT, there is a now a Strategic Workforce group looking at issues for the whole of the Health and Social Care Partnership. There is also an Urgent Care Workforce which is chaired by Jon Rouse. We are also looking at workforce modelling, liaising with sectors to develop their models and baseline, how many they have, how many they actually need in the future and determining the gap.

Paul Bishop (PB) asked – does it look at local areas? SH responded that it is linked to the locality strategy working with individuals but it is also looking at GM as a whole.

4.4	Equalities Update

Matthew Wright (MW) the Equality Group making good progress. Breakthrough UK a disabilities rights organisation has been doing an audit exercise looking at the patient journey in relation to equalities at the 4 HT Hub sites. The exercise looked at service approach and potential barriers that prevent individuals from having an equitable experience. Through mixed methodology, 1to1 interviews, walk throughs and listening events etc. This has been completed for all sites now. The Equalities Advisory Group are meeting next week to bring together results from this equalities benchmarking exercise and the results of this will allow the group to develop an equality implementation action plan for each sector. It will highlight areas of best practice to be adopted across GM but also indicate areas for development, this will be sent out to all in October. Each action plan will go in to the governance process to action and to implement. Each sector has developed Patient participation groups to tap into this, areas without one are being supported to doing this so the engagement mechanisms are appropriate to ensure that patient care is at the forefront of implementation. The patient participation mechanism for each sector will be responsible for ensuring that the equalities plan is actioned and delivered, it will be reported as a standard item through their individual program boards but also the HT Programme Board as it currently exists.

FC we have a thriving PPG, very interactive process from a locality to CCG level, and they do make changes. Perhaps what is disconnected at a local level is Bolton and Salford so it may be more effective to combine our PPG to work more effectively, and we could use our collective resource to best advantage.

ID	Type	Risk / Issue / Action / Decision / Outcome Description	Owner
7	Action	Injection of pace for a single business case, progress discussion with JR regarding funding, via NHS route/ treasury or via private funding, and feed this back to partnerships to progress it.	HTJC

5	Risks and dependencies

Risks need to be dealt with. Push on with implementation

6	AOB

No other business was raised.

7	Questions from the public

PW asked the members of the public in attendance if they had any questions. Alastair commented that he is encountering similar problems in Australia too. Beverley had no comments.

MEETING: **WBCCG Governing Body** **Item Number: 10.2**

DATE: **Tuesday 24 January 2017**

REPORT TITLE:	**Chairperson's Report – Audit Committee**
CORPORATE OBJECTIVE ADDRESSED:	**Function as an organisation that consistently delivers its statutory duties**
REPORT AUTHOR:	**Maurice Smith**
PRESENTED BY:	**Maurice Smith**
RECOMMENDATIONS/DECISION REQUIRED:	**Governing Body to note comments**
EXECUTIVE SUMMARY The Audit Committee was fully informed by all standard reports.	
FURTHER ACTION REQUIRED:	As per agreed actions section.
EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**	

CHAIRPERSON'S REPORT

Chairperson's Name	**Maurice Smith (Chair)**
Committee Name	Audit Committee
Date of Meeting	13 December 2016
Name of Receiving Committee	Governing Body
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	Mike Tate

The top 3 risks identified during the meeting & initials of lead with designated responsibility		
1.	Audit and assurance of Better Care Fund and Transformation Fund	
2.	Year-end accounts and possibility of 'reduced surplus'.	
3.		

Attendance at the meeting[#]:	Quorate

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes

Narrative report outlining the key issues of the meeting

The Audit Committee was fully informed by all standard reports.

Better Care Fund (BCF)/Transformation Fund
It was agreed that a workshop relating to governance of the BCF and Transformation Fund would be held following the March 2017 Audit Committee meeting.

Internal Audit Progress Report
Since the previous Audit Committee meeting, three reports had been finalised as noted below:

- Equality and Diversity, Commissioning – significant assurance achieved.
- Quality Innovation Productivity and Prevention (QIPP) – significant assurance achieved.
- Quality of Commissioned Services – high assurance achieved.

Internal Audit Follow Up
The Internal Audit Follow Up Report which sets out the completion of the most recent phase of follow-up reviews for recommendations that had reached their agreed deadlines was reviewed by the Committee.

Audit Committee Update – MIAA Insight
The Committee received the report identifying events, briefing notes and benchmarking undertaken by MIAA.

External Audit Progress Report:
A report was presented which sets out the current status of the work being undertaken by the CCG's 2016/17 financial statements.

Anti-Fraud Progress Report:
The Committee received a progress report on the work undertaken during the period September 2016 to November 2016.

[#] **Excellent** (well attended) **Acceptable** (some apologies) **Unacceptable** (not quorate)

Chief Finance Officer Report:
The Committee received the report which included updates on the following:
- CCG Losses and Compensation Register
- Reporting on Gifts and Hospitality
- Summary of Internal and External Audit issues
- Update on Financial Governance issues.

Gifts and Hospitality Register:
The register was received and noted.

GBAF Quarter 2 Report:
The Committee reviewed the Q2 iteration of the Governing Body Assurance Framework.

Appointment of Local CCG Auditors:
Grant Thornton has been confirmed as the CCG's local auditors.

Agreed actions from the Meeting		Name of lead with designated responsibility for the action/s
4	**BCF and Transformation Fund** Determine relevant personnel to attend the workshop relating to governance of BCF and Transformation Fund.	CH/EB
5.1	**Internal Audit Progress Report** Pass on the Audit Committee's congratulations to the Quality Team on the achievement of receiving high assurance in respect of governance arrangements for Quality, Safety and Safeguarding Groups and Clinical Governance Committee.	JS
7.1	**Anti-Fraud Progress Report** Bring NHS Protect Standards self-assessment to the March Audit Committee.	KW
8.1	**Chief Finance Officer Report** • Re-word Section 9.5 of the Chief Finance Officer report. • Liaise with AC regarding suitable dates for 2017 Audit Committee meetings ensuring that May half-term holiday week is avoided.	CH EB
8.4	**Gifts and Hospitality Register** Add an item to the Gifts and Hospitality register relating to an invitation that had been declined.	TA

Chairperson's Additional Comments

I think I am correct in reporting that in four years, the CCG has not received any internal audit reports judged below significant or high assurance – a pleasing 'High Assurance' report received on this occasion for the Quality team's governance arrangements – nor has it received anything other than an unqualified external audit report at year-end.

This is a significant achievement by the wide range of staff who contribute to such assurances for the governing body.

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MEETING: Governing Body **Item Number:** 10.3

DATE: 24 January 2017

REPORT TITLE:	**Chairperson's Report from the Clinical Governance Committee held on 5 October 2016** **Draft Chairperson's Report from the Clinical Governance Committee held on 7 December 2016.**
CORPORATE OBJECTIVE ADDRESSED:	**CO 2: Commissioning high quality services, which reflect the populations' needs, delivering outcomes and patent experience within resources available.** **CO 3: Function as an effective commissioning organisation that puts patients first.** **CO 4: Function as an organisation that consistently delivers its statutory duties and participates fully in Greater Manchester Devolution.**
REPORT AUTHOR:	**Dr Ashok Atrey – 5 October 2016** **Julie Southworth – 7 December 2016**
PRESENTED BY:	**Dr Ashok Atrey**
RECOMMENDATIONS/DECISION REQUIRED:	**Information**
EXECUTIVE SUMMARY **Chairperson's Reports from the Clinical Governance Committee held on Wednesday 7 September 2016 and Wednesday 7 December 2016.**	
FURTHER ACTION REQUIRED:	**None**
EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**	

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CHAIRPERSON'S REPORT

Chairperson's Name	Dr A Atrey
Committee Name	Clinical Governance Committee
Date of Meeting	5 October 2016
Name of Receiving Committee	Governing Body
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	J Southworth, Director of Quality and Safety

The top 3 issues identified during the meeting & initials of lead with designated responsibility		
1.	**Adverse media coverage WWL EOLC** - A tabled paper produced by WWLFT in response to adverse media attention that the Trust has been subject to recently in the Daily Mail was presented to the Committee. The tabled paper gave background information to the coverage and events and also the 5 families concerned. The Committee felt it was important to reflect on the issues raised in light of the adverse attention rather than the individual cases and to learn lessons about how to respond in such situations.	**SF**
2.	**Winterbourne View update -** The CCG continues to work closely with the Local Authority to plan and monitor the discharge plans of patients on the CCGs Winterbourne View register. There were no admissions or discharges of patients in the past month. The CCG continues to be involved in the GM Fast Track delivery programme for transforming Care and has appointed a new clinical case manager funded by the programme. There is an increased focus on the Winterbourne View agenda across NHSE and Greater Manchester.	**SM**
3.	**Clinical Governance Quality Workshop – November 2016:** The Committee supported a change in emphasis from a reactive monitoring and assurance perspective towards a more proactive quality improvement outlook. It was agreed that the November Clinical Governance Committee meeting should be replaced by a seminar/workshop to which the wider quality team will be invited to consider how the CCG may approach the Quality agenda differently going forward.	**SF**

Attendance at the meeting:	Acceptable

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes

Narrative Report Outlining the Key Issues of the Meeting
SAFETY

Update on Marie Stopes International (MSI): It is now 6 weeks since the original alert and although there has been a slight increase in waiting time service levels are still within 7 days for terminations. MSI are covering any additional travel costs incurred by patients as a result of attending alternate providers. A warning notice has been issued by the CQC. A new Chief Nurse has been appointed and it is hoped that services will resume next week. GPs will be notified when services resume.

Safeguarding Adults & Children – Hate Crime: The Committee received a paper providing a definition, overview and awareness of hate crime. The paper set hate crime in the context of safeguarding and explained the different forms of hate crime and provided national statistics for 2015/2016.

Strategy for Quality & Safety 2016-2019: The strategy was presented to the Committee. The strategy is intended to be reflective of the WBCCG pledge to commission high quality, safe care for now and for our future generations. The Committee supported a change in emphasis from a reactive monitoring and assurance perspective towards a more proactive quality improvement outlook. It was agreed that the November Clinical Governance Committee meeting should be replaced by a seminar/workshop to consider how the CCG may approach the Quality agenda differently going forward.

Serious Incidents and Never Events (SINE) Dashboard (Position as at 31 August 2016): The Committee reviewed the dashboard and the following was noted:

- WWLFT: 0 new reports, 3 closed
- BCHFT: 4 new reports, 1 closed
- 5BPFT: 2 new reports, 3 closed

A significant improvement in incident reporting has been seen across all providers since the inception of the SINE agenda with good practices now in place.

Richmond House Commissioner Visit: WBCCG undertook a Commissioner Visit to Richmond House – Intermediate Care Service to determine the views of Patients, Service Users and Staff on the service. During the visit the overall impression gained by the Visiting Team was of a professional, dedicated team who were striving to deliver quality safer care to Patients/Service Users. The visit was in the main encouraging and a number of areas of good or notable practice were observed. As is always expected there were some areas where improvement can be made. These findings have been shared with Richmond House. The Committee agreed with the Commissioner recommendations.

BCHFT QSSG Chairperson's Report (1 September 2016): The top issues highlighted related to ***Safeguarding Training*** – Figures are significantly under target. The CCG were informed that the team had experienced difficulties due to staff sickness however were expecting to see compliance in the November 2016 figures.
Liverpool Community Trust (Capsticks) Report Letter– The CCG received a letter from the Chief nurse/Director of Quality regarding assurance on the report on Liverpool Community Trust. There are some similarities between BCHFT and Liverpool. BCHFT have completed a 36 point action plan that the CCG has not yet had sight of.
Local QSG Stocktake – The CCG submitted the Learning Disabilities Mortality Retrospective Review to NHSE however there was limited information available from BCHFT. It was requested that BCHFT review the document and include further details and narrative. A refreshed updated

Learning Disability Mortality Retrospective Review to be submitted for the November 2016 QSSG.

5BPFT QSSG Chairperson's Report (8 August 2016): The top issues highlighted related to; ***Safeguarding Assurance*** – The CCG raised concerns about incorrect completion of the safeguarding proforma by the 5BP Safeguarding Team despite numerous communications and meetings. A separate meeting has been requested to discuss safeguarding issues.
Staffing Levels – The Trust identified issues with staffing levels on Cavendish and Lakeside Wards and Tier 3 CAMHS. The Trust outlined the actions that are in place to address the concerns and a further update will be provided at the November QSSG meeting.
CQC Re-inspection Initial Feedback – The CQC re-inspection report is due in October 2016 and is expected to be positive. Initial feedback from the Trust is that the CQC Inspectors were impressed with how the Trust has turned around the End of Life Service and Secure Services in a short space of time with the same teams in place.

Winterbourne View Update Report: The Committee was updated on the following: The CCG continues to work closely with the Local Authority to plan and monitor the discharge plans of patients on the CCGs Winterbourne View register. There were no admissions or discharges of patients in the past month. The CCG continues to be involved in the GM Fast Track delivery programme for transforming Care and has appointed a new clinical case manager funded by the programme. There is an increased focus on the Winterbourne View agenda across NHSE and Greater Manchester.

CLINICAL EFFECTIVENESS

Greater Manchester Integrated Stroke Service 12 Month Review: The Greater Manchester Operational Delivery Network (GMODN) have now completed and reported on the 12 month review of the GM centralised stroke pathway. The consensus of the Committee was that the report relied heavily on the statistics that were contradictory at times. Further clarification on information will be sought by the CCG.

HCAIs Dashboard report 31 July 2016: Wigan Borough Health Economy cases in year shows 42 against a target of 81 for the year. WWL cases in year to date are 11 against a trajectory of 19 for the year.

PATIENT/SERVICE USER/CARER/STAFF EXPERIENCE:

Adverse Media Coverage WWLFT: A tabled paper produced by WWLFT in response to adverse media attention that the Trust has been subject to recently in the Daily Mail was presented to the Committee. The paper gave background information to the coverage and events and the 5 families concerned. The Committee felt it was important to reflect on the issues raised in light of the adverse attention rather than the individual cases and to learn lessons about how to respond in such situations.

Patient Story: A patient story was circulated for information.

ANY OTHER BUSINESS:

Two papers will be circulated to the Committee via e-mail regarding:

- Immunisation and Vaccination
- Cancer

ITEMS FOR INFORMATION:

Quality Delivery Plan 2016 – 2017 Update 23 September 2016: The report was circulated for information.	
Agreed actions from the Meeting	**Name of lead with designated responsibility for the action/s**
As noted within the DRAFT minutes of the meeting and actions log	*As noted within the DRAFT minutes of the meeting and actions log*
Chairperson's Additional Comments	
Nothing added.	

CHAIRPERSON'S REPORT

Chairperson's Name	Julie Southworth
Committee Name	Clinical Governance Committee
Date of Meeting	7 December 2016
Name of Receiving Committee	Governing Body
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	J Southworth, Director of Quality and Safety

The top 3 issues identified during the meeting & initials of lead with designated responsibility		
1.	HIS Implementation. Letter to be forwarded to Pauline Law	**AW/SF**
2.	IAPT	**JC**
3.	Prescribing Rebates	**LS**

Attendance at the meeting:	Acceptable

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes

Narrative Report Outlining the Key Issues of the Meeting

SAFETY

The Quality and Safeguarding Report Q2 was circulated. The purpose of the report was to provide an overview on the activities within the Q2 period. The report highlighted areas of concern relating to Providers and also seeks to evidence the actions that are being taken to drive the required improvements in quality and safety. The following areas were highlighted:

- WWL Adverse Media Attention and Never Event in June 2016.
- BCHFT Quality Performance Review on Liverpool Community Trust and Wigan Audiology Service.
- 5BPFT Mental Health homicide and the CQC re-inspection which took place in July 2016.
- Acute Services NHS Foundation Trusts – Out of Borough.
- Intermediate Care and Community Bed Providers.
- Primary Care – PN Champions
- Wigan Borough Care Homes and the Care Home Strategy.
- Safeguarding. Serious Case Review and Domestic Homicide Review Update.

Serious Incidents and Never Events (SINE) Dashboard for both September and October were circulated. There were no 60 day breaches.

Both the SINE Panel and the 5BP QSSG Terms of Reference were circulated for approval with no significant changes made to the originals. The Committee approved the Terms of Reference.

5BPFT re-inspection was reported on. The report showed an upgrading from "requires improvement" to "good", which is an illustration of the effort the Trust has made to improve the quality of care provided. A letter of congratulations is to be sent to Simon Barber signed by both the Chief Officer and the Chair of the CCG.

The recent Commissioner Visit in relation to the MSK services was reported as being a positive experience visiting both Boston House and Leigh Health Centre. The staff were found to be both professional and dedicated and feedback to our staff that they felt these visits were beneficial and enhanced relationships.

MIAA Quality of Commissioned Services Final Report was circulated. The report focused on 2 areas:

- Providing an overview of the quality assurance received by the CCG Governing Body and its sub-committees and;
- evaluating the quality monitoring process for its main Provider WWL.

The report awarded the CCG High Level of Assurance, which reflects the work carried out over the past years and should be noted that no other MIAA review within the organisation has been awarded this level of assurance.

Safeguarding Contractual Standard collaborative GM document was circulated for approval. The content of the document has been refreshed and has been approved by the GM Safeguarding Collaborative. WBCCG Safeguarding Team has localised the document. The Committee approved the Contractual Standards 2017/18.

QSSG – WWL identified 3 top issues as:

- Adverse media attention.
- VTE assessments relating to implementation of HIS have been highlighted as a significant concern. This is being managed through risk assessment processes. However further concerns are also emerging around radiology and medicines management. It was resolved to write to the Trust requesting an explanation of any remedial actions.
- National Cancer Patient Experience Survey

QSSG – BCHFT identified 3 top issues as:

- Safeguarding training and compliance.
- District Nursing service
- Safeguarding in general good practice.

Winterbourne View update reported that Wigan had been set a trajectory by GM to reduce the number of inpatients to 16 by March 2017 and 2 discharges to supported community placements had been completed since the last report.

CLINICAL EFFECTIVENESS

Locality Nurse Champions were appointed in September 2013 to each of the 6 WBCCG

Localities. The roles are now fully established and continue to grow with the meetings being well attended. However, there was some concern raised that all practices did not attend.

Effective Use of Resources (EUR) – 2 policies were approved:
- Surgical procedures on the prepuce (circumcision) policy and
- experimental and unproven treatments policy.

Continuing Healthcare presented a report on the position to date regarding current issues relating to NHS Continuing Health Care.

Improving Access to Psychological Therapies (IAPT) update reported that although the CCG had achieved over 50% for June 2016, monitoring of the performance of recovery rates and the remedial action plan would continue via the contract monitoring and performance groups and the Finance and Performance Committee. The action plan is now being worked through and improvement has been seen.

HCAIs Dashboard reported:
Clostridium *difficile (C.difficile)*:
- Wigan Borough Health Economy Cases in year to date – 57
- Monthly count of Trust (WWLFT) apportioned cases in year to date now 16. (one further case in December 2016 not reflected in the November dashboard.

Meticillin Resistant Staphylococcus Aureus (MRSA):
The dashboard circulated showed no cases having been attributed or assigned. However, SF advised the meeting that one case had been reported at WWLFT in November, which was currently undergoing investigation.

Draft Care Home Strategy was circulated for discussion. The purpose of the strategy is to bring together the different CCG workstreams currently on-going with care homes, aiming to co-ordinate and structure this work and to develop a pro-active approach with regard to the CCG's sphere of work.

Prescribing Rebates Report was circulated for discussion. The CCG has not accessed these in the past, but is currently re-evaluating the position. It was noted that more CCGs were now taking up this option. The Clinical Governance Committee agreed to accept the proposals with caveats as discussed and listed in the minutes.

Medicines Management Group Chairperson's report identified the top 3 areas as:
- QIPP 2016/17 update. Discussion around prescribing rebates
- NICE Quality and Productivity Case Study. Now on NICE Website
- Prescribing Budget update.

PATIENT/SERVICE USER/CARER/STAFF EXPERIENCE:
Patient Story: A 5BP patient story was circulated for information.

ANY OTHER BUSINESS:
No Any Other Business raised.

ITEMS FOR INFORMATION:
- Performance Report
- Service User Experience of Care Newsletter Q2

- Quality Enabling Group Chairperson's update
- Cancer and Palliative Care Local Implementation Team update.

Agreed actions from the Meeting	**Name of lead with designated responsibility for the action/s**
As noted within the DRAFT minutes of the meeting and actions log	*As noted within the DRAFT minutes of the meeting and actions log*
Chairperson's Additional Comments	
Nothing further to add.	

NHS
Wigan Borough
Clinical Commissioning Group

MEETING: Governing Body **Item Number:** 10.4

DATE: 24 January 2017

REPORT TITLE:	**Chairperson's Report from the Corporate Governance Committee.**
CORPORATE OBJECTIVE ADDRESSED:	**Function as an organisation that consistently delivers its statutory duties and participates fully in Greater Manchester Devolution.**
REPORT AUTHOR:	**Dr Tony Ellis**
RECOMMENDATIONS/DECISION REQUIRED:	**For information only**
EXECUTIVE SUMMARY **Chairman's report from the Corporate Governance Committee Meeting held on Tuesday 8 November 2016.**	
FURTHER ACTION REQUIRED:	**None**
EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**	

CHAIRPERSON'S REPORT

Chairperson's Name	Tony Ellis
Committee Name	Corporate Governance Committee
Date of Meeting	8 November 2016
Name of Receiving Committee	Governing Body
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	Julie Southworth

The top 3 risks identified during the meeting & initials of lead with designated responsibility		
	Ambulance response times may result in delayed care.	**MT**
	If ICNT programme is not fully implemented there is a significant finance and quality risk.	**TA**
	If financial recovery plan is not delivered then statutory duty will not be met	**MT**

Attendance at the meeting:	Acceptable

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes

Narrative report outlining the key issues of the meeting

Minutes were agreed as true and accurate.

No additional declarations of interest were raised.

HR Update:

- Recruitment is now slowing down and the CCG's turnover rate remains below the national average.
- Two Fellowship appointments have been made but 3 have still not been filled. As a result of this the CCG is now looking at offering this opportunity to nurses and different groups.
- Both long term and short term sickness have decreased over the past 2 months. The annual sickness absence rate remains below the HENW North West's average.
- No significant moves on staffing profile.
- Staff survey showing an 86% take up. This is still being driven forward.

The Committee received the report.

Communications and Engagement Update:

Communications and Engagement reported a busy month highlighting:

- From October 2016 the Communications and Engagement Teams merged into one team. This facilities delivery against the joint strategy and plans.
- The Communications Team produced 2 short videos to support the SharetoCare project in its nomination for the iNetwork Annual Awards.
- Patients leaflets have been produced in relation to cancer referrals and COPD emergency pack information. AM also confirmed that a patient Reader Panel was now in operation to provide feedback on the leaflets before publication.
- Wellfest Week was held during the week commencing 3 to 11 September, which brought together all health and social care organisations to participate in activities.
- Winter Pressures Campaign is now being planned, but will now run until Easter 2017.
- APMS Consultation will be going live within the next 2/3 weeks
- The recent Practice closure is being managed.
- Website review is going well, however there has been a slight delay as we await essential

feedback from users before implementation. The feedback so far has been positive.
- CCG Staff Awards are continuing with good feedback and more staff nominating their colleagues.
- Patients Forums met on the 13 October 2016.
- Now working with Leigh Centurions.

The Committee received the report.

Information Governance Update:
- The current IG Toolkit (IGTK) workbook provides the full details of all evidence and actions required to allow for upload onto the online version of the IG Toolkit.
- November has been designated IG training month for staff mandatory training.
- As with previous years, the IGTK will be audited as part of the CCG's internal audit process and the initial review will take place with colleagues from Mersey Internal Audit Agency in November 2016.
- The Information Governance Framework was approved for onward submission to the Governing Body for ratification.

The Committee received the report.

Information Management & Technology Update (IM&T):
The Committee was briefed on the current situation in relation to IM&T services, Primary Care IT and IT Projects. Continued work is progressing on all aspects of IM&T to ensure that the CCG is best positioned to ensure an appropriate delivery of service.
The Committee received the report.

Corporate Governance Report:
The Committee was briefed on activity at the CCG mainly during Quarter 2 in respect of those areas of business covered in the Governance Delivery Plan highlighting: Equality & Diversity, Emergency Preparedness, Resilience and Response (EPRR), MP letters, Freedom of Information requests, complaints, Coroner reports and sustainability.

The Quarter 2 Governing Body Assurance Framework (GBAF) was circulated with 3 extreme risks noted as ambulance response times, Integrated Care & Nursing Therapies Programme (ICNT) and the CCG's Financial Recovery Plan. The new high risks added this quarter were shortage of Paediatric acute and community beds in the Borough and arrangements for Neuro-Rehabilitation patients within the Taylor Unit.
The Committee accepted the report.

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NHS
Wigan Borough
Clinical Commissioning Group

MEETING: **Governing Body** **Item Number: 10.5**

DATE: **24 January 2017**

REPORT TITLE:	**Chairperson's Report – Finance and Performance Committee**
CORPORATE OBJECTIVE ADDRESSED:	**Function as an organisation that consistently delivers its statutory duties**
REPORT AUTHOR:	**Mohan Kumar**
PRESENTED BY:	**Mohan Kumar**
RECOMMENDATIONS/DECISION REQUIRED:	**Governing Body to note comments**
EXECUTIVE SUMMARY A narrative report of the Finance and Performance meeting held on 24 October 2016 and 21 November 2016.	
FURTHER ACTION REQUIRED:	
EQUALITY AND DIVERSITY: Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.	

CHAIRPERSON'S REPORT

Chairperson's Name	Mohan Kumar **(Chair)**
Committee Name	Finance and Performance Committee
Date of Meeting	24 October 2016
Name of Receiving Committee	Governing Body Meeting
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	Mike Tate

The top 3 risks identified during the meeting & initials of lead with designated responsibility		
1.	Ensuring the financial recovery plan is backed and supported by SLT/CLT	MT
2.	WWL Contract	MT
3.	Ensuring Right Care approach is integrated into CCG plans	MK/MT

Attendance at the meeting:	Quorate.

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes.

Narrative report outlining the key issues of the meeting
Minutes – 26 September 2016: The minutes were approved as a true and accurate record. **Financial Recovery Plan and Letter:** A presentation was provided on the latest version of the draft Financial Recovery Plan. A list of schemes had been identified to deliver savings and evidence what will be undertaken to deliver any shortfall. The list will support the letter that will be submitted to GM Health and Social Care Partnership on 31 October 2016. The Chief Finance Officer and Deputy Chief Finance Officer will be meeting with the GM Health and Social Care Partnership Team to discuss WBCCG Financial Recovery Plan on 4 November 2016. Debate took place regarding the five GP Clinical Panels relating to ENT, Gastroenterology, Pain Management, Urology and Respiratory Medicine. GP Clinical Panels will look at the quality of referrals and, if the referral is not via the agreed pathway, the referral should be redirected and an alternative solution offered. WBCCG needs to examine referrals to establish why we are an outlier in these five areas. **Right Care Update:** The Deputy Chief Finance Officer provided a verbal update. Whilst some progress had been made regarding obtaining clinical involvement, further clinical input is required. WBCCG has been categorised as a Wave 2 CCG and this involves a high degree of scrutiny regarding financial sustainability. Right Care is featured in the financial planning process. MK will be attending the Right Care event and collating the Borough plan. **Financial Planning Update 2017/19:** A presentation was provided on Financial Planning. High level financial plans will be submitted to GM Health and Social Care Partnership on 26 October 2016 (national deadline is 1 November 2016). The importance of financial planning was emphasised. This must be in place to enable

contractual offers to be made to all 3 Providers by 1 November 2016.

Outpatient Redesign: Jennie Gammack presented a report on progress regarding Outpatient Redesign. The report described the barriers to implementation and some of the proposed solutions in order to ensure successful implementation. The specialities covered by the programme are Cardiology, Urology, Pain Management, Rheumatology, ENT, Ophthalmology, Respiratory and Dermatology. Discussion was around swift implementation, ensuring lessons learnt from the exercise are taken forward and integrating this into our transformation plans.

Month 06 Performance Report: The Committee received the Performance Report and was informed of the key messages relating to favourable and adverse trends.

Month 06 Activity Report: The Committee received the Activity Report which monitors the trends in activity at WWLFT relating to non-elective activity, elective inpatients and day cases, outpatients and A&E attendances. An additional report was also received titled, 'October Finance and Performance Activity Actions Points' which was reviewed by the Committee.

Month 06 Finance Report: The Committee received the Finance Report. Reference was made to the Executive Summary and the key messages, as noted within the report.

Improving Access to Psychological Therapies (IAPT) Report: The Committee received the update on performance of IAPT compliant services and actions taken regarding recovery rate. The document was received for information.

Agreed actions from the Meeting	Name of lead with designated responsibility for the action/s
Financial Recovery Plan Discuss the Financial Recovery Plan at Senior Leadership Team (SLT), Clinical Leadership Team (CLT) and Governing Body during October/November.	MT
Financial Planning Update 2017/19 Meeting to take place with Bolton re block contracting model for 2017/18. Bring results of the discussion back to the Finance and Performance Committee.	MT
Month 06 Performance Report • Remove the words 'Area/Unit' when referring to Ambulatory Assessment from future Performance Reports. • Undertake some analysis on patients who arrive at A&E by ambulance and the outcome of those patients for the next Finance and Performance Committee meeting.	WS WS

Chairperson's Additional Comments
It is vital for the financial recovery plan is backed and supported by the leadership team. The various CCG redesign work and implementation plans need to be aligned with right care objectives and local STP. It is vital for all teams and committees are cited on the plans and work

cohesively towards common objectives in finance and performance. The objective in enhancing AAA performance will be around commissioning ambulatory assessment as the common goal for all patients that fit into the criteria irrespective of which part of the hospital they are assessed in. Only patients requiring admission for clinical reasons need be admitted. All others require ambulatory assessment and the teams sufficiently deployed to make this a common standard in safety and efficiency.

CHAIRPERSON'S REPORT

Chairperson's Name	Mohan Kumar **(Chair)**
Committee Name	Finance and Performance Committee
Date of Meeting	21 November 2016
Name of Receiving Committee	Governing Body Meeting
Date of Receiving Committee Meeting	24 January 2017
Officer Lead	Mike Tate

The top 3 risks identified during the meeting & initials of lead with designated responsibility		
1.	WWL contract	MT
2.	Ensuring robust financial plan	MT
3.	Activity tracking and response	Team

Attendance at the meeting:	Quorate.

Was the agenda fit for purpose and reflective of the committees Terms of Reference?	Yes.

Narrative report outlining the key issues of the meeting

Minutes – 24 October 2016:
The minutes were approved as a true and accurate record.

Contractual Update 17/18
MT provided a presentation relating to WWL contract offer. JC updated the Committee on progress regarding the 5BP and BCHFT contract offers. The Committee also received and noted the responses from WWL, 5BP and BCHFT to the CCG contract offer letters.

Two Year Financial Plan 17/18 Update
The Committee received a verbal update. The Planning timetable has been brought forward by three months. The savings plan next year focuses on the following areas: ICNT, Ambulatory Assessment, Outpatient Redesign and delivery of Right Care Wave 2. It was noted that the CCG must have Delivery Teams as we will be monitored by NHSE on delivery. CCG Leads for this work are Mike Tate (Executive Lead), Craig Hall (Operational Lead) and the Mohan Kumar (Clinical Lead). The CCG financial system remains under pressure. Final submission to be made on 18 December 2016.

Diabetes Tender Paper
The Committee received a paper detailing the outcome of the diabetes tender following a seven month negotiation period with the lead provider. It became apparent that the service offered by the provider as part of the procurement had a number of exclusions that were not in the original business case. This required extra investment. This paper will be submitted to the Governing Body meeting to be held on 22 November 2016 for a decision.

Month 07 Performance Report

The report includes all CCG performance measures contained within the Delivering the Forward View planning guidance. The Committee received the report and was informed of the key messages relating to favourable and adverse trends. The following was highlighted:

- 18W RTT: Incomplete Patients Waiting More than 52 Weeks: At 20 October 2016, no-one was waiting over 52 weeks.
- IAPT Recovery Rate: It was noted that July performance was below the standard of 50.00%, at 46.75%. June is the only month in the current financial year where performance has been above standard. It was reported that there are three separate contracts performing at different levels: Making Space, BCHFT and 5BP. It was questioned whether 5BP are receiving more complex referrals and whether there should be a grading system to determine severity. Also queried which patients are using which service.

A dashboard relating to A&E by Ambulance at WWL was tabled which highlighted ambulance attendances by month, by disposal, by age and by top 10 primary diagnosis. Reference was made to response times for ambulances and consistent failure to meet targets. It was noted that this is being followed up at GM level.

Month 07 Activity Report:

The Activity Report monitors the trends in activity at WWL relating to non-elective activity, elective inpatients and day cases, outpatients and A&E attendances. The following was highlighted:

- Monthly Activity Tracker – Latest 12 months WWL. Urgent care activity is reducing. The importance of monitoring of coding analysis was noted.
- Ambulatory Care Sensitive Conditions (ACSC) Transformational Plans Dashboard: There was a significant drop (lowest ever) in ACSC conditions in September. It was noted that ICNT has not yet commenced.

Month 07 Finance Report:

The Committee received the Finance Report. The Executive Summary and key messages were highlighted.

Draft A&E Delivery Board Minutes (27 October 2016).

The minutes were received and noted. It was agreed to submit the new Terms of Reference for the A&E Delivery Board to the Finance and Performance Committee following agreement by Senior Leadership Team (SLT).

Training Group (9 September 2016):

The minutes were received and noted. It was agreed that these minutes should also be submitted to the Corporate Governance Committee.

	Name of lead with designated responsibility for the action/s
Performance Report: • **18W RTT: Incomplete Patients Waiting More than 52 Weeks: At 20 October 2016, no-one was waiting over 52 weeks. WS to verify this before the Q2 assessment.**	**WS**

• **IAPT Recovery Rate: It was questioned whether 5BP are receiving more complex referrals and whether there should be a grading system to determine severity. Also queried which patients are using which service. TA to follow this up outside this meeting.**	**TA**
Activity Report: • **Send email, to be signed off by Dr Tim Dalton, to WWL Medical Director to ascertain why WWL had decided not to proceed with the meeting to discuss the audit undertaken by CCG Data Quality Team.** • **Provide an update relating to the drop in ACSC conditions.**	**TD** **WS**
Items for Information: • **Submit the new Terms of Reference for the A&E Delivery Board to the Finance and Performance Committee.** • **Arrange for the Training Group minutes to be submitted to the Corporate Governance Committee.**	**JC** **CH**

Chairperson's Additional Comments
The ongoing discussion around agreeing a contract with WWL requires careful negotiation in common goals, right care objectives and efficiency gains. This needs to be done keeping in mind our transformation plans and the key objectives of safe and effective care outside the hospital, efficiency, and health and social care integration. Key areas of redesign need to be aligned with shared objectives and a gain share approach among all stakeholders.

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NHS
Wigan Borough
Clinical Commissioning Group

MEETING: Governing Body **Item Number:** 10.6

DATE: 24 January 2017

REPORT TITLE:	**Service Design and Implementation Committee Chairperson's report from the meeting held on the 15 November 2016**
CORPORATE OBJECTIVE ADDRESSED:	**All corporate objectives are met.**
REPORT AUTHOR:	**Dr Pete Marwick**
PRESENTED BY:	**Dr Pete Marwick**
RECOMMENDATIONS/DECISION REQUIRED:	**Receive**

EXECUTIVE SUMMARY

The Governing Body are asked to receive the Chairperson's report of the Service Design and Implementation Committee meeting held on the 15 November 2016 for information.

FURTHER ACTION REQUIRED:	

EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**

NHS
Wigan Borough
Clinical Commissioning Group

MEETING: Governing Body **Item Number:** 10.7

DATE: 24 January 2017

REPORT TITLE:	**Minutes from the Primary Care Commissioning Committee.**
CORPORATE OBJECTIVE ADDRESSED:	**Function as an organisation that consistently delivers its statutory duties.**
REPORT AUTHOR:	**Julie Screen** **Presented by Gary Cook**
RECOMMENDATIONS/DECISION REQUIRED:	**Information**
EXECUTIVE SUMMARY **Ratified Minutes from the Public Meeting of the Primary Care Commissioning Committee held on 1 November 2016.**	
FURTHER ACTION REQUIRED:	**None**
EQUALITY AND DIVERSITY: **Confirmed that any changes to service or procedure introduced as a result of this report do not impact adversely on any of the protected groups covered by the Equality Act 2010.**	

Wigan Borough Clinical Commissioning Group

OPEN MEETING

Minutes of the Meeting of the Primary Care Commissioning Committee
Held on 1 November 2016 2016 in Meeting Room 17, Wigan Life Centre

Present:
(Chair) Dr Gary Cook, Secondary Care Consultant Governing Body Member (GC)
Frank Costello, Lay Member (FC)
Linda Scott, Associate Director Clinical Services (LS) – Deputising for Julie Southworth
Craig Hall, Deputy Chief Finance Officer (CH) – Deputising for Mike Tate
Debbie Szwandt, Assistant Director Primary Care (DS)
Claire Roberts, Assistant Director Strategy and Collaboration (CR)
Gary Young, Patient Forum Representative (GY)
Laura Browse, Head of Primary Care, NHS England (LB)
John Marshall, Associate Director Strategy and Collaboration (JM)
Dr James Weems, GP Representative (JW)
Will Blandamer, Assistant Director Partnerships and Reform, (WB)
Aaron Barker, Primary Care Commissioning Manager (AB)
Julie Screen - Minute Taker (JS)

	AGENDA		Action
1.	**Chairman's Welcome**		
	The Chairman opened the November meeting of the Primary Care Commissioning Committee at 10.00am and introductions were made. No members of the public were present.		
2.	**Apologies for Absence**		
	Trish Anderson, Julie Southworth, Mike Tate, Ernie Rothwell, Catherine Johnson		
3.	**Declarations of Interest**		
	Individuals were asked to declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of Wigan Borough Clinical Commissioning Group, in writing to the Chair, as soon as they are aware of it and in any event no later than 28 days after becoming aware.		
4.	**Minutes and Actions**		
	The minutes were agreed as true and accurate. Action log refers.		
5.	Standing Agenda Items		
	5.1	**Primary Care Commissioning Programme Update** • Process for the Management of a GP Practice Closure A Briefing Paper was provided detailing the process for the management of	

		a GP Practice Closure (Contract Exit). A confidential item was scheduled to be covered fully in the Closed part of the meeting, which is a GP retiring and handing back his GMS contract. WB expressed concerns of politics around the closure of a GP practice. It was in no way suggested that the Local Authority be involved in decision making but that assistance they could provide in managing the politics of the situation could be of benefit. MPs and local councilors are being briefed on APMS contracts and it would be helpful for them and ward members to be kept informed of developments. The Local Authority can assist with this. JW asked if patients will be free to choose which practice they move to and what if practices won't accept new patients. LB confirmed that there are ramifications for surgeries that close their lists and it is not in their interests to do so. It was asked what reasonable grounds of refusal of new patient registrations are. This is predominantly due to geographical boundaries. There are a number of patients that currently reside "out of area" of Wigan borough CCG. These patients will also need to be included within the assignment process. This would suggest that there needs to be close liaison with neighbouring CCGs. This should be made clear going forward. **The Committee received the report**.	
	5.2	**Primary Care Quality Improvement Programme Update** A briefing paper was provided to the Committee outlining the CCGs progress and next steps against the development of the Primary Care Quality Improvement Programme. Fourteen GP practices have had their CQC Inspection report published during Q2 2016/17. Two of these were rated 'requires improvement' and will require monitoring. FC commented that overall the picture is pleasing, however felt that CQC ratings presume that all 5 components are of equal weighting and found this concerning, especially the 'are services safe' component. This is more concerning than for example, 'are services well led.' LB responded that CQC have powers to immediately intervene where services are found not be safe or to pose clinical risk to allow further investigation to take place. GC queried what the process is when a component for a practice is rated 'requires improvement.' The CCG does not have the capacity to follow up individual requires improvement ratings. ***Action: LB to check whether these are picked up as contractual issues.*** The CCG will not lose sight of ratings and will revisit or request submission of evidence of improvement. Remedial/breach notices may be issued. LS commented that it would be a useful enhancement to the report if remedial and breach notices were to be included. The Primary Care Commissioning Committee has a responsibility to have oversight of this.	**LB**

		Action: To be captured and included from January 17. It was fed back to the Committee that the Governing body found it useful to see hospital referrals by GP practice. ***Action: GC requested that this is included as an area in the Primary Care Quality Improvement Programme going forward.*** Appendix A shows that 14 of the 63 GP practices received a CQC inspection rating in Quarter 2, 6 practices had a requires improvement for are "services safe". FC expressed concerns regarding the other 49 practices and commented that they should be self-assessing and self-improving utilizing peer support and peer reviews. **The Committee received the report**.	**DS** **DS**
	5.3	**Finance Update** CH presented the report for CJ covering the position at end Sept 16. Overall the Primary Care budgets are £286k underspent in the year to date. • Delegated budget - £140k underspent mainly relating to GMS contracts due to practice list sizes being lower than expected and PMS contracts due to savings realised following the PMS review process. These have been reinvested by the CCG into the Primary Care Standards payments. • Quality Improvement - £106k underspend mainly due to slippage against Clinical Engagement, general pay and non-pay and the LWEG funded element of the GP Fellowship Scheme. • Better Care Fund - £33k underspend due to slippage against the GP Fellowship scheme. The year-end forecast outturn position reported at the end of September is £391k underspent. GM HSCP has reported a forecast outturn position of £326k against the delegated budget. Planning guidance for 2017 – 2019 was published on 22nd September 2016 with a deadline for final submission by 23rd December 2016. WB commented that Primary Care Commissioning Intentions should be linked to the Locality Plan and shared with the Joint Commissioning Executive. FC asked if there were any figures for residents not registered with a GP. JM felt that while this information would be useful it would be unlikely to impact on allocation. GC felt that this would be difficult to quantify and that A&E attendance may capture those not registered with a GP. JW commented that population size in relation to list size is not reliable. GY asked if there was provision for the travelling community. It was confirmed that the travelling community have access to services if required. **The Committee received the report**.	
	5.4	**NHS England Update** • Primary Care Support Services National Action Plan	

		There have been significant senior management / executive structure changes at Capita. There is now a faster route to deal with queries and a clearer escalation process in place. Raj Patel is doing national work on escalation rather than operational work on patient risk with Capita. ***Action: LB will provide a further update in January 17.*** • Annual Electronic General Practice Self Declaration(eDEC) LB spoke through the Wigan Borough CCG Summary of E-dec 2015/16 submission. DS confirmed that the information goes to the Primary Care Operations Group. There were no questions regarding E-declaration. • New Models of Care The New Models of Care event on 5 October 2016 was well represented. Jon Rouse discussed the GP Forward View. Clarity is being gained and when confirmation is received regarding finances NHSE will visit CCGs to discuss. **The Committee received the report**.	**LB**
	5.5	**Primary Care Transformation** • Primary Care Standards CR tabled a paper: Wigan Borough Quality & Engagement Scheme: Analysis and Review of Qtr 2 Data Submissions. Highlights included: o Further work will be undertaken to refine the data analysis process and specify the content and structure of quarterly reports. Updated reports will be presented to the Primary Care Committee following Qtr 3 data submissions. o Practice reports will be compiled with support from the Business Intelligence team. The reports will highlight areas that require data validation or review. They will also identify areas where practices need to provide further assurance or information about their plans to meet requirements where insufficient evidence has been submitted as part of Qtr 2 returns. o A meeting of the internal CCG Primary Care GM Standards Assurance Group will take place on 3 November to review the Qtr 2 submission process and assign actions to take forward in advance of the Qtr 3 submission. o The Primary Care GM Standards Development and Review Group, chaired by Dr Hari Sukavasi, Clinical Director, will take place on 8 November 2016. The group will review the submission process from a practice perspective and identify support needs based on the data submissions. o A borough wide education event is planned for 15 February 2017 which will focus on implementation of the primary care standards. There has already been agreement that part of the session will focus on standard 8 (childhood Asthma), but other topics will be informed by the Standards Development and review Group and the Primary Care Education Sub-group. ***Action: CR to e-mail paper to all. An update to be provided at January 2017.*** LB informed the group that that a GM level Quality Surveillance Group is	**CR**

		commencing work on 2 November 16. LB asked if this report could be included in the work and referenced to Wigan Borough for metrics. This was agreed. CH questioned why a third of GP practices are closed on Wednesday afternoons. JW explained that historically Wednesday afternoons were used for education of GPs either personal or in groups. DS commented that practices sub contract OOH for emergency appointments. JM confirmed that the practices pay for this cover and that the Wednesday closure has no impact on A&E pressures. GC said that this comes back to Clusters and the Accountable Care Organisation (ACO) principles and was valuable data mapping. FC commented that overall this was a very useful baseline. • GP Access 7 Day Service DS presented a briefing paper. The paper had previously been presented at Joint Commissioning Executive, Integrated Care Organisation Board and Primary Care Ops group meetings. DS requested support from the Committee for this programme of work. FC commented that the patient forum held on the 13th October was a productive session. WB felt that there was excellent commitment to ongoing work with partners. LS confirmed that this stream of work will continue to be monitored through the Joint Commissioning Executive. An options paper will go to the Joint Commissioning Executive and Senior Leadership Team in the next four weeks. Following this an update will be provided to the Committee. ***Action: Update to be provided January 2017.*** **The Committee received the report.**	**DS**
6.	**Items for Information**		
	6.1	Primary Care Assurance Report (PCAR submission)	
	6.2	NHS England e-Declaration guidance	
7.	**Any Other Business**		
	There being no other business the meeting closed at 11.30am.		
11.	**Date and Time of Next Meeting**		
	Tuesday 3 January 2017, 10.00am in Meeting Room 17, Wigan Life Centre.		