NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 12th February 2019 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

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			Date and time of next meeting ~ Tuesday 9 April – Governing Body Board Meeting		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 13 November 2018
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~ Dr S Reehana **Clinical**	Chair
Dr Asghar	Board Member
Dr D Bush	Board Member
Dr M Kainth	Board Member
Management	
Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Dr H Hibbs	Chief Officer
Mr S Marshall	Director of Strategy and Transformation
Ms S Roberts	Chief Nurse Director of Quality
Lay Members/Consultant	
Mr J Oatridge	Lay Member
Mr P Price	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member

In Attendance	
Ms K Garbutt	Administrative Officer
Mr M Hartland	Chief Finance Officer – Dudley CCG (Strategic Financial Adviser)
Mr P McKenzie	Corporate Operations Manager
Ms A Smith	Head of Integrated Commissioning

Apologies for absence

Apologies were received from Dr R Rajcholan, Dr J Parkes, Mr M Hastings, Ms S Gill, Dr R Gulati and Mr J Denley

Declarations of Interest

WCCG.2230 There were no declarations of interest declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing

WCCG.2231 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 11 September 2018 be approved as a correct record subject to the amendment below ~

WCCG.2200 – Finance and Performance Committee

Mr P Price referred to the second paragraph, final 2 sentences. It should read "Mr T Gallagher also referred to page 10 of the report ….."

Matters arising from the Minutes

WCCG.2232 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2233 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer Report

WCCG.2234 Dr Hibbs presented the report. She highlighted that progress continued to be made relating to the Sustainability and Transformation Plan (STP) Clinical Strategy. The initial five key priority areas have been approved by the clinical leadership group, namely Primary Care, Mental Health, Cancer, Transforming Care Partnership and Local Maternity System plan.

Dr Hibbs pointed out that the Black Country Transforming Care Programme (TCP) has made significant progress in the last quarter to support patients out of hospital and in the community, 16 patients were discharged in the last quarter, 34 in total this year. Particular progress has been made to support children and young people out of inpatients beds.

The initial engagement has taken place relating to the NHS Long Term Plan. The plan is due to be published in late November or early December 2018. From December staff, patients, public and other stakeholders will be engaged to develop out local response to the plan and to develop our local implementation plan.

Mr J Oatridge commented upon the good staff we have within the Wolverhampton Clinical Commissioning Group (WCCG) and their capabilities. Dr S Reehana supported this.

Mr Price queried the aggregation of the financial working together. Dr Hibbs stated that the message from NHS Improvement is working together in an integrated way enables providers and commissioners to live within their means. Mr Hartland added that we are currently managing this on a system basis and we will work towards it when we receive further details.

RESOLVED: That the above is noted.

Emergency Preparedness, Resilience and Response (EPRR)

WCCG.2235 Mr L Trigg gave an overview of the report which is to give the Governing Body assurance that the CCG is compliant with EPRR core standards assessed as substantially compliance and to sign off the 2017/2018 work plan. The work programme is set out on page 49 and there will be more reporting back and training.

Mr Trigg pointed out that the core standards do not capture the entire EPRR agenda. Work is being delivered around the Prevent agenda, Urgent Care support and crisis communications.

RESOLVED That the above is noted.

Commissioning Intensions

WCCG.2236 Dr Hibbs referred to the report which is to give an overview of the Joint Black Country and specific Wolverhampton commissioning intentions for 2019/20 which take into account National, STP and Local Placed Based Intentions. This has been presented in a number of forums.

The Black Country JCC is leading on a number of specific programme areas, in particular:

- Transforming Care Programme
- Urgent and Emergency Care
- Elective Care
- Maternity
- Mental Health Services
- Cancer

In addition the Clinical Leadership Group has developed a Clinical Strategy for the Black Country STP which includes a focus on the areas listed below:

- Primary Care
- Children and Young People
- Cardiovascular Disease
- MSK
- Respiratory Disease
- Frailty

RESOLVED: That the above is noted

Commissioning Committee

WCCG.2237 Dr Kainth presented the report. He referred to the Black Country Local Maternity Plan. He highlighted that the Black Country Local Maternity Plan has been developed to improve outcomes and provide a safer service for patients.

Dr Asghar arrived

Dr Kainth referred to the Draft Mental Health Strategy update which is a joint collaboration of NHS Wolverhampton CCG and the City of Wolverhampton Council. The strategy outlines current services and what has been achieved to date.

Dr Kainth pointed out the Committee was presented with a report regarding the current Community Dermatology Contract which ceases in December 2019. The provision of a community service is in line with strategic objectives and in addition the incumbent Trust based service is expected to cease. The Committee agreed to the expansion and re-procurement of this service. Ms S Roberts felt there could possibly be a potential risk to the service however Dr Kainth felt there is a market interest to deliver the service. Ms Roberts stated that some progress is being made regarding sharing photographs and this will be part of the procurement going forward.

Mr Hartland queried the impact and timings on The Royal Wolverhampton Trust (RWT) regarding potentially the A&E closing at The Princess Royal Hospital Telford (PRH). Dr Hibbs stated there have been numerous discussions between different organisations and the proposed date for closure of A&E at PRH is 18 December 2018 between 10.00 pm – 8.00 am. However this has not yet been finalised. If this takes place there might be 6 or 7 additional ambulances during the period and may have an impact on patients being admitted to wards. If the timings are from 8.00

pm – 8.00 am then the ambulances would increase substantially. We are aware and involved in the discussions.

RESOLVED: That the above is noted.

Ms A Smith arrived

Better Care Fund (BCF) update

WCCG.2238 Ms A Smith gave an overview of the report. She stated that the Governing Body will receive a quarterly update. She highlighted the following in the report ~

- Rapid Intervention Team Burdett Nursing Award
- Sharing Data – Fibonacci
- Fibonacci – Nursing Times Aware Shortlist
- Co-location of North East and Social Care teams

Ms Smith also mentioned that housing colleagues are playing an increasingly important part in the work delivered by the BCF Programme relating to collaborative working. Mr Price expressed his support with this. He enquired if there are currently any risks regarding staffing issues. Ms Smith stated there have been a number of changes and a new Project Manager is scheduled to start on the 10 December 2018.

Dr Hibbs stated that good work had been carried out relating to Fibonacci. Ms Smith confirmed this will be replaced by Graphnet which is a wider tool with a richer source of information. A lot of work is currently taking place to implement Graphnet. Mr McKenzie also confirmed that information governance work is also being covered relating to Graphnet.

Mrs A Smith left

RESOLVED: That the above is noted.

Management of Excess Treatment Costs associated with Clinical Research

WCCG.2239 Mr P McKenzie presented the report. He pointed out that NHS England have development a new model for commissioning the management of Excess Treatment Costs associated with research.

The model developed includes Local Clinical Research Networks managing arrangements on a day to day basis with a single CCG hosting commissioning arrangement on behalf of the other Clinical Commissioning Groups (CCG's) in the region. He pointed out that Wolverhampton CCG has been asked to act as the Host CCG for the West Midlands region.

Mr Oatridge asked what the financial implications are on Wolverhampton CCG. Mr McKenzie stated he understands funds are pooled and Wolverhampton are acting as a "banker".

Dr Hibbs stated her understanding is Wolverhampton are acting as host and the administration work has no bearing on the CCG. NHS England are carrying out all the administrative work.

RESOLVED: That the Governing Body agreed to act as the host CCG for commissioning arrangements for managing Excess Treatment Costs for the West Midlands, accepting delegated authority from the other CCG's to perform this function in line with the draft policy.

Quality and Safety Committee

WCCG.2240 Ms S Roberts presented the report. She pointed out that the cancer performance is below target and is a concern for Wolverhampton. She went through the risk mitigation. She also mentioned the impact on patients due to the waits and working with the Trust regarding harm reviews. Currently there is a member of staff at the CCG who attends the harm review meetings. Cancer Alliance are working with us on a weekly basis and they have supported the Trust working with clinicians.

RWT is currently reporting the highest standardised Hospital Mortality Index in the country. Ms Roberts went through the risk mitigation highlighting that an independent medical expert continues to support the Trust with mortality reduction priorities; this is in addition to external analytical support also in place.

Ms Roberts pointed that there are still concerns around the sepsis pathways. She highlighted that the staff turnover rate at Black Country Partnership is still being monitored.

She pointed out quality concerns were identified at a nursing home providing discharge. Accessing provision could potentially impact on the quality and safety of care provided and also to the Urgent Care system within Wolverhampton.

RESOLVED: That the above is noted.

Remuneration Committee

WCCG.2241 Mr Price gave a brief overview of the report. He pointed out that the Committee agreed a list of mandatory training requirements for Governing Body members which will be delivered through the on-going programme of Governing Body development sessions.

Dr Reehana pointed out that the safeguarding training for GPs is different and how this is going to be addressed. Ms Roberts stated this was discussed at the Quality and Safety Committee. An updated training programme in light of the changes will be carried out at the Governing Body Development early spring.

RESOLVED: That the above is noted

Finance and Performance Committee

WCCG.2242 Mr T Gallagher referred to the reports and focused on the report for October 2018. He pointed out that we are meeting all our metrics as stated on the table on page 165 of the report. RWT data indicates a financial under performance and the CCG are challenging this.

He highlighted that referrals from GP practices into RWT are reducing although further work needs to be undertaken which is in part the success of the referral management.

Mr Gallagher pointed out the Quality, Innovation, Productivity and Prevention (QIPP) Programme Delivery Board on page 173 is presently differently which was requested by a recent audit. We are achieving QIPP supported by the reserves we hold.

The Trust is continuing to focus on reducing the backlog and to sustain or reduce Referral to Treatment Time (RTT) waiting list size against the March 2018 baseline and is currently on track to achieve this with August RTT waiting list. He referred to the Delayed Transfers of Care. We are making progress however at present we are still not meeting our threshold. There is a lot of work being carried out through the Better Care Fund.

RESOLVED: That the above is noted.

Primary Care Commissioning

WCCG.2243 Ms S McKie presented the report. She pointed out that following the retirement of Dr N Mudigonda last year the practice is performing well and there is no compromise to the quality of service.

The GP workforce position and projects are underway locally and across the STP footprint to address recruitment and retention of GPs.

A discussion took place regarding the evaluation of the primary care models and how this can be carried out. Currently the Primary Care team are building a dashboard.

RESOLVED: That the above is noted

Communication and Engagement update

WCCG.2244 Ms McKie presented the report. She pointed out extended hours for GP surgeries. All patients registered with a Wolverhampton practice can now access appointments up until 8.00 pm weekdays and at weekends.

Planning is well underway to begin promoting the new Patient Access App to the public of Wolverhampton. We hope to encourage many patients to download it, register at their surgery for online services and have access to booking appointment at their GP practice, ordering prescriptions and looking at their medical records.

The campaign relating to Stay Well – help us help you is now underway with the first part in September and October focusing around uptake of the flue jab.

Ms McKie pointed out she had attended the Voluntary Sector 30 year celebrations. This was a wonderful event and she carried out a presentation. The return on the investment into the voluntary sector is very good. Dr Reehana added that there is a lot of learning with the voluntary sector.

Ms H Ryan asked when the support packs for over the counter medicines will be distributed. Ms Roberts report this is imminent once a date is known she will let Ms Ryan know.

RESOLVED: That the above is noted

Minutes of the Quality and Safety Committee

WCCG.2245 RESOLVED: That the above minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2246 RESOLVED: That the above minutes are noted

Minutes of the Primary Care Commissioning Committee

WCCG.2247 RESOLVED: That the above minutes are noted

Minutes of the Commissioning Committee

WCCG.2248 RESOLVED: That the above minutes are noted

Black Country and West Birmingham Joint Commissioning Committee Minutes

WCCG.2249 RESOLVED

Any Other Business

WCCG.2250 RESOLVED: That the above is noted.

Members of the Public/Press to address any questions to the Governing Board

WCCG.2251 The following questions were submitted ~

Question 1 ~ How do we ensure serious incident data is accurate and reported appropriately?

Answer ~ Ms Roberts stated that we work hard with the Trust. The reporting is right against the national framework and looked at their governance framework. Serious reporting are looked at and compared. Visits take place and stress tests undertaken. We also benchmark with other CCG's and Trusts. Ms Roberts confirmed she would be happy to discuss this outside the meeting.

Question ~ How do we ensure services are safe?

Answer ~ Ms Roberts stated we look at national learning, local alerts, feedback through our quality meetings. Ms Roberts happy to discuss outside the meeting.

RESOLVED: That the above is noted.

DRAFT

Date of Next Meeting

WCCG.2252 The Board noted that the next meeting was due to be held on **Tuesday 12 February 2019** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.30 pm

Chair……..

Date ……

DRAFT

Wolverhampton Clinical Commissioning Group Governing Body

Action List

12 February 2019

Date of meeting	Minute Number	Action	By When	By Whom	Status
NO ACTIONS					

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
12 February 2019

Agenda item 6

TITLE OF REPORT:	Chief Officer Report
AUTHOR(s) OF REPORT:	Dr Helen Hibbs – Chief Officer
MANAGEMENT LEAD:	Dr Helen Hibbs – Chief Officer
PURPOSE OF REPORT:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
RECOMMENDATION:	That the Governing Body note the content of the report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties. By its nature, this briefing includes matters relating to all domains contained within the BAF.
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body Members on matters relating to all the overall running of Wolverhampton Clinical Commissioning Group (WCCG).

2. CHIEF OFFICER REPORT

2.1 Extended Access in Wolverhampton

2.1.1 There have been a number of exciting developments and improvements in the provision of access to Primary Care appointments within Wolverhampton. The four groups of GPs in Wolverhampton (Wolverhampton Total Health, Wolverhampton Care Collaborative, Unity and Vertical Integration) which are made up of different GP Practices working together, have delivered key improvements for patients and these have been positively recognised by NHS England following an assurance visit.

2.1.2 Patients are able to access appointments from 6:30pm – 8:00pm on Monday to Friday and access is also provided on Saturdays, Sundays and Bank Holidays (hours determined by the groups) at four hubs in different geographical locations in Wolverhampton. Routine and urgent clinical appointments are both available within these hubs, and specialist clinics are also available at some of these sites. These include Diabetes Clinics and NHS Health Checks.

2.1.3 Currently, over 2700 additional primary care appointments are available each month across Wolverhampton. The utilisation rate of these appointments is approximately 85%. As the number of appointments available has grown over the year and promotion of services offered has increased due to a robust communications plan, the number of patients accessing them has grown. Did Not Attend (DNA) rates are lower in the hubs than in Practices offering appointments during core hours. To date, patient feedback has been very positive. This is measured using satisfaction surveys, information on NHS Choices websites, and from feedback from Patient Participation Groups (PPG).

2.1.4 Over the Christmas period all four hubs offered appointments on Christmas day, Boxing Day and New Year's Day, making Primary Care Services easier to access for Wolverhampton patients over the busy bank holiday period. All of the hub providers considered last year's utilisation figures to support them with planning opening hours and how many clinicians needed to be available. The groups wanted more available access to appointments on Boxing Day to ensure practices weren't saturated with demand on the 27th when they reopened. The hubs offered various types of appointments with GPs, Advanced Nurse Practitioners, Pharmacists and Practice Nurses.

2.1.5 Communications and advertising of the extended access has taken many forms. Information is circulated to practices, pharmacies and community venues. Practices receive information leaflets and posters to distribute themselves or via the PPG. There is also advertising in the form of a bus campaign, online advertising, and in local press. This message is supported by the national promotional campaign which uses radio advertising along with other methods.

2.1.6 The CCG Primary Care team have been working with the IT team to extend access to online services for patients. Implementation of different consultation types is a priority in both the General Practice Forward View (GPFV) and also the recently published Long Term Plan. Pilots are currently being undertaken to support the roll out and development of online services (triage and consultation) and these services are in addition to a wider plan that also includes raising awareness of prescription ordering, online booking of appointments and improved patient access. Alongside this, the introduction of a two way texting system for practices and patients to use has led to reduced DNA rates as text reminders sent to patients include a message asking patients to text back if they wish to cancel.

2.2 **Sustainability and Transformation Plan (STP)**

2.2.1 Work with the Black Country STP continues. The NHS Long Term Plan has made it clear that all STP areas are expected to evolve to become Integrated Care Systems by 2021. The previous development work done across the Black Country puts us in a good position to move this work forward. In this year's planning round the STP has to submit an annual plan based on CCG local planning to cover the next year and later in the summer, it has to submit a longer term plan as a response to the NHS Long Term Plan. The last STP stocktake meeting took place on 14 December 2018. Performance issues and system development were discussed and the STP was commended on progress and improved engagement.

2.3 **Vocare Care Quality Commission (CQC) Inspection**

2.3.1 A re-inspection of Wolverhampton Urgent Care Centre (Vocare) undertaken on 8 November 2018 has resulted in the service being rated as "good" overall. Every key question resulted in good rating. The service had previously been rated as "Requires Improvement" in February 2018. Inspectors recognised the significant improvements that had been made to the quality of care provided by the service and confirmed that it would be taken out of special measures.

2.3.2 A copy of the full report can be viewed on the CQC website: Wolverhampton Urgent Care Centre CQC Report (https://www.cqc.org.uk/sites/default/files/new_reports/AAAH9556.pdf).

2.4 **WeCAN Multi-agency Neglect Assessment Tool**

2.4.1 The Deputy Designated Nurse for Safeguarding Children (DDNSC) presented a Neglect Assessment tool that was written during her previous role, to Wolverhampton Safeguarding Board (WSB). Following the endorsement of the WSB, the tool, now named the WeCAN (Wolverhampton's Children's Assessment of Neglect) has been adapted to be in line with Wolverhampton's Thresholds of Need document and is due to become the new multi-agency assessment tool for Neglect for Wolverhampton.

2.4.2 At present, it is in the process of becoming an electronic document that is a live and ongoing assessment of each individual child that all agencies will be able to access and update whenever they have contact with a family. The vision for this is to reduce the amount of assessments that a child is having and provide the family and professionals with a clear, up to date and current plan to address any aspect of Neglect.

2.4.3 An implementation plan is in place from the WSB that is being supported by the DDNSC to ensure a robust roll out of the tool is carried out across all agencies.

2.4.4 The WeCAN will enrich and support Wolverhampton's new Neglect Strategy which is due to be launched later this year.

2.5 **Estates / IM&T**

2.5.1 IT work has started to support the transition of Bilston Urban village to the EMIS clinical system and the subsequent merger with Ettingshall Medical Centre followed by the migration of Pennfields Medical Centre from TTP to EMIS.

2.5.2 The IT team have also started the Windows 10 project, initially being rolled out at CCG Headquarters and then across the GP estate.

2.5.3 Progress has been made within the South East (Bilston) Locality with regards to Utilisation studies being completed and options papers being developed for an Estates solution in the locality. We are working with the Local Authority and Royal Wolverhampton NHS Trust and we have commissioned a building projects company, RLB to take the project up to an Outline Business Case. Meetings have taken place with the local GP Practice senior partners for input and have these have been well received. The Estates team continue to work with the North East locality and have received further Estates and Technology Transformation Fund (ETTF) funding so that business cases and options papers similar to the Bilston locality can be developed.

2.5.4 Previously agreed and supported ETTF projects are progressing and the first practice (Newbridge Surgery) in the South West Locality have targeted 1 June 2019 as a completion date for the re-development of their building which includes a large extension to add consulting rooms.

2.5.5 We are working with STP colleagues to develop our Operating Plans over both 12 months and five years. Both of these will be written from an STP perspective however we need to write our own plans to support this, particularly as we have a transition year in line with the NHS Long Term Plan.

2.6 **Expansion of Medicines Reviews in Care Homes Service**

2.6.1 NHSE provided funding for an 18 month programme across the STP. Wolverhampton already has an excellent care homes review service run by clinical pharmacists in conjunction with elderly care consultant across the city. This new service will allow for greater service provision in Wolverhampton whilst providing others across the STP to pilot a similar service in their respective area. The Medicines Optimisation Team in Wolverhampton are the leading on this programme on behalf of the STP.

2.7 **The Black Country Integrating Pharmacy and Medicines Optimisation Programme**

2.7.1 The black country STP were one of 7 pilot sites to be chosen by NHS England / NHS Improvement to explore opportunities towards embedding a cultural shift towards systems leadership. Creating the right environment and incentives to support the integration of services. Developing sustainable and autonomous systems, that can make the decisions

required to improve care in their area within their share of the budget. The Black Country Medicines Optimisation and Pharmacy Group have decided to prioritise, Transfer of Care, Medicines Safety, Mental health prescribing and polypharmacy. The Wolverhampton Medicines Optimisation Team are acting as lead CCG for this programme and plan to showcase its work at a regional event for the region.

3. CLINICAL VIEW

3.1 Not applicable to this report.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable to this report.

5. KEY RISKS AND MITIGATIONS

5.1. Not applicable to this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Not applicable to this report.

Quality and Safety Implications

6.2. Not applicable to this report.

Equality Implications

6.3. Not applicable to this report.

Legal and Policy Implications

6.4. Not applicable to this report.

Other Implications

6.5. Not applicable to this report.

Name **Dr Helen Hibbs**
Job Title **Chief Officer**
Date: **29 January 2019**

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Dr Helen Hibbs**	**29/01/19**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
February 2019

Agenda item 7

TITLE OF REPORT:	**NHS England Consultation on which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs**
AUTHOR(s) OF REPORT:	Hemant Patel, Head of Medicines Optimisation
MANAGEMENT LEAD:	Hemant Patel, Head of Medicines Optimisation
PURPOSE OF REPORT:	This report confirms the Governing Body response to the NHS England consultation on developing guidance for CCGs on items which should not routinely be prescribed in Primary Care
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	Public. The response will be upload to the consultation website
KEY POINTS:	• NHS England have begun a further consultation exercise on developing guidance for CCGs on items that should not be routinely prescribed in Primary Care • The guidance aims to reduce unwarranted variation by providing clear guidance to CCGs on items that should not be prescribed to ensure that best value is obtained from prescribing budgets.
RECOMMENDATION:	That the Governing Body Agree the draft response to be submitted on behalf of the CCG
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The report seeks to gain Governing Body views on potential patient engagement on the consultation response to ensure they are effectively taken into account.
2. Reducing Health	

Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	The consultation will result in guidance to the CCG on prescribing which will aim to support the management of the prescribing budget.

1. BACKGROUND AND CURRENT SITUATION

1.1. NHS England are undertaking a further national consultation on the development of guidance for CCGs on items which should not be routinely prescribed in primary care.

1.2. The consultation is taking place for three months which begun in Nov 2018 and is available on the NHS England website https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed-update/

2. CCG RESPONSE

2.1. The response must be owned and signed off by the Governing Body at its January meeting. The development of a draft CCG response has been informed by GP members and the Head of Medicines Optimisation.

2.2. The draft response is written as follow:

What capacity are you responding?
Clinical Commissioning Group

Name Wolverhampton CCG

Have you read the *document Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs?*
Yes

Equality and Health Inequalities
NHS England has legal duties which require giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and having regard to the need to reduce inequalities between patients in

access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. An initial Equality and Health Inequalities Assessment (EHIA) has been carried out on these proposals and this can be read here. Further information on our duties can be read at https://www.england.nhs.uk/about/equality/

Do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?
No

Do you feel there is evidence we should consider in our proposals on the potential impact on health inequalities experience by certain groups e.g. people on low incomes; people from BME communities?

Yes

Please provide further information on why you think this might be the case

Patients on low incomes may be unable to afford to purchase medicines available over the counter. In particular rubefacients have high levels of patient acceptability locally and were previously promoted by national and local prescribing advisers as a means to control costs of topical NSAIDs in the early days of prescribing advice.

Do you feel there is evidence we should consider in our proposals on the potential impact on health inequalities experience by certain groups e.g. people on low incomes; people from black and minority ethnic (BME) communities? No

Please provide further information on why you think this might be the case

Section 3: How will the guidance be updated and reviewed?

Thinking about the process for future update and review of the guidance:

How do you feel about the proposed process for identification of items for possible addition to the guidance or indeed possible removal, from the guidance?

Neither agree or disagree

If needed, please provide further information.

Section 4: Proposals for CCG commissioning guidance

Please select which items you would like to share your views on (please select)?

- **Reviewed item Rubefacients (excluding topical NSAIDs)**

New items

- **Aliskiren**
- **Amiodarone**
- **Bath and shower preparations for dry and pruritic skin conditions**
- **Blood glucose testing strips for type 2 diabetes**
- **Dronedarone**
- **Minocycline**
- **Needles for Pre-Filled and Reusable Insulin Pens**
- **Silk Garments**

Rubefacients (excluding topical NSAIDs) Do you agree with the proposed recommendations for Rubefacients (excluding topical NSAIDs)?

Agree

If needed, please provide further information

Aliskiren - Do you agree with the proposed recommendations for Aliskiren?

Agree

If needed, please provide further information

Amiodarone - Do you agree with the proposed recommendations for Amiodarone?

Agree

Bath and shower preparations for dry and pruritic skin conditions Do you agree with the proposed recommendations for bath and shower emollient preparations?

Agree

Blood glucose testing strips for type 2 diabetes Do you agree with the proposed recommendations for blood glucose testing strips?

Agree

Dronedarone Do you agree with the proposed recommendations for Dronedarone?

Agree

Minocycline Do you agree with the proposed recommendations for Minocycline?

Agree

Needles for Pre-Filled and Reusable Insulin Pens Do you agree with the proposed recommendations for needles for pre-filled and reusable insulin pens?

Agree

Please provide further information

Some patients that find the less expensive needles unsuitable should have the ability to trial a more expensive needle or have their current needle re-prescribed.

Silk Garments Do you agree with the proposed recommendations for silk garments?

Agree

3. CLINICAL VIEW

3.1. The views of the Clinical Members of the Governing Body are being sought through discussion of this paper and they will contribute to the final response.

PATIENT AND PUBLIC VIEW

3.2. The consultation is seeking public and patient views on this matter and the CCG has made available the link to the consultation on its website.

4. KEY RISKS AND MITIGATIONS

4.1. The exact risks and impact of any guidance on items which should not be prescribed will not be known until it is published and assessed. There is the potential for damage to the CCGs reputation should guidance and subsequent CCG decisions lead to items which are currently prescribed no longer being available.

There may also be a risk that alternative, more expensive items are prescribed as a result.

4.2. The potential risks, particularly to the CCG's reputation could be mitigated by the CCG responding to the consultation with a robust reasoned response.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. There is no immediate impact of the consultation; there may be a financial impact from any guidance published as a result.

Quality and Safety Implications

5.2. There are no quality and safety implications arising from this report.

Equality Implications

5.3. There may be equality implications arising from the impact of the guidance when it is published. NHS England will be required to consider this as the guidance is developed.

Legal and Policy Implications

5.4. The consultation will support the drafting of NHS England Commissioning guidance for the CCG, which the CCG will need to have regard to in developing it's own policies and commissioning decisions.

Other Implications

5.5. The guidance will impact on Medicines Optimisation and the prescribing budget, details of which will not be available until the guidance is published.

Name Hemant Patel
Job Title Head of Medicines Optimisation
Date: **28 January 2019**

ATTACHED:

NHS England Consultation Document Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	Dr Reehana Dr Stone Sought via Paper	09.01.19 09.01.19
Public/ Patient View	Via access to the on line consultation	
Finance Implications discussed with Finance Team	N/a at this stage	
Quality Implications discussed with Quality and Risk Team	N/a at this stage	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a at this stage	
Information Governance implications discussed with IG Support Officer	N/a at this stage	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a at this stage	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a at this stage	
Any relevant data requirements discussed with CSU Business Intelligence	N/a at this stage	
Signed off by Report Owner (Must be completed)	**Hemant Patel**	**28/01/2019**

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NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

NHS England

Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

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Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs

Version number: 1

First published:

NHS England Gateway publication number:

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact NHS England on england.medicines@nhs.net

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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1 Background

1.1 What is the issue we are trying to tackle?

It is important that the NHS achieves the greatest value from the money that it spends. In 2017, the cost of prescriptions dispensed in the community was £9.17 billion[1] and we know that across England there is significant variation in what is being prescribed and to whom.

In addition, patients continue to receive medicines which have been proven to be ineffective or in some cases dangerous, and/or for which there are other more effective, safer and/or cheaper alternatives.

Clinical Commissioning Groups (CCGs) therefore asked for a nationally co-ordinated approach to the development of commissioning guidance to ensure consistency and address unwarranted variation. As part of the review of medicines which could be considered to be of a 'low clinical priority', NHS England has continued to partner with NHS Clinical Commissioners to support CCGs in ensuring that they use their prescribing resources effectively and deliver the best patient outcomes from the medicines their local population use. To lead the work, NHS England hosted a clinical working group in partnership with NHS Clinical Commissioners, with prescriber and pharmacy representatives and relevant national stakeholders.

The aim is that our guidance will help support a more equitable process for making decisions about medicines; but CCGs will need to take individual decisions on implementation locally, ensuring they take into account their legal duties to advance equality and have regard to reduce health inequalities.

As a result of our work, NHS England and NHS Clinical Commissioners have identified a number of further products which fall under one or more of the criteria outlined in section 1.4 below. We are also using this document to provide an update to guidance issued in November 2017 for Rubefacients (see section 4)

1.2 What is the objective of this work and what are we doing now?

The objective of this work is to support CCGs in their decision-making, to address unwarranted variation (see appendix 4 for details), and to provide clear national advice to make local prescribing practices more effective. The current financial situation means that CCGs need to make increasingly difficult decisions about how to spend the NHS budget and this means prioritising those things that will give patients the best clinical outcomes. Any savings from implementing the proposals will be reinvested in improving patient care.

Having completed the first stage of our work in 2017 and early 2018 (see section 1.4 for links to this work), we set out in this document, further proposed national guidance for CCGs on medicines which can be considered to be of low priority for NHS funding. This guidance is being sent out for consultation nationally, and we encourage CCGs to take part in this consultation by engaging with their communities and local professionals. Further information and guidance on how to do this can be found in section 1.7 and section 6.

[1] NHS Digital Prescription Cost Analysis 2017

1.3 Who will the commissioning guidance be addressed to?

This guidance is addressed to CCGs to support them to fulfil their duties around appropriate use of their resources. We expect CCGs to take the proposed guidance into account in formulating local polices, and for prescribers to reflect local policies in their prescribing practice. The guidance does not remove the clinical discretion of the prescriber in accordance with their professional duties.

This guidance is issued as general guidance under the NHS Act 2006 and is addressed to CCGs to support them to fulfil their duties around appropriate use of prescribing resources. The objective of this guidance is to support CCGs in their decision-making, to address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective.

1.4 How have these proposals been developed?

CCGs are regularly having to take difficult decisions about their local drug formularies and are supportive of wider national level guidance for their actions. The 'low value medicines project' (now re-termed 'low priority prescribing' project) and working group led jointly by NHS England and NHS Clinical Commissioners (NHSCC) was established in April 2017 as CCGs asked for a nationally co-ordinated approach to the creation of commissioning guidance. The aim was to reduce unwarranted variation and introduce a more equitable framework from which CCGs can take an individual and local implementation decision.

During 2017/18 CCG guidance was published by NHS England and NHSCC for:

- Items that should not be routinely prescribed in primary care (Nov 2017); and
- Conditions for which over the counter items should not routinely be prescribed in primary care (March 2018)

Feedback from CCGs via NHSCC demonstrates that this national co-ordinated approach and CCG guidance, outlining national recommendations, has been a helpful lever to initiate and support local decision making and to implement changes. It was agreed that NHS England should continue to work jointly with NHSCC to address further low priority items that should not routinely be prescribed. Further items from NHSCC's initial list were reviewed in line with the criteria as set out in section 1.6. This list was informed by the PrescQIPP drop list.

In the joint clinical working group, items were considered for inclusion if they were:

- Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns;

- Items which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation; and/or

- Items which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding.

The group assigned one or more of the following recommendations to items considered:

- Advise CCGs that prescribers in primary care should not initiate {item} for any new patient;
- Advise CCGs that prescribers in primary care should not initiate {item} that cost {price} for any new patient.
- Advise CCGs to support prescribers in deprescribing {item} in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change;
- Advise CCGs to support prescribers in deprescribing {item} that cost {price} in all patients and where appropriate ensure the availability of relevant services to facilitate this.
- Advise CCGs that if, in exceptional[2] circumstances, there is a clinical need for {item} to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional;
- Advise CCGs that all prescribing should be carried out by a specialist; and/or
- Advise CCGs that {item} should not be routinely prescribed in primary care but may be prescribed in named circumstances such as {circumstance}.

Subsequently NHS England's Board considered the proposals prior to them being formally consulted upon publicly.

1.5 Who has been involved in developing the proposal in this consultation?

NHS England and NHS Clinical Commissioners established a joint clinical working group to develop these proposals. More detail on the membership of this working group is in included Appendix 1.

A stakeholder meeting was held in November 2018 to discuss the emerging recommendations outlined in this consultation document.

1.6 What evidence has been used in developing these proposals?

The joint clinical working group considered information from various sources and organisations which are set out at the relevant parts of section 4. The group also considered recommendations from NICE, where relevant, in order to support CCGs in implementing NICE guidance across the country. In particular it identified items which NICE consider to be "Do not do's[3]".

Where NICE guidance was not available, the group considered evidence from a range of sources, for example; the MHRA, the British National Formulary, MTRAC – Center

[2] In this context, "exceptional circumstances" should be interpreted as: Where the prescribing clinician considers no other medicine or intervention is clinically appropriate and available for the individual
[3] Practices NICE recommend should be discontinued completely or should not be used routinely

for Medicines Optimisation and PrescQIPP CIC evidence reviews. In reaching its recommendations for the products identified in section 4, the group reviewed each product against the following criteria:

- **Legal Status** i.e. is it prescription only, or is it available over the counter in pharmacies and/or any retail outlet?
- **Indication** i.e. what condition is it used to treat?
- **Background** i.e. a general narrative on the drug incl. pack size, tablet size, whether administered orally etc.
- **Patent Protection** i.e. is the drug still subject to a patent?
- **Efficacy** i.e. is it clinically effective?
- **Safety** i.e. is the drug safe?
- **Alternative treatments and exceptionality for individuals** i.e. do alternatives exist and if so, who would they be used for?
- **Equalities and Health Inequalities** i.e. are there groups of people who would be disproportionately affected?
- **Financial implications, comprising:**
    - **Commissioning/funding pathway** i.e. how does the NHS pay for the drug?
    - **Medicine Cost** i.e. how much does the drug cost per item?
    - **Healthcare Resource Utilisation** i.e. what NHS resources would be required to implement a change?
    - **Annual Spend** i.e. what is the annual spend of the NHS on this item?
- **Unintended consequences** (see Appendix 2)

1.7 Who are we consulting and how can they respond?

This consultation, which is being nationally co-ordinated but which also encompasses a local element, is addressed to all CCGs, the public and patients, and any relevant interest group or body. **It will be open for 3 months from 28 November 2018 until 28 February 2019.**

Please see section 6: Next Steps for details on how to submit responses. If you are unable or unwilling to reply online, you may also reply by post to: NHS England, PO Box 16738, Redditch, B97 9PT.

During the national consultation phase individual CCGs can provide a response to the commissioning guidance, based on its own local consultation and engagement activities. This could include but is not limited to:

- The CCG's own perspective on the guidance;
- The outcome of any relevant local consultations; and/or
- Local engagement with patient participation groups, local community groups representing people with protected characteristics, Healthwatch and/or discussion with the local overview and scrutiny committee of the Local Authority

The potential equality impact of these proposals has been considered and is outlined in the Equality and Health Inequalities Impact Assessment document published alongside this consultation. We believe that the proposals are likely to have a neutral or positive impact on individuals with protected characteristics. If you do not agree,

and/or if you think there will be direct or indirect negative impact on people with protected characteristics, you can let us know by providing your views to the relevant consultation questions.

1.8 Confidentiality

It is our intention to publish a summary of the responses we receive to this consultation on the NHS England website in due course. You can respond with your name and/or organisation, you can remain anonymous or ask that your details are kept confidential and excluded from the published summary of responses. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential.

Please also be aware that the summary may include details taken from any area of the consultation response, and so please bear this in mind when providing your comments. If you would prefer any particular comments are kept confidential (i.e. not published) please make this clear.

If you provide us with any personal information (i.e. name or email address) we will process, hold and store this in accordance with the General Data Protection Regulation and the Data Protection Act 2018. Your details will be kept for the minimum time necessary to allow us to complete the consultation exercise and use the outcomes of that consultation as part of our decision-making.

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2 Definitions and scope

2.1 Definitions

Annual Spend: Unless otherwise indicated this is the total value from the Prescription Analysis for England 2018 produced by NHS Digital. Prescriptions written by General Medical Practitioners and non-medical prescribers (nurses, pharmacists etc.) in England represent the vast majority of prescriptions included. Prescriptions written by dentists and hospital doctors are also included provided that they were dispensed in the community. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. Prescriptions written in England but dispensed outside England are not included. The figure quoted is the net ingredient cost which refers to the cost of the drug before discounts and does not include any dispensing costs or fees. It does not include any adjustment for income obtained where a prescription charge is paid at the time the prescription is dispensed or where the patient has purchased a prepayment certificate.

Item: An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the Drug Tariff.

MHRA: Medicines and Healthcare products Regulatory Agency. They regulate medicines, medical devices and blood components for transfusion in the UK.

NHS Clinical Commissioners: NHSCC are the independent membership organisation for CCGs, providing their collective voice, facilitating shared learning and delivering networking opportunities for CCG members.

NICE: The National Institute for Health and Care Excellence. They provide the NHS with clinical guidance on how to improve healthcare.

PHE: Public Health England. They protect and improve the nation's health and wellbeing, and reduce health inequalities.

Routinely: Regularly, as part of the usual way of doing things rather than for an exceptional reason.

2.2 Scope

The following chapter sets out the process for how NHS England and NHS Clinical Commissioners will conduct the process to review and update the guidance to CCGs as appropriate. Chapter 4 sets out draft guidance on the products that have been identified as being of low priority prescribing for one or more of the reasons outlined in section 1.4. For each, this consultation provides advice to commissioners based on the latest available evidence and the clinical consensus that has been reached by our joint clinical working group. It seeks views on whether this advice can implemented in practice and clinically sound. Full details of the questions can be seen on the online consultation form and in Appendix 3.

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3 How will the guidance be updated and reviewed?

The NHS England and NHS Clinical Commissioners joint clinical working group will continue to meet and update the proposals as a result of this consultation.

The guidance will be reviewed at least annually; the joint clinical working group will identify potential items[4] to be retained, retired or added to the current guidance. There will be three stages:

Item identification
Organisations represented on the joint clinical working group will, taking into account previous feedback, identify items from the wide range of items that can be prescribed on NHS prescription in primary care in the categories defined in section 1.4.

Item prioritisation
The joint clinical working group will prioritise items based on the following criteria:

- Safety Issue
- Evidence of efficacy
- Degree of variation in prescribing
- Cost to the NHS
- Strong clinician or patient feedback

A consultation document will be made available and a public consultation will be undertaken. Feedback will be collated and then published on the NHS England website.

Item selection for inclusion or removal from the guidance
The joint clinical working group will consider the feedback and produce a final list of recommendations for consideration by NHS England and NHS Clinical Commissioners to update the proposed commissioning guidance for items which should not be routinely prescribed in primary care.

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[4] An item is anything which can be prescribed on an NHS prescription. More information on what is prescribed on an NHS prescription is available in the Drug Tariff.

4 Proposals for updated CCG commissioning guidance

Guidance on rubefacients was issued in November 2017; this is an update to that guidance to consider exclusion of capsaicin cream in line with NICE guidance. We are consulting on the proposal to exclude capsaicin cream only and not the inclusion of rubefacients as a whole.

4.1 Rubefacients (excluding topical NSAIDs[5])

Recommendation	• Advise CCGs that prescribers in primary care should not initiate rubefacients (excluding topical NSAIDs *and capsaicin*) for any new patient. • Advise CCGs to support prescribers in deprescribing rubefacients (excluding topical NSAIDs *and capsaicin*) in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
2018 update	The working group proposes to exclude capsaicin cream as well as topical NSAIDs. i.e. capsaicin can now be prescribed as per NICE guidance. Capsaicin cream falls within **NICE guidance** • Neuropathic Pain: Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate oral treatments. • Osteoarthritis: Topical capsaicin should be considered as an adjunct to core treatments for knee or hand osteoarthritis.
Exceptions and further recommendations	No routine exceptions have been found.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.
Annual Spend	£5,481,000 (source: NHS BSA, 2017/18)
Background and Rationale	Rubefacients are topical preparations that cause irritation and reddening of the skin due to increased blood flow. They are believed to relieve pain in various musculoskeletal conditions and are available on prescription and in over-the-counter remedies. They may contain nicotinate compounds, salicylate compounds, essential oils and camphor. The BNF states *"The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain."* NICE have issued the following "Do not do" recommendation:

[5] This proposal does not relate to topical non-steroidal anti-inflammatory drug (NSAID) items such as Ibuprofen and Diclofenac.

	Do not offer rubefacients for treating osteoarthritis. Due to limited evidence and NICE recommendations the joint clinical working group considered rubefacients (excluding topical NSAIDS) suitable for inclusion in this guidance.
Further Resources and Guidance for CCGs and prescribers	PrescQIPP CIC Drugs to Review for Optimised Prescribing – Rubefacients NICE CG177 Osteoarthritis: care and management BNF: Soft-tissue disorders Patient information leaflets: https://www.prescqipp.info/media/1404/patient-information-changes-to-rubefacients-prescribing.pdf

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5 Proposals for new Commissioning Guidance

5.1 Aliskiren

Recommendation	• Advise CCGs that prescribers in primary care should not initiate aliskiren for any new patient. • Advise CCGs to support prescribers in deprescribing aliskiren in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Exceptions	None
Background	Aliskiren is a renin inhibitor which inhibits renin directly; renin converts angiotensinogen to angiotensin. It is indicated for essential hypertension either alone or in combination with other antihypertensives.
Annual Spend	£939,300 (NHS BSA, 2017/18)
Rationale for recommendation	NICE state there is insufficient evidence of its effectiveness to determine its suitability for use in resistant hypertension. Whilst aliskiren has shown comparable efficacy to other antihypertensive agents in terms of blood pressure reduction, its effects on mortality and long-term morbidity are currently unknown.
Category	Products which are clinically effective but where more cost-effective products are available this includes products that have been subject to excessive price inflation.

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5.2 Amiodarone

Recommendation	• Advise CCGs that prescribers should not initiate amiodarone in primary care for any new patient. • Advise CCGs that if, in exceptional circumstances, there is a clinical need for amiodarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.
Exceptions	Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180.It may also be suitable in patients prior and post cardioversion or in specific patients who also have heart failure or left ventricular impairment.
Background	Treatment of arrhythmias, particularly when other drugs are ineffective or contra-indicated, including paroxysmal supraventricular, nodal and ventricular tachycardias, atrial fibrillation and flutter, ventricular fibrillation, and tachyarrhythmias associated with Wolff-Parkinson-White syndrome (initiated in hospital or under specialist supervision).
Annual Spend	£1,095,700 (NHS BSA, 2017/18)
Rationale for recommendation	Amiodarone has an important place in the treatment of severe cardiac rhythm disorders where other treatments either cannot be used or have failed. It has potential major toxicity and its use requires monitoring both clinically and via laboratory testing. NICE clinical guideline on Atrial Fibrillation (AF) CG 180 puts greater emphasis on rate rather than rhythm control and has clarified the place of amiodarone in the treatment pathway: https://www.nice.org.uk/guidance/CG180 NICE have issued the following “Do not do” recommendation: **Do not offer amiodarone for long-term rate control.**
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

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5.3 Bath and shower preparations for dry and pruritic skin conditions

Recommendation	• Advise CCGs that prescribers in primary care should not initiate bath and shower preparations for any new patient. • Advise CCGs to support prescribers in deprescribing bath and shower preparations in this category and substitute with "leave-on" emollients and, where appropriate, to ensure the availability of relevant services to facilitate this change.
Exceptions	None
Background	Emollient bath and shower preparations are routinely prescribed for dry and pruritic skin conditions including eczema and dermatitis.
Annual Spend	£15,800,000 (NHS BSA 2017/18)
Rationale for recommendation	A multicentre pragmatic parallel group RCT looking at emollient bath additives for the treatment of childhood eczema (BATHE) showed that there was no evidence of clinical benefit for including emollient bath additives in the standard management of childhood eczema. 'Leave-on' emollient moisturisers can still be used for treating eczema and these emollients can still be used as soap substitutes. Patients should be counselled on the use of any emollients as soap substitutes and the risk of using bath and shower emollients should be fully explained.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

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5.4 Blood glucose testing strips for type 2 diabetes

Recommendation	In patients with type 2 diabetes: • Advise CCGs that prescribers in primary care should not initiate blood glucose testing strips that cost >£10 for 50 strips for any new patient • Advise CCGs to support prescribers in deprescribing blood glucose testing strips that cost >£10 for 50 strips and where appropriate, ensure the availability of relevant services to facilitate this change. The intention of this recommendation is not that patients be de-prescribed blood glucose testing strips or not initiated on them. It is intended to encourage CCGs and prescribers to consider more cost-effective alternatives.
Exceptions	Patients with type 2 diabetes who have been trained in carbohydrate counting and utilise an appropriate carb counting meter.
Background	There are currently over 40 different types of Blood Glucose Test (BGT) strips available in the UK.
Annual Spend	£173,110,700 (NHS BSA, 2017/18)
Rationale for recommendation	BGT meters are classed as appliances and as such are not subjected to the same licensing arrangements as medicinal products. The quality of a meter is measured against a set international standard ISO 15197:2013. They range in price from £5.45 to £16.53[6] therefore promoting use of more cost effective test strips first line will enable savings to be made whilst not affecting patient care. Rationalising the amount of meters and test strips in use allows the education of healthcare professionals who in turn can better assist patients with their testing. Patients should therefore be switched from more expensive meters to cost effective options. NICE guidance outlines specific criteria for when self-monitoring of blood glucose may be suitable in patients with type 2 diabetes. https://www.nice.org.uk/guidance/ng28/chapter/1-Recommendations#self-monitoring-of-blood-glucose
Category	Products which are clinically effective but where more cost-effective products are available this includes products that have been subject to excessive price inflation.

[6] NHS Drug Tariff 2018

5.5 Dronedarone

Recommendation	• Advise CCGs that prescribers should not initiate dronedarone in primary care for any new patient; • Advise CCGs that if, in exceptional circumstances, there is a clinical need for dronedarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional;
Exceptions	Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180.
Background	Dronedarone is used for the maintenance of sinus heart rhythm after cardioversion in clinically stable patients with paroxysmal or persistent atrial fibrillation, when alternative treatments are unsuitable (initiated under specialist supervision).
Annual Spend	£1,663,400 (NHS BSA 2017/18)
Rationale for recommendation	Dronedarone was originally approved to prevent atrial fibrillation from coming back or to lower the heart rate in adults who have had or have non-permanent atrial fibrillation. In September 2011 this indication was restricted to the maintenance of normal heart rhythm in 'persistent' or 'paroxysmal' atrial fibrillation after normal heart rhythm has been restored. This followed a review of data that became available since its authorisation including data from the PALLAS study. NICE clinical guideline on Atrial Fibrillation (AF) CG 180 puts greater emphasis on rate rather than rhythm control and has clarified the place of dronedarone in the treatment pathway: https://www.nice.org.uk/guidance/CG180
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

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5.6 Minocycline for acne

Recommendation	• Advise CCGs that prescribers in primary care should not initiate minocycline for any new patient. • Advise CCGs to support prescribers in deprescribing minocycline in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Exceptions	None
Background	Minocycline is a tetracycline antibiotic that can be used for many indications but is mainly used in primary care for acne.
Annual Spend	£ 637,400 (NHS BSA 2017/18)
Rationale for recommendation	Minocycline is mainly used for acne however there are various safety risks associated with its use. NICE CKS advises *Minocycline is not recommended for use in acne as it is associated with an increased risk of adverse effects such as drug induced lupus, skin pigmentation and hepatitis.* A PrescQIPP CIC review found there is no evidence to support the use of one tetracycline over another in terms of efficacy for the treatment of acne vulgaris and alternative once daily products are available.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

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5.7 Needles for Pre-Filled and Reusable Insulin Pens

Recommendation	• Advise CCGs that prescribers in primary care should not initiate insulin pen needles that cost >£5 per 100 needles for any new diabetes patient • Advise CCGs to support prescribers in deprescribing insulin pen needles that cost>£5 per 100 needles and, where appropriate ensure the availability of relevant services to facilitate this change.
Exceptions	None
Background	Pen needles are available in a complete range of sizes from 4mm to 12mm; different needles will fit different pens, however some pen needles will fit all major insulin delivery pen devices currently available.
Annual Spend	£33,229,300 (NHS BSA, 2017/18)
Rationale for recommendation	There are many different types of insulin pen needles available at a varying cost from £3.95 to £30.08 for 100[7]. Rationalising use ensures that the most cost effective options are used first line. In addition, the Forum for Injection Technique (FIT) UK considers the **4mm needle to be the *safest* pen needle** for adults and children regardless of age, gender and Body Mass Index (BMI). Using needles of a shorter length helps to prevent intramuscular injection of insulin. (IM injection of insulin should be avoided as it can result in unpredictable blood glucose levels). Therefore needle choice should be the most cost effective 4mm needle. For patients currently using longer pen needle lengths (8mm, 12mm), it is advisable to change to a shorter needle length (6mm or less) but only after discussion with a healthcare professional, to ensure they receive advice on the correct injection technique.
Category	Products which are clinically effective but where more cost-effective products are available this includes products that have been subject to excessive price inflation.

[7] NHS Drug Tariff

5.8 Silk Garments

Recommendation	• Advise CCGs that prescribers in primary care should not initiate silk garments for any new patient. • Advise CCGs to support prescribers in deprescribing silk garments in all patients and, where appropriate, ensure the availability of relevant services to facilitate this change.
Exceptions	None
Background	Silk Garments are typically prescribed for eczema or dermatitis. These products are knitted, medical grade silk clothing which can be used as an adjunct to normal treatment for severe eczema and allergic skin conditions. Four brands of knitted silk garments are currently listed as an appliance in part IX A in the Drug Tariff and are relatively expensive.
Annual Spend	£1,204,000 (NHS BSA, 2017/18)
Rationale for recommendation	The PrescQIPP document on silk garments states that the evidence relating to their use is weak and is of low quality. In addition due to limited evidence supporting the efficacy of silk clothing for the relief of eczema, the NIHR HTA programme commissioned the CLOTHES trial, which aimed to examine whether adding silk garments to standard eczema care could reduce eczema severity in children with moderate to severe eczema, compared to use of standard eczema treatment alone: The CLOTHing for the relief of Eczema Symptoms trial (CLOTHES trial). Overall the trial concluded that using silk garments for the management of eczema is unlikely to be cost-effective for the NHS.
Category	Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

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6 Consultation Format

NHS England and NHS Clinical Commissioners are grateful to individuals and organisations who take the time to respond to this consultation. During the 3 month consultation period, we will work with patient representative bodies, charities, Royal Colleges and industry to gather views across the range of stakeholders. We will also be asking CCGs to respond and undertake their own local engagement activities.

If you would like to respond to this consultation you can do so by:

- Using the online web-form here. Questions from the online form are listed in appendix 3. Individuals may also want to contact their local CCG to inform a local response. You can find contact details for your local CCG on the NHS website.

- Written enquiries can be submitted to england.medicines@nhs.net or to the postal address: NHS England, PO Box 16738, Redditch, B97 9PT. Please note that NHS England and NHS Clinical Commissioners will not be able to respond to every response individually.

Following the close of the consultation period, NHS England and NHS Clinical Commissioners will analyse and consider all responses received. A summary of the responses will be published on the NHS England and NHS Clinical Commissioners website to provide CCGs with an opportunity to reflect on what has been heard.

NHS England and NHS Clinical Commissioners, via the joint clinical working group, will review the responses received and develop finalised commissioning guidance. The finalised commissioning guidance will then be published with the expectation that CCGs should 'have regard to' it, in accordance with the NHS Act 2006.

Individual CCGs will then need to make a local decision on whether to implement the national commissioning guidance, with due regard to both local circumstances and their own impact assessments.

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Appendix 1 - Membership of the joint clinical working group

Dr Graham Jackson (Co-chair)	NHSCC Co-chair and Clinical Lead, Buckinghamshire ICS	NHSCC & Buckinghamshire ICS
Dr Bruce Warner (Co-chair)	Deputy Chief Pharmaceutical officer	NHS England
Raj Patel	Deputy Director of Primary Care	NHS England
Julie Wood	Chief Executive	NHSCC
Michele Cossey	Regional Pharmacist	NHS England/NHS Improvement
David Geddes	Director of Primary Care Commissioning	NHS England
Jonathan Underhill	Medicines Clinical Adviser	NICE
Claire Potter	Medicines Regulation & Prescribing	Department of Health and Social Care
Carol Roberts	Chief Executive	PrescQIPP
Margaret Dockey	Information Services Manager	NHS BSA
Manir Hussain	Deputy Director of Primary Care & Medicines Optimisation & Chair of Pharmacy Local Professional Network	Staffordshire CCGs & NHS England
Clair Huckerby	Consultant Pharmacist Primary Care MO	Dudley CCG
Kate Arnold	Deputy Clinical Director, Medicines Management and Optimisation.	Birmingham and Solihull CCG
Paul Gouldstone	Head of Medicines Management	Enfield CCG
Steve Pike	GP Medicines Optimisation Lead	Coastal West Sussex CCG
David Paynton	National Clinical Lead	Royal College of GPs
Robbie Turner	Director for England	Royal Pharmaceutical Society
Andrew Green	Clinical and Prescribing Policy Lead.	GPC
Alex Williams	Deputy Director of Medicines Policy Team	NHS England
Margaret Williams	Chief Nurse	Morecambe Bay CCG
Jan MacDonald	Group Manager, Access & Information for Medicines & Standards	MHRA

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Appendix 2 – Unintended Consequences

The working group considered the potential unintended consequences of its recommendations. These are set out in the table below. Please consider unintended consequences when submitting responses to the consultation.

Potential Unintended Consequences of issuing the proposed guidance	**Response**
Interactions with secondary care and consequent costs	This will need monitoring but is not inevitable. For some products, joint local guidance with secondary care providers may be appropriate.
Use of appointments in primary care	The group recognised that there could initially be increased use of appointments in primary care however this is not expected to be sustained.
Some alternative treatments may not be clinically identical, such as side-effect profile	Prescribers should make a shared decision with patients and CCGs should provide appropriate resources (e.g. decision-support tools) to facilitate this.
Alternative treatments could, in some cases, be prescribed with cost consequences.	This is an opportunity to review medication, and if appropriate to de-prescribe. Although alternatives may need to be considered including their cost impact. Guidance on suitable alternatives and the indication for use will be provided. In the implementation plan for the proposed guidance, monitoring of prescribing patterns would be undertaken and mitigations instigated if appropriate.
Individual prescribers' decision making.	Prescribers must recognise and work within the limits of their competence, as recommended by the GMC and other professional regulators/bodies. Nationally accessible resources (e.g. patient information leaflets) and local professional support should be provided to prescribers. The proposed guidance does not remove the clinical discretion of the prescriber in deciding what is in accordance with their professional duties.
People currently on treatment stopping or altering their treatments	Prescribers should endeavour to explain the rationale for any proposed changes in treatments to come to a shared decision.
Complaints about general practice and associated administration time	The group discussed the potential for numbers of complaints to rise and the impact this would have on general practice workload and parts of the NHS.

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	Therefore to support communication of the changes proposed in the guidance, educational aids will be produced.
Effect on medicines supply	The group recognised that by proposing guidance on individual items there is potential for alternative items to see increased demand. NHS England will work with Department of Health colleagues to ensure that pharmaceutical companies are aware of the proposed guidance and potential need for increased supply in some other products.

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Appendix 3 - Consultation Questions

Please note this is an adapted version of a questionnaire designed for an internet web page. To view the questionnaire in its intended format and submit responses please visit
https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed/

About you

Which age group are you in?
Under 18/19 – 29/30 – 39/40 - 49/50 – 59/60 - 69/70 - 79/80+/Prefer not to say

Please indicate your gender
Male/Female/Intersex/Trans/Non-binary/Prefer not to say

Do you consider yourself to have a disability?
Yes/No/Prefer not to say

Please select what you consider your ethnic origin to be. Ethnicity is distinct from nationality.

White
- Welsh/English/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Other ethnic group
- Chinese
- Any other ethnic group

Mixed
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

Black or Black British
- Black - Caribbean
- Black - African
- Any other Black background

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Please indicate your religion or belief
No religion/Muslim/Buddhist/Sikh/Christian/Atheist/Hindu/Any other religion/Jewish/Prefer not to say

Please indicate the option which best describes your sexual orientation
Heterosexual/Gay/Lesbian/Bisexual/Prefer not to say

Introduction

In what capacity are you responding?

Patient/Family member, friend or carer of patient/Member of the public/Patient representative organisation/Voluntary organisation or charity/Clinician/Clinical Commissioning Group/NHS Provider organisation/Industry/Other NHS Organisation/Other Healthcare Organisation/Professional Representative Body/Regulator/Other (please specify)

Name (optional)
Email address (optional)

Have you read the *document Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs?*

- Yes
- No

Equality and Health Inequalities

NHS England has legal duties which require giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and having regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. An initial Equality and Health Inequalities Assessment (EHIA) has been carried out on these proposals and this can be read here. Further information on our duties can be read at https://www.england.nhs.uk/about/equality/

Do you feel there are any groups, protected by the Equality Act 2010, likely to be disproportionately affected by this work?
Yes (please tick all that apply)/No

Age/disability/gender reassignment/race/religion or belief/sex/sexual orientation/marriage and civil partnership/pregnancy and maternity

Please provide further information on why you think this might be the case.

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Do you feel there is evidence we should consider in our proposals on the potential impact on health inequalities experience by certain groups e.g. people on low incomes; people from black and minority ethnic (BME) communities?
Yes/No

Please provide further information on why you think this might be the case

Section 3: How will the guidance be updated and reviewed?

Thinking about the process for future update and review of the guidance:

How do you feel about the proposed process for identification of items for possible addition to the guidance or indeed possible removal, from the guidance?

Agree/Neither agree or disagree/Disagree/Unsure

If needed, please provide further information.

Section 4: Proposals for CCG commissioning guidance

Please select which items you would like to share your views on (please select)?

Reviewed item
Rubefacients (excluding topical NSAIDs)

New items
Aliskiren
Amiodarone
Bath and shower preparations for dry and pruritic skin conditions
Blood glucose testing strips for type 2 diabetes
Dronedarone
Minocycline
Needles for Pre-Filled and Reusable Insulin Pens
Silk Garments

Rubefacients (excluding topical NSAIDs)
Do you agree with the proposed recommendations for Rubefacients (excluding topical NSAIDs)?
On the webform for each of the 9 medicines, each of the proposed recommendations will be included and for each recommendation one of the following options can be selected.

Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Aliskiren
Do you agree with the proposed recommendations for Aliskiren?

Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Amiodarone
Do you agree with the proposed recommendations for Amiodarone?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Bath and shower preparations for dry and pruritic skin conditions
Do you agree with the proposed recommendations for bath and shower emollient preparations?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Blood glucose testing strips for type 2 diabetes
Do you agree with the proposed recommendations for blood glucose testing strips?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Dronedarone
Do you agree with the proposed recommendations for Dronedarone?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Minocycline
Do you agree with the proposed recommendations for Minocycline?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Needles for Pre-Filled and Reusable Insulin Pens
Do you agree with the proposed recommendations for needles for pre-filled and reusable insulin pens?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

Silk Garments
Do you agree with the proposed recommendations for silk garments?
Agree/Neither agree or disagree/Disagree/Unsure
If needed, please provide further information

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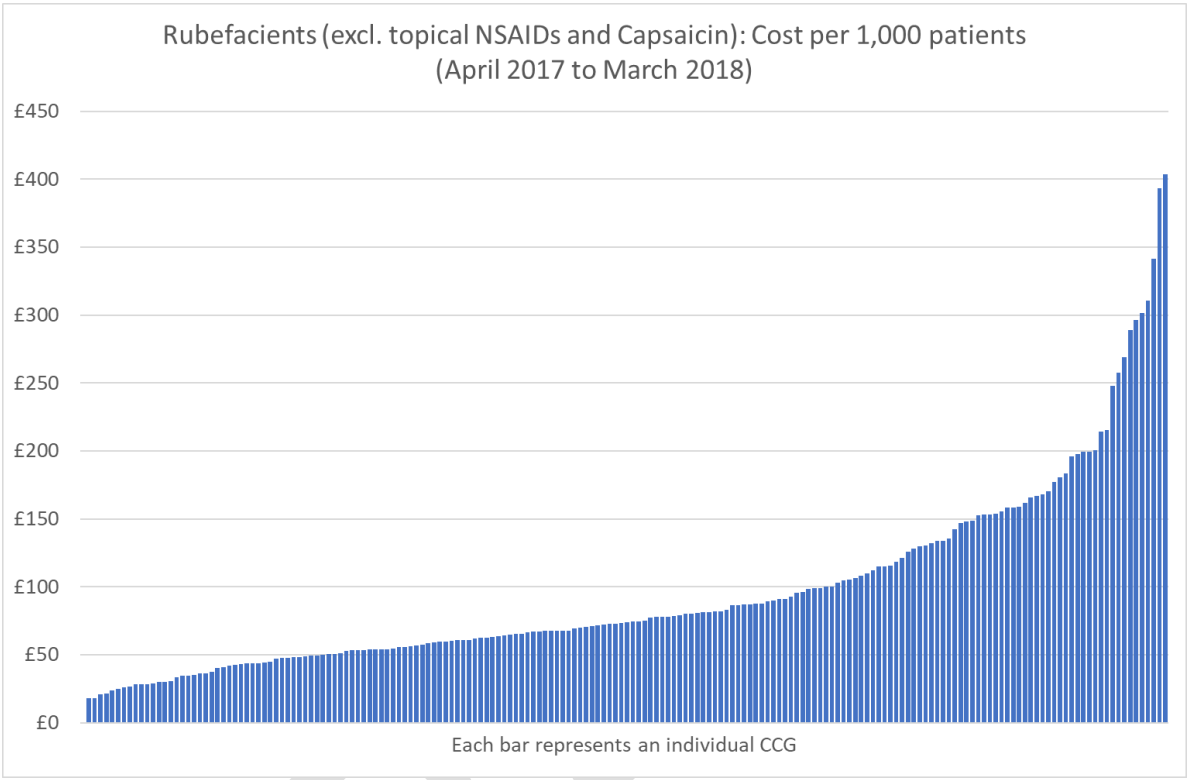
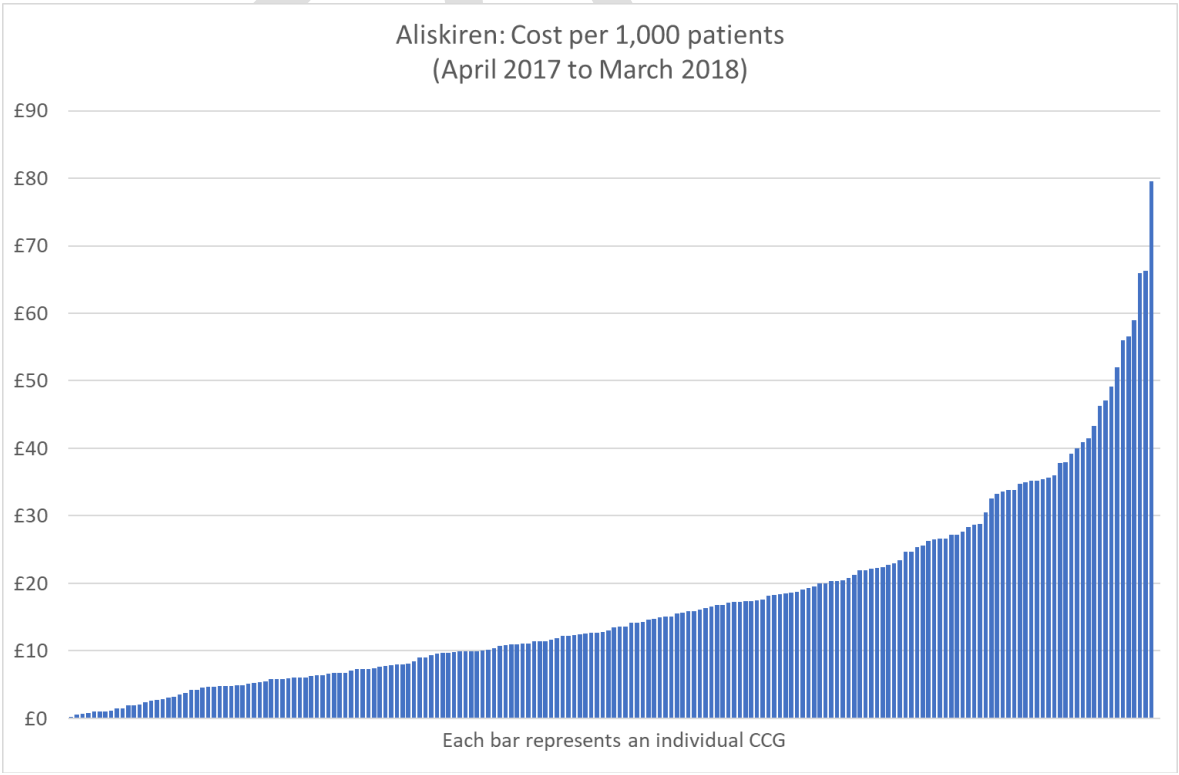
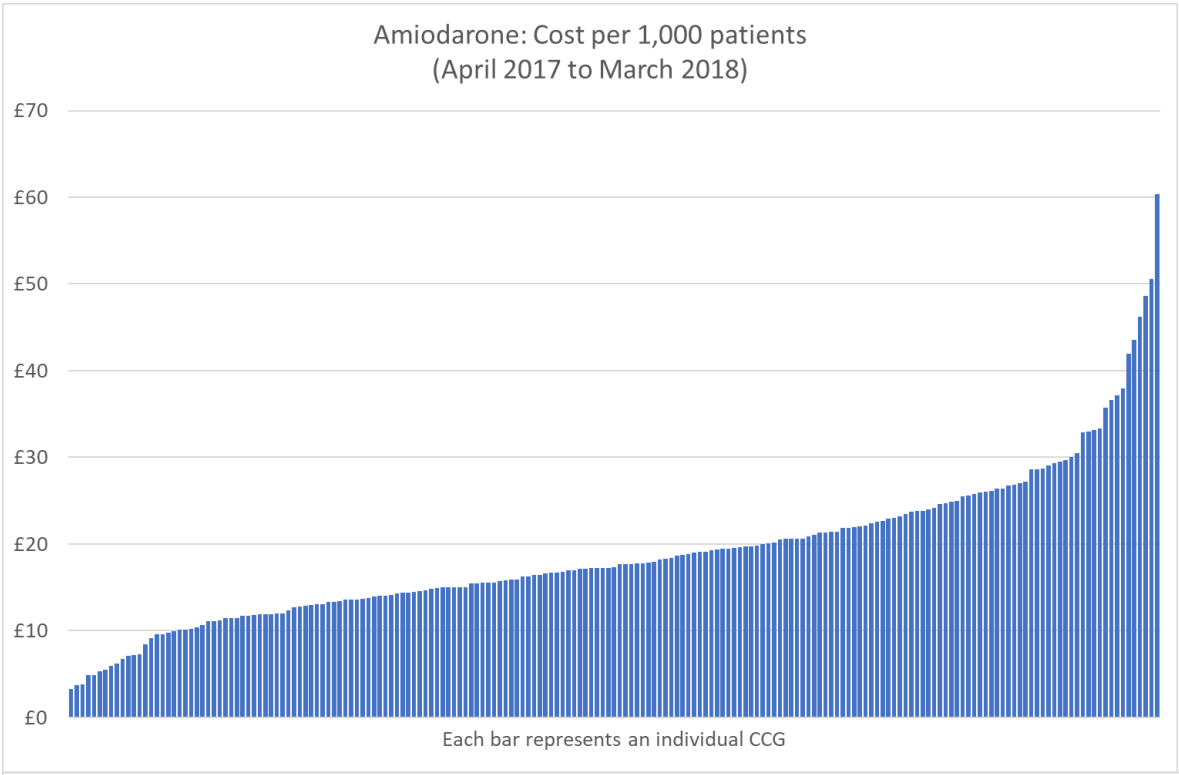
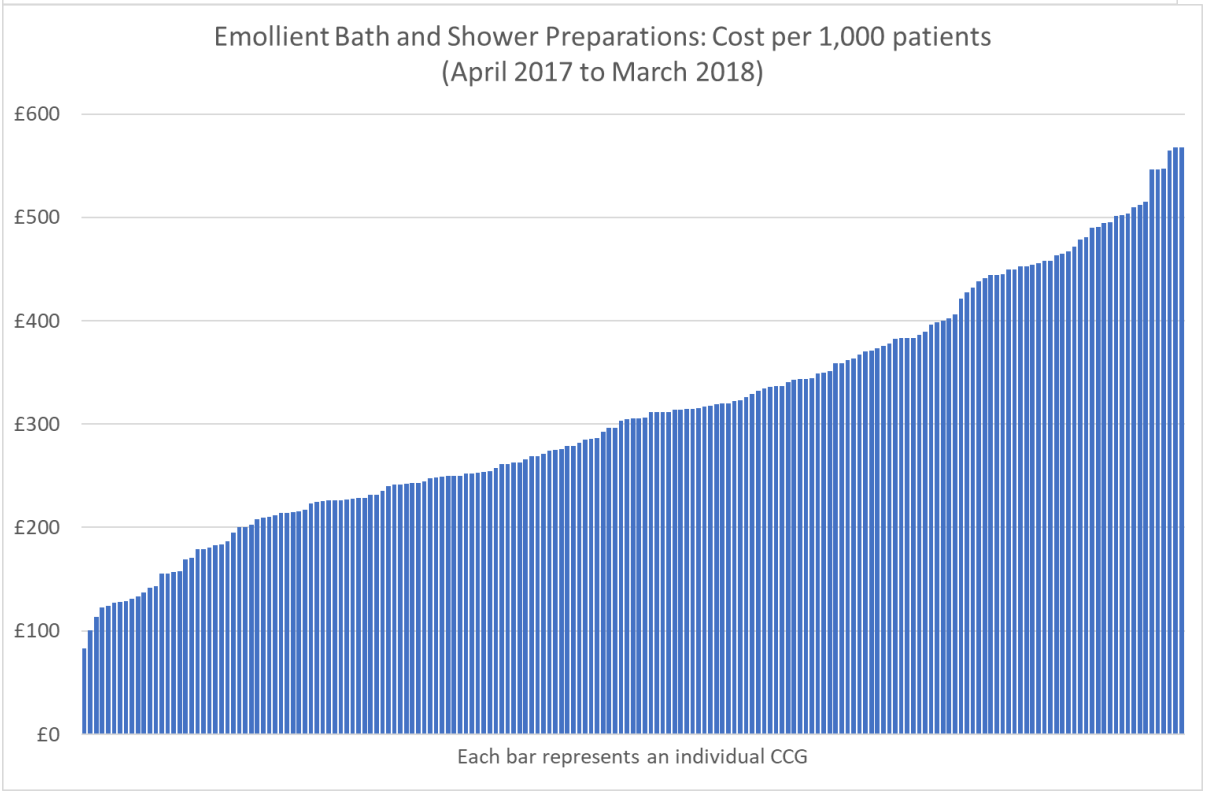
Appendix 4 - Prescribing variation data

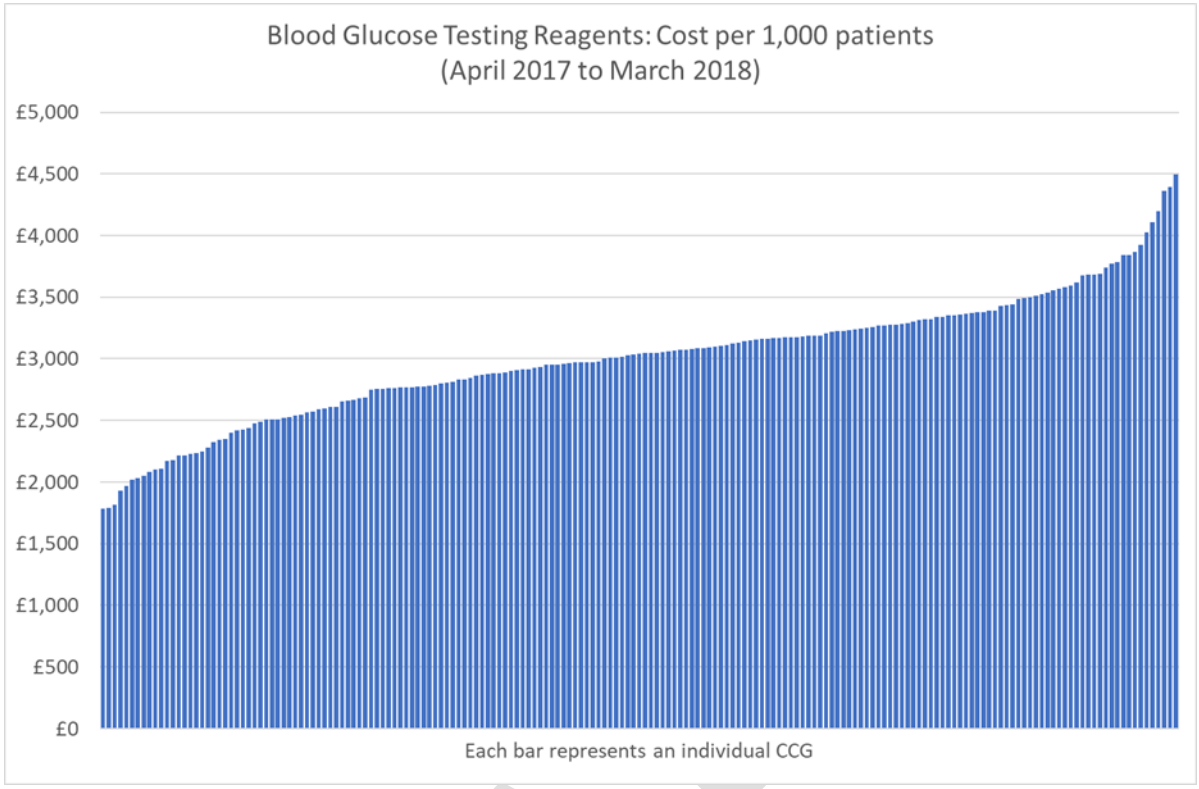
Cost as measured by Net Ingredient Cost per 1,000 patients registered to CCG.

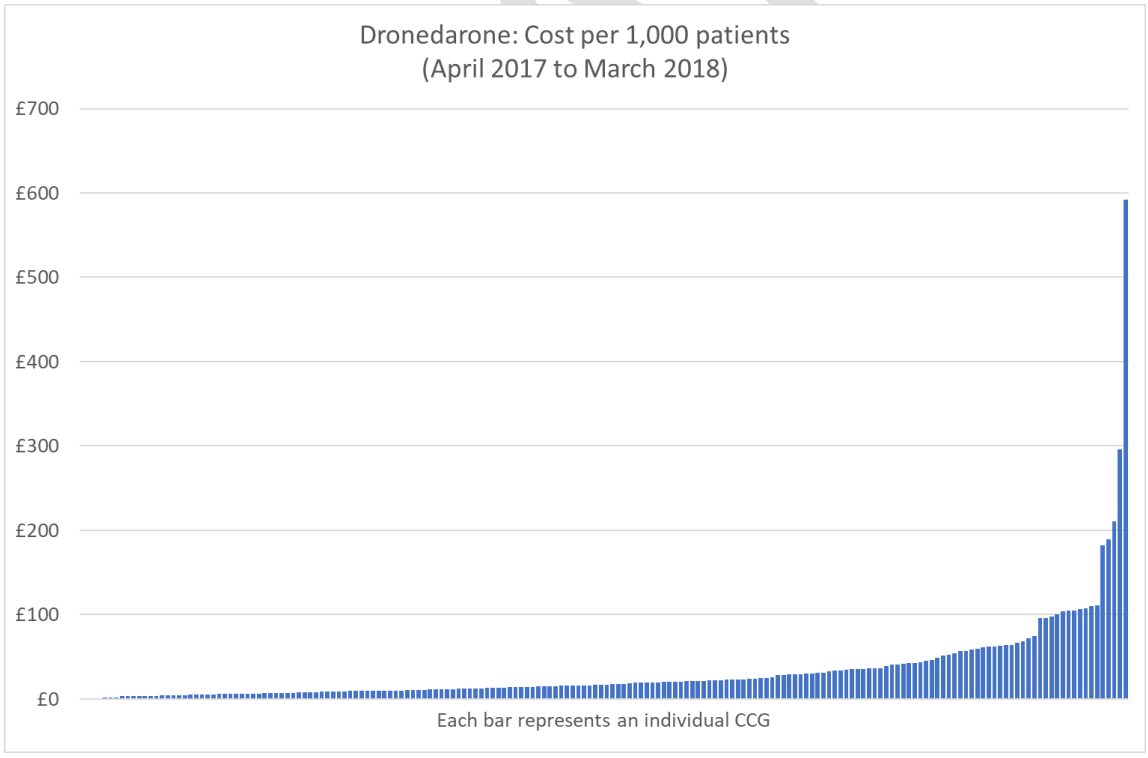


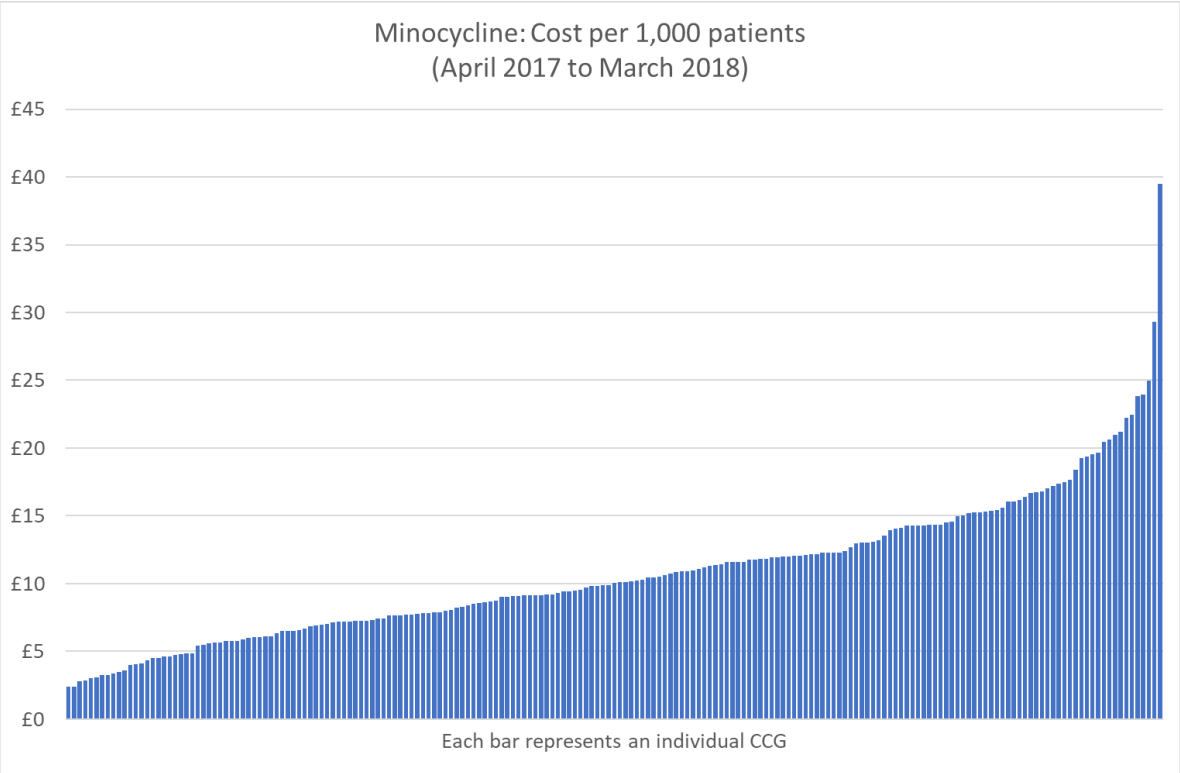


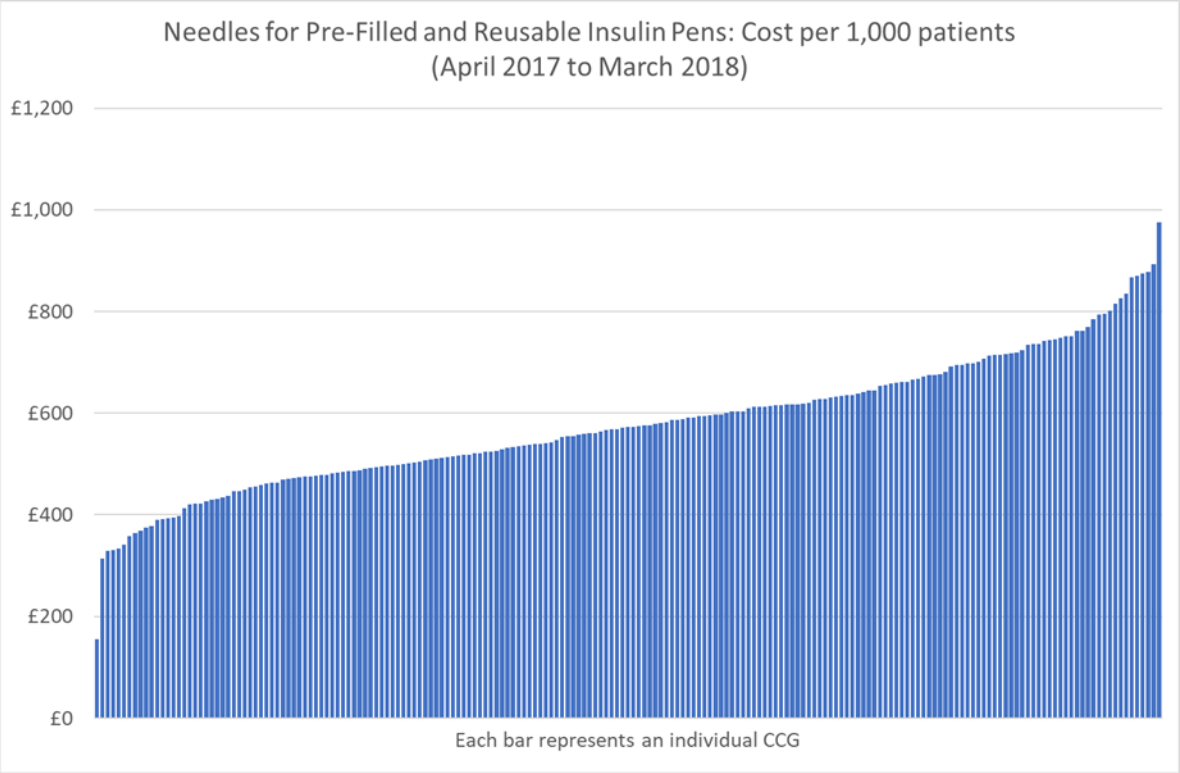

Amiodarone: Cost per 1,000 patients
(April 2017 to March 2018)
£70
£60
£50
£40
£30
£20
£10
£0
Each bar represents an individual CCG

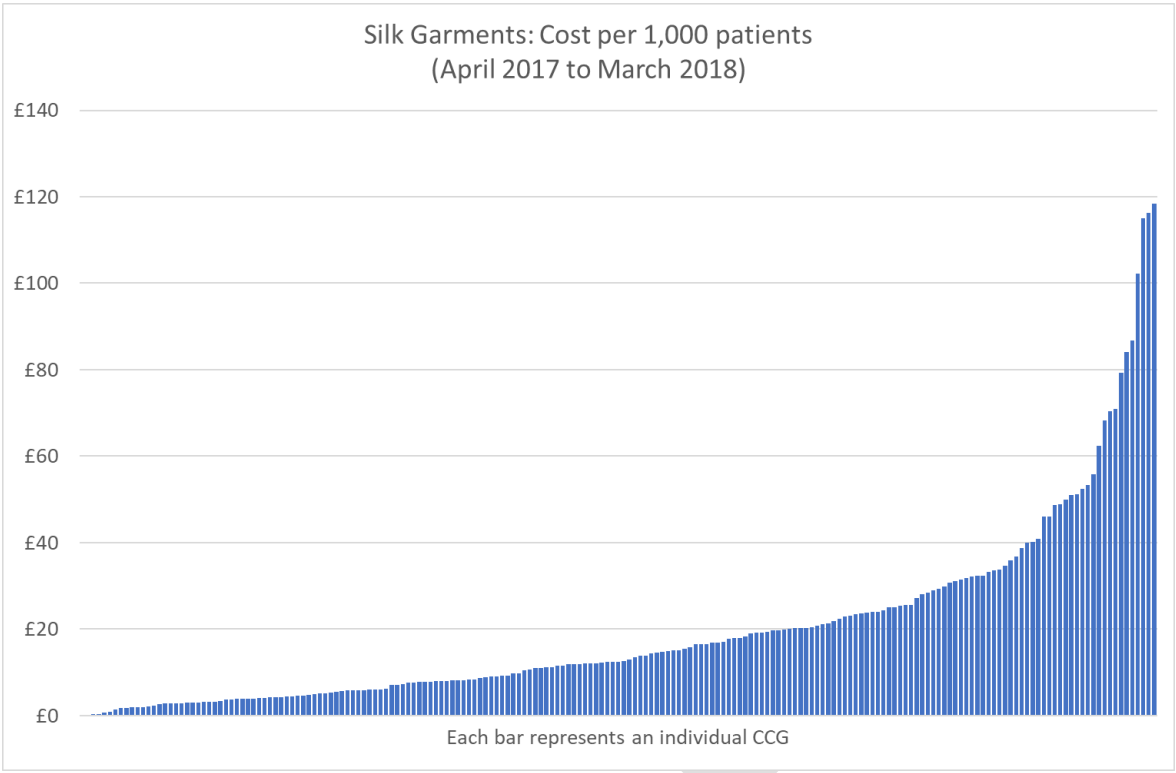

Emollient Bath and Shower Preparations: Cost per 1,000 patients
(April 2017 to March 2018)
£600
£500
£400
£300
£200
£100
£0
Each bar represents an individual CCG


Blood Glucose Testing Reagents: Cost per 1,000 patients
(April 2017 to March 2018)
£5,000
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Each bar represents an individual CCG


Dronedarone: Cost per 1,000 patients
(April 2017 to March 2018)
£700
£600
£500
£400
£300
£200
£100
£0
Each bar represents an individual CCG


Minocycline: Cost per 1,000 patients
(April 2017 to March 2018)
£45
£40
£35
£30
£25
£20
£15
£10
£5
£0
Each bar represents an individual CCG


Needles for Pre-Filled and Reusable Insulin Pens: Cost per 1,000 patients
(April 2017 to March 2018)
£1,200
£1,000
£800
£600
£400
£200
£0
Each bar represents an individual CCG


Silk Garments: Cost per 1,000 patients
(April 2017 to March 2018)
£140
£120
£100
£80
£60
£40
£20
£0
Each bar represents an individual CCG

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 FEBRUARY 2019

Agenda item 8

TITLE OF REPORT:	**Governing Body Assurance Framework and Risk Register**
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide assurance to the Committee on the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
KEY POINTS:	• This report outlines the current work underway to support risk management across the CCG, including the work of the Governing Body Committees. • The latest updated version of the GBAF and Strategic risk register, which has been reviewed by the Audit and Governance Committee will be circulated before the meeting. • Governing Body is asked to review and comment on the GBAF and Risk Register.
RECOMMENDATION:	That the Governing Body • Considers report and updated risk profile for the CCG • Considers the Governing Body Assurance Framework.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Audit and Governance Committee is responsible for maintaining an overview of the CCG's arrangements for managing risk and providing assurance to the Governing Body that they are operating effectively. The Committee agreed an updated version of the Risk Management Strategy in February 2018.

1.2. The CCG's risk management arrangements are designed to provide assurance to the Governing Body that risks to the CCG achieving its objectives are identified and effectively managed. A key element of this is the CCG's Governing Body Assurance Framework (GBAF) which outlines the overall risk to the CCG achieving each of its Corporate Objectives. This is supported by a Corporate level and Committee level risk register as well as regular risk assessment and review by teams throughout the CCG.

2. ASSURANCE FRAMEWORK UPDATE

2.1. The latest updated version of the GBAF, which was considered by the Audit and Governance Committee at its meeting in November 2018 has been updated by the Senior Management Team (SMT), and will be circulated in advance of the meeting. The GBAF gives an update on the risk profile against each of the defined Corporate Objectives and the Governing Body should use it to make an assessment for each objective based on the overall risk of it not being achieved. To support the Governing Body, an indicative score from the management team is given based on the updated risk profile, including the identified Corporate Risks which impact on the achievement of each objective. Details of the change in score from the previous assessment of the GBAF in September 2018 are provided for reference.

2.2. A key support for the development of the GBAF is the CCG's Strategic Risk Register, which includes an update on each of the identified risks, including those reviewed by the Governing Body Committees, which take place at each meeting. An update on the risk register and movement in individual risks will be given at the meeting.

3. COMMITTEE RISK REVIEWS

3.1. In addition to supporting the Governing Body with their review of the Strategic Risk Register, Committees have also continued to review their own assigned risk registers at each meeting. These discussions are supported by work in CCG teams

to identify operational risks and discussion at team meetings to escalate risks as appropriate to committees.

3.2. The current number of risks on each Committee Risk Register is as follows (Previous numbers in brackets):-

Committee	Number of Risks				
	Red	Amber	Yellow	Green	TOTAL
Commissioning Committee	0 (0)	3 (3)	0 (1)	0 (0)	3 (4)
Finance and Performance Committee	0 (0)	2 (4)	7 (4)	0 (0)	9 (8)
Primary Care Commissioning Committee*	0 (0)	3 (3)	0 (0)	0 (0)	3 (3)
Quality and Safety Committee	1 (1)	3 (3)	2 (2)	0 (0)	6 (6)
TOTAL	**1 (1)**	**11 (13)**	**9 (7)**	**0 (0)**	**20 (21)**

3.3. Work continues to ensure that discussions of the risk profile at committees is an embedded part of the committees operation. This includes not just discussing the risks outlined on the committee's risk register, but also considering whether risks are identified as a result of issues discussed throughout the meeting.

4. RISK MANAGEMENT ARRANGEMENTS

4.1. As reported at the last meeting, in line with the agreed recommendations from the Internal Audit review of Risk Management, a programme of regular deep dives into areas of risk has commenced at SMT. The outcome of the first Deep Dive into GBAF Domain 3c – Continuing to Meet Our Statutory Duties and Responsibilities was reported to the Audit and Governance Committee in November 2018.

4.2. The Governance and risk team populated a risk profile for the domain comprising risks identified on the strategic, committee and team risk registers. SMT used this to provide an overview of management of risks in this area throughout the organisation by the use of a facilitated discussion to determine whether risks had been identified correctly, managed appropriately and whether the score for the domain was therefore appropriate.

4.3. As a consequence of the discussion, SMT identified actions in relation to CCG staff capacity challenges, NHS Constitutional Standards and how risks associated with the STP would be managed. This included work with staff to better understand the challenges that they face as a consequence of the emerging changes associated with the STP and demonstrates how more mature risk management arrangements are driving concrete actions across the CCG.

4.4. The Governance and Risk Team have also commenced a regular programme of table top reviews of organisational risk registers, reviewing risks identified at a Corporate, Committee, Team and Programme level. This has helped to identify themes for further work, including on-going partnership working and the impact of the work to implement CCG's Primary Care strategy moving into business as usual. It is also helping to identify areas where the team's support would be beneficial and to develop plans to further enhance arrangements.

5. CLINICAL VIEW

5.1. A clinical view has not been sought for the purpose of this report; however, if relevant, a clinical view is always sought via the appropriate committee membership.

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable for the purpose of this report.

7. KEY RISKS AND MITIGATIONS

7.1. The CCG BAF and Risk Register on-going refresh work is critical, as failure to identify and manage risks is a risk to the achievement of the CCG's strategic objectives.

8. IMPACT ASSESFSMENT

Financial and Resource Implications

8.1. There are no financial implications arising from this report at this stage.

Quality and Safety Implications

8.2. Quality is at the heart of all CCG work and whilst no impact assessment has been undertaken for the purpose of this report, all risks have a patient safety and quality impact assessment

Equality Implications

8.3. There are no Equality Implications associated with this report.

Legal and Policy Implications

8.4. There are no legal implications arising from this report.

Other Implications

8.5. There are no other implications arising from this report

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: January 2019

ATTACHED:

GBAF and Risk Register.

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	Not Applicable	
Public/ Patient View	Not Applicable	
Finance Implications discussed with Finance Team	Not Applicable	
Quality Implications discussed with Quality and Risk Team	Not Applicable	
Equality Implications discussed with CSU Equality and Inclusion Service	Not Applicable	
Information Governance implications discussed with IG Support Officer	Not Applicable	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Owner	January 2019
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**31/01/2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12th February 2019

Agenda item 9

TITLE OF REPORT:	Quarterly Update Better Care Fund Programme
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning
MANAGEMENT LEAD:	Andrea Smith
PURPOSE OF REPORT:	To provide an update on progress of the Better Care Fund Programme
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• This report provides key highlights, risks and Issues across the programme • The national planning guidance for BCF post March 2019 has still not been published. Preparatory work is being undertaken to shape the programme for the future.
RECOMMENDATION:	To inform the Governing Body on the work being undertaken within the Better Care Fund Programme
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both the quality and the patient experience.
2. Reducing Health Inequalities in Wolverhampton	The BCF programme strives to ensure that health inequalities are reduced across the City. The plan is based on data and evidence which allows us to understand the health inequalities that we are aiming to address
3. System effectiveness delivered within our financial envelope	The Better Care fund programme is supported by a pooled budget with the City of Wolverhampton Council. The pooling of resources gives us the opportunity to use our resources more effectively together

1. BACKGROUND AND CURRENT SITUATION

1.1. The Better Care Fund Programme is a programme of work across multiple organisations across the City including WCCG, City of Wolverhampton Council (CWC), Royal Wolverhampton Trust (RWT), Black Country Partnership Foundation Trust (BCPFT), Wolverhampton Homes, Wolverhampton Voluntary Sector.

1.2. Organisations work together in an integrated way aiming to improve pathways and services to patients moving care closer to home where appropriate.

1.3. The programmes vision statement is "*'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them to live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs'*

1.4. This is visualised below:-

Figure 1 BCF Vision

1.5 The Programme consists of 5 Workstreams; Adult Community Care, Mental Health, CAMHS, Dementia and Integration. Each workstream has a lead from WCCG and CWC and a Provider lead and members from all key stakeholders appropriate to the work being undertaken.

2. NATIONAL METRICS

2.1. **Delayed Transfers of Care**.

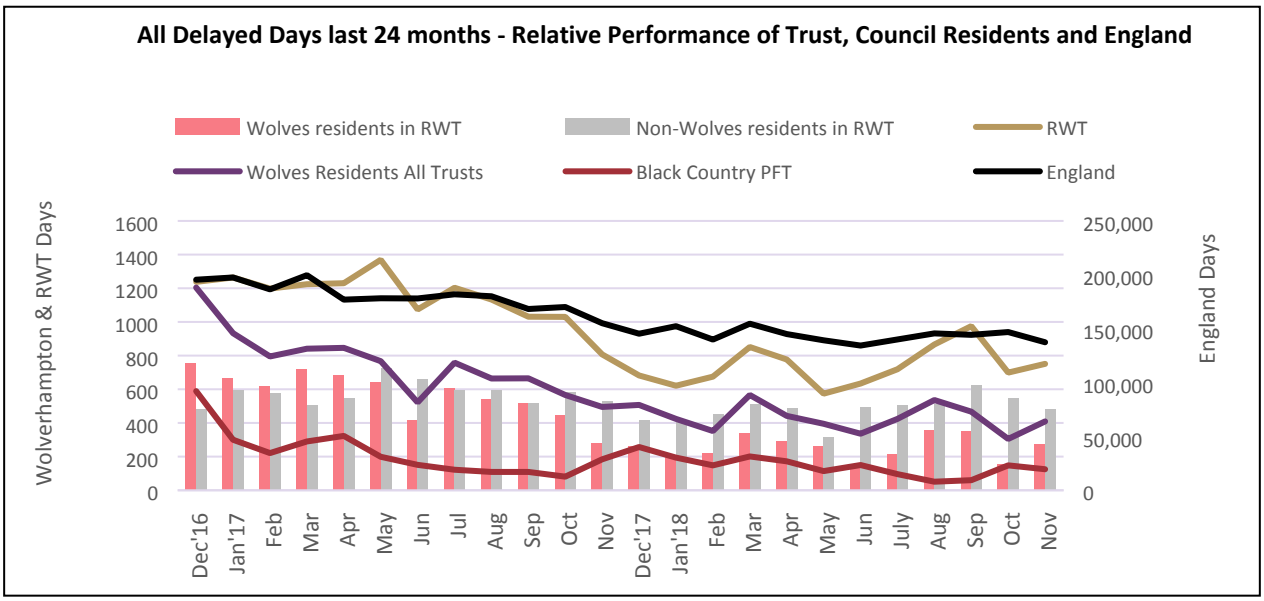

Figure 2 - Relative performance between December 2016 and November 2018 (Source: NHS Statistics)

2.2. The last 24 months data from December 2016 to November 2018, is set out in Figure 1 above. This shows a significant overall reduction in the levels of monthly delayed days over this period, however March, July and August saw reversals in this trend with increases in delays both locally and nationally. However, October saw the best DToC performance for Wolverhampton residents for many years and although November has since seen an increase in the number of delays it is still within target.

2.3. The relative performances of residents from the City of Wolverhampton Council (CWC) and patients treated in the Royal Wolverhampton Trust (RWT) and the Black Country Partnership Foundation Trust (BCPFT) are also included in the chart.

2.4. The latest daily delays rate per 100,000 population aged 18 and over for Wolverhampton residents when calculated over the eight months of the year to date is 6.8 against an NHS England 'ambition' of 7.4 and so remains below target. Additionally, the last ten months relative performances against comparators are shown below.

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
England	11.5	11.5	11.1	10.3	10.3	10.4	10.8	11.1	10.9	10.5
Wolverhampton	6.4	9.2	7.5	6.4	5.7	6.9	8.7	7.8	4.9	6.8
West Midlands	12.6	13.5	13.6	12.3	12	11.9	12.3	12.1	11.7	12.1
CIPFA Group	9.5	10	9.2	9.5	8.7	8.5	9.8	10.2	10.3	9.2

Figure 3 Daily Delays Rate per 100,000 18+

2.5. **Reduction of Non-Elective Admissions**.

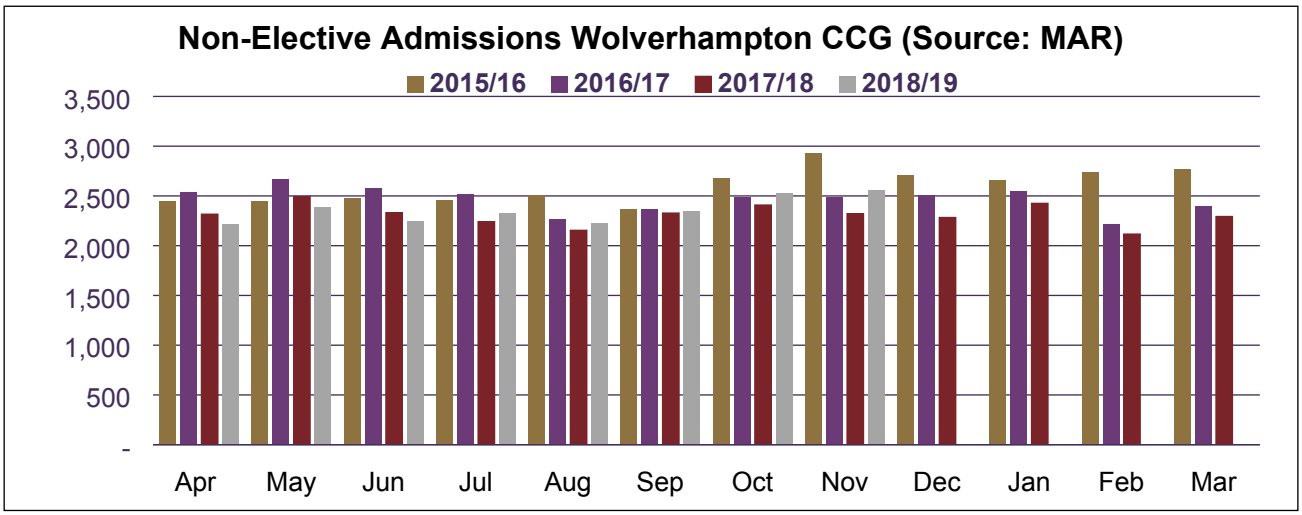

Figure 4 Non-elective admissions

2.6. The columns shown above in Figure 4 represent the Emergency Admission figures over the last 44 months contained within the NHS Monthly Activity Reports (MAR) for the Wolverhampton CCG and until recently these indicated an overall long-term trend of reduction since a peak in November 2015.

2.7. However, the five months since July have seen the first sustained monthly year on year increases in Emergency Admissions since June/July 2016. This can be compared with the growth in the equivalent rate at national level in Figure 5 below.

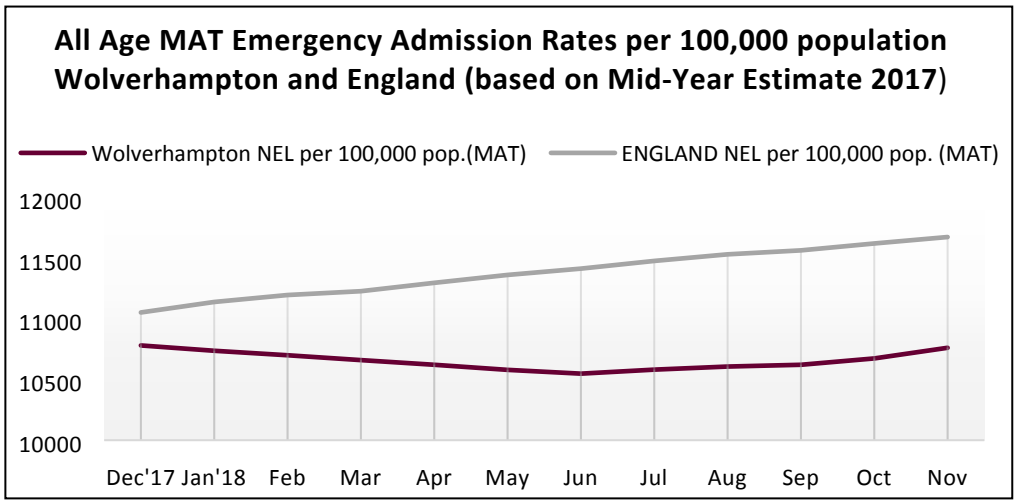

Figure 5 Admission rates

2.8. Permanent Admissions to Residential Homes.

2.9.1 The latest reported number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of December (Figure 5) of 31 is higher than last year and continues the trend of increases since the start of the reporting year with the monthly target of just under 22 admissions (260 in the year) being met only twice in the year to date.

2.10 The year-end total for 2017-18 was 283 which although above the target figure of 260 was 102 admissions (26.5%) lower than the outturn in the previous year. The latest year-end estimate based on nine months performance is now 327 admissions and 26% above target.

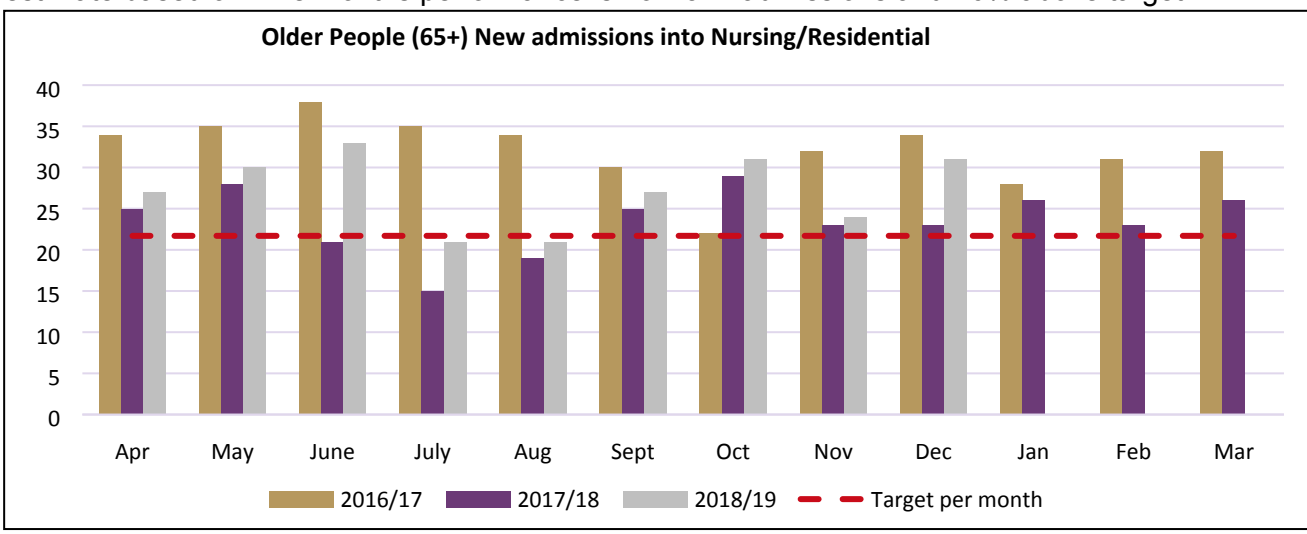

Figure 6 – Permanent Admissions of Older People to Care Homes over the last 33 months (Source: CareFirst)

2.11 Reablement – The proportion of older people (over 65) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services.

2.12 This figure is currently only calculated once a year and is made available each October as part of the SALT Return.

2.13 The provisional outturn for ASCOF 2B Part 1 (Effectiveness of reablement) based on the latest SALT Return for 2017-2018 is 80.7% which represents an improvement on the same figure for 2016-2017 of 74.5%.

3 HIGHLIGHTS

3.1 Co-Location of the NE Community Neighbourhood team

During the middle of December the first of the Community Neighbourhood teams was located at Wolverhampton Science Park. The core team consist of Community Matrons, District Nurses, and the Social Care team for the North Locality. In addition there are hot desks to allow additional staff such as Mental Health, Social Prescribing and Housing Colleagues to work with the team.

In a very short time there has already been positive feedback about the professions working together to manage patients and undertaking joint visits. This all supports our vision of care closer to home and more personalised care.

Work is ongoing with the team, now that they are settled to enhance the integrated working and to widen this further in line with the NHS long term plan in exploring how the team work in the future with Primary Care Networks.

Suitable premises will be sought for the South East and South West localities to enable this integrated model or working to be rolled out across Wolverhampton.

3.2 MDT working

Work continues to roll out MDTs across the City. There are three locality based MDT meetings which meet monthly and there are now a number of Primary Care based MDTs in place. Some are individual practice based and some are practices working together. Again, in line with the Long Term Plan we will be working to deliver MDTs wrapped around Primary Care Networks in the future where possible.

The current MDTs are proving positive and effective. The MDT held on 30th January with Parkfield Medical Practice and Duncan Street Surgery was extremely well attended with presence from GPs, Compton Care, Social Worker, CPN, Practice Nurse Practitioner, Social Prescribing Link Worker, Thrive to Work, Wolverhampton Homes and District Nursing. The MDT meetings are an opportunity to discuss patients with complex needs and to have support from a wide range of organisations and professions in the management of the patient.

Below is a case study from an MDT meeting

The Scenario…

- 82 year old male with a medical history of Hypertension, Type 2 Diabetes, Hypercholesterolemia and Chronic Kidney Disease 3.
- Over the last year (2018) patient has experienced 2 bouts of acute chronic renal failure. In August 2018 he refused to have further treatment following his bloods tests and refused to engage with health professionals.
- Attends dialysis appointments 3x a week
- Patient does not want any help or support from services
- Patient is the main carer for his wife who suffers with severe dementia who will be returning from a Respite Care Home. Patient is in discussion with Social Worker to arrange leaving current home and moving into 'Very Sheltered Housing

What we did…

Worked with Social Prescribing, Community Matrons, Clinical Pharmacist, Social Worker and Advance Nurse Practitioner

GP made referral via WUCTAS to Community Matron for patient to be seen, Social Prescribing Team met with patient once consent gained, they managed to meet with patient and his family and arranged;

- A Blister Pack to be arranged as patient was starting to get confused with his medication and had started to rely on others - **Social Prescriber arranged this with Pharmacist, patient receives Medication via Blister Pack**
- Patient informed their Social Worker he will look after his wife, however will need to attend his dialysis appointment 3x a week, this became a worry to his family, if there is no one to look after his wife during his appointment's he will not attend, also the appointments are based at different places each time (Wolverhampton, Cannock and Walsall) **ANP discussed patients appointments with Renal Lead at New Cross, Community Matron also followed up Dialysis to be at one setting**
- Social Services and patient are working on moving from current address to Very Sheltered accommodation – **Form Is in process Social Care Manager will monitor application progress**

The Outcome…

Patient's appointments are now 3x weekly at Walsall Hospital, sitting service has been arranged by the Social Workers, patients wife is not alone during his dialysis appointments, this has helped a lot due to ensure patient is now compliant with treatment.

Community Matron went out to see patient and mentioned he is doing very well, getting support from family and excellent support from the Social Prescribing Team.

3.3 Winter Pressures

In order to support winter pressures the BCF team worked together to put in place a number of short term solutions across the City. Social Care have led on the expansion of their Rapid Assessment service and additional reablement service so that this now has more capacity and operates City wide. The CCG, in collaboration with partners have commissioned a number of Step Up beds in a nursing home with the aim of supporting admission avoidance. These beds are for patients who are not unwell enough to be admitted to hospital but because of their presenting wellbeing and/or social situation require a period of additional support. The Step up beds are supported by social care and by a service run by the Red Cross that can transport patients to and from the Step up (and Step Down) beds and can resettle patients back home when required. The beds are accessible from RITs, ED, CDU and the Frailty Unit.

4 CLINICAL VIEW

4.11 Clinical view is taken upon each individual project that the programme delivers where necessary

5 PATIENT AND PUBLIC VIEW

5.11 Patient and public view is taken upon each individual project that the programme delivers where necessary

6 KEY RISKS AND MITIGATIONS

6.11 Outline the key risks associated with the report; this should include any reputational risks, litigation etc. You should also highlight any controls or actions in place to mitigate these risks.

6.12 Highlight whether the report either specifically relates to risks included on the risk register or if any risks need to be escalated.

7 IMPACT ASSESSMENT

Financial and Resource Implications

7.11 This report acts as a progress update and any financial implications are managed through the BCF Programme Board.

Quality and Safety Implications

7.12 This report acts as a progress update and any quality and safety implications are managed through the BCF Programme Board.

Equality Implications

7.13 Each individual project within the BCF Programme will undertake an equality impact assessment.

Legal and Policy Implications

7.14 Any legal and policy implications for individual projects will be managed by the BCF Programme Board.

Other Implications

7.15 N/A

Name: Andrea Smith
Title: Head of Integrated Commissioning
Date: 30.01.19

ATTACHED:

RELEVANT BACKGROUND PAPERS
Wolverhampton Integration and Better Care Fund Plan 2017-19

REPORT SIGN-OFF CHECKLIST

	Details/ Name	Date
Clinical View	**N/A**	**30.01.19**
Public/ Patient View	**N/A**	**30.01.19**
Finance Implications discussed with Finance Team	**N/A**	**30.01.19**
Quality Implications discussed with Quality and Risk Team	**N/A**	**30.01.19**
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	**30.01.19**
Information Governance implications discussed with IG Support Officer	**N/A**	**30.01.19**

Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	**30.01.19**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	**30.01.19**
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	**30.01.19**
Signed off by Report Owner (Must be completed)	**Andrea Smith**	**30.01.19**

NHS
Wolverhampton
Clinical Commissioning Group

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions
2. Reducing health inequalities in Wolverhampton	a. Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings
3. System effectiveness delivered within our financial envelope	a. Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. Greater integration of health and social care services across Wolverhampton Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' c. Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework d. Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
Tuesday 12th February 2019

Agenda item 10

TITLE OF REPORT:	EU Exit (Brexit) Assurance
AUTHOR(s) OF REPORT:	Tally Kalea
MANAGEMENT LEAD:	Mike Hastings
PURPOSE OF REPORT:	To provide the Governing Body assurance that the CCG is Fulfilling its duties in preparation for the possibility of a 'No Deal' EU Exit (Brexit) scenario
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Commissioners seek assurance and support local providers • Wolverhampton CCG is well placed in terms of Capacity and Business Continuity
RECOMMENDATION:	• Governing body receive and discuss this report • Be assured that robust communications and plans are in place for a 'No Deal' scenario
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The CCG has an assurance plans and supporting mechanisms in place to enable it to respond to a full range of incidents, both internally and externally.
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	The CCG is carrying out its statutory duty and seeking assurances from Providers to ensure system delivery continues.

1. BACKGROUND AND CURRENT SITUATION

1.1. *"It is a word that is used as a shorthand way of saying the UK leaving the EU - merging the words Britain and exit to get Brexit, in the same way as a possible Greek exit from the euro was dubbed Grexit in the past. Further reading: The rise of the word Brexit*
Why is Britain leaving the European Union?
A referendum - a vote in which everyone (or nearly everyone) of voting age can take part - was held on Thursday 23 June, 2016, to decide whether the UK should leave or remain in the European Union. Leave won by 51.9% to 48.1%. The referendum turnout was 71.8%, with more than 30 million people voting.
When is the UK due to leave the EU?
For the UK to leave the EU it had to invoke Article 50 of the Lisbon Treaty which gives the two sides two years to agree the terms of the split. Theresa May triggered this process on 29 March, 2017, meaning the UK is scheduled to leave at 11pm UK time on Friday, 29 March 2019. A European court has ruled that the UK can decide to stop the process. Alternatively it can be extended if all 28 EU members agree, but at the moment all sides are focusing on that date as being the key one, and Theresa May has put it into British law."
(BBC Website https://www.bbc.co.uk/news/uk-politics-32810887)

1.2. As you will be aware, the Government and the EU have now agreed the basis upon which the UK will leave the EU in March 2019. 'No deal' exit is not the Government's policy, but it is our duty to prepare for all scenarios.

1.3. An Operational Response Centre has been established By NHS England to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.

1.4. Commissioners must engage with local Providers to seek assurance based around the guidance in key areas including;

- Workforce
- Medicines and Vaccines
- Medical Devices,

- Goods and Services
- Data Protection
- Reciprocal Health
- Clinical Trials and investment

1.5. Wolverhampton CCG (WCCG) has appointed Mike Hastings, Director of Operations as the organisations EU Exit Senior Responsible Officer (SRO). He will be supported by the Operations team.

1.6. A 'no deal' Brexit has been discussed with WCCG's SRO, The Royal Wolverhampton NHS Trust (RWT) and Wolverhampton Council. A meeting will be arranged to triangulate plans.

1.7. Due to the lively political negotiations, details change hourly so this reports sets out high level responsibility for the CCG.

2. Main Body Of Report

2.1. NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU Exit (Brexit) as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

2.2. Commissioners are closely working internally, with NHSE and local Providers to ensure that all aspects of a 'No deal' scenario has minimal impact on organisational processes and patient care.

2.3. WCCG are expected to provide support to Providers to test existing Business Continuity and Incident Management Plans against Brexit Risk Assessment

2.4. WCCG has sent communications including EU Exit Readiness Guidance (Appendix one) and an EU tracker (Appendix two) to Provider organisations seeking assurance that robust plans are in place, where relevant, for a no deal scenario. This includes The Royal Wolverhampton NHS Trust and Wolverhampton GP Practices. This is to be returned to NHSE by Monday 21st January 2019

2.5. WCCG will continue with business continuity planning in line with legal requirements under the Health and Social Care Act 2012, including taking into account guidance and working with wider system partners to ensure plans across the health and care

system are robust. These organisational and system-wide plans will be completed at the latest by the end of January 2019

2.6. Key Points to bear in mind:-

- Seek Assurance from Providers that Risk Assessments and Business Continuity plans have been taken out and tested, this in hand with the RWT Emergency Planning Lead
- Review capacity and activity plans and as well as annual leave and command and control arrangements which is being undertaken at CCG,RWT and GP level
- The Governing Body can be assured that Operational programmes of work are being considered, discussed and supported for all areas that commissioners are responsible for.

3. CLINICAL VIEW

3.1. Not applicable

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable

5. KEY RISKS AND MITIGATIONS

5.1. Failure to progress would leave WCCG exposed both in terms of compliance and also in its key role in managing the local health economy, as the commissioning organisation, and, in extremis, as the tactical tier for supporting NHS England and local Providers.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Not Applicable

Quality and Safety Implications

6.2. Not Applicable

Equality Implications

6.3. Not applicable

Legal and Policy Implications

6.4. It has been identified nationally that Commissioners must seek assurance from Providers and assist where necessary, failure to comply would leave commissioners at risk of not supporting national guidance.

Other Implications

6.5. Not applicable

Name: Tally Kalea
Job Title: Commissioning Operations Manager
Date: 16/01/2019

ATTACHED: EU Exit Readiness Guidance (Appendix one)
EU tracker (Appendix two)

RELEVANT BACKGROUND PAPERS
(Including national/CCG policies and frameworks)

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		

Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**T Kalea**	**18/01/19**

Department of Health & Social Care

EU Exit Operational Readiness Guidance

Actions the health and care system in England should take to prepare for a 'no deal' scenario.

Published on 21 December 2018

Contents

Purpose

The EU Exit Operational Readiness Guidance, developed and agreed with NHS England and Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a 'no deal' exit. This will ensure organisations are prepared for, and can manage, the risks in such a scenario.

This guidance has been sent to all health and care providers, including adult social care providers, to ensure the health and care system as a whole is prepared. Adult social care providers are advised to use this guidance as a prompt to test their own contingency plans. A further letter has also been sent in parallel to local authorities and adult social care providers to address specific adult social care issues.

Overview

The EU Exit Operational Readiness Guidance summarises the Government's contingency plans and covers actions that all health and adult social care organisations should take in preparation for EU Exit.

All organisations receiving this guidance are advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. In addition, the actions in this guidance cover seven areas of activity in the health and care system that the Department of Health and Social Care is focussing on in its 'no deal' exit contingency planning:

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The impact of a 'no deal' exit on the health and adult social care sector is not limited to these areas, and the Department is also developing contingency plans to mitigate risks in other areas. For example, the Department is working closely with NHS Blood and Transplant to co-ordinate 'no deal' planning for blood, blood components, organs, tissues and cells (as detailed in the two technical notices on blood and organs, tissues and cells and the recent letter to the health and care system sent by the Secretary of State for Health and Social Care on 7 December 2018).

The actions in this guidance factor in the Government's revised border planning assumptions which were detailed in the Cabinet Office's guidance on 7 December 2018.

In preparation for a 'no deal' exit, the Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system. The Operational Response Centre will also work with the devolved administrations to respond to UK-wide incidents.

The Operational Response Centre has been established to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.

Working closely with the Operational Response Centre, NHS England and Improvement will also establish an Operational Support Structure for EU Exit. This will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required. Contact details for the regional EU Exit leads are below:

Region	Contact details for regional EU Exit lead
North East	England.euexitnortheast@nhs.net
North West	England.euexitnorthwest@nhs.net
Midlands	England.mids-euexit@nhs.net
East of England	England.eoe-euexit@nhs.net
London	England.london-euexit@nhs.net
South East	England.se-euexit@nhs.net
South West	England.sw-euexit@nhs.net

NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU Exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

This guidance and the planning assumptions within it represent the most up to date information available. Further operational guidance will be issued and updated to support the health and care system to prepare for the UK leaving the EU prior to 29 March 2019.

Summary

This section summarises seven areas where the government is focussing ‘no deal’ exit contingency planning in the health and care system, and where local action is required. Detailed actions for providers, commissioners and NHS England and Improvement regional teams are listed in Annex A (pages 15 to 33). Please read the summary and the action card that is applicable to your organisation.

Common to all of the groups of medical products listed below, it should be noted that government departments have also been working to design customs and other control arrangements at the UK border to ensure goods, including medical supplies, can continue to flow into the UK without being delayed by additional controls and checks.

However, the EU Commission has made clear that, in a ‘no deal’ exit, it will impose full third country controls on people and goods entering the EU from the UK. The cross-government planning assumption has therefore been revised to prepare for the potential impacts that the imposition of third country controls by member states could have. The revised assumption shows that there will be significantly reduced access across the short straits, for up to six months.

Supply of medicines and vaccines

- The Government recognises the vital importance of medicines and vaccines, and has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a ‘no deal’ scenario.

- The plan covers medicines used by patients and service users in all four nations of the UK, as well as the UK Crown Dependencies. The Department is working very closely with the devolved administrations, the Crown Dependencies and other government departments to explore specific issues related to the various supply chains for medicines in the UK, as well as potential mitigations. The plan covers medicines used by all types of providers, including private providers.

- Earlier this year, the Department undertook an analysis using Medicines and Healthcare Products Regulatory Agency and European Medicines Agency data, on the supply chain for all medicines (including vaccines and medical radioisotopes). This identified those products that have a manufacturing touch point in the EU or wider EEA countries.

- In August 2018, the Department for Health and Social Care wrote to pharmaceutical companies that supply the UK with prescription-only and pharmacy medicines from, or via, the EU or European Economic Area (EEA) to prepare for a no deal scenario.

Companies were asked to ensure they have a minimum of six weeks' additional supply in the UK, over and above their business as usual operational buffer stocks, by 29 March 2019. Companies were also asked to make arrangements to air freight medicines with a short shelf life, such as medical radioisotopes.

- Since then, there has been very good engagement from industry to ensure the supply of medicines is maintained in a 'no deal' exit.

- The Department will support manufacturers taking part in the contingency planning and is already providing funding for the provision of additional capacity for the storage of medicines.

- In October, the Department invited wholesalers and pre-wholesalers of pharmaceutical warehouse space to bid for government funding to secure the additional capacity needed for stockpiled medicines, and funding for selected organisations has now been agreed.

- On 7 December 2018, the Department wrote to UK manufacturers of medicines currently using the short straits crossings of Dover and Folkestone as they will want to review supply arrangements in light of the Government's updated planning assumptions.

- Whilst the six-week medicines stockpiling activity remains a critical part of the Department's UK-wide contingency plan, it is now being supplemented by additional national actions.

- The Government is working to ensure there is sufficient roll-on, roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK.

- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of all these products will continue unimpeded after 29 March 2019. This includes all medicines, including general sales list medicines.

- In the event of delays caused by increased checks at EU ports, the Department will continue to develop the UK-wide contingency plan for medicines and vaccines with pharmaceutical companies and other government departments.

- UK health providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions and the public should be discouraged from stockpiling.

- Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

- The Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines; arrangements are also likely to be put in place to monitor the unnecessary export of medicines.

- The Department is putting in place a “Serious Shortage Protocol”. This will involve changes to medicines legislation that will allow flexibility in primary care dispensing of medicines. Robust safeguards will be put in place to ensure this is operationalised safely, including making authoritative clinical advice available.

- Public Health England (PHE) is leading a separate UK-wide programme ensuring the continuity of supply for centrally-procured vaccines and other products that are distributed to the NHS for the UK National Immunisation Programme or used for urgent public health use. In addition to the national stockpiles that PHE has in place to ensure continued supply to the NHS, PHE continues to work alongside contracted suppliers on their contingency plans to ensure that the flow of these products will continue unimpeded in to the UK after exit day.

Supply of medical devices and clinical consumables

- On 23 October 2018, the Secretary of State for Health and Social Care wrote to all suppliers of medical devices and clinical consumables updating them on the contingency measures the Department is taking to ensure the continuity of product supply.

- One of these measures is to increase stock levels of these products at a national level in England.

- The Department is working with the devolved nations and Crown Dependencies to ensure that national contingency arrangements are aligned and able to support specific preparedness measures necessary to meet the needs of their health and care systems.

- The Department is also developing contingency plans to ensure the continued movement of medical devices and clinical consumables that are supplied from the EU directly to organisations delivering NHS services in England.

- The Department has asked all suppliers that regularly source products from EU countries to review their supply chains and determine what measures they need to take to ensure the health and care system has access to the products it needs.

- NHS Supply Chain officials are also contacting suppliers who routinely import products from the EU to establish what measures are required to ensure they can continue to provide products in a ‘no deal’ scenario. Products are already being ordered.

- The Government is working to ensure there is sufficient roll-on/roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK. This will help facilitate the flow of products to both NHS and private care providers.

- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of these products will continue unimpeded after 29 March 2019.

- There is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and, if the situation changes, will provide further guidance by the end of January 2019.

- The Department continues to engage directly with industry suppliers, trade associations, NHS providers and other government departments to develop its contingency planning approach and ensure the continued supply of medical devices and clinical consumables into the UK.

Supply of non-clinical consumables, goods and services

- The Department has identified categories of national suppliers for non-clinical consumables, goods and services that it is reviewing and managing at a national level. Examples of relevant categories include food and laundry services.

- For these categories, the Department is engaging with suppliers and industry experts to identify and plan for any supply disruption. Where necessary, there will be cross-government work to implement arrangements at the point of EU Exit to ensure continued supply.

- On food, for example, the Department is engaging with both suppliers and health experts to identify and plan for any food items that might suffer supply disruption in the event of a ‘no deal’. Standard guidelines will be developed for health and adult social care providers on suitable substitution arrangements for any food items identified as being at risk.

- The Department is also conducting supply chain reviews across the health and social care system to assess commercial risks. This includes reviews for high-risk non-clinical consumables, goods and services, and a self-assessment tool for NHS Trusts and Foundation Trusts. The results of these self-assessments were received at the end of November, and the Department is conducting analysis of the data, that will be used to provide additional guidance to Trusts and Foundation Trusts in January 2019.

Workforce

- The current expectation is that there will not be a significant degree of health and care staff leaving around exit day. Organisations can escalate concerns through existing reporting mechanisms to ensure there is regional and national oversight.

EU Settlement Scheme

- Through the EU Settlement Scheme, EU citizens will be able to register for settled status in the UK if they have been here for five years, or pre-settled status if they have been here for less than five years. This will ensure the rights of EU citizens are protected in the UK after EU Exit, and guarantee their status and right to work.

- Some EU citizens working in the health and care system would have been able to register for EU settled status under the pilot scheme that was open between the 3rd and 21st December 2018. People that did not register under the pilot scheme do not need to worry as the scheme will be fully open by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register.

- More information, including where to register, can be found on this website.

Professional regulation (recognition of professional qualifications)

- Health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.

- Health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.

- Health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019 will be subject to future arrangements.

Reciprocal healthcare

- These plans are without prejudice to the rights and privileges available to Irish citizens in the UK, and UK citizens in Ireland, under the Common Travel Area arrangements.

- In a ‘no deal’ scenario, UK nationals resident in the EU, EEA and Switzerland may experience limitations to their access to healthcare services. The Government is therefore seeking to protect current reciprocal healthcare rights through transitional bilateral agreements with other member states.

- The Government has recently introduced the Healthcare (International Arrangements) Bill to ensure we have the legal powers to enter into such agreements in a ‘no deal’ scenario. The Bill could support a broad continuance of the existing reciprocal healthcare rights under current EU regulations (such as the European Health Insurance Card).

- The Government will issue advice via www.gov.uk and www.nhs.uk to UK nationals living in the EU, to UK residents travelling to the EU and to EU nationals living in the UK. It will explain how the UK is working to maintain reciprocal healthcare arrangements, but this will depend on decisions by member states. It will set out what options people might have to access healthcare under local laws in the member state they live in if we do not have bilateral agreements in place, and what people can do to prepare. These pages will be updated as more information becomes available.

- As is currently the case, if UK nationals living in the EU face changes in how they can access healthcare, and if they return permanently to the UK and take up ordinary residence here, they will be entitled to NHS-funded healthcare on the same basis as UK nationals already living here.

- It is not possible to quantify how many people might return due to changes in reciprocal healthcare, and it is important to note that people might return to the UK for many other reasons such as changes in legal status or costs of living.

Research and clinical trials

EU research and innovation funding schemes

- The Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a ‘no deal’ scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after EU Exit, until the end of 2020.

- This means that successful bids for EU programme funding until the end of 2020 will receive their full financial allocation for the lifetime of the project.

Clinical networks

- In a ‘no deal’ scenario, UK clinicians would be required to leave European Reference Networks (ERNs) on 29 March 2019. However, the UK will seek to strengthen and build new bilateral and multilateral relationships – including with the EU – to ensure clinical expertise is maintained in the UK.

- The Department and NHS England are in contact with the ERNs and no action is required at this stage. Further information will be communicated to the NHS and professional bodies in due course.

Clinical trials and clinical investigations

- The Government has issued guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a ‘no deal’ scenario.

- The Department continues to engage with the life sciences industry regarding contract research and clinical trials of IMPs and medical devices. The Department is working closely with the NHS and is undertaking a comprehensive assessment of the potential impact of ‘no deal’ exit on clinical trials and investigations, to gain a greater understanding of those which might be affected by supply issues. This includes examining supply chains for IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA. This assessment aims to conclude in January 2019 and, if necessary, further guidance will be issued thereafter.

- All organisations participating in and/or recruiting patients to clinical trials or clinical investigations in the UK should contact their relevant trial sponsors for confirmation of plans for supply chains for IMPs and medical devices as soon as possible.

- The Department has communicated with Sponsors of trials to emphasise their responsibility for ensuring the continuity of IMP supplies for their trials. The Government will monitor for any clinical trials or clinical investigations impacted due to disruptions to clinical trial supplies. Organisations should therefore continue to participate in and/or recruit patients to clinical trials and clinical investigations from 29 March 2019, unless they receive information to the contrary from a trial sponsor, organisation managing the trial or investigation, or from formal communications.

Clinical Trial Regulation

- For EU-wide trials, the new EU Clinical Trial Regulation (CTR) will not be in force in the EU on 29 March 2019 and so will not be incorporated into UK law.

- However, the Government has stated the UK will align where possible with the CTR without delay when it does come into force in the EU, subject to usual parliamentary approvals. This will provide certainty for organisations conducting trials in the UK.

- Those organisations carrying out clinical trials should follow the normal process for seeking regulatory approval.

Data sharing, processing and access

- It is imperative that personal data continues to flow between the UK, EU and EEA member states, following our departure from the EU. The Department for Digital, Culture, Media and Sport and the Information Commissioner's Office (ICO) have released guidance on data protection in a 'no deal' scenario, which can be viewed on gov.uk and the ICO website.

- The European Commission is unlikely to have made a data protection adequacy decision regarding the UK before EU Exit. An adequacy decision is where the European Commission is satisfied that a transfer of personal data from the EU/EEA to a country outside the EU/EEA would be adequately protected.

- Transfers of personal data from the UK to the EU/EEA should not be affected in a 'no deal' scenario. This is because it would continue to be lawful under domestic legislation for health and adult social care organisations to transfer personal data to the EU/EEA and adequate third countries in the same way we do currently.

- At the point of exit, EU/EEA organisations will consider the UK a third country. This will mean the transfer of personal data from the EU/EEA to the UK will be restricted unless appropriate safeguards are put in place.

- In order to ensure that personal data can continue to be transferred from organisations in the EU/EEA to the UK in the event there is no adequacy decision, alternative mechanisms for transfer may need to be put in place. This is the case even if organisations are currently compliant with the GDPR.

- One solution you could consider, which the ICO states that most businesses find to be a convenient safeguard, particularly when dealing with non-public organisations, is to use one of the standard contractual clauses (SCCs) approved by the EU Commission. Guidance on these SCCs can be found in the links to gov.uk and the ICO website

above. Further information will be issued in due course. For now, health and adult social care organisations should follow the instructions detailed in Annex A to identify data flows that may be at risk in a ‘no deal’ exit.

ANNEX A – Action cards

Card 1 – Action card for providers

Role

All providers of NHS services – including NHS Trusts and Foundation Trusts, primary care organisations and independent sector organisations who provide NHS services – must consider and plan for the risks that may arise due to a ‘no deal’ exit.

All providers should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments, and escalating any points of concern on specific issues to regional NHS EU Exit or departmental mailboxes listed in this guidance. Officials monitor these mailboxes and will respond to queries. Contact details for the regional NHS EU Exit Teams are included in the overview on page 5.

Clinical Commissioning Groups and NHS England should agree the handling of communications with general practice in line with existing delegation arrangements.

Actions for providers

Local EU Exit readiness preparations

Risk assessment and business continuity planning

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
    - The seven key areas identified nationally and detailed below.
    - Potential increases in demand associated with wider impacts of a ‘no deal’ exit.
    - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

Communications and escalation

All providers to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.

NHS providers to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview on page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential ‘no deal’ exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

Reporting, assurance and information

NHS providers to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.

- For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox

Supply of medicines and vaccines

All health and adult social care providers to:

- Follow the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.

- Note that there is no need to contact suppliers of medicines directly.

- Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.

- Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

- Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.

- Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.

- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

Supply of medical devices and clinical consumables

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.

- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.

- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.

- Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.

Supply of non-clinical consumables, goods and services

All providers to:

- Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.

- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.

- Continue to update local business continuity plans to ensure continuity of supply in a ‘no deal’ scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be

engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.

- Await further advice from the Department on what actions should be taken locally.

NHS Trusts and Foundation Trusts to:

- Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.

- Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.

Workforce

- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.

- Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register. Further information can be viewed here.

- Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.

- Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.

- Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.

- Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.

- Escalate concerns through existing reporting mechanisms.
- Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.

Professional regulation (recognition of professional qualifications)

- Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

Reciprocal healthcare

All providers to:

- Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).
- Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.

NHS Trusts and Foundation Trusts to:

- Maintain a strong focus on correctly charging those who should be charged directly for NHS care. Information on implementing the current charging regulations can be viewed on the webpage here.
- Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.

- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

GP practices to:

- Promote completion of the supplementary questions section of the GMS1 form, and then, as appropriate, send the form to NHS Digital (NHSDigital-EHIC@nhs.net) or the Department for Work and Pensions' Overseas Healthcare Team (overseas.healthcare@dwp.gsi.gov.uk). The response on a person's non-UK EHIC/S1 helps the Department seek reimbursements from EU member states for those who are covered by the reciprocal healthcare arrangements. More information on the GMS1 form can be found here. Further information for primary care staff on providing healthcare for overseas visitors from the EU/EEA can be found here.

Research and clinical trials

EU research and innovation funding schemes

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.

- Provide information about your Horizon 2020 grant here. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.

- Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.

Clinical trials and clinical investigations

- Follow the Government's guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.

- Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical

consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.

- Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.

- Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a ‘no deal’ exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.

- Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.

- Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk

Data sharing, processing and access

- Investigate your organisation’s reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.

- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.

- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a ‘no deal’ scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.

- Ensure that your data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance

with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.

Queries

For queries relating to specific topics areas, providers should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk.
- Workforce to WorkforceEUExit@dhsc.gov.uk.
- Third Health Programme grants to EU-Health-Programme@dhsc.gov.uk.
- Horizon 2020 grants to EUGrantsFunding@ukri.org
- IMPs or clinical devices to imp@dhsc.gov.uk.

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

Card 2 – Action card for commissioners

Role

In addition to current responsibilities, commissioners – including Clinical Commissioning Groups, Primary Care Commissioning and specialised commissioning – should ensure that their contracted health and care services are ready to manage the risks arising in a ‘no deal’ exit.

Commissioners should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments and escalating any points of concern on specific issues to the relevant mailboxes.

Commissioners should also liaise with providers of services that they commission, to ensure they are taking account of the actions for providers outlined in this guidance. EU Exit and its implications on health and care services should be discussed at commissioner board level on a regular basis to ensure sufficient oversight.

Actions for commissioners

Local EU Exit readiness preparations

Risk assessment and business continuity planning

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
    - The seven key areas identified nationally and detailed below.
    - Potential increases in demand associated with the wider impacts of a ‘no deal’ exit.
    - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, including taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Support providers to test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

Communications and escalation

All commissioners to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019.

NHS commissioners to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit, into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview at page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential ‘no deal’ exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

Reporting, assurance and information

NHS commissioners to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.

- For queries relating to specific topics areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox.

Supply of medicines and vaccines

- Promote the Secretary of State's message: healthcare providers should not stockpile medicines beyond their business as usual stock levels, and no clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the supply of medicines and vaccines is being developed alongside pharmaceutical companies and other government departments.

- Advise providers that there is no need to contact suppliers of medicines directly.

- Ensure providers are encouraging staff to reassure patients that they should not store additional medicines at home as the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU.

- Inform providers that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

- Inform providers that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.

- Be aware that the UK-wide contingency plan for medicines and vaccines is kept under review, and the Department will communicate further guidance as and when necessary.

- Share letters from the Department aimed at an NHS and wider health and care provider audience (such as the third sector, private sector and home care).

- Note that the Department has engaged directly with specialist commissioning leaders about prisons and defence. This is to address their specific needs and concerns relating to medicine supply.

- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

Supply of medical devices and clinical consumables

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, we will provide further guidance by the end of January 2019.

- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.

- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.

- Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.

Supply of non-clinical consumables, goods and services

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care, adult social care and public health services.

- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.

- Check your providers continue to update their local business continuity plans to ensure continuity of supply in a 'no deal' scenario.

- Await further advice from the Department on where actions should be taken locally by commissioners and providers of NHS-commissioned services.

Workforce

- Ensure healthcare providers that deliver your commissioned services publicise the EU Settlement Scheme to their health and care staff who are EU citizens, and support them to apply for the scheme.

- Monitor the workforce impacts of EU Exit in your primary and secondary care providers' business continuity plans and highlight risks to WorkforceEUExit@dhsc.gov.uk.

- Ensure your providers' board-approved business continuity plans include workforce planning.

- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.

- Publicise the EU Settlement Scheme to your staff who are EU nationals and actively support them to apply for the scheme when it opens in March 2019. Further information can be viewed here.

- Monitor the impact of EU Exit on your own workforce regularly, and update your local business continuity plans as necessary.

- Send workforce queries to WorkforceEUExit@dhsc.gov.uk

Professional regulation (recognition of professional qualifications)

- Inform your staff and healthcare providers that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.

- Inform your staff and healthcare providers that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.

- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

Reciprocal healthcare

- Note that, in a 'no deal' scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.

- Inform NHS Trusts and Foundation Trusts that they should continue to maintain a strong focus on correctly charging those who should be charged directly for NHS care.

- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

Research and clinical trials

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a ‘no deal’ scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after Exit, until the end of 2020.

- Ensure your providers who receive Horizon 2020 grants input basic information about their awards into a portal, which can be accessed here, as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.

- Ensure your providers who receive Third Health Programme grants contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding their awards and any queries that they have, as soon as possible.

Clinical trials and clinical investigations

- Support your providers to respond to the Department's comprehensive assessment of the expected impact of a ‘no deal’ exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.

- Support your providers who run clinical trials or investigations in the UK to consider their supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA as soon as possible. Providers should contact relevant trial Sponsors, and if multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.

- Support your providers to participate in and/or recruit to clinical trials and investigations up to and from 29 March 2019. This should occur unless providers receive information to the contrary from a trial Sponsor, organisation managing the clinical trial or investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.

- Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk.

Data sharing, processing and access

- Investigate your organisation’s reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.

- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.

- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a ‘no deal’ scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.

- Ensure that your data and digital assets are adequately protected, by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory, to be completed by end March

2019, but early completion will enable health and adult social care organisations more time to identify and quickly address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Commissioners should discuss these costs with their regional NHS EU Exit support team. Feedback from commissioners will inform decisions on whether further guidance on cost collection is required.

Queries

For queries relating to specific topics areas, commissioners should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk.
- Workforce to WorkforceEUExit@dhsc.gov.uk.
- Third Health Programme grants to EU-Health-Programme@dhsc.gov.uk.
- Horizon 2020 grants to EUGrantsFunding@ukri.org
- IMPs or clinical devices to imp@dhsc.gov.uk.

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

Card 3 – Action card for NHS England and Improvement regional teams

Role

In addition to current responsibilities, NHS regional teams will be required to provide regional system oversight in a ‘no deal’ scenario. The forthcoming NHS EU Exit Operational Support Structure will operate at a national and regional level, and support existing regional teams. Its functions will include monitoring local preparations, responding to the escalation of issues, and co-ordinating assurance and reporting arrangements at regional level.

NHS regional teams should communicate the necessary actions to providers and commissioners, and ensure that these instructions are being followed. This assurance should be gained through reporting on resilience and business continuity plans, and through existing meetings with providers and commissioners in your area. Once the dedicated NHS EU Exit regional teams are established, they will undertake assurance of local business continuity plans in relation to EU Exit.

Regional NHS leads and mailboxes for EU Exit have been established. Further details of the structure and function of the regional operational support teams will be communicated as the functions are implemented.

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Global and Public Health Directorate / EU and International Health / EU Exit Preparedness

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EU Exit Tracking

(Step 1: Choose from dropdown) (Region)	Midlands	
(Step 2: Choose from dropdown) (DCO)	West Midlands	
(Step 3: Choose from dropdown) (Organisation Type)	Commissioner	
(Step 4: Choose from dropdown) (Commissioner/Provider)	NHS Wolverhampton CCG	
(Step 4: Provide the organisation name if not in the list above)		
(Step 5: Add date of update)		

INSTRUCTIONS (NEEDS UPDATE)

NOTES:

All organisations are separated under the new Regional areas as of 1 April 2019.

Please ensure you identify the correct dropdown to identify as a Commissioner or Provider as the questions are different for each.

Commissioners please respond to questions regarding your providers including all providers (Trusts, primary care - GPs, dentists etc)

If your organisation is not listed please use 'other' in the drop down and ensure you provide the full name.

Cells are protected so that questions or required responses cannot be manually altered. This is to ensure consistency in responses for analytical purposes.

RAG is automated.

There is no provision to identify partial achievement. If you cannot answer 'yes' as work is not complete, insert 'no' and please use the actions and comments fields to explain.

All yellow fields must be completed.

Shaded areas indicate that the question shaded is not relevant to your organisation.

QUERIES

All queries to be forwarded to your DCO contact who will liaise with the Regional EU Exit Teams as required.

EU Exit Tracking

Region	Midlands
DCO	West Midlands
Commissioner/Provider	NHS Wolverhampton CCG

Supply of medicines and vaccines

ID	Question	Response yes / no	If no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
MV1	Have you promoted / adhered to the Secretary of State's message to healthcare providers that they should not stockpile medicines beyond their business as usual stock levels, and no clinician should write longer prescriptions for patients. **This will need to include clear and repeated communication to all relevant parties, with confirmation responses.**						
MV2	Have you advised providers that there is no need to contact suppliers of medicines directly.						
MV4	Will you encourage staff to reassure patients that they should not store additional medicines at home as the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU.						
MV5	Are you aware that the Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily.						
MV6	Are you aware that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.						
MV7	Are you aware that the UK-wide contingency plan for medicines and vaccines is kept under review, and the Department will communicate further guidance as and when necessary						
MV8	Are you prepared (e.g. have sufficient resources) to update planning/processes in this area should any further guidance be provided by the Department						
MV9	Have you shared letters from the Department aimed at an NHS and wider health and care provider audience (such as the third sector, private sector and home care) to all relevant parties (note that the Department has engaged directly with specialist commissioning leaders about prisons and defence. This is to address their specific needs and concerns relating to medicine supply.)						
MV10	Do you have plans and resources in place to continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.						
MV11	Have pharmacists and emergency planning staff met at a local level to discuss and agree local contingency and collaboration arrangements.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/Provider	**NHS Wolverhampton CCG**

Supply of Medical Devices and Consumable Goods

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
MDC1	Are you aware that there is no need to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. NOTE: Officials in the Department will continually monitor the situation and if the situation changes, we will provide further guidance by the end of January 2019.						
MDC2	Will you send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.						
MDC3	Are you aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.						
MDC4	Can you confirm you will send queries regarding medical devices and clinical consumables to mdcccontingencyplanning@dhsc.gov.uk.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/ Provider	**NHS Wolverhampton CCG**

Supply of non-clinical consumables, goods and services

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
NCC1	Are you aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care, adult social care and public health services.						
NCC2	Have you undertaken commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.						
NCC4	Are you prepared (e.g. have sufficient resources) to update your planning/processes in this area based on further guidance provided by the Department on where actions should be taken locally by commissioners and providers of NHS-commissioned services.						
NCC5	Have you submitted the results of your self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk.						

EU Exit Tracking

Region	Midlands
DCO	West Midlands
Commissioner/ Provider	NHS Wolverhampton CCG

Workforce

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
W2	Will you ensure your providers publicise the EU Settlement Scheme to staff who are EU nationals and have actively supported them to apply for the scheme when it opens in March 2019.						
W3	Have you determined how many staff in your organisation are EU nationals?						
W4	Has your organisation got systems in place to monitor the workforce impacts of EU Exit in your primary and secondary care providers' business continuity plans and have these risks been highlighted via WorkforceEUExit@dhsc.gov.uk.						
W5	Have you ensured your providers board-approved business continuity plans include workforce planning.						
W6	Has your organisation assessed whether it has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU. Please estimate impact in commentary .						
W11	Do you monitor the impact of EU Exit on workforce regularly, and update local business continuity plans as necessary. Please state frequency in commentary.						
W13	Have you informed staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.						
W14	Have you Informed staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/Provider	**NHS Wolverhampton CCG**

Reporting Assurance and Information

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
RH1	Are you aware that in a 'no deal' scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.						
RH2	Have you informed NHS Trusts and Foundation Trusts (and had confirmation response) that they should continue to maintain a strong focus on correctly charging those who should be charged directly for NHS care.						
RH6	Please confirm that there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.						
RH7	Will ensure your GP practices promote completion of the supplementary questions section of the GMS1 form, and then, as appropriate, send the form to NHS Digital (NHSDigital-EHIC@nhs.net) or the Department for Work and Pensions' Overseas Healthcare Team (overseas.healthcare@dwp.gsi.gov.uk).						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/ Provider	**NHS Wolverhampton CCG**

Clinical Trials and Clinical Investigations

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
CTI1	Will you support your providers to respond to the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations.						
CTI2	Will you support your providers who run clinical trials or investigations in the UK to considered their supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA as soon as possible (as a single approach to the Sponsor where multiple sites are involved within the UK, then coordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation)						
CTI3	Will you support your providers to participate in and/or recruit to clinical trials and investigations up to and from 29 March 2019. This should occur unless providers receive information to the contrary from a trial Sponsor, organisation managing the clinical trial or investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.						
CTI4	Will you send queries concerning IMPs or medical devices to imp@dhsc.gov.uk.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/Provider	**NHS Wolverhampton CCG**

Research and Clinical Trials

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
RCT1	Are you aware that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after Exit, until the end of 2020.						
RCT3	Have you ensured that your providers who receive Horizon 2020 grants input basic information about their awards into the portal.						
RCT4	Will you contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding Third Health Programme grants and any queries that you have.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/Provider	**NHS Wolverhampton CCG**

Data Sharing Processing and Access

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
DS1	Have you investigated your organisations reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.						
DS2	Are you following advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, in particular to determine where to use and how to implement standard contractual clauses and you have had confirmation response that action has been taken .						
DS3	Has your organisation protected data and digital assets by completing a annual Data Security and Protection Toolkit assessment. (This self-audit of compliance with the 10 Data Security Standards is mandatory, to be completed before end March 2019)						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/ Provider	**NHS Wolverhampton CCG**

Finance

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
F1	Have you recorded costs (both revenue and capital) incurred in complying with this guidance. (Costs with a direct financial impact should be recorded separately to opportunity costs).						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/Provider	**NHS Wolverhampton CCG**

Communication and Escalation

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
CE1	Is your board sighted on EU Exit preparation and have taken steps to raise awareness amongst staff.						
CE2	Have you communicated EU Exit preparation actions to the wider health community including Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards						
CE3	Have you reviewed capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019.						
CE4	Is there an escalation route for different types of issues potentially arising from or affected by EU Exit, into the regional NHS EU Exit teams as identified in the EU Exit Operational Readiness Guidance						
CE5	Have you confirmed your organisation's Senior Responsible Officer for EU Exit preparation and identified them to your regional EU Exit team. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts.						
CE6	Have you provided name/s of your nominated Regional NHS lead for EU Exit and their contact details to the Regional EU Exit team						
CE7	Will you escalate any issues you have identified as having a potentially widespread impact immediately to the DCO and regional EU Exit team.						
CE8	Have you identified named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.						

EU Exit Tracking

Region	**Midlands**
DCO	**West Midlands**
Commissioner/ Provider	**NHS Wolverhampton CCG**

Risk Assess and Business Continuity

ID	Question	Response yes / no	if no, why have you responded no?	Date this will be achieved by	Actions required to achieve green RAG	Commentary	RAG
Have you undertaken an assessment of risks associated with EU Exit for the following areas:							
RABC1	1. Potential increases in demand associated with the wider impacts of a 'no deal' exit.						
RABC2	2. Locally specific risks						
RABC3	3. Supply of medicines and vaccines						
RABC4	4. Supply of medical devices and clinical consumables						
RABC5	5. Supply of non-clinical consumables, goods and services						
RABC6	6. Workforce						
RABC7	7. Reciprocal healthcare						
RABC8	8. Research and clinical trials; and						
RABC9	9. Data sharing, processing and access						
RABC10	Have you continued business continuity planning in line with legal requirements under the Health and Social Care Act 2012						
RABC11	Does your business continuity planning take into account the EU Exit Operational Guidance, working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide						
RABC12	Are you testing existing business continuity and incident management plans against EU Exit risk assessment scenarios. These are due by the end of February to ensure these are fit						

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 FEBRUARY 2019

Agenda item 11

TITLE OF REPORT:	Black Country Joint Commissioning Committee (BCJCC) Assurance Report
AUTHOR(s) OF REPORT:	Alastair McIntyre, STP Portfolio Director
MANAGEMENT LEAD:	Helen Hibbs, Accountable Officer
PURPOSE OF REPORT:	This report provides a summary of business considered at the Black Country Joint Commissioning Committee meeting on 8th November 2018, for assurance.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The BCJCC met on 8 November 2018; • Matters under discussion included the Dudley MCP, Right Care and Transforming Care;
RECOMMENDATION:	That the Governing Body Notes the Report
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Proactively drive our contribution to the Black Country STP</u> The CCG is an active participant in the work of the Joint Committee, which provides reports on its work after each meeting.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Black Country Joint Commissioning Committee (BCJCC) was established in 2017 and comprises representatives from Dudley, Sandwell and West Birmingham, Walsall and Wolverhampton CCGs.

1.2. In line with the Committee's terms of reference, updates are provided after each of its meetings to the Governing Body.

2. 10 NOVEMBER 2018 JOINT COMMITTEE MEETING

2.1. The following matters were discussed at the 10 November 2018 meeting of the BCJCC.

2.2. **Terms of Reference.**

2.2.1. The meeting attendance was quorate.

2.3. **Action Log and Matters Arising**

2.3.1. There had been satisfactory progress on most items.

2.3.2. In regards to action 102, three dates had been set for the interviews for the chair of the Clinical Leadership Group (CLG). *Post meeting and post interview, Prof Nick Harding has been appointed as Chair with Dr Jonathan Odum as vice chair.*

2.4. **Place-Based Commissioning Update – Dudley MCP Progress and discussion**

2.4.1. Paul Maubach presented on the Dudley MCP progress to date.

2.4.2. The place based solution identified for Dudley in response to significant challenges in Dudley around disease, changing of conditions and increased demand is a Multi-speciality Community Provider (MCP). Key issues are managing demand from long term conditions and the coordination of complex needs, supporting Primary Care, population health management, and the MCP providing a mechanism for ensuring the right services are brought together. This will involve working as a partnership with a single leadership and organisation.

2.4.3. A preferred provider has been selected and is working towards NHSE/I ISAP checkpoint 2 assurance in Quarter 4. The start date for mobilisation is yet to

be confirmed but is likely in 2019/20, subject to satisfactory progress and approvals.

2.4.4. Black Country JCC was in unanimous support of Dudley MCP project and understands the challenges faced by the system and its effect on all other organisations. BC JCC agreed to formally write a letter of support to Chair and AO of Dudley CCG.

2.5. **Stroke**

2.5.1. The JCC received a presentation from Midlands and Lancashire CSU on some modelling at a West Midlands level on demand for Stroke Services and potential impacts on services. Following discussion the JCC asked for further work to be done on workforce and workforce supply to go along side demand projections. This will be fed back to the NHS England led West Midlands Stroke Programme Board meeting on 19th November.

2.6. **Right Care**

2.6.1. Lucy Heath presented to the JCC on the RightCare Programme and the National Priority Initiative for MSK. There has been a baseline assessment for each CCG to assess whether they meet the components. Walsall and Wolverhampton are at 96%, Dudley is at 92% and Sandwell and West Birmingham have been increased to over 90%. This has been approved at region. In regards to a system readiness to make changes, it was suggested the Black Country was somewhere in the middle. Alastair McIntyre and Dr Helen Hibbs have made a request of resources suggesting they would benefit from the support. It was noted an executive lead for MSK needs to be identified. Dr Helen Hibbs confirmed they are reviewing appointing leads to the programmes of work.

2.7. **Programme Performance**

2.7.1. There was no performance report this month.

2.8. **Risk Register**

2.8.1. The risk register update was deferred until next time.

2.9. **Transforming Care**

2.9.1. Dr Helen Hibbs gave an update on the TCP work. There has been a lot of work within this area. Numbers of patients in hospital beds are still providing a challenge. There has been acceptance that the number at the end of the programme will not meet the trajectories set; current modelling suggests there will be 20 in patients for CCGs not 16 and 35 inpatients for Specialised

Commissioning not 27. It was noted following the Walsall case being in the media, there is additional focus on children and young people and learning disabilities. There is a commissioning team and case manager half day event in December. The PMO support in TCP will need to continue. This may be absorbed within the STP PMO. Dr Helen Hibbs noted it is not just about numbers but around ensuring our citizens receive the best possible care in the least restrictive setting. The Black Country has a high rate of discharges but admissions are still occurring. The Black Country is leading a piece of work around a quality and outcomes dashboard. The patients need to have good experiences of care and be better in the community setting.

2.10. The next meeting of the BCJCC was due to take place on 10 January 2019.

3. CLINICAL VIEW

3.1. The CCG Clinical Chairs are members of the BCJCC and provide a clinical perspective on its work.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

5.1. There are no specific risks associated with this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. There are no specific financial implications associated with this report.

Quality and Safety Implications

6.2. There are no specific quality and safety implications associated with this report.

Equality Implications

6.3. There are no specific equality and diversity implications associated with this report.

Legal and Policy Implications

6.4. There are no specific legal or policy implications associated with this report.

Other Implications

6.5. There are no other implications associated with this report.

Name Alastair McIntyre
Job Title Portfolio Director
Date: November 2018

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
Signed off by Report Owner (Must be completed)	**Alastair McIntyre**	**November 2018**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 February 2019

Agenda item 12

TITLE OF REPORT:	**Commissioning Committee – January 2019**
AUTHOR(s) OF REPORT:	Dr Manjit Kainth
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in January 2019
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	This report is submitted to meet the Committee's constitutional requirement to provide a written summary of the matters considered at each meeting and to escalate any significant issues that need to be brought to the attention of the Governing Body.
RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1 The purpose of the report is to provide an update from Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) from the January 2019 meeting.

2. MAIN BODY OF REPORT

2.1 Diagnostic Pathway for Autistic Spectrum

The Committee was presented with a report of an all age strategy developed by Wolverhampton CCG working collaterally with the City Council towards a clear pathway across the system. This will include further conditions such as ASD and ADHD and will ensure the quality and safety of the service.

The Committee noted the above and assurance was given

Action - That Governing Body notes the decision made by the Committee

2.2 Glaucoma Referral Refinement Service

The Committee was presented with a report to ensure safety and performance continuation with a change to the pathway for a small number of patients with suspected glaucoma; activity and financial input are minimal as the infrastructure is in place to enable this change.

The Committee noted the above and approval was given.

Action - That Governing Body notes the decision made by the Committee

2.3 Contracting Update Report

Royal Wolverhampton NHS Trust

Activity/ Performance

The Committee was updated with the current performance of Cancer, whereby the trust continues to perform below the required contract standard. Updates were also given in relation to Referral to Treatment waiting times, A&E 4 hour target, Ambulance handover and Diagnostics.

Activity Queries

Following on from the November 2018 report, queries remain outstanding for Phlebotomy and Community Children's Nursing services; both of which are subject to ongoing investigation by RWT.

2019/20 Planning Round

Good progress is being made via the three sub-groups. The next phase of work relates to interpretation of national planning guidance and incorporation of the requirements into an initial offer.

Dermatology

Work continues on a project to re-procure community dermatology services which involves movement of some activity out of RWT. A second joint meeting is due to take place with the trust in February.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

Improving access to Psychological Therapies (IAPT) Targets

The CCG is investing additional funding in the IAPT service at BCPFT to help ensure delivery of the Recovery target. The trust is currently in the process of recruiting additional staff and sourcing training, and we are awaiting feedback on where they are in the plan and their current position.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

The CCG has received a Contract Extension Proposal from WMAS which requests a significant increase in funding. Further detail is awaited from WMAS to validate their figure. A specific paper will be taken to the private Governing Body meeting in February to provide an update and outline the CCG's options.

Business Cases Panel

Extension of Biologics in Rheumatoid Arthritis (RA)

A business case was received from RWT for the extension of current NICE pathway for Biologics in Rheumatoid Arthritis. The business case asks for approval to allow 4th and 5th line therapy thus preventing treatment delays and avoiding the need for Individual Funding Requests. The committee approved the business case.

Action - The Governing Body notes the updates provided and the support for the RA Biologics business case.

2.2 Medicines Optimisation Strategy

The Committee was presented with a Strategy to delivery corporate objectives across the CCG and STP. It outlines how the plan to achieve medicines management optimisation to deliver a safety and value.

Key deliverables include –

- Patient ordering of repeat prescriptions
- Care homes
- Reviews
- Effects on the local health economy
- High cost drug validation
- Delivering of the QIPP programme

The Committee noted the above and approval was given

Action - That Governing Body notes the decision made by the Committee

2.2 Review of Risks

The committee received an update of the risk register highlighting the current risks.

Action - That Governing Body notes the update provided.

3. RECOMMENDATIONS

- Receive and discuss the report.
- Note the action being taken.

Name: **Dr Manjit Kainth**

Job Title: **Lead for Commissioning & Contracting**

Date: **31st January 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 February 2019

Agenda item 12

TITLE OF REPORT:	**Commissioning Committee – November 2018**
AUTHOR(s) OF REPORT:	Dr Manjit Kainth
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in November 2018
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	This report is submitted to meet the Committee's constitutional requirement to provide a written summary of the matters considered at each meeting and to escalate any significant issues that need to be brought to the attention of the Governing Body.
RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1 The purpose of the report is to provide an update from Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) from the November 2018 meeting.

2. MAIN BODY OF REPORT

2.1 Contracting Report

Royal Wolverhampton NHS Trust

Activity/ Performance

The Committee noted the key points raised at the November 2018 Contract Review Meeting.

Cancer – A positive position for this service was reported with improvements in trajectories being attained.

E-Referrals - The CCG is currently awaiting a reply from the Trust clarifying which service areas they believe should be exempt from the electronic referral requirements.

Risk/gain share agreement

The agreement is currently going through the final stage of governance in each organisation; after which sign off will follow.

Ambulance Referrals

This service has been in high demand over the last month it has not been established if this is solely due to Wolverhampton patients. The Committee raised the point that an approach be made to WMAS with regard to patient triage which may reduce service demands.

Delayed Transfer of Care

The service is currently running above target due to local authority challenges, with delayed discharge numbers for Walsall and Staffordshire patients were noted as particularly high.

Diagnostics

This service was performing well until October 2018, but has recently dipped due to demand pressures in certain areas. A private provider has been commissioned on an ad hoc session basis to help alleviate current pressures.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

The Committee noted that achievement of the IAPT target remains a significant risk but that discussions are on-going with the Trust to try to resolve this.

There are no other performance concerns with BCPFT at this present time.

Marie Stopes International – Termination of Pregnancy Service

The Committee received an update of the currently position of this service, with a further paper scheduled to presented in January 2019.

Action - That Governing Body notes the updates provided.

2.2 Review of Risks

The committee received an update of the risk register highlighting the current risks.

Action - That Governing Body notes the update provided.

3. RECOMMENDATIONS

- Receive and discuss the report.
- Note the action being taken.

Name: **Dr Manjit Kainth**

Job Title: **Lead for Commissioning & Contracting**

Date: **31st January 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
12th February 2019

Agenda item 13

TITLE OF REPORT:	Quality and Safety Assurance Report
AUTHOR(S) OF REPORT:	Sally Roberts, Chief Nurse & Director of Quality Yvonne Higgins, Deputy Chief Nurse
MANAGEMENT LEAD:	Sally Roberts Chief Nurse & Director of Quality
PURPOSE OF REPORT:	To provide the Governing Body detailed information collected via the clinical quality monitoring framework pertaining to provider services. Including performance against key clinical indicators (reported by exception). November Data.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	**This report is confidential due to the sensitivity of data and level of detail.**
KEY POINTS:	This report provides an update of Quality and safety activities and discusses issues raised through Q&S Committee, these are described as: • Cancer performance remains challenged • Mortality indicators remain concerning and requiring further understanding and assurance • Maternity performance issues showing improvement, further understanding of caesarean section rates required • There is a new amber risk regarding an emerging concern relating to HCAI which could potentially impact on the Quality and Safety of care provided. • In addition assurance and update was received by committee relating to safeguarding activities and arrangements, CCG complaints, NICE assurance, SEND, E&D, CHC quality update and IPC quarterly report. • FOI, Information governance and GDPR update reports were received for assurance in January committee. • Serious incident policy and internal audit review of serious incidents were received by committee. • No new key risks or issues were identified by committee.

RECOMMENDATION:	Provides assurance on quality and safety of care, and compliance with CCG constitutional standards and to inform the Governing Body as to actions being taken to address areas of concern.

1. **Key areas of concern are highlighted below:**

	Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation
	Level 2 RAPs in place
	Level 1 close monitoring
	Level 1 business as usual

Key issue	Comments	RAG
Cancer Performance for 104 and 62 day waits is below expected target. This may impact on the quality and safety of care provided to patients.	Cancer performance at Royal Wolverhampton Hospital Trust (RWT) against 62 and 104-day cancer pathways is not being achieved. In addition, the trust is predicting possible failure of the 2 week wait, 2 week wait Breast Symptomatic, 31 Day First Treatment, 31 Day Sub Surgery, 31 Day Sub Radiotherapy, 62 Day wait for First Treatment, 62 Day Screening and 62 Day Consultant Upgrade for October 18. The Trust experienced the highest ever number of 2 week wait referrals during October 2018, receiving 1,705 referrals against a plan of 1,380 (23.6%). Assurance is required relating to the actual or potential impact of harm to patients as a result of the delay. Key areas of concern remain Urology and increased referral patterns. **Risk Mitigation:** • National cancer lead and Medical Director for NHSI visited the site and walked through pathways and sought assurance from the clinical teams. Awaiting formal feedback but informal feedback supports the actions already underway across the system. • Additional diagnostic capacity fully supported by NHSI and CCG. • IST actions are now complete, most pathways reviewed and streamlined. • Additional IST support has been offered and trust is working with them to agree priority pathways. • Predicted decline in performance as a result of the Trust addressing the backlog requirements. • Progression with completion of 62 day harm reviews and thematic review of 104 day harm reviews undertaken by RWT, with support from CCG. These are now up to date and no significant harm has yet to be identified. • CCG are actively following up late tertiary referrals with each provider • Weekly system wide assurance calls continue to provide updates on current performance and progress against agreed actions and biweekly face to face meetings have been added for further assurance. Attendance includes NHSE, NHSI, Cancer alliance, Trust and chaired by CCG. • Dedicated theatre for RALPH now operational and additional WLI activity for prostate surgery in place.	

Key issue	Comments	RAG
	• Cancer alliance has asked for wider system discussions with regards sustainable urology pathways going forwards.	
Mortality: RWT is currently reporting the highest Standardised Hospital Mortality Index in the country	The SHMI for July 2017 to June 2018 has seen a slight reduction 1.22 to 1.20 and the banding still remains higher than expected. RWT remains a national outlier for this performance. The expected mortality rate has risen slightly to 3.3% and the crude death rate is 3.9%. RWT has a high percentage of in-hospital deaths for the local health economy compared with the national mean. The trust has received a high number of CQC outlier reports in preceding quarter across a range of clinical areas. **Risk Mitigation:** • Bereavement Suite opened in December; the Medical examiner role has been appointed to and commenced in January 2019. This role will include increased focus on the inclusion of families within the revised mortality review process and a family liaison role is also being explored • The numbers of outstanding level one structured judgement reviews (SJRs) are decreasing and key themes are being identified. 55 cases requiring SJR 2s have been identified up to October 2018 and the aim is for all to be completed by end of December 2018. • The review from the independent external mortality expert is expected by the end of January 2019 and additional analytical support will commence January 2019. • The trust have identified issues related to coding and these areas are being addressed by the trust, FCE coding and Primary and secondary diagnosis coding are the significant outlier areas, the trust are currently reviewing software available to support the correct coding. • The trust have reviewed and responded to all CQC outlier reports, CQC have accepted all mitigation put forward by the trust thus far with no follow up actions required to date. • Nursing audits are underway to support the lessons identified from mortality reviews, these will focus on a set of nursing indicators and reported at ward level for compliance monthly, CCG have asked to be part of the audit process in March to seek assurance of process. • Recruitment for key roles to support mortality reduction, including increasing capacity within critical care outreach team and palliative care team, is progressing. • Further work relating to identification and management of sepsis care has been undertaken by the trust in collaboration with CCG, this follows CCG challenge to CQUIN audit methodology to ensure the whole patient pathway is followed. • The CCG are working collaboratively with Public Health to determine next steps and scoping of a wider	

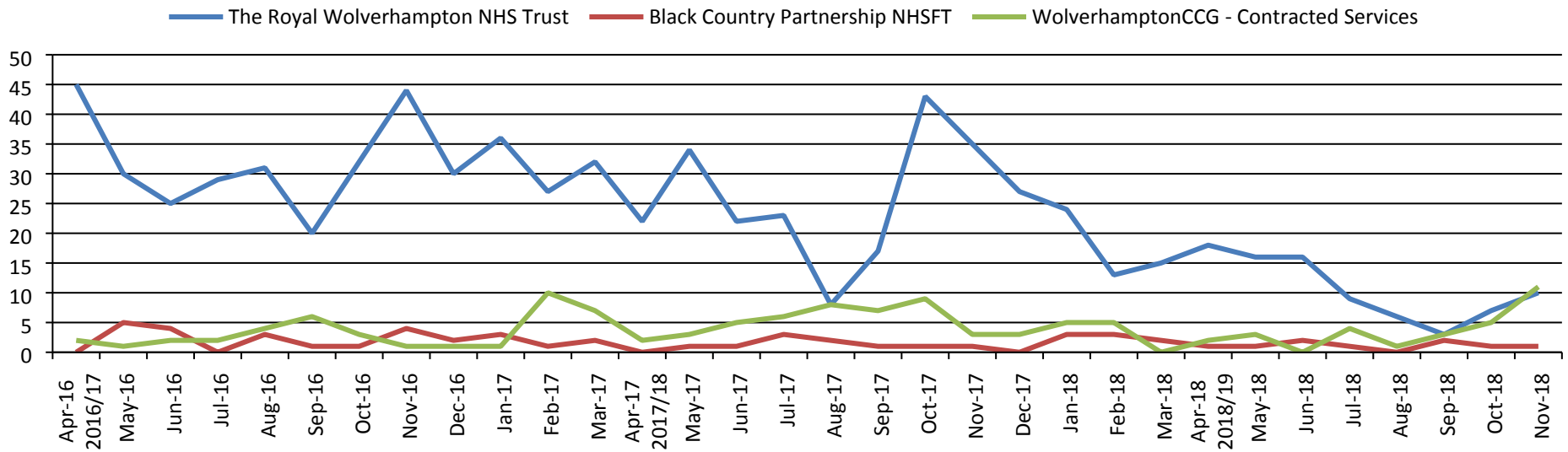
Key issue	Comments	RAG
	system piece of work relating to avoidable mortality, this will focus on healthy ageing and management for community and primary care services. • System wide mortality reduction strategy meetings continue. • Remains a high risk on the WCCG risk register.	
Concerns around sepsis pathways	Following the CQC mortality outlier alert in relation to sepsis and sepsis CQUIN performance, the CCG require further assurance in relation to sepsis pathways. **Risk Mitigation:** • Quarter 2 sepsis CQUIN data identified improved performance with both recognition of sepsis and time taken for administration of antibiotics. • The introduction of a sepsis team will commence February 2019. • Challenge has been offered to the trust in relation to a serious incident involving delayed recognition of sepsis and a revised action plan has been received identifying clear actions to drive improvement. • CCG are in regular contact with the trust to ensure whole patient pathway for sepsis management is supported.	
Black Country Partnership (BCP) (Workforce issues and adult MH beds capacity issues)	Issues identified in relation to capacity of adult mental health beds and also in terms of retention and recruitment. BCPFT staff turnover rate decreased to 14.53% and the vacancy rate also decreased to 13.59% in October Since October 2017, the trust has reported five 12-hours ED breaches. Four breaches were due to bed capacity issues and one was caused by a MH patient secure transport arrangement delay. A further 12 hour ED breach relating to a mental health patient was reported in December 2018. **Risk Mitigation:** • Following on from the system wide Mental Health (MH) 12 hour breach review meeting, a meeting with Cygnet Healthcare to discuss current MH bed capacity provision and referral to discharge processes i.e. time of request to time of bed allocation and actual transfers to service etc will be held in February 2019.	
Quality concerns identified at a Nursing Home providing discharge to access (D2A)	Recruitment of registered nurses and in particular clinical lead roles remains a challenge. Three month utilisation and occupancy review has been shared with CCG. CQC inspection report now published detailing the Provider rated as RI (Requires Improvement) in all domains. Further quality and safety concerns raised by the RITs team and CHC assessors relating to individual patients care requirements. **Risk Mitigation:**	

Key issue	Comments	RAG
provision could potentially impact on the quality and safety of care provided and also on the urgent care system within Wolverhampton	• The Quality Nurse Advisor Team have spent 2 weeks intensively supporting the home. They identified that predominantly residents were safe, however clinical leadership and oversight was not robust. This is particularly apparent when there is an increased use of temporary staffing. • Clear actions to drive improvement relating to medication safety, Clinical leadership and medical cover have been identified by Probert and an improvement plan is now in place • Probert and RWT have agreed a MOU, this offers support to the home with regards clinical education, medication safety and from end of March will allow Probert access to RWT bank staffing. Plans are in place to support a joint staffing arrangement from April with RWT; clinical fellows will initially be appointed to support the home through RWT recruitment arrangements. • The next review meeting with the Provider is planned for the 23rd January 2019 and the home is also on the CQC Information Sharing Meeting agenda for January 2019 • WCCG QNA team will support the recruitment process for new staff and will monitor progress through a detailed action plan which has been agreed with the Provider. • There are 3 safeguarding reviews and 3 serious incidents currently under review and being supported by CCG, outcomes are yet to be determined. • The CHC DTA clinical nurse support is also now in place at the home regularly and is able to support patient flow and identify and mitigate quickly issues as they arise. • The homes capacity for the past 3 months is under review, however current data available requires further scrutiny.	
Emerging concern relating to HCAI which could potentially impact on the Quality and safety of care provided.	The Royal Wolverhampton Trust is currently not achieving training trajectories for hand hygiene and within year there have been an increased number of MRSA cases. As a system, Wolverhampton has been identified as being in the bottom 30 CCG's for gram negative infections. **Risk Mitigation:** • Further analysis will be undertaken relating to emerging HCAI risk. • The CCG continues to attend the IP committee at RWT to gain assurance relating to actions to drive improvement in training compliance. • System wide meeting was held, supported by NHSI, to identify key actions to drive improvement relating to gram negative infections. • The three key actions identified to drive improvement relate to catheter management, hydration and antibiotic prescribing	

2. PATIENT SAFETY

2.1 Serious Incidents

Chart 1: Serious Incidents Reported by Month



In total 22 Serious Incidents (SIs) were reported in November 2018 which is an increase compared to 13 SI's reported in October 2018. There were 10 SI's reported by RWT, 1 SI reported for BCPFT and 11 SI's were reported by WCCG-contracted services relating to care homes. All serious incidents were reported within the national timescale of two working days.

Chart 2: Serious Incident Types Reported November 2018

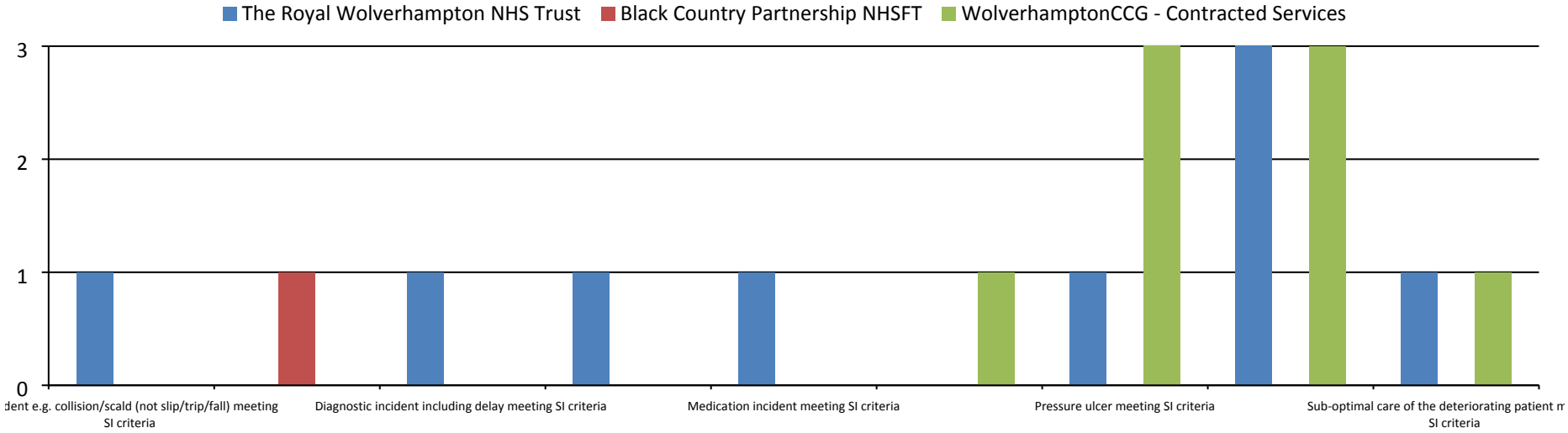


Chart 2 shows the breakdown of serious incident types reported by each provider for November 2018. WCCG contracted other providers was the highest reporting provider (11) .The most reported incident types across all providers were; pressure ulcers and slips trips, falls (both 7), followed by Sub-optimal care of the deteriorating patient meeting SI criteria (2).

Assurance

- A WCCG representative attends multiple review groups to provide assurance that serious incidents are being appropriately identified.
- Scrutiny of completed serious incident reports continues across all providers.
- Regular monitoring of compliance via CQRMs
- Announced and unannounced visits undertaken to follow up on action plans

2.2 Never Events

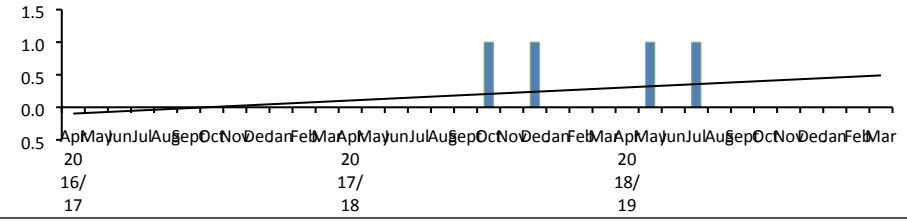
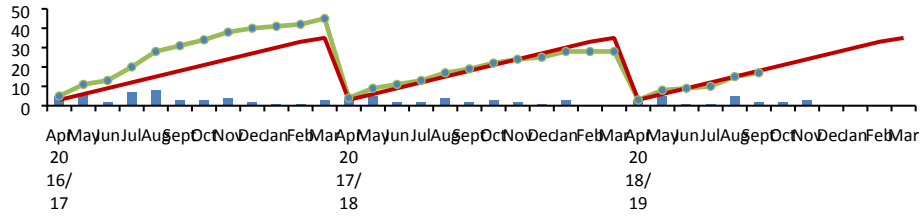
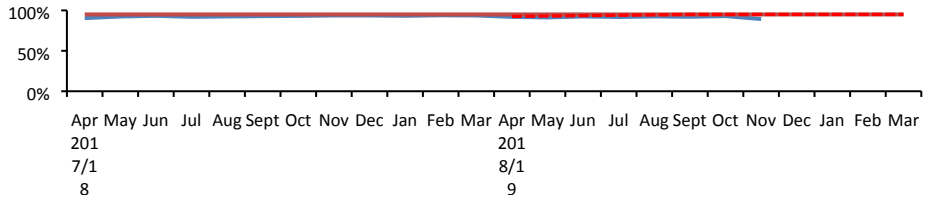
Table 1: Reported Never Events

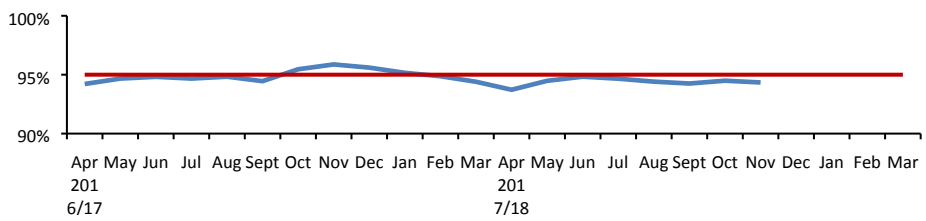
	Yr 16-17	Yr 17-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Yr to date
Royal Wolverhampton	**5**	**4**	2	0	2	0	0	0	0	0					**4**
Black Country Partnership	**0**	**0**	0	0	0	0	0	0	0	0					**0**
Other providers	**0**	**1**	0	0	0	0	0	0	0	0					**0**
Total Reported	**5**	**5**	2	0	2	0	0	0	0	0					**4**

There were no Never Events reported in November 2018.

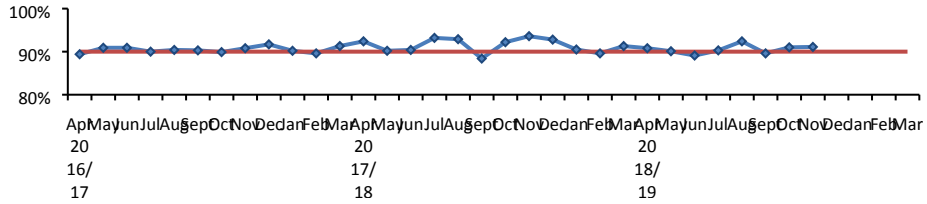
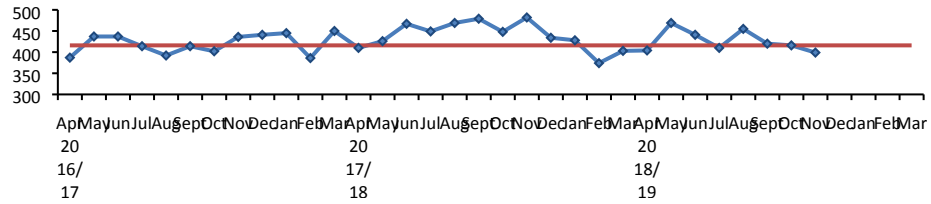
3. ROYAL WOLVERHAMPTON HOSPITAL TRUST

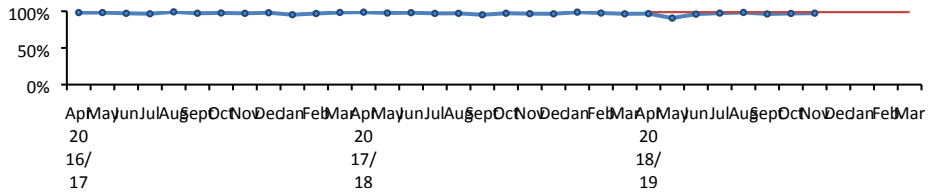
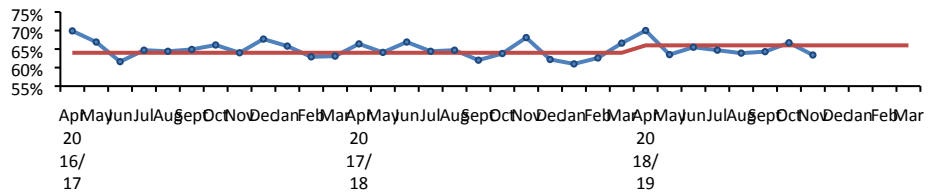
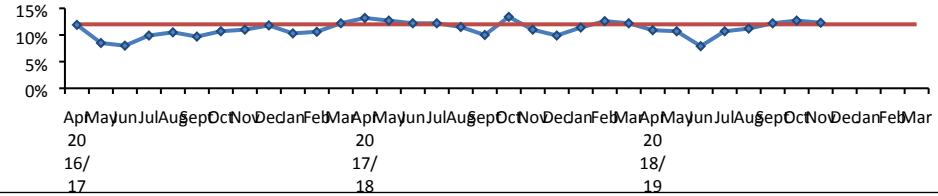
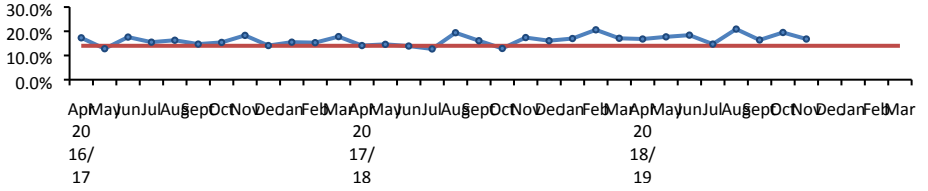
3.1 Infection Prevention

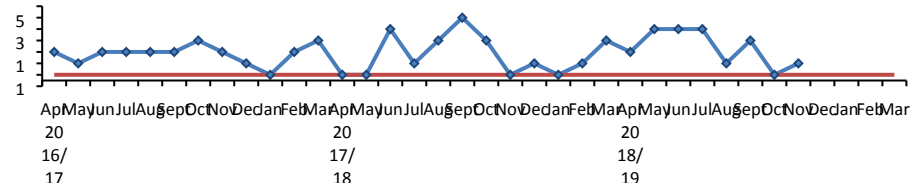
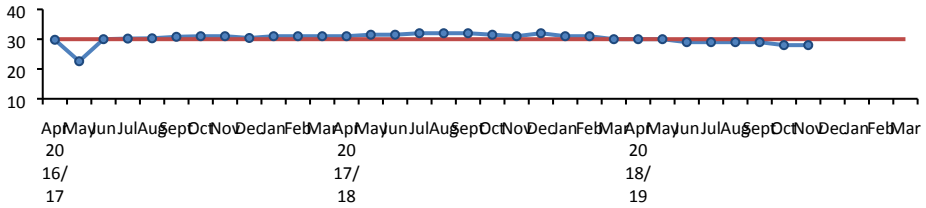
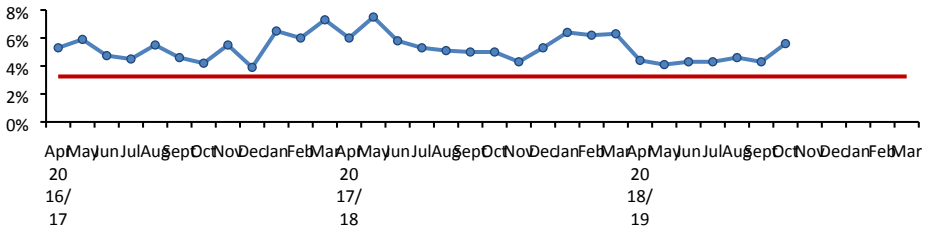
Measure	Trend	Target	Assurance/Analysis
MRSA		**0**	No new MRSA bacteraemia cases were reported for November 2018.
C. Diff		**<35**	The Trust continues to remain below the monthly trajectory for 2018/19. A combination of antibiotic diversity, attendance at ward huddles and strong environmental controls is thought to have contributed. Three C. Difficile cases were reported for November 2018. The Trust has planned additional cleaning in ED for a 3-month period to ascertain the possible impact on the rest of the hospital. The deep clean programme continues across the Trust to ensure optimal environmental control.
Hand Hygiene - All Staff		**95%**	The Trust is currently failing the national and locally revised trajectory for hand hygiene compliance. The hand hygiene compliance for November fell to 89.34%. The trust is taking the following actions to meet target :- • Gain assurance that each directorate has an effective process non-compliance/holding staff to account and staff awareness - the worst performing directorates have been attending the Infection Prevention and Control Committee to present their actions. • Monitor and discuss at IPCG every month and part of directorate accountability (chaired by Executive Directors)

Measure	Trend	Target	Assurance/Analysis
Infection Prevention Training		**95%**	The IP training compliance for November is 94.34%; which is just below national standard of 95%. The trust is ensuring that Infection Prevention compliance is incorporated in local induction, yearly appraisal and training needs analysis. The specific question around compliance with mandatory training is present on the annual appraisal documents.

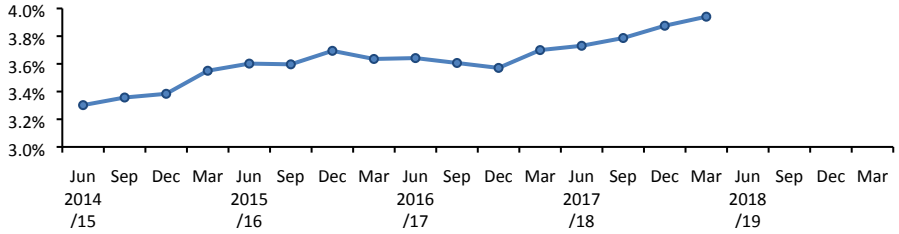
3.2 Maternity

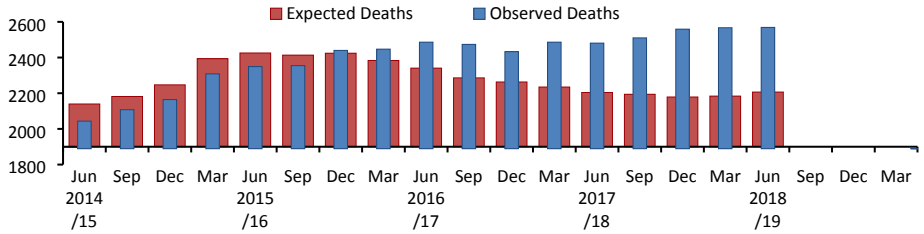
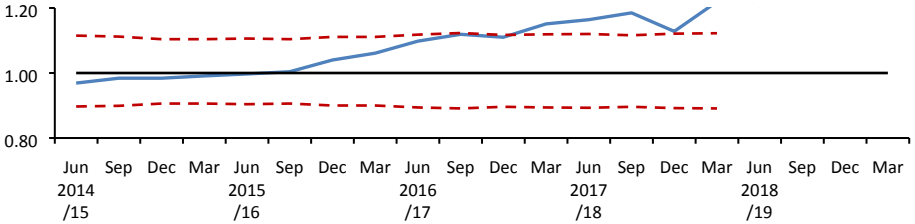
Measure	Trend	Target	Assurance/Analysis
Bookings at 12+6 weeks		>90%	Booking activity continues to be monitored closely.
Number of Deliveries (mothers delivered)		<416	The number of deliveries decreased slightly in November 2018 to 399 from 416 in October. The Trust is predicting over 5000 births by end of this financial year, which will exceed their annual threshold.

Measure	Trend	Target	Assurance/Analysis
One to One care in established labour		100%	Ongoing recruitment of Midwives continues, with a number commencing in post shortly.
Breastfeeding (initiated within 48 hours)		>=66%	The rate of breast feeding initiation in November 2018 dropped slightly to 63.4%.
C-Section - Elective (Births)		<12%	The elective rate for elective C-Sections was 12% for November 2018, meeting the 12% threshold for the third consecutive month.
C-Section - Emergency (Births)		<14%	Emergency C-section case rate decreased slightly in November 2018 but remains above the threshold of 14% at 16.8%. An initial analysis of C-section rates found increases related to patient acuity. The directorate are auditing caesareans and will also conduct an audit of the inductions that take place to ascertain any trends or themes which may be impacting this will be presented in January 2019.

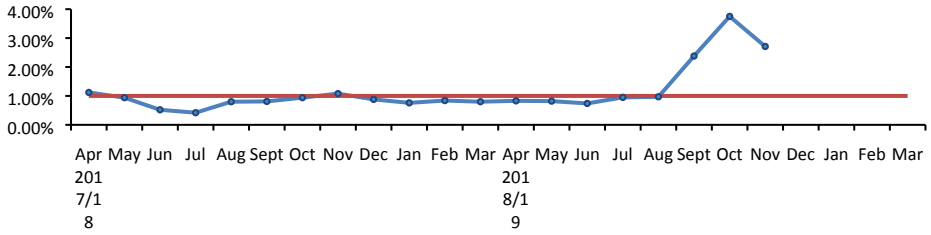
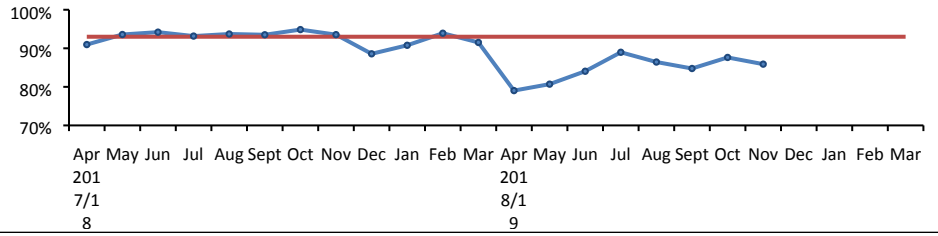
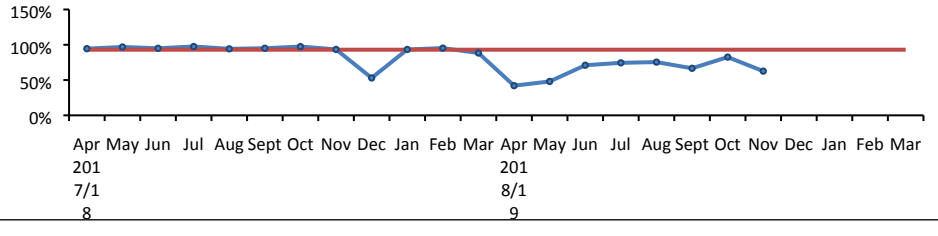
Measure	Trend	Target	Assurance/Analysis
Admission of full term babies to Neonatal Unit		0	One full term baby was admitted to neonatal unit for this reporting period.
Midwife to Birth Ratio (Worked)		<=30	The worked ratio has been at or below the threshold of 1:30 for more than six months (September 1:29, October 1:28, November 1:28, national 1:28). The trust is in line with the national threshold of midwife to birth ratio of 1:28.
Maternity - Sickness Absence		<3.25%	October 2018 saw a rise in Maternity Sickness Absence from 4.3% in September to 5.6% in October. November data not yet available.

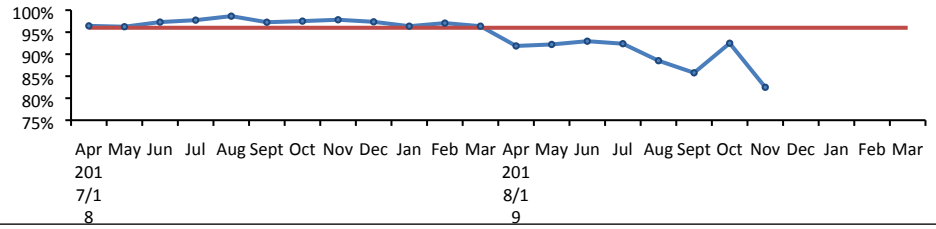
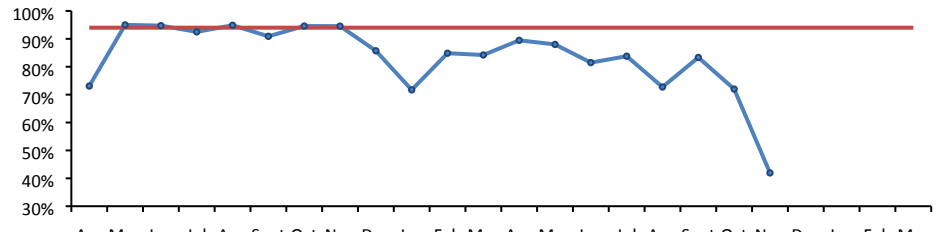
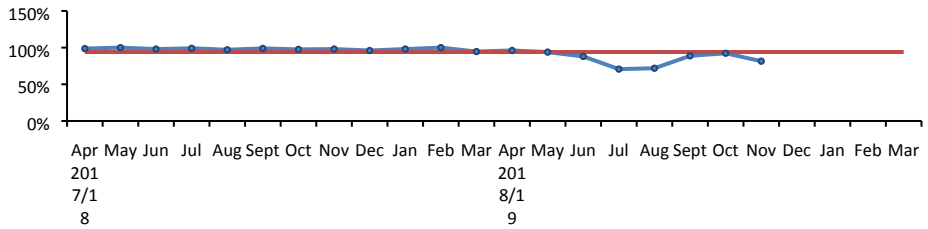
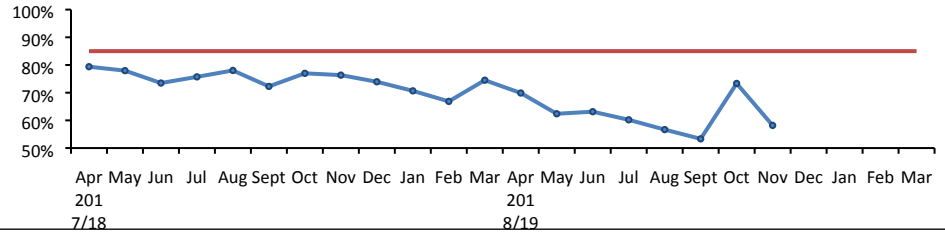
3.3 Mortality

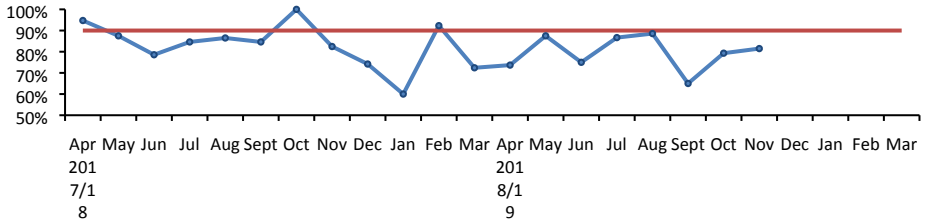
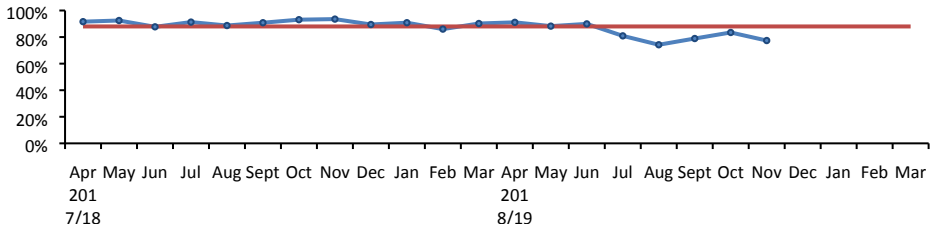
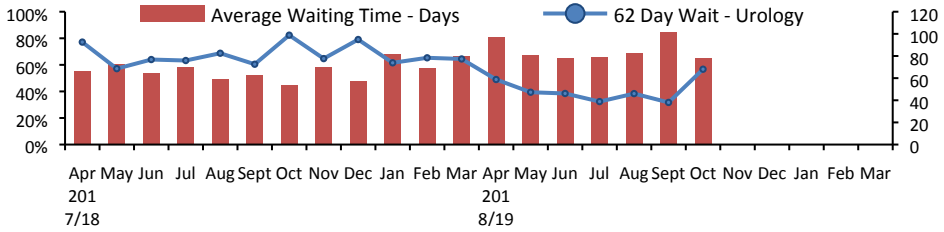
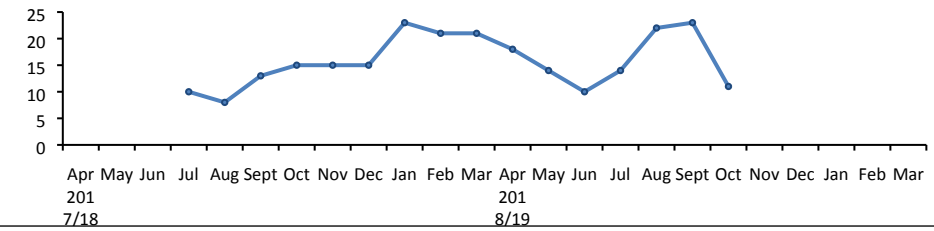
Measure	Trend	Target	Assurance/Analysis
Mortality – Inpatient deaths		**N/A**	Latest published version of the SHMI data which relates to July 2017 to June 2018 period shows a slight drop in SHMI and the trust still remains a national outlier with reporting 20% more deaths than expected. The Trust has recruited to the Medical Examiner (ME) role; these individuals commenced in December 2018.

Measure	Trend	Target	Assurance/Analysis
Mortality - SHMI Observed vs. Expected Deaths		**N/A**	The ME role will provide an initial review of care relating to their admission episode. It is anticipated this will reduce the overall SJRs required by the directorate teams. The Trust is currently working on expansion of palliative care team and to invest into sepsis and critical care outreach team, and to ensure appropriate safe staffing levels across the trust.
Mortality - SHMI		**N/A**	

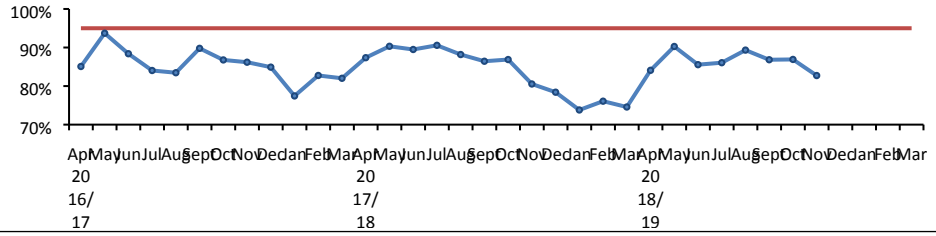
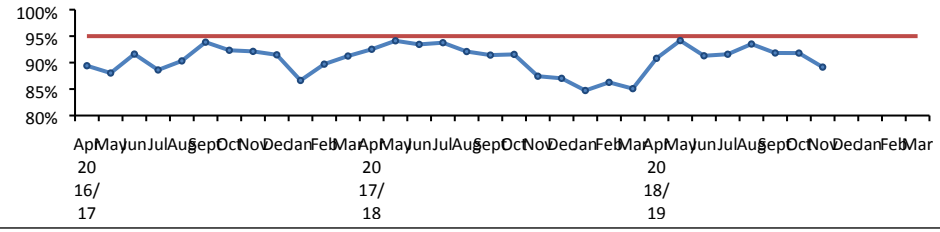
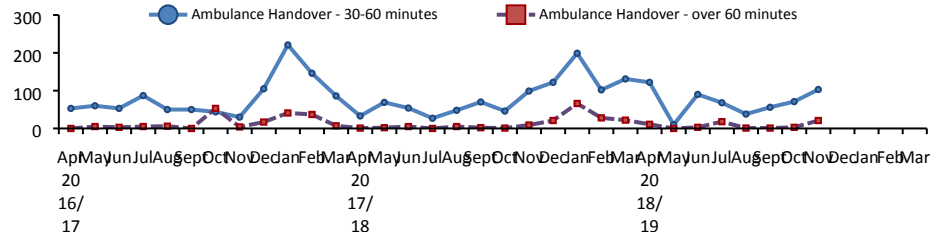
3.4 Cancer Waiting Times

Measure	Trend	Target	Assurance/Analysis
6 Week Diagnostic RRT		**<1%**	The Trust continues to fail in achieving the target. November data was 2.71%. This is largely down to a significant rise in urgent Gastroscopy referrals; this in turn has had an adverse effect on the routine waiting times. Capacity challenges in Radiology are centred on CT and MRI Heart, although this backlog is reducing. The Trust is monitoring this through their weekly performance meeting. Trust is undertaking additional Saturday lists to help reduce the backlog and is seeking to outsource some activity to a private provider. A demand and capacity review has identified a shortfall in capacity based on referral rates; an action plan is in development to address this.
2 Week Wait Cancer		**93%**	The 2 week wait cancer performance position declined slightly in November 2018 to 85.89% and remains below target.
2 Week Wait Breast Symptomatic		**93%**	Despite a significant improvement in the 2 week wait breast symptomatic from 66.67% in September to 82.54% in October, the figure fell to 62.64% in November.

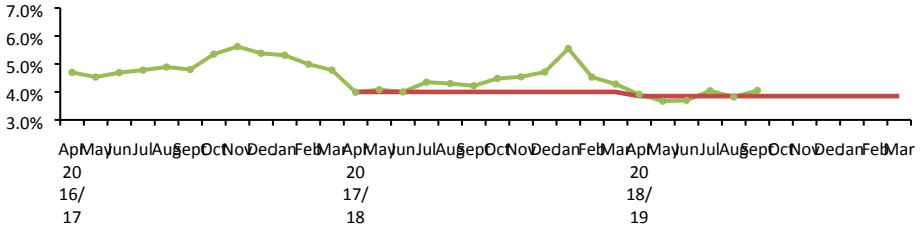
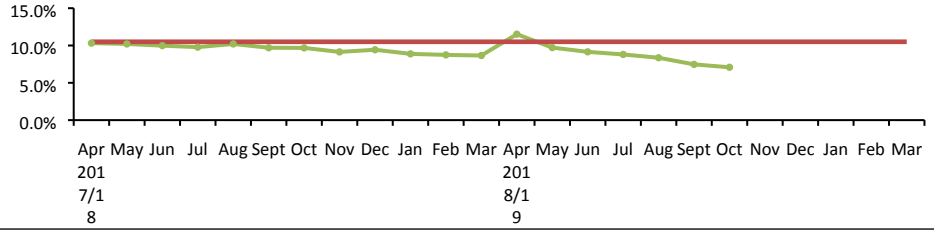
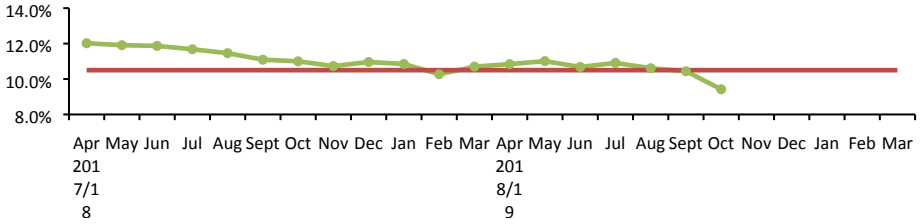
Measure	Trend	Target	Assurance/Analysis
31 Day to First Treatment		**96%**	November saw a decline back down to 82.48%. from 92.49% in October. The trust has not achieved this target for this financial year.
31 Day Sub Treatment - Surgery		**94%**	November saw a sharp decline for 31 day sub treatment surgery target from 72% in October down to 41.94% in November.
31 Day Sub Treatment - Radiotherapy		**94%**	31 day sub treatment radiotherapy saw a decline to 81.51% in November.
62 Day Wait for First Treatment		**85%**	Performance decreased significantly from 73.33% in October to 58.18% in November 2018.

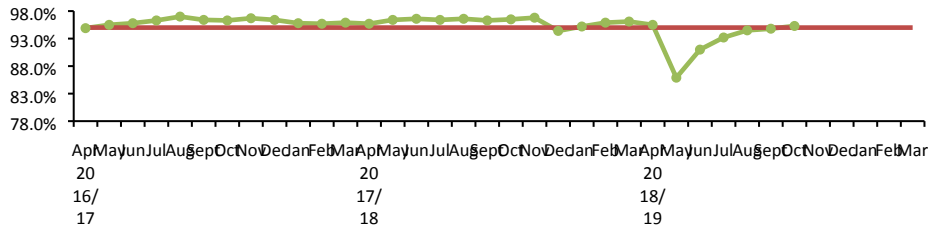
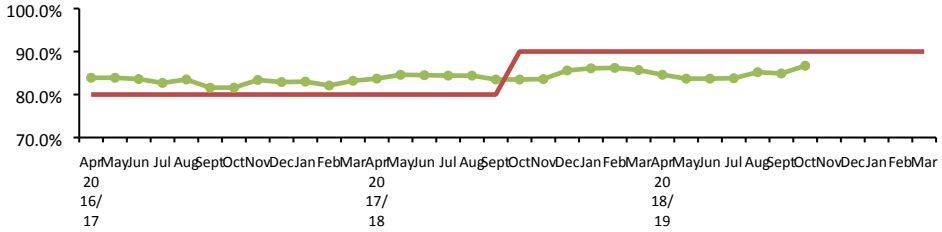
Measure	Trend	Target	Assurance/Analysis
62 Day Wait - Screening		**90%**	62-day wait screening target performance increased in November to 81.48%.
62 Day Wait - Consultant Upgrade (local target)		**88%**	The 62-day wait consultant upgrade (local target) performance improved slightly from 78.91% in September 2018 to 83.46% in October 2018. However it has declined to 77.4% in November.
62 Day Wait - Urology		**85%**	The average waiting time decreased in October to 78, compared to 102 in September 2018. Performance for Urology in October was 56.72% compared to September at 31.71%. November data not yet available.
Patients over 104 days		**N/A**	11 patients identified over 104 days October 2018. November data not yet available.

3.5 Total Time Spent in Emergency Department (4 hours)

Measure	Trend	Target	Assurance/Analysis
Time Spent in ED (4 hours) - New Cross		**92%**	Performance for New Cross declined in November to 82.3% and remains below target. Winter planning has been finalised to support peak flow times.
Time Spent in ED (4 hours) - Combined		**95%**	The Trust did not achieve the combined target for November 2018; overall performance declined to 89.15% in November from 91.8% in October.
Ambulance Handover		**N/A**	Ambulance handover performance saw another increase during November 2018 for the 30-60 minutes target from 71 in October to 103. The over 60 minute increased sharply from 3 in October to 21 in November.

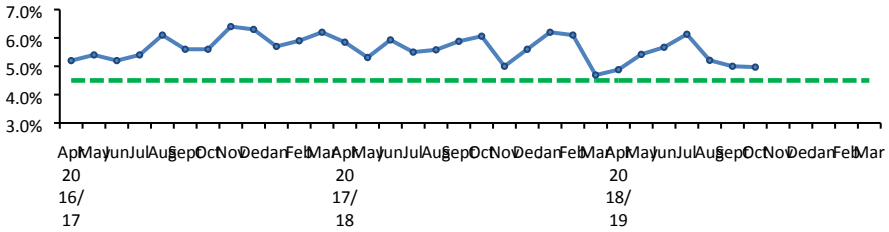
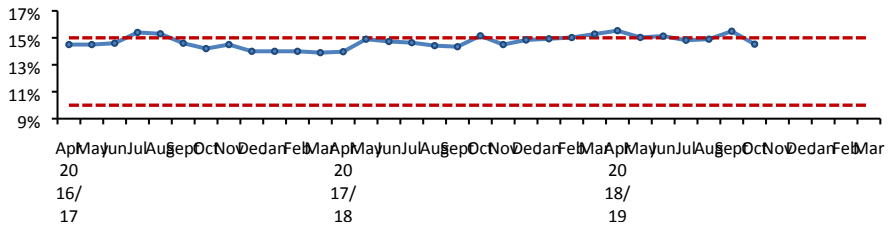
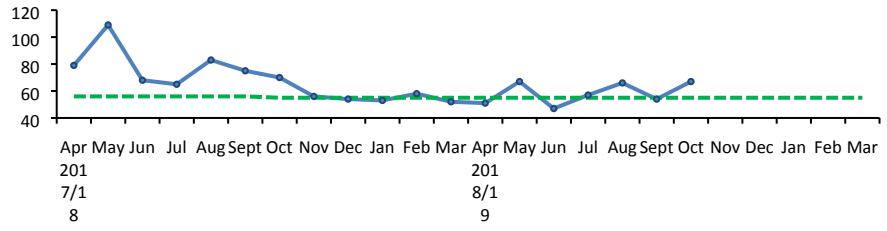
3.6 Workforce and Staffing

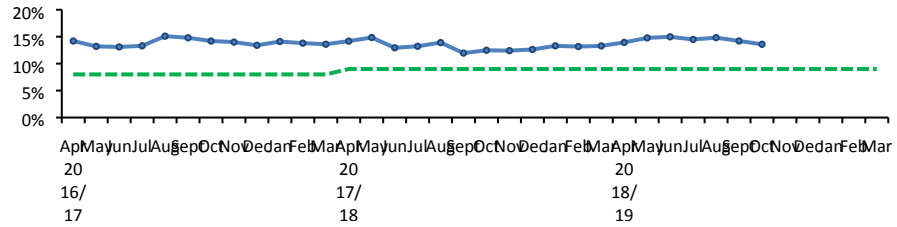
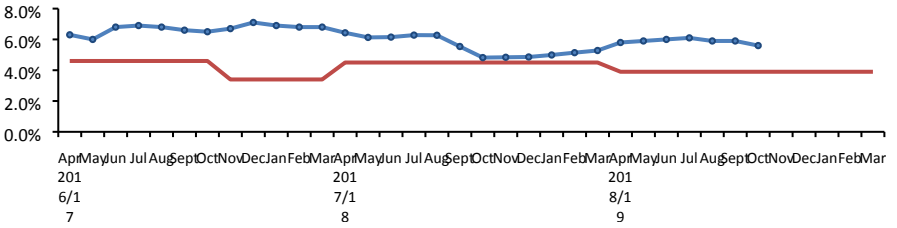
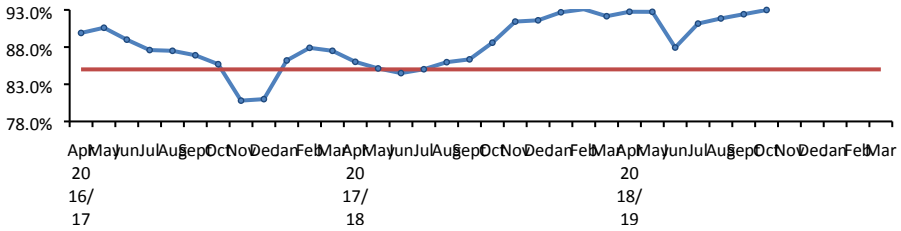
Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**3.85%**	The sickness absence rate remains above the Trust target at 4.05% for September 2018 (reported one month in arrears). November data not yet available.
Vacancy Rates (%)		**10.5%**	There continues to be significant improvement in the vacancy rate, driven by large number of staff joining the Trust and improvements in turnover. November data not yet available.
Staff Turnover Rates (%)		**10.5%**	Trust turnover levels remain below the Trust target for October 2018 at 9.42%. Further improvements are required in the 24 month retention rate and turnover rate for AHPs. The Attract and Retain work stream has been refreshed and will report to the Workforce and Organisational Development Committee in December 2018. November data not yet available.

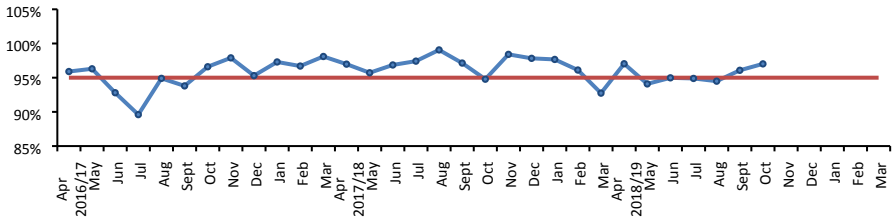
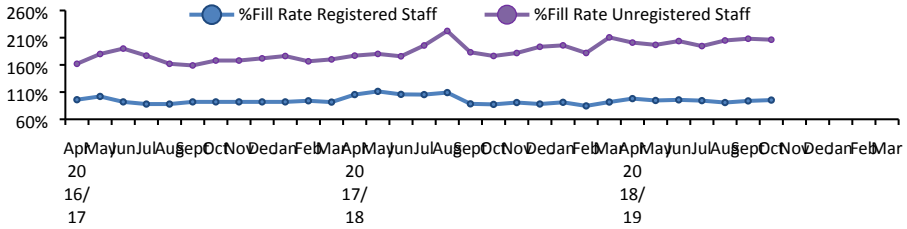
Measure	Trend	Target	Assurance/Analysis
Mandatory Training Rate (%)		**95%**	Performance has improved in relation to Generic Mandatory Training compliance and this is now in line with the target of 95% compliance. November data not yet available.
Appraisal Rate (%)		**90%**	Appraisal compliance remains below target, although performance has improved marginally over the last month. Further work is being undertaken over the coming months to improve the appraisal process to include a focus on performance and talent management. November data not yet available.

4. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

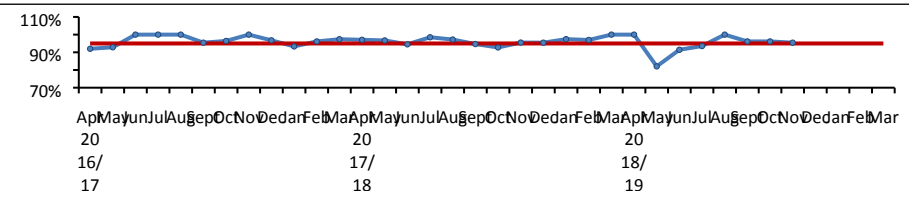
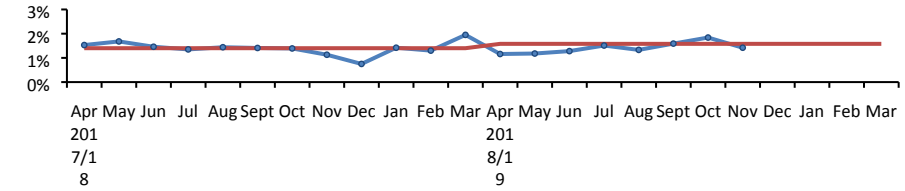
4.1 Workforce and Staffing

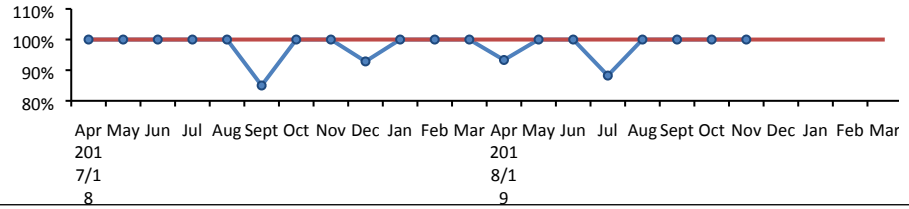
Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**<4.5%**	Sickness absence rate decreased by 0.25% to 4.97% in October. November data not yet available.
Staff Turnover Rates (%)		**10-15%**	Turnover decreased to 14.53% and returned to green rating on the Trust risk register, having been amber in September. November data not yet available.
Average Time to Recruit		**55**	This KPI remains outside the 55 working day target, at 67 working days in October. November data not yet available.

Measure	Trend	Target	Assurance/Analysis
Overall vacancy rate		**<9%**	The vacancy rate reduced from 14.21% in September to 13.59% in October and remains red against the Trust's target. November data not yet available.
Agency Usage (%)		**<3.9%**	Agency usage remains above target at 5.6% November data not yet available.
Mandatory Training Rate (%)		**85%**	Performance against all mandatory training remains above the 85% target. November data not yet available.

Measure	Trend	Target	Assurance/Analysis
% of Shifts filled (Bank and Rostered)		**95%**	Registered nurse fill rate has improved slightly (95.3%) compared to 95% in September. November data not yet available.
Safe Staffing - %Fill Rate Registered Staff		**N/A**	

4.2 Quality Performance Indicators

Measure	Trend	Target	Assurance/Analysis
CPA % of Service Users followed up within 7 days of discharge		**95%**	BCP continues to meet the target for this indicator - November 2018 (95.45%).
% of people with anxiety or depression entering treatment		**1.40%**	The Trust managed to achieve target for October 2018 at 1.84%. However, the figure for November dropped below target to 1.58%.

Measure	Trend	Target	Assurance/Analysis
% of inpatients with Crisis Management plan on discharge from secondary care		**100%**	Compliance with this indicator remained the same for November 2018 at 100%.

5.0 PRIVATE SECTOR PROVIDERS

5.1 Vocare

Performance continues to improve and there are no quality issues or concerns and no serious incidents have been reported for November 2018.

An announced CQC visit took place on 8th November 2018 and no concerns were identified. The visit has been deemed to be assuring and positive. A full report has been published and has rated Vocare as **"Good"**. WCCG continues to monitor the quality of care and performance for the provider through monthly CQRM's.

6.0 SAFEGUARDING

6.1 Safeguarding Children

- The Designated Nurse (DN) chaired the second ICS / NHSE funding Safeguarding meeting. Task and finish groups are to be established to review the safeguarding role and functions of the CCG's, in view of ensuring a standardised approach and practice occurs across the ICS. The leads for the NHSE funding work streams provided feedback on the work carried out by the groups and will be completing an update to Lorraine Millard to be relayed to NHSE in regards to the proposed use of the funds.
- In relation to this the Deputy Designated Nurse (DDN) held a further NHSE work stream meeting in regards to working with Adolescents. The scoping work that had been requested was fedback by all members and decisions were made in regards to how to use the funds to make a difference to the adolescents in the ICS. An initial proposal of a training event to key staff in the ICS that either work directly with, or manage staff working with adolescents was drafted. It is envisaged that this will include the invitation of adolescent services to provide information and networking and the use survivors of exploitation and issues that adolescents are involved in to be

key note speakers. Most importantly the Children's teams that work in the areas, such as BeSafe in Wolverhampton, will be invited to attend and be part of the event, so they are able to give advice to professionals and also feedback to the children themselves. A further meeting is occurring in January to progress the proposal. The event is planned to be held in the early summer.

- The Designated Doctor and DDN are involved with work in regards to the Early Adopter programme of forming a Black Country Child Death Overview Panel (CDOP). A steering group was attended which reviewed 3 options that were to be presented at the stakeholder event at the end of the month. The DDN attended the Stakeholder event and facilitated discussions and understanding of the options that are being considered. A clear decision on a preferred option was not reached at the event, but a SWOT analysis occurred on each option that will be analysed and explored further at the steering group meeting due to be held in January 19.

- A meeting occurred with the DN and Linda Sanders, Independent Chair of the Wolverhampton Safeguarding Board. This was to review the function and processes that occur with the Serious Case Review Committee that the DN is the chair of.

6.2 Safeguarding Adults

- Domestic Homicide Review (DHR10) is in progress. IMR's have been submitted to the DHR Author. A draft report is awaited

- The Wolverhampton 'Orange' campaign took place in November/December. This is a worldwide campaign to end violence against women and girls. WCCG supported the campaign by wearing orange ribbons, using email banners, TV screens, posters, display in the UOWSP Lockside Café, staff photographs and the UOWSP kindly lit up the building with interior and exterior orange lighting

- In November, 7 LeDeR reviews were in progress and 4 had been completed and submitted to University of Bristol. Online training is now available, supported by face to face updates/support with reviewers by the Black Country Local Area Contacts as required

- Price Waterhouse Cooper carried out an audit of WCCG's Safeguarding arrangements in November, the outcome is awaited

- Safeguarding Adults Core Level 3 training took place for Primary Care, CCG staff and some external NHS England staff in November. The evaluations were extremely positive. The next session is planned for March 2019.

6.3 Care Homes

Falls have decreased slightly during November (39) when compared October (43). Of the 39 falls, 8 were for patients sustaining injuries that required GP attendance or visit to A&E.

There was 1 acquired pressure injuries occurred during the month of November which is a decrease when compared to October (4). This was grade 3.

Use of the RITs team in November increased to 74 (compared to October, 63 and 51 in September). Unscheduled GP visits also showed slight improvement, down to 44 in November (compared to 47 in October).

Mortality data showed that an equal number of nursing home residents died in a care home and at a hospital in November (both 14). Of the14 patients who died in hospital, 8 had an advanced care plan or end of life pathway in place.

7.0 PRIMARY CARE QUALITY DASHBOARD

1a Business as usual
1b Monitoring
2 Recovery Action Plan in place
3 RAP and escalation

Data for September 2018		
Issue	**Concern**	**RAG rating**
Infection Prevention	Four IP audits were undertaken in October – 3 silver 1 bronze . All practices have now have aTIV flu vaccine orders Awaiting uptake figures from Immform	1b
MHRA	Since 1st April 2018	1a

	• 29 weekly field safety bulletins with all medical device information included. • 5 device alerts/recalls • 10 drug alerts/recalls	
Serious Incidents	None to report at present	1a
Quality Matters	Currently up to date: 12 open 5 overdue 3 closed	1b
Practice Issues	Issues relating to DocMan, and one practice around notes returns and complaints are being managed.	1b
Escalation to NHSE	On-going process	1a
Complaints	Details of 36 complaints received since 1st November 2017 28 now closed 8 still under investigation	1a
FFT	In August 2018 • 5 practices submitted no data (one later supplied the data) • 1 zero submission • 2 submitted fewer than 5 responses (supressed data)	1b
NICE Assurance	NICE assurance is now linked to GP Peer Review system – last meeting on 12th September	1a
CQC	2 Practices currently have Requires Improvement rating, are being supported with their action plan.	1b
Workforce Activity	Work around recruitment and development for all staff groups including new roles continue.	1a
Training and Development	A training business was presented to Workforce Task and Finish Group – for further discussion. Work continues on Practice Nurse Strategy and documents. Training for nurses and non-clinical staff continues as per GPFV	1a
Training Hub Update	Procurement of new Training Hub provision is currently on hold – contract will be rolled over if necessary	2

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WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 14

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 29th January 2019**
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	• **Receive** and **note** the information provided in this report.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The organisation has a number of finance and performance related statutory obligations including delivery of a robust financial position and adherence with NHS

	Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG must secure the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money; and has effective systems in place to ensure compliance with its statutory functions, meet a number of constitutional, national and locally set performance targets.
• **Domain2:** Performance – delivery of commitments and improved outcomes	The CCG must meet a number of constitutional, national and locally set performance targets.
• **Domain 3:** Financial Management	The CCG aims to generate financial stability in its position, managing budgets and expenditure to commission high quality, value for money services. The CCG must produce a medium to long term plan that allows it to meet its objectives in the future.

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1. FINANCE POSITION

The Committee was asked to note the following year to date position against key financial performance indicators;

Financial Targets				
Statutory Duties	**Target**	**Out turn**	**Variance o(u)**	**RAG**
Expenditure not to exceed income	£9.986m surplus	£9.986m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£420.731m	£420.731m	Nil	G
Revenue Administration Resource not exceeded	£5.560m	£5.392m	Nil	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£359k	£132k	(£227k)	G
Maximum closing cash balance %	1.25%	0.46%	(0.79%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£10.374m	£10.374m	Nil	G
Programme Cost *	£302,726k	£304,662k	£1,937k	G
Reserves *	£1,863k	£0k	(£1,863k)	G
Running Cost *	£4,169k	£4,095k	(£74k)	G

- The net effect of the three identified lines (*) is breakeven.

- Underlying recurrent surplus metric of 2% is being maintained.
- Programme Costs YTD inclusive of reserves is showing a small overspend.
- Royal Wolverhampton Trust (RWT) M8 data indicates a financial under performance.
- Continuing Care payments continue to require close monitoring to ensure all costs are captured and monitored.
- The CCG control total is £9.986m which takes account of the 17/18 year end performance.
- The CCG is reporting achieving its QIPP target of £13.948m.
- The Programme Boards QIPP deliverability report identifies the need to deploy reserves in order to meet the QIPP target as planned.
- The CCG is currently reporting a nil net risk.

The table below highlights year to date performance as reported to and discussed by the Committee;

		YTD Performance M09						
	Annual Budget £'000	Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)
Acute Services	200,649	150,486	150,599	112	0.1%	200,529	(120)	(0.1%)
Mental Health Services	39,000	29,256	29,290	34	0.1%	39,400	400	1.0%
Community Services	40,802	30,612	30,490	(123)	(0.4%)	40,748	(54)	(0.1%)
Continuing Care	15,107	11,330	11,141	(189)	(1.7%)	14,794	(313)	(2.1%)
Primary Care Services	53,576	40,183	40,409	226	0.6%	53,867	290	0.5%
Delegated Primary Care	36,023	27,017	27,428	411	1.5%	36,023	0	0.0%
Other Programme	17,545	13,840	15,305	1,465	10.6%	19,375	1,830	10.4%
Total Programme	**402,702**	**302,726**	**304,662**	**1,937**	**0.6%**	**404,737**	**2,035**	**0.5%**
Running Costs	5,560	4,169	4,095	(74)	(1.8%)	5,460	(100)	(1.8%)
Reserves	2,483	1,863	0	(1,863)	(100.0%)	548	(1,935)	(77.9%)
Total Mandate	**410,745**	**308,757**	**308,757**	**(0)**	(0.0%)	**410,745**	**(0)**	**(0.0%)**
Target Surplus	9,986	7,489	0	(7,489)	(100.0%)	0	(9,986)	(100.0%)
Total	**420,731**	**316,247**	**308,757**	**(7,489)**	(2.4%)	**410,745**	**(9,986)**	(2.4%)

- Within the Forecast out turn there is a commitment of £1.107m of non-recurrent investment to support the RWT transformational agenda.

- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, and the 1% reserve. For 19/20 the CCG will need to reinstate the Contingency and 1% reserve which will be a first call on growth monies.

- The CCG is now required to report on its underlying financial position, a position which reflects the recurrent position and financial health of the organisation and is meeting the planning requirements of a 2% recurrent surplus as shown below.

- The extract from the M9 non ISFE demonstrates the CCG is on plan, achieving 1.9% recurrent underlying surplus.

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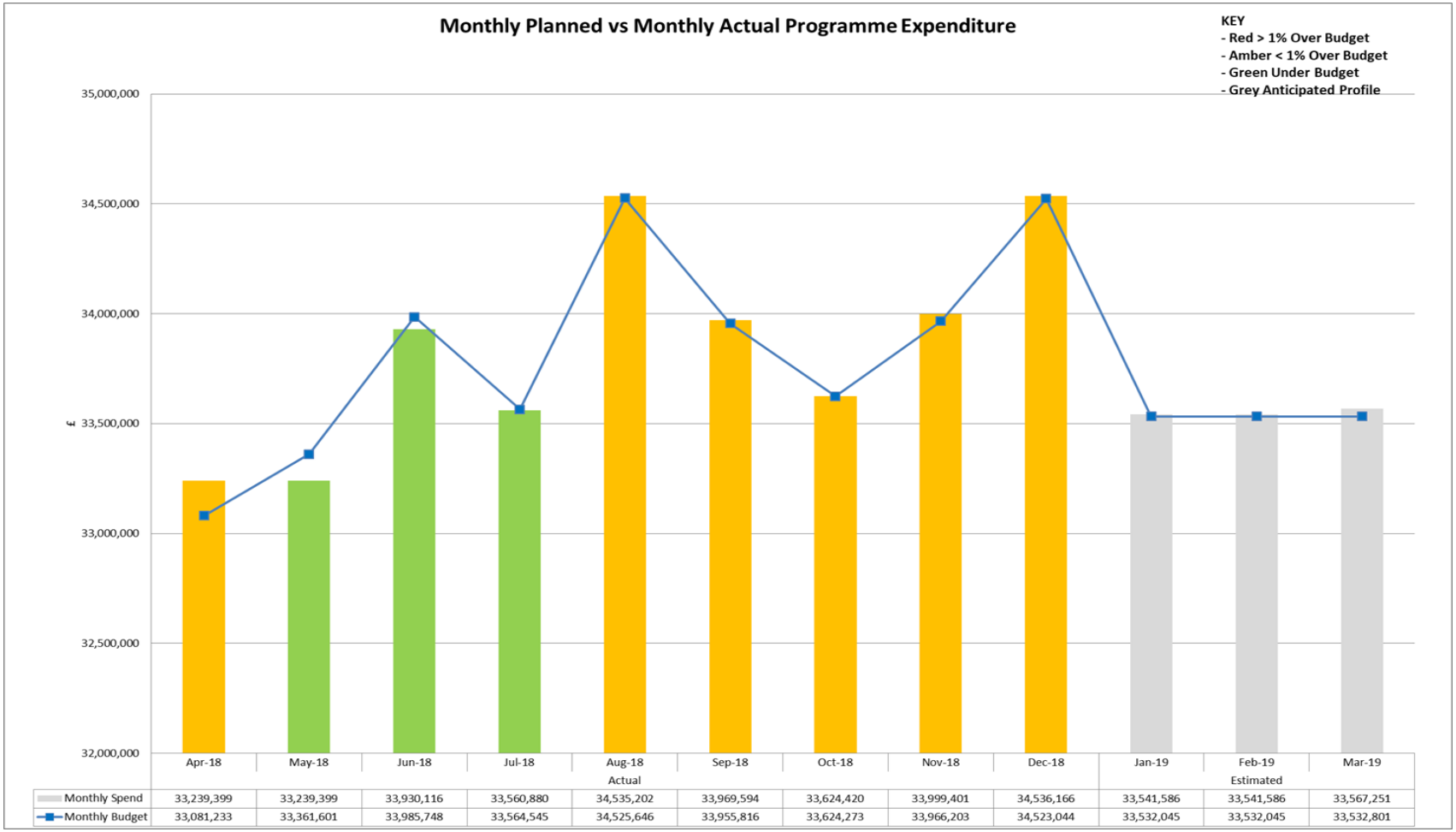
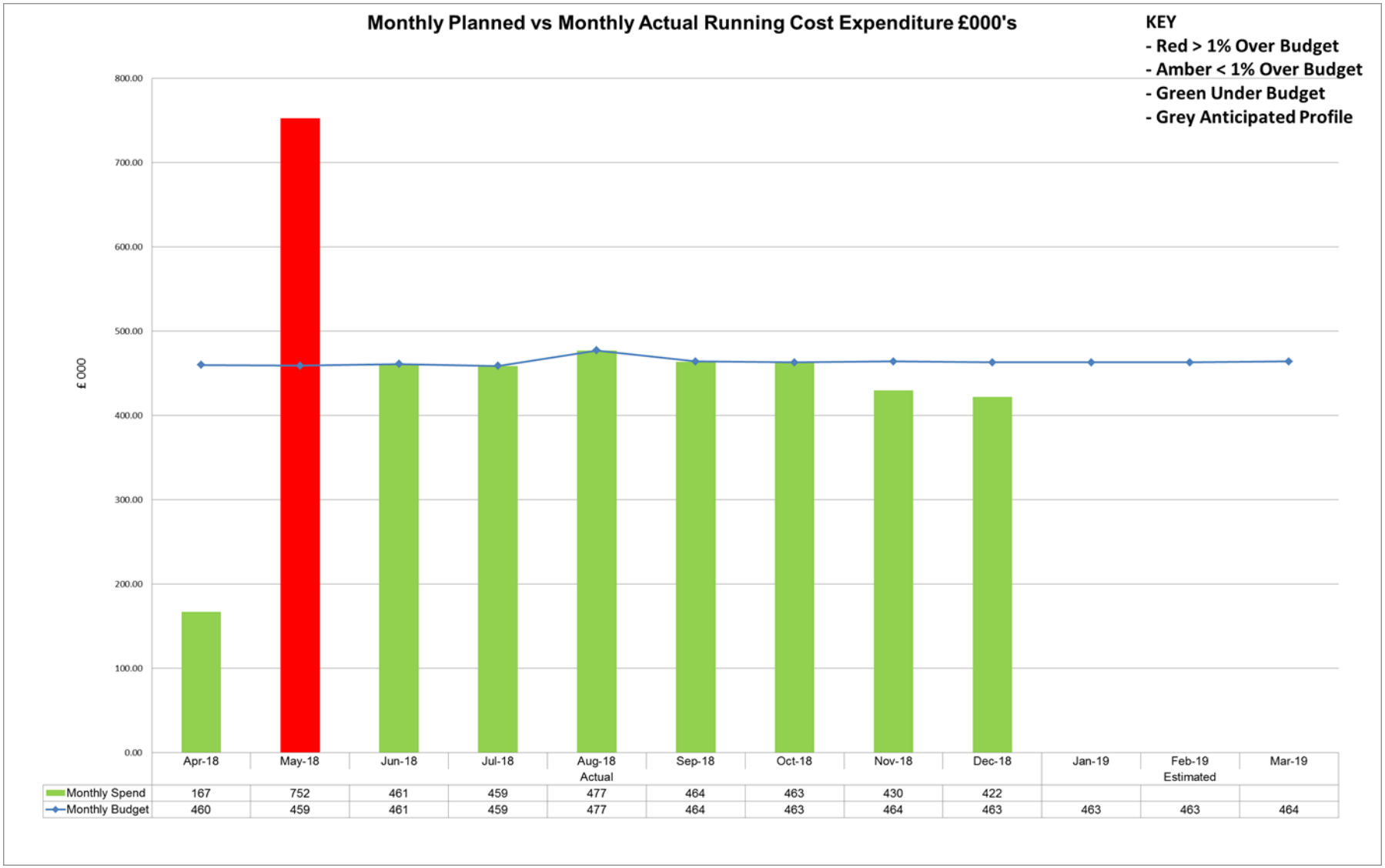
CCG UNDERLYING POSITION	Forecast Net Expenditure				Remove Non Recurrent Items				Part/Full Year Effects		2018/19 Underlying Position
	Plan	Actual	Variance	Variance	NR Allocations & Matched Expenditure	NR QIPP Benefit	Contingency	Other NR Spend / Income	QIPP	Other	
	£m	£m	£m	%	£m	£m	£m	£m	£m	£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	410.745				(8.464)						402.281
Acute Services	200.649	200.529	0.120	0.1%	(1.198)	-		(5.720)			193.611
Mental Health Services	39.000	39.400	(0.400)	(1.0%)	(1.849)	-		(0.648)			36.903
Community Health Services	40.802	40.748	0.054	0.1%	-	-		0.397			41.145
Continuing Care Services	15.107	14.794	0.313	2.1%	-	-		(0.133)			14.661
Primary Care Services	53.576	53.867	(0.290)	(0.5%)	(2.148)	-		0.571			52.290
Primary Care Co-Commissioning	36.571	36.571	-	0.0%	0.285	-		(0.304)			36.552
Other Programme Services	19.480	19.375	0.105	0.5%	(3.551)	-	(2.021)	0.238			14.041
Commissioning Services Total	405.185	405.285	(0.100)	(0.0%)	(8.461)	-	(2.021)	(5.599)	-	-	389.204
Running Costs	5.560	5.460	0.100	1.8%	(0.003)	-		0.100			5.557
TOTAL CCG NET EXPENDITURE	410.745	410.745	0.000	0.0%	(8.464)	-	(2.021)	(5.499)	-	-	394.761
IN YEAR UNDERSPEND / (DEFICIT)	-	0.000	0.000	0.0%						**Underlying Underspend / (Deficit)**	7.520
										% RRL	1.9 %



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
					Actual						Estimated	
Monthly Spend	33,239,399	33,239,399	33,930,116	33,560,880	34,535,202	33,969,594	33,624,420	33,999,401	34,536,166	33,541,586	33,541,586	33,567,251
Monthly Budget	33,081,233	33,361,601	33,985,748	33,564,545	34,525,646	33,955,816	33,624,273	33,966,203	34,523,044	33,532,045	33,532,045	33,532,801


Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£ 000's
800.00
700.00
600.00
500.00
400.00
300.00
200.00
100.00
0.00
Apr-18
May-18
Jun-18
Jul-18
Aug-18 Actual
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19 Estimated
Mar-19
Monthly Spend 167 752 461 459 477 464 463 430 422
Monthly Budget 460 459 461 459 477 464 463 464 463 463 463 464

Delegated Primary Care allocations for 2018/19 as at M09 are £36.571m. The forecast outturn is £36.571m delivering a breakeven position.

The 0.5% contingency and 1% reserves are showing an underspend year to date but are expected to be fully utilised by year end.

The table below shows the outturn for month 9:

	YTD budget £'000	YTD spend £'000	YTD Variance £'000 o/(u)	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
General Practice GMS	16,732	16,967	235	22,309	22,309	0		0	0
General Practice PMS	1,437	1,130	(307)	1,916	1,916	0		0	0
Other List Based Services APMS incl	1,825	2,137	312	2,433	2,433	0		0	0
Premises	2,113	1,849	(264)	2,817	2,817	0		0	0
Premises Other	71	48	(23)	94	94	0		0	0
Enhanced services Delegated	665	560	(106)	887	887	0		0	0
QOF	2,851	2,768	(83)	3,802	3,802	0		0	0
Other GP Services	1,324	1,969	646	1,765	1,765	0		0	0
Delegated Contingency reserve	137	0	(137)	183	183	0		0	0
Delegated Primary Care 1% reserve	274	0	(274)	366	366	0		0	0
Total	**27,428**	**27,428**	**(0)**	**36,571**	**36,571**	**0**		**0**	**0**

2018/19 forecast figures have been updated on quarter 3 list sizes to reflect Global Sum, Out of Hours, MPIG, Rent adjustments and DES.

2. QIPP

The key points to note are as follows:

- The submitted finance plan required a QIPP of £13.948m or 3.5% of allocation.
- NHSE is focussing on QIPP delivery across Medicines Optimisation and Right Care schemes such as Respiratory, Diabetes and Paediatrics.
- The plan assumes full delivery of QIPP on a recurrent basis as any non-recurrent QIPP will potentially be carried forward into future years.
- For Month 9 QIPP is being reported as delivering on plan supported through the planned application of reserves and underspends in the overall position.

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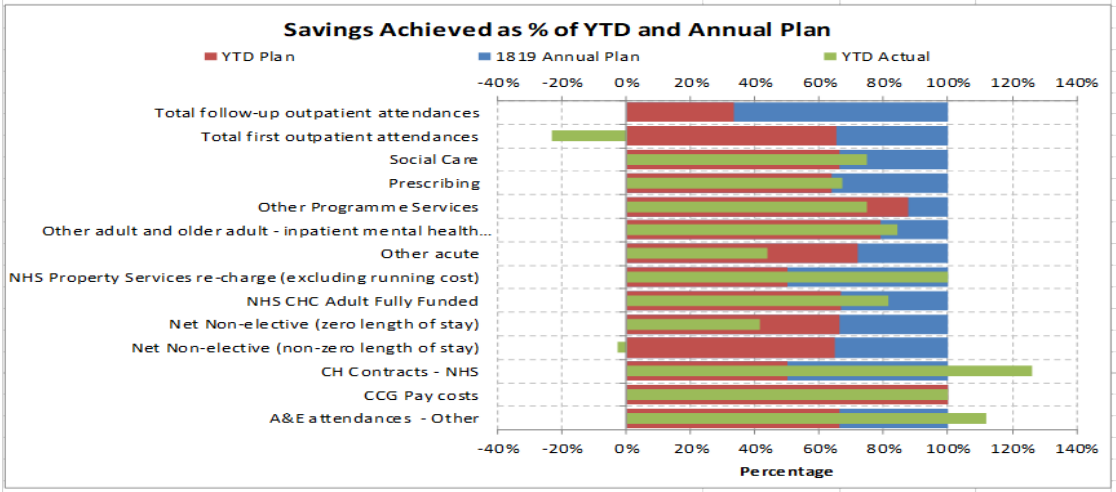
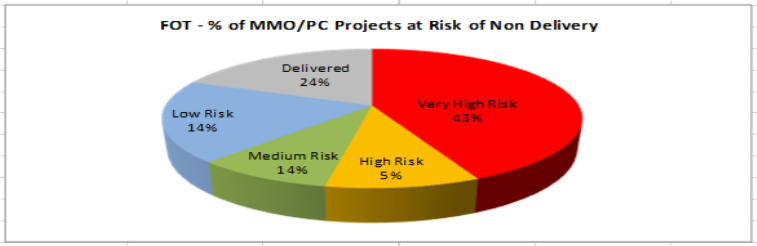
QIPP Programme Delivery Board

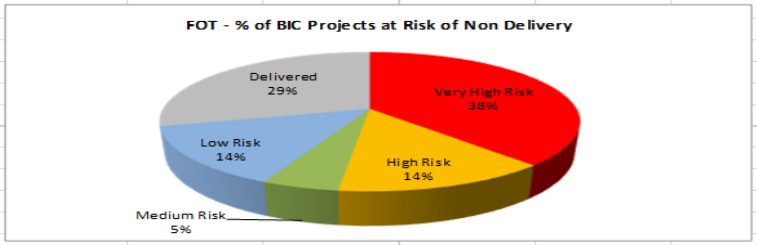
Mth 9 - Dec 18/19

Source : Annual Non ISFE Plan and Monthly Project Leads Updates - all figures shown as £`000

Area of Spend Category	Annual Plan	April to Dec (YTD) Plan	YTD (Non ISFE)	Variance from Plan (YTD)	FOT (Non ISFE)	FOT Variance from Annual Plan	Dec (YTD) Prog Brd diff from Plan	Dec (FOT) Prog Brd diff from Plan
A&E attendances - Other	200	132	132	0	200	0	-92	-24
Acute OP	0	0	0	0	0	0	0	0
CCG Pay costs	115	115	115	0	115	0	0	0
CH Contracts - NHS	281	141	141	0	281	0	-214	-319
Net Non-elective (non-zero length of stay)	4921	3199	3199	0	4921	0	3334	4303
Net Non-elective (zero length of stay)	1618	1072	1072	0	1618	0	400	558
NHS CHC Adult Fully Funded	400	266	266	0	400	0	-59	75
NHS Property Services re-charge (excluding running cost)	100	50	50	0	100	0	-50	50
Other acute	1256	906	906	0	1256	0	352	33
Other adult and older adult - inpatient mental health (excluding dementia)	950	750	750	0	950	0	-50	0
Other Programme Services	160	140	140	0	160	0	20	40
Prescribing	2507	1603	1603	0	2507	0	-75	94
Social Care	500	332	332	0	500	0	-42	0
Total first outpatient attendances	718	468	468	0	718	0	635	718
Total follow-up outpatient attendances	221	74	74	0	221	0	74	221
Grand Total	13947	9248	9248	0	13947	0	4233	5749







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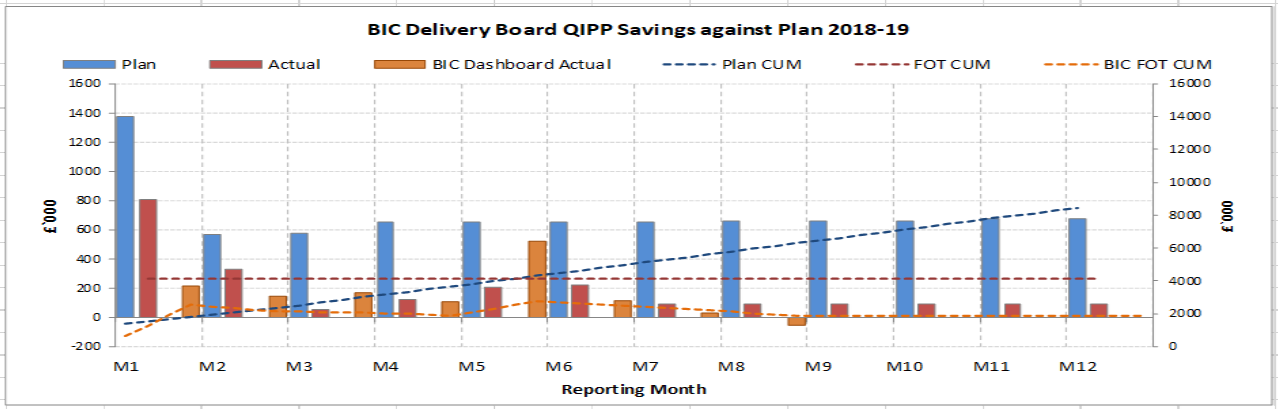
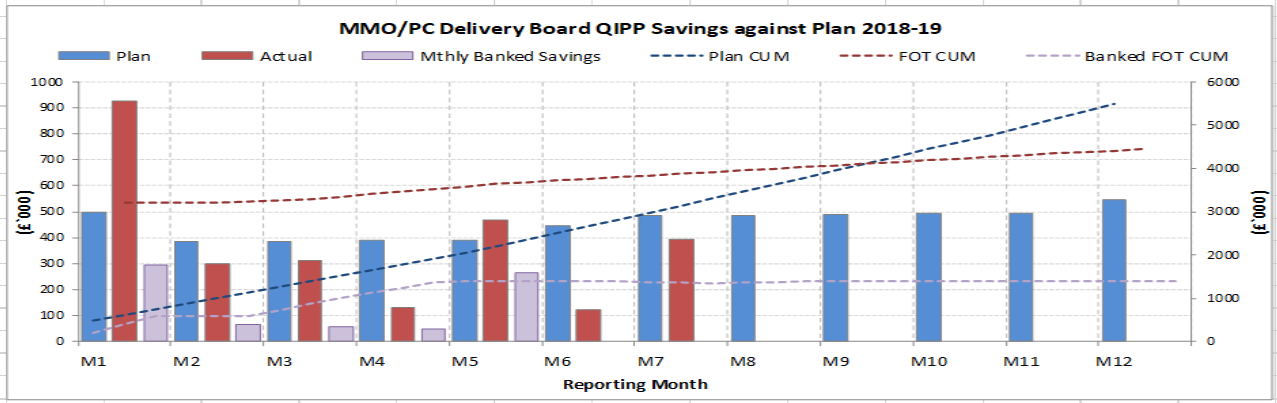
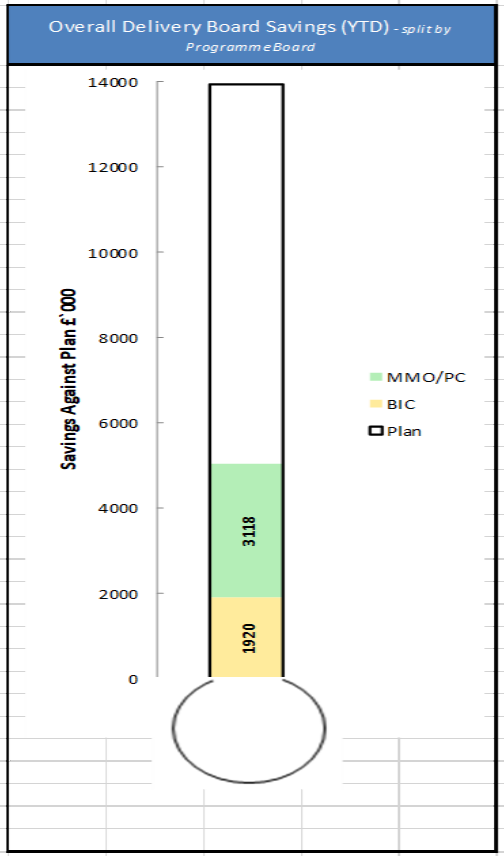
QIPP Programme Delivery Board

Mth 9 - Dec 18/19

Source : Annual Non ISFE Plan and Monthly Project Leads Updates - all figures shown as £`000







3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 30th November is shown below:

	31 December '18 £'000	30 November '18 £'000	Note	Change In Month £'000
Non Current Assets				
Assets	0	0	1	0
Accumulated Depreciation	0	0	2	0
	0	0		
Current Assets				
Trade and Other Receivables	2,803	2,646	3	157
Cash and Cash Equivalents	132	288	4	-156
	2,935	2,934		
Total Assets	**2,935**	**2,934**		
Current Liabilities				
Trade and Other Payables	-43,224	-40,763	5	-2,460
	-43,224	-40,763		
Total Assets less Current Liabilities	**-40,289**	**-37,830**		
TOTAL ASSETS EMPLOYED	**-40,289**	**-37,830**		
Financed by:				
TAXPAYERS EQUITY				
General Fund	40,289	37,830	6	2,459
TOTAL	**40,289**	**37,830**		

Key points to note from the SoFP are:

- The cash target for month 9 has been achieved.
- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days, (98% for non-NHS invoices and 99% for NHS invoices);

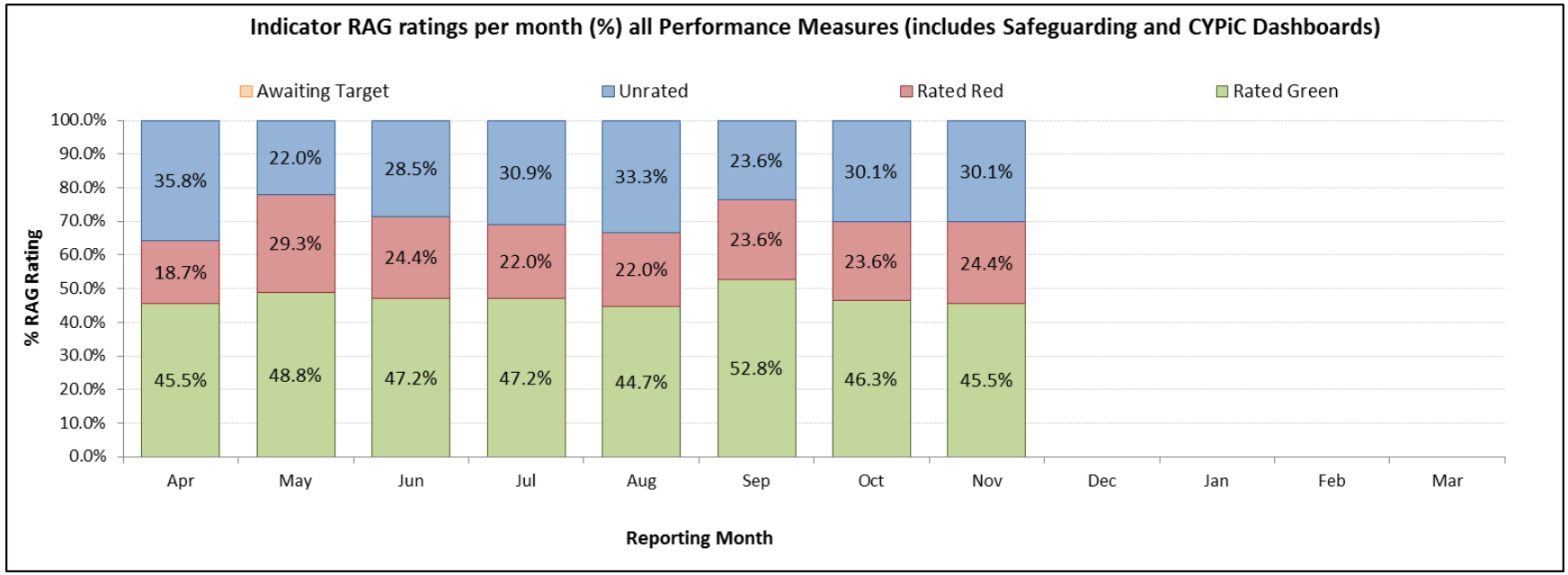
- **PERFORMANCE**

  The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Nov-18

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	9	8	15	14	0	2	0	0	**24**
Outcomes Framework	8	8	7	7	11	11	0	0	**26**
Mental Health	23	24	3	4	15	13	0	0	**41**
Sub Totals	***40***	***40***	***25***	***25***	***26***	***26***	***0***	***0***	***91***
RWT - Safeguarding	5	6	3	4	4	3	0	0	**13**
RWT - Children & Young People in Care (CYPiC)	0	0	0	0	6	6	0	0	**6**
BCP - Safeguarding	12	10	0	2	1	1	0	0	**13**
Dashboard Totals	***17***	***16***	***3***	***6***	***11***	***10***	***0***	***0***	***32***
Grand Total	**57**	**56**	**28**	**31**	**37**	**36**	**0**	**0**	**123**



Exception highlights were as follows;

3.1. Royal Wolverhampton NHS Trust (RWT)

3.1.1. EB3 – Referral to Treatment Time (18weeks), EBS4 - 52 Week Waiters

- The Trust's verified performance for November was 90.8%; M8 in-year trajectory (as agreed with NHSI) of 91.3% has not been achieved however performance is better than the National position of 87.3%.
- November performance has been affected by a continued increase in referrals for Gastroscopy and now include Colonoscopy and Flexi Sigmoidoscopy all of these are having an adverse effect on the routine waiting time - this is directly linked with increased referrals from cancer.

- The Trust is continuing to focus on the National requirement to sustain or reduce RTT waiting list size against the March 18 baseline and is currently on track to achieve this with November list size of 32,608 from 33,858 in March 2018.
- The Trust is also reducing the backlog of patients waiting 18+ weeks from 3,348 in March18 to 2,997 in November
- The CCG's performance for patients registered with a Wolverhampton GP (06A) waiting start treatment at any Trust is 91.38%.
- Zero 52 week waiters have been reported by the Trust, however there is one Wolverhampton T&O patient who remains waiting over 52 weeks at The Royal Orthopaedic Hospital NHS FT.
- National validated data has confirmed an increase in the % of patients waiting less than 6 weeks from referral to Diagnostic Test (97.29% against the 99% target). Failing areas include: Colonoscopy (83.49%), Flexi-Sigmoidoscopy (85.05%), Gastroscopy (88.58%), MRI (98.16%) and Peripheral Neurophys (87.07%).

3.1.2. Urgent Care (4hr Waits, Ambulance Handovers,12 Hr Trolley Breaches)

89.15% of A&E attendances were admitted, transferred or discharged within 4 Hours in November; falling short of the national target of 95% and the monthly PSF trajectory target of 90.49%. No patient breached the 12 hour decision to admit target.
The Black Country STP achieved 85.7% and England 87.6%
There have been no further 12hr Trolley Breaches (YTD =5) during November.
November continued to see a significant rise in ambulance conveyance numbers in month compared with the same period last year, with an overall increase of 1,769 (5.41%) year to date.
There were also breaches of both handover targets with 21 exceeding 60 minute handover and 103 breaches of 30-60 minute handovers both of these were the highest seen in year since March.
January2019 has seen the first Winter Assurance Sitrep Exception Report submission as performance fell below 80% for 14th January 2019. Shortage of ED Doctors, peaks in ambulance arrivals and patient flow culminated in the 76.9% performance

3.1.3. Cancer 2WW, 31 Day and 62 Day

- November validated national performance for the 62 Day from referral to 1st definitive treatment has been confirmed as 60.43% (based on 45.5 breaches out of 115, with 17 patients at 104+ days).

- The Trust had previously advised that performance would be low in month as a high proportion of the scheduled activity was for patients who had breached 62 days (mainly urology). November was first month of the extra Saturday lists for Urology, the Trust achieved the local recovery trajectory for November of 57.60%.
- All 104+ patients had a harm review and no harm was identified.
- The Trust has reported another month of high numbers of referrals; 1,642 received in November and 1,705 in October with a sustained increase in Breast referrals following Breast Cancer Awareness last month.
- The Trust received 20 Tertiary Referrals in November; only 5 were received by the standard of day 38, 9 by day 62, 4 were over 62 days but under 104 and 2 had already breached 104 days at d133 (Urology from Alexandra Hospital) and d138 (UGI from Dudley Group).
- IST has completed demand and capacity modelling for diagnostics and has confirmed that RWT has a shortfall of 56 hrs per week; it has been agreed that this needs a system wide response/solution.
- Current performance levels :

Ref	Indicator	Target	Nov18	YTD
EB6	2 Week Wait (2WW)	93%	85.89%	84.62%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	62.64%	65.39%
EB8	31 Day (1st Treatment)	96%	82.48%	89.52%
EB9	31 Day (Surgery)	94%	41.94%	75.79%
EB10	31 Day (anti-cancer drug)	98%	82.50%	97.81%
EB11	31 Day (radiotherapy)	94%	81.51%	87.53%
EB12	62 Day (1st Treatment)	M8=57.6% (Recovery) 85% (National)	58.18%	61.52%
EB13	62 Day (Screening)	90%	81.48%	80.24%

- The Trust has alerted the CCG/NHSE/NHSI on a high number of patients choosing to defer their appointments from December until January, this will severely affect 2WW performance across January and February with recovery anticipated towards the end of February.

3.1.4. Electronic Discharge Summary

- Performance for the Electronic discharge summary is divided into 2 sections :
  - Excluding Assessment Units which has seen an increase in performance and is achieving 95.32% (against a 95% target).
  - Assessment Units which is currently showing as failing (91.30%) against the 18/19 increased target of 92.5%. This indicator has failed to achieve target since July 2017 and is to be scheduled for discussion as part of the 18/19 contract planning rounds.
- The final contracted target figures are in discussion, however the Trust has not submitted an exception report as November meets the original 17/18 target of 90%, whereas the CCG base performance against the 17/18 yearend target of 92.5% until the target has been agreed by Contract Variation Order (CVO). Early indications are that the December performance has a further decline to 89.58% and remains RED.

3.1.5. Delayed Transfers of Care

Delays for the Royal Wolverhampton NHS Trust in November have achieved both the NHS delays (excluding Social Care = 0.84% against a 2.00% target) and all delays (including social care of 3.17% based on 17/18 threshold of 3.5%)
The Trust has identified the main areas of delays remain:
Further Non Acute NHS (top NHS delay = 3.53 average bed day delay)
Care Packages in Home (top Social Care delay = 7.73 average bed day delay, additional NHS element of 0.3 average bed day)
The proportion of Staffordshire patient delays at the Trust during November has been confirmed as 49.93% of the total delays (Wolverhampton patients = 36.22%).

The CCG are monitoring data received daily from the Trust and note that the number of delays during December have remained consistent with November levels with the average number of delayed patients of 20, and a maximum number of days average of 29.

3.1.6. Serious Incident Breaches (SUIs) - RWT

- 1 breach was identified for November (see table below), there have been no reported Never Events for November however the YTD total for 18/19 is currently at 4 incidents.
- Incidents are now reported as a serious incident if there is an act or omission that is suspected to have led to serious harm, rather than reporting according to a particular category or outcome.

Ref	Indicator	Nov18	YTD
LQR4	SUIs reported no later than 2 working days	0	2
LQR5	SUIs 72 hour review within 3 working days	0	0
LQR6	SUIs Share investigation and action plan within 60 working days	1	25

3.1.7. Safeguarding

- 6 out of the 19 Safeguarding and Young People in Care (CYPiC, formally known as LAC) indicators were reported as achieving targets for November 2018 (and 9 non submissions).
- ***Children:*** The CCG Deputy Designated Nurse (Rachel Stone) has held an NHSE work stream meeting in regards to working with Adolescents. Scoping work has been shared with work stream members with an initial proposal of a training event key Integrated Care System (ICS) staff who work with or manage staff working with adolescents.
- ***Adults:*** There were 7 Learning Disabilities Mortality Reviews (LeDeR) in progress during November (with 4 completed and submitted to the University of Bristol). Online training is available (supported by face to face updates and support with reviewers by the Black Country Local Area Contacts.

3.1.8. Infection Prevention

- Hand Hygiene compliance remains below the 95% target at 89.34%.
  - Trust Actions: to gain assurance from each directorate that an effective process non-compliance/holding staff to account and staff awareness (with worst performing directorates attending the Infection Prevention and Control Committee to present their action plans for improvement
  - Communications campaign (email and social media) to increase the uptake of hand hygiene training.
- Infection Prevention Training (Level 2) has remains below the 95% target at 94.34%.
  - Infection prevention compliance is discussed monthly with directorates with non-compliant staff names raised with line managers
  - Discussions with Human Resources team to incorporate into local induction programmes and annual appraisals.

3.1.9. CHC Checklist (LQR11)

- The performance for the Continuing Health Care checklist has seen a decrease in performance during November to 80.00% and the lowest performance level since June 2015.
- The increase in breaches has been confirmed as templates not being completed in full, no patient consent and requests for out of area patients

3.2. Black Country Partnership NHS Foundation Trust – (BCPFT)

3.2.1. % People Moving to Recovery (LQIA01)

- Local data has reported as achieving the 50% target each month for 18/19, however, national reporting is based on extracts from the Mental Health Minimum Data Set and a rolling 3 month calculation. The latest data confirms achievement of the 50% target performance for the 4th consecutive month during 2018/19 in October with 52.17%.

3.2.2. IAPT Access (LQIA05)

- November failed to achieve the 2018/19 in-month target of 1.58% with 1.42%, this has impacted on the Year to Date which remains below the cumulative target (YTD= 11.97% against a YTD target of 12.67%); performance is measured against the Year End target of 19%. Based on the November data, subsequent months will need to achieve 1.76% (an additional 53 patients per month) to meet the year end 19% target.
- The CCG are exploring the use of Serenity (local counselling service) and IESO (national electronic on-line therapy) to support access rates. Named individuals at the CCG have been granted access to the Open Exeter system to provide 3rd party providers (The What! Centre and WPH) the opportunity to submit Mental Health Minimum Data Set (MHMDS) extracts without the mandatory N3 connection.

3.3. Other Providers : Nuffield – Wolverhampton

3.3.1. Referral to Treatment Time (18weeks)

- The performance for the Nuffield (Wolverhampton) has been included within this report due to a discrepancy in reported numbers.
- The monthly SQPR submission direct to the CCG had previously indicated that the independent sector provider had consistently achieved 100% of incompletes within 18 weeks, however national reporting is showing performance below the 92% target. The November performance has been confirmed as 87.16%.
- The variation in reporting is to be discussed with the provider as part of the Contract Review Meeting.

4. RISK and MITIGATION

The CCG submitted a M9 position which included 0.6m risk which has been fully mitigated. This is a reduction from the previous month as at this stage of the financial year FOT expenditure levels become more certain.

The key risks are as below:

- Likely over performance in Acute contracts excluding RWT where a Gain/Risk share agreement applies removing the main areas of risk;
- The Mental Health/LD portfolio continues to present a real financial challenge and currently presents a risk of c £150k;
- The risk associated with primary care services has reduced since the cost pressures in relation to prescribing (NCSO and Cat M), have been realised and reflected in the month 9 financial position. However, a residual risk of £300k remains until the full impact of these cost pressures is known.

CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)								
	Plan	Actual	Variance	Variance	Contract	QIPP	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investments Uncommitted	Further QIPP Extensions	Non Recurrent Measures	Delay / Reduce Investment Plans	Other Mitigations	Potential Funding	TOTAL MITIGATIONS
	£m	£m	£m	%	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	410.745																		
REVENUE RESOURCE LIMIT (CUMULATIVE)	420.731																		
Acute Services	200.649	200.529	0.120	0.1%	(0.150)	-				(0.150)				-	0.150				0.150
Mental Health Services	39.000	39.400	(0.400)	(1.0%)	(0.150)	-				(0.150)				-	0.150				0.150
Community Health Services	40.802	40.748	0.054	0.1%		-				-				-					-
Continuing Care Services	15.107	14.794	0.313	2.1%		-				-				-					-
Primary Care Services	53.576	53.867	(0.290)	(0.5%)		-		(0.300)		(0.300)				-	0.300				0.300
Primary Care Co-Commissioning	36.571	36.571	-	0.0%		-				-				-					-
Other Programme Services	19.480	19.375	0.105	0.5%		-				-				-					-
Commissioning Services Total	405.185	405.285	(0.100)	(0.0%)	(0.300)	-	-	(0.300)	-	(0.600)	-	-	-	-	0.600	-	-	-	0.600
Running Costs	5.560	5.460	0.100	1.8%		-				-				-					-
Unidentified QIPP						-				-									
TOTAL CCG NET EXPENDITURE	410.745	410.745	0.000	0.0%	(0.300)	-	-	(0.300)	-	(0.600)	-	-	-	-	0.600	-	-	-	0.600

The key mitigations are as follows:

- The CCG holds a Contingency Reserve of c £2m and this will be held to cover the identified risks.

In summary the CCG is reporting:	**£m Surplus(deficit)**	
Most Likely	£9.986	No risks or mitigations, **achieves** control total
Best Case	£10.586	Control total and mitigations achieved, risks do not materialise **achieves** control total
Risk adjusted case	£9.986	Adjusted risks and mitigations occur. CCG **achieves** control total
Worst Case	£9.386	Adjusted risks and no mitigations occur. CCG **misses** revised control total

5. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. There were no significant changes to the procurement plan to note.

6. RISK REPORT

The Committee received and considered an overview of the risk profile for the Committee including Corporate and Committee level risks.

7. QUALITY PREMIUM

The Committee received an update on the indicative position as to the current achievement against the 2018/19 Quality Premium Scheme.

8. OTHER RISK

Breaches in performance and increases in activity will result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and national agreed targets and are being managed to operate within the CCG's financial constraints. Activity and Finance performance is discussed monthly through the Finance and Performance Committee Meetings to provide members with updates and assurance of delivery against plans.

A decline in performance can directly affect patient care across the local healthcare economy. It is therefore imperative to ensure that quality of care is maintained and risks mitigated to ensure patient care is not impacted. Performance is monitored monthly through the Finance and Performance Committee and through the following committees; including Clinical Quality Review Meetings, Contract Review Meetings and Quality and Safety Committee.

9. RECOMMENDATIONS

- **Receive** and **note** the information provided in this report.

Name: Lesley Sawrey
Job Title: Deputy Chief Finance Officer
Date: 30th January 2019

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Performance Indicators 18/19

Current Month: Nov-18

Key:

(based on if indicator required to be either Higher or Lower than target/threshold)

- Improved Performance from previous month
- Decline in Performance from previous month
- Performance has remained the same

18/19 Reference	Description - Indicators with exception reporting highlighted for info	Target	Latest Month Performance	YTD Performance	Variance between Mth	Trend (null submissions will be blank) per Month (A M J J A S O N D J F M Yr End)
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92.0%	No Data	90.79%		
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	99.0%	No Data	98.48%		
RWT_EB5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95.0%	89.15%	91.76%	↓	
RWT_EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93.0%	85.89%	84.68%	↑	
RWT_EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93.0%	62.64%	62.82%	↑	
RWT_EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96.0%	82.48%	89.46%	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94.0%	41.94%	76.71%	↓	
RWT_EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	98.0%	82.50%	97.80%	↓	
RWT_EB11	Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	94.0%	81.51%	87.04%	↓	
RWT_EB12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.	Stretch from 73.91% to Yr End 85.2%	58.18%	61.32%	↓	
RWT_EB13	Percentage of Service Users waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	90.0%	81.48%	79.92%	↑	
RWT_EBS1	Mixed sex accommodation breach	0	0	0	→	
RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	0	0	0	→	
RWT_EAS4	Zero tolerance Methicillin-Resistant Staphylococcus Aureus	0	0	2	→	
RWT_EAS5	Minimise rates of Clostridium Difficile	Mths 1-11 = 3 Mth 12 = 2	3	22	→	
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	0	→	
RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	0	103	558	↑	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	0	21	58	↓	
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	0	0	5	→	
RWT_EBS6	No urgent operation should be cancelled for a second time	0	0	0	→	
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	95.0%	94.32%	92.73%	↑	
RWTCB_S10B	Duty of candour (Note : Yes = Compliance, No = Breach)	Yes	Yes	0		
RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	99.0%	99.85%	99.86%	↑	

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18/19 Reference	Description - Indicators with exception reporting highlighted for info	Target	Latest Month Performance	YTD Performance	Variance between Mth	Trend (null submissions will be blank) per Month A M J J A S O N D J F M	Yr End
RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95.0%	98.69%	98.64%	↓		
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	95.0%	95.32%	95.72%	↓		
RWT_LQR2	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all assessment units [e.g. PAU, SAU, AMU, AAA, GAU etc.]	Q1 - 90% Q2 - 90% Q3 - 92.5% Q4 - 95%	91.30%	84.21%	↑		
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	2.0%	0.84%	1.02%	↑		
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the date of incident occurrence (as per SI Framework). Exceptions will be considered with Chief Nurse discussions.	0	0	2	↑		
RWT_LQR5	Serious incident (SI) reporting – 72 hour review to be undertaken and uploaded onto the STEIS system by the provider (offline submission may be required where online submission is not possible). To be completed within 3 working days of the incident occurrence date. Note: Date of occurrence is equal to the date, the incident was discovered	0	0	0	→		
RWT_LQR6	Serious incident reporting - Share investigation report and action plan, all grades within timescales set out in NHS Serious Incident Framework. 60 working days of the incident being identified unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.	0	1	25	↑		
RWT_LQR7	Number of cancelled operations - % of electives	0.8%	0.64%	0.48%	↓		
RWT_LQR10	DToC – compliance with checklist *awaiting confirmation of removal to Schedule 6	95.0%	No Data	No Data			
RWT_LQR11	% Completion of electronic CHC Checklist	98.0%	80.00%	88.04%	↓		
RWT_LQR12	E-Referral - ASI rates	10.0%	No Data	26.03%			
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	90.0%	91.10%	90.55%	↑		
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	80.0%	95.71%	90.20%	↑		
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	60.0%	96.08%	85.41%	↑		
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	92.5%	99.65%	99.66%	↓		
RWT_LQR21	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Combined Safeguarding Dashboard. (Submit : Yes if all Dashboard is compliant, No if breaches)	Yes	No	No			n/a
RWT_LQR22a	Number of Avoidable Grade 2 Hospital Acquired Pressure Injuries (HAPI) *Note : Updated KPI, to be CVO'd into contract	<40 per yr TBC	No Data	9			
RWT_LQR22b	Number of Avoidable Grade 3 HAPI *Note : Updated KPI, to be CVO'd into contract	<30 per yr TBC	No Data	6			
RWT_LQR22c	Number of Avoidable Grade 4 HAPI *Note : Updated KPI, to be CVO'd into contract	<2 per yr TBC	No Data	2			
RWT_LQR23a	Number of Avoidable Grade 2 Community Acquired Pressure Injuries (CAPI) *Note : Updated KPI, to be CVO'd into contract	<10 per yr TBC	No Data	3			
RWT_LQR23b	Number of Avoidable Grade 3 Community Acquired Pressure Injuries (CAPI) *Note : Updated KPI, to be CVO'd into contract	<10 per yr TBC	No Data	1			
RWT_LQR23c	Number of Avoidable Grade 4 CAPI *Note : Updated KPI, to be CVO'd into contract	0	No Data	0			
RWT_LQR25	Integrated MSK Service - % of patients on an MSK community pathway, discharged to the community service post elective spell.	95.0%	No Data	No Data			

18/19 Reference	Description - Indicators with exception reporting highlighted for info	Target	Latest Month Performance	YTD Performance	Variance between Mth	Trend (null submissions will be blank) per Month A M J J A S O N D J F M Yr End
RWT_LQR26	**% of patient with a treatment summary record at the end of the first definitive treatment - DRAFT indicator awaiting CVO**	75.0%	No Data	No Data		
RWT_LQR27	Hospital and General Practice Interface for 6 areas as detailed in the Service Conditions Local Access Policies, Discharge Summaries, Clinic Letters, Onward referral of patients, Results and treatments, Feedback/Communications *Note : 18/19 - awaiting confirmation of removal to SDIP	0.0%	No Data	No Data		
RWT_LQR28	All Staff Hand Hygiene Compliance	95.0%	89.34%	91.80%	⇩	
RWT_LQR29	Infection Prevention Training Level 2	95.0%	94.34%	94.39%	⇧	
BCP_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	92.00%	95.78%	96.55%	⇩	
BCP_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	0	⇨	
BCP_DC1	Duty of Candour Note : 1 = Yes, 0 = Breach	YES	1	8		
BCP_NHS1	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	99.00%	No Data	99.90%		
BCP_MHSDS1	Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	90.00%	No Data	95.73%		
BCP_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	90.00%	100.00%	100.00%	⇨	
BCP_EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	0	0	0	⇨	
BCP_EAS5	Minimise rates of Clostridium Difficile	0	0	0	⇨	
BCP_EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	53.00%	100.00%	80.95%	⇧	
BCP_EH1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	75.00%	75.51%	85.46%	⇩	
BCP_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	95.00%	96.94%	98.78%	⇩	
BCP_EH9	The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period	32.00%	No Data	10.16%		
BCP_EH10a	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (0-19 year olds)	95.00%	No Data	100.00%		
BCP_EH11a	Number of CYP with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (0-19 year olds)	85.00%	No Data	100.00%		
BCP_EH10b	Number of patients with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (19 year olds and above)	85.00%	No Data	77.78%		
BCP_EH11b	Number of patients with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (19 year olds and above)	85.00%	No Data	100.00%		
BCP_EBS1	Mixed sex accommodation breach	0	0	0	⇨	
BCP_EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	95.00%	95.45%	94.78%	⇩	
BCP_LQGE01a	Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	90.00%	No Data	100.00%		
BCP_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themsleves against clinical advice or who are AWOL)	100.00%	100.00%	97.69%	⇧	
BCP_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	80.00%	No Data	95.24%		
BCP_LQGE06	IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	85.00%	No Data	84.52%		

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18/19 Reference	Description - Indicators with exception reporting highlighted for info	Target	Latest Month Performance	YTD Performance	Variance between Mth	Trend (null submissions will be blank) per Month A M J J A S O N D J F M	Yr End
BCP_LQGE08	% compliance with local anti-biotic formulary for inpatients.	95.00%	No Data	No Data			
BCP_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	95.00%	96.32%	96.88%	↓		
BCP_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	95.00%	100.00%	99.48%	→		
BCP_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	7.50%	2.62%	1.41%	↑		
BCP_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	95.00%	99.34%	99.58%	↓		
BCP_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	85.00%	87.04%	95.48%	↓		
BCP_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	85.00%	93.88%	99.04%	↓		
BCP_LQGE15	Percentage of SUIs that are reported onto STEIS within 2 working days of notification of the incident	100.00%	100.00%	100.00%	→		
BCP_LQGE16	Update of STEIS at 3 working days of the report. The provider will keep the CCG informed by updating STEIS following completion of 48 hour report (within 72 hours of reporting incident on STEIS. Day one commences as of reporting date). CCG will do monthly data checks to ensure sufficient information has been shared via STEIS and report back to CQRM.	100.00%	100.00%	100.00%	→		
BCP_LQGE17	Provide commissioners with Level 1 (concise) and Level 2 (comprehensive) RCA reports within 60 working days and Level 3 (independent investigation) 6 months from the date the investigation is commissioned as per Serious Incident Framework 2015 page 41. All internal investigations should be supported by a clear investigation management plan.	100.00%	100.00%	60.00%	→		
BCP_LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target - >50%, Sanction: GC9]	50.00%	60.87%	58.55%	↑		
BCP_LQIA02	75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target - >75% Sanction: GC9]	75.00%	75.51%	85.46%	↓		
BCP_LQIA03	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target - >95%, Sanction: GC9]	95.00%	96.94%	98.78%	↓		
BCP_LQIA04	Percentage achievement in data validity across all IAPT submissions on final data validity report [Target - >80%, Sanction: GC9]	80.00%	No Data	92.90%			
BCP_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,970 = 19% of prevalence.	1.58%	1.42%	12.00%	↑		
BCP_LQIA05CUM	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,970 = 19% of prevalence. CUMULATIVE	1.58% per month 19% by Year End	11.97%	11.97%	↑		
BCP_LQCA01	Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'Improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard)' in 'Documents Relied Upon'	90.00%	100.00%	96.90%	↑		
BCP_LQCA02	Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS) - Audit of 10% of CAMHs caseload to be reported each quarter	80.00%	No Data	100.00%			
BCP_LQCA03	Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	95.00%	100.00%	100.00%	→		
BCP_LQCA04	Every person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis.	100.00%	100.00%	100.00%			

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WOLVERHAMPTON CCG
GOVERNING BODY
12 February 2019

Agenda item 15

TITLE OF REPORT:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 13 November 2018**
AUTHOR(s) OF REPORT:	Peter Price – Interim Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Chief Finance Officer
PURPOSE OF REPORT:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
RECOMMENDATION:	• **Receive** this report and **note** the actions taken by the Audit and Governance Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	n/a
2. Reducing Health Inequalities in Wolverhampton	n/a
3. System effectiveness delivered within our financial envelope	n/a

1. BACKGROUND AND CURRENT SITUATION

1.1 Internal Audit Progress Report
The Internal Audit Progress Report updated the Committee on activity since the last meeting and updates for Risk Management, Finance, Safeguarding, Quality and Safety, Information Governance, Audit Follow Up and Delegated Commissioning. The committee noted and accepted the report.

1.2 Internal Audit Charter
Following a recommendation from the last Committee meeting that the Head of Internal Audit opinion was added to the document a revised version was presented to the Committee and accepted.

1.3 Internal Audit of Finance
The Internal Audit of Finance document was presented to the Committee. The Senior Internal Audit Manager advised that the positive comments had been received for the document.

1.4 Internal Audit of Quality and Safety
The Internal Audit of Quality and Safety was received by the Committee in a positive way. There had been one low risk and one advisory reported.

1.5 Primary Care Internal Audit Framework including Draft Reporting Template
The document highlighted key areas of Commissioning and procurement of Primary Medical Services, Contract Oversight and Management Functions, Primary Care Finance and Governance.

1.6 External Audit Progress Report
The External Audit Progress Report headlined progress to date. The Committee were also advised that an audit plan summarising the external audit approach to key risks was expected to be produced in February 2019and that Annual Accounts Workshop dates had been emailed out to staff.

1.7 Governance Statement
The Corporate Governance Manager presented a report to give the committee an insight into the themes and content which were likely to be included in the Annual Governance Statement. This would include of the role of the STP under the leadership of the Accountable Officer.

1.8 Risk Register/Board Assurance Framework including GBAF and Risk Register
The version of the Risk Register/Board Assurance Framework that was presented at the Committee had also be presented at the Senior Management Team. A table top review had also been undertaken by the CCG Governance team. The Chair noted that the culture around risk was changing and that it was being discussed more at Committees. The Committee noted the report.

1.9 Risk Management Progress including Deep Dives
This report had also been discussed at SMT and the template which would be used was also shared with the Committee. The Committee asked if a further update could be given at the next meeting around staff retention.

1.10 Whistleblowing
There had been no issues raised under the Whistleblowing policy. The Operations Governance Manager took on board comments made by the Committee.

1.11 Feedback to and from the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum
The Chair highlighted the Governing Body had discussed Cancer Targets and Mortality. The Black Country Joint Governance Forum had not taken place but had been discussed in the Committee.

1.12 Compliance with Constitution and Principles of Good Governance
This item was not discussed.

1.13 Losses and Compensation Payments – Quarter 2 2018/2019
There were no losses or special payments were reported in quarter 2 2018/19

1.14 Suspensions, Waiver and Breaches of SO/PFPS
There were 14 breaches of PFPs in quarter 2 2018/2019. During the same period 17 waivers were raised and 32 non-healthcare invoices were paid with a purchase order numbers being raised. The Committee discussed value for money of some of the contracts that the CCG had and asked the Director of Finance to look into this.

1.15 Receivable/Payable Greater than £10,000 and over 6 months old
The Committee noted that as at 30 September 2018, there were 0 receivables and 21 payables over £10,000 and greater than 6 months old.

1.16 Receivable/Payable Greater than £10,000 and over 6 months old

The progress report was presented to the Committee for information and noted.

CLINICAL VIEW

1.1. N/A

2. PATIENT AND PUBLIC VIEW

2.1. N/A

3. KEY RISKS AND MITIGATIONS

3.1. The Audit and Governance Committee will regularly scrutinise the risk register and Board Assurance Framework of the CCG to gain assurance that processes for the recording and management of risk are robust. If risk is not scrutinised at all levels of the organisation, particularly at Governing Body level, the CCG could suffer a loss of control with potentially significant results.

4. IMPACT ASSESSMENT

Financial and Resource Implications

4.1. N/A

Quality and Safety Implications

4.2. N/A

Equality Implications

4.3. N/A

Legal and Policy Implications

4.4. N/A

Other Implications

4.5. N/A

Name: Tony Gallagher
Job Title: Chief Finance Officer

Date: 14 November 2018

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
12 FEBRUARY 2019

Agenda item 16

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 6 November 2018 and 4 December 2018
AUTHOR(s) OF REPORT:	Sue McKie, Primary Care Commissioning Committee Chair
MANAGEMENT LEAD:	Mike Hastings, Associate Director of Operations
PURPOSE OF REPORT:	To provide the Governing Body with an update from the meeting of the Primary Care Commissioning Committee on 6 November 2018 and 4 December 2018.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	**Primary Care Quality Report** The uptake of flu jabs is increasing week on week and the issue of low stock has now been resolved. Friends and Family Test has seen the best results so far in September 2018 at 2.1%, an increase of 0.7% since April.
RECOMMENDATION:	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Commissioning Committee works with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our financial envelope	Primary Care issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Commissioning Committee met on 6 November 2018 and 4 December 2018. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Commissioning Committee – 6 November 2018

2.1 Primary Care Quality Report

2.1.1 The Primary Care Quality Assurance Co-ordinator (WCCG), Liz Corrigan, updated the Committee around primary care quality, providing an overview of activity in primary care and assurances around mitigation and actions taken where issues have arisen. The following issues were highlighted:

- 36 complaints have been received since 1 November 2017 of which 28 are now closed and 8 remain under investigation.
- Friends and Family Test results remain stable with a 1.8% uptake for the population in Wolverhampton.
- A GP Retention Scheme has been agreed across the Black Country. A co-design event was held on 25 September 2018 where the following areas of focus were identified:
    - Portfolio careers
    - Peer mentoring support
    - Pre-retirement coaching

2.2 Quarterly Primary Care Assurance Report

2.2.1 The Primary Care Transformation Manager (WCCG), Jo Reynolds, provided an overview of the activity taking place from the work programmes within the GP Forward View work and Primary Care Strategy. The following areas were highlighted:

- QOF+ has been launched with 100% of practices signed up.
- Extended Access is fully in place, with 100% coverage of the requirement for an additional 30 minutes across Wolverhampton.
- Online consultation and triage pilots have been launched in this quarter.
- Care Navigation cohort 2 has been launched.

2.3 **Primary Care Operational Management Group Meeting**

2.3.1 The Director of Operations (WCCG), Mike Hastings, provided an update from the meeting and highlighted the following:

- The Project Group Meetings for the Health and Beyond mergers are now underway.
- Estates work in Wolverhampton has a Bilston focus particularly around the utilisation of buildings in that area.

2.4 **Primary Care Contracting Update**

2.4.1 The Primary Care Contracts Manager (WCCG), Gill Shelley, provided an update on primary care contracting and the following was noted:

- Alternative Provider Medical Contracts Procurement
  The advertisement has been live throughout October 2018 and the evaluation and moderation is currently underway with a view of bringing a report to the December 2018 Committee meeting outlining the outcome of the procurement exercise and preferred bidders.

- Post Payment Verification (PPV) of the Quality and Outcome Framework (QOF)
  NHS England is supporting the CCG with this piece of work. A practice from each model of care group has been chosen at random by the Local Medical Committee.

- Post Payment Verification (PPV) of Local Enhanced Services (LES)
  NHS England is supporting the CCG with this piece of work. The chosen areas to be reviewed are ear syringing and simple and complex dressings.

2.5 **Healthwatch Wolverhampton: GP Communication**

2.5.1 The Primary Care Transformation Manager (WCCG), Jo Reynolds, provided an update on the report recently published by Healthwatch Wolverhampton regarding a survey that focussed on how much communication patients receive from their GP practice and what level of awareness and involvement there is with Patient and Participation Groups.

2.6 **Thrive into Work Specification**

2.6.1 The Primary Care Transformation Manager (WCCG), Jo Reynolds, updated the Committee around a service specification that has been developed in partnership with the Thrive into Work Programme. The purpose of the programme is to enable a targeted approach to recruitment which encourages practices to contact patients who meet the participation criteria to take part in the research programme.

Primary Care Commissioning Committee (Private) – 6 November 2018

2.7 The Committee met in private to receive updates on feedback from a recent LMC meeting, enhance service specification, NHS England consultation around Medicines of Limited Clinical Value and Over the Counter and the current position around the recent Docman issues.

Primary Care Commissioning Committee – 4 December 2018

2.8 **Primary Care Quality Report**

2.8.1 Primary Care Quality Assurance Co-ordinator (WCCG), Liz Corrigan, updated the Committee around primary care quality, providing an overview of activity in primary care and assurances around mitigation and actions taken where issues have arisen. The following issues were highlighted:

- Ms Corrigan had shadowed one of the Infection Prevention Practice visits, which had provided a useful insight into the process.
- The uptake of flu jabs has been increasing week on week following a slow start. The issue of low stock had now been resolved.
- Friends and Family Test uptake had seen the best results so far in September 2018 at 2.1%, an increase of 0.7% since April, for the population of Wolverhampton.
- A Practice Nurse Strategy was being developed at STP level which focusses on staff rentention.

2.9 **Primary Care Operational Management Group Update**

2.9.1 The Director of Operations (WCCG), Mike Hastings, provided an update from the meeting and highlighted that discussion continues around primary care estates work in Bilston. It was noted that recent meeting had taken place with a number of local practices and the Local Authority had been very positive.

2.10 **Primary Care Contracting Update**

2.10.1 The Primary Care Contracts Manager, Gill Shelley, provided an update on primary care contracting and the following was noted:

- General Medical Services contract variations had been processed for Penn Manor Medical Centre, Woden Road Surgery, Bradley Medical Centre, Church Street Surgery, Tettenhall Medical Practice, Warstones Medical Practice and Grove Medical Centre.
- The Quality Outcomes Framework Post Payment verification process, supported by NHS England, was due to take place at the end of February 2019 with practices being given 2 weeks' notice of the visit.

2.11 **Enhanced Services**

2.11.1 The Head of Primary Care (WCCG), Sarah Southall, presented a report around the time limited enhanced services designed to improve performance in meeting a number of NHS Constitutional Standards.

2.11.2 The Committee had agreed to approve the service specification in principle at its last meeting due to the need to commence the service, subject to circulation of the full specification. Clinical input had been sought from the CCG Chair and Accountable Officer and further minor changes had been made. It was noted that there needs to be an agreed process for when a decision is required and timescales are short.

2.12 **Unprocessed Files associated with Docman**

2.12.1 The IM&T Infrastructure Project Manager (WCCG), Ramsey Singh, provided an update on the impact of a national issue with the Docman Document Management System used by GP Practices. The issue revolved around a large number of documents being sent to practices by providers but not being processed by the system. The CCG had worked with individual practices to collate the information and embed a plan to ensure they are reviewed. It was noted that the majority of outstanding documents had now been reviewed, the vast majority being duplicate copies of documents already in the system and to date no significant impact to patient care had been identified.

Primary Care Commissioning Committee (Private) – 4 December 2018

2.13 The Committee met in private to receive items around Primary Care Commissioning Intentions, the APMS procurement exercise and the local protocol for interim phased return.

3. CLINICAL VIEW

3.1. Not applicable.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and public views are sought as required.

5. KEY RISKS AND MITIGATIONS

5.1. Project risks are reviewed by the Primary Care Operational Management Group.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Any Financial implications have been considered and addressed at the appropriate forum.

Quality and Safety Implications

6.2. A quality representative is a member of the Committee.

Equality Implications

6.3. Equality and inclusion views are sought as required.

Legal and Policy Implications

6.4. Governance views are sought as required.

Other Implications

6.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Sue McKie
Job Title: Lay Member for Public and Patient Involvement, Committee Chair
Date: 17 January 2019

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Sue McKie**	**17/01/19**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 February 2019

Agenda item 17

TITLE OF REPORT:	**Communication and Participation update**
AUTHOR(s) OF REPORT:	Sue McKie, Patient and Public Involvement Lay Member Helen Cook, Communications, Marketing & Engagement Manager
MANAGEMENT LEAD:	Mike Hastings – Director of Operations
PURPOSE OF REPORT:	This report updates the Governing Body on the key communications and participation activities in November, December 2018 and January 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the **public** domain
KEY POINTS:	The key points to note from the report are: 2.1.1 **Stay Well – Help us help you** 2.1.2 **Christmas and New Year GP and Pharmacy opening times** **2.1.4 Self Care – over the counter medicines**
RECOMMENDATION:	• **Receive** and **discuss** this report • **Note** the action being taken
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework.

1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place November, December 2018 and January 2019, to provide assurance that the Communication and Participation Strategy of the CCG is being delivered effectively.

2. KEY UPDATES

2.1. Communication

2.1.1 Stay Well – Help us help you

Our national winter campaign has now moved from the flu phase and into promotion of extended opening hours for GP surgeries and NHS111.

Along with the national promotion, in Wolverhampton we have a bus campaign on both the rear of buses and on the inside of buses. We are also promoting extended GP appointments online through AdMessenger. Running since the end of October, there have already been over 200,000 impressions leading to over 8,000 hits on the Primary Care Extended Hours page on the CCG website. https://wolverhamptonccg.nhs.uk/primary-care/gp-extended-opening-hours. This page was also advertised via social media and via the front page of the website.

2.1.3 Christmas and New Year GP and Pharmacy opening times

During December we promoted the Christmas and New Year Pharmacy opening times via social media, online and with printed materials delivered to GP surgeries and pharmacies.

2.1.4 Patient Access App

Patient Access

Promotion of the Patient Access App is starting on a variety of media and sites. These will include social media, promotion at Molineux Stadium digitally and printed, printed materials and online.

2.1.5 **Self Care – over the counter medicines**

During December we worked with the Medicines Management team to design and print material around how the prescribing of over the counter medicines is changing. The material included leaflets, posters, checklists for GPs and receptionists and pull up banners. The material was distributed to GPs and pharmacists in January to help support and promote the changes to the public. We have also created a Self Care page on the CCG website to encourage people to manage their conditions where possible and to provide them with useful resources: https://wolverhamptonccg.nhs.uk/your-health-services/self-care

2.1.6 **Cold weather alert warnings**

During January we have released a press release and regular tweets whenever we have had a weather warning to inform the public about how to stay well in the colder weather.

2.1.7 **Press Releases**

Press releases since the last meeting have included:

January 2019

- Join the fight against antibiotic resistance!
- SPACE Care Home Improvement Event 2018
- A New Year, A Healthier You: Your guide for 2019
- I'm sweet enough
- Thousands of women in Wolverhampton put lives at risk as screening attendance falls
- Cold weather warning for Wolverhampton patients
- Walk this way to beat the Winter blues
- Play Your Care Right in Wolverhampton

December 2018

- Festive reminder for Wolverhampton patients to order repeat prescriptions
- Wolverhampton CCG scoops prestigious national award
- Be a Good Neighbour this Christmas

November 2018

- New flu vaccine to help over 65s and ease pressure on local NHS
- Choose Self Care for Life: Choose the Pharmacist for expert health advice
- People at risk need to take action on World Diabetes Day
- One too many? Change is possible
- Confused about cold and flu?
- Breathe easier and seek treatment on World COPD Day

2.2. Communication & Engagement with members and stakeholders

2.2.1 **Share your views on skin (Dermatology) service**
We are asking the public and our stakeholders from 14 January to 18 February 2019 their views on improving skin (Dermatology) services for the residents of Wolverhampton. This is an opportunity for public and stakeholders to have their say and help shape the future design of community dermatology services.

We currently have an online survey https://www.surveymonkey.co.uk/r/WGZY2BK to fill in, promotion on the website and via social media, as well as targeted engagement and a public focus group planned for the 4 February.

2.2.2. **Wolverhampton Integrated Care Alliance (ICA)**
On 31 January the first of a series of engagement events for the ICA was held for clinicians and managers from City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Wolverhampton Primary Care, Royal Wolverhampton Hospitals Trust and Black Country Partnership Foundation Trust. The event held at The Molineux Stadium was well attended by over 70 stakeholders. Attendees heard about what the ICA will mean for the organisations involved and also heard about work beginning on the first four clinical workstreams.

2.2.3 **GP Bulletin**
The GP bulletin is twice monthly and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

2.2.4 **Practice Nurse Bulletin**
The *January* edition of the Practice Nurse Bulletin included the following topics:

- Practice Makes Perfect Forum
- New Safeguarding Adult Referral
- Weighing babies guidance
- Coroners Report recommendations
- Winter preparations guides
- Safer sharps
- Diabetes Community Group programme
- Training and events
- West Mids Urgent Care newsletter
- Capacity Tracker for Care Homes

The *November* edition of the Practice Nurse Bulletin included the following topics:

- Practice Makes Perfect Forum
- Coroners Report following death from an unrecognised drug
- CQC publish local care profiles
- RCN Beat the flu campaign
- FGM Campaign
- Health Education England staff and learner mental wellbeing survey
- Training and events

3. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning. GP leads for the new models of care have been meeting with their network PPG Chairs to allow information on the new models, and provide an opportunity for the Chairs to ask questions. All the new groupings have decided to meet on a regular quarterly basis.

4. PATIENT AND PUBLIC VIEWS

Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

Reports following consultations and public engagement are made available online on the CCG website. 'You said – we did' information is also available online following the outcome of the annual Commissioning Intentions events and decision by the Governing Body.

4.1 PPG Chair / Citizen Forum meeting

The PPG Chair / Citizen Forum meetings took place in November and January with attendance remaining low, particularly from local Citizens Forum representatives. The group provided feedback on their various practice and group activity.

The group have received presentations from David King on the CCGs Equality Objectives, Sharon Sidhu on the CCGs Commissioning Intentions and Sarah Southall and Karen Evans on the Primary Care 5 Year Forward View. As is expected from this group there was much discussion and questions for the presenters, much of which related to how the CCG can improve their engagement. This discussion subsequently led to further meetings and a proposal from a group member on how to achieve this. This proposal for an event has been discussed with the lay member and CCG officers who provided some useful suggestions. The proposal was presented at the January meeting for wider discussion with other representatives where it was well received.

5. LAY MEMBER MEETINGS – attended:

5.1 Primary Care Commissioning
CCG Governing Body
CCG Governing Body Development
Quality and Safety
Strategic communications
JEAG
1:1 meetings with patient representatives and equality lead re engagement
Unity (Medical Chambers) PPG hub
STP GPFV facilitated workshop on the primary care interface with secondary care
Participation in the APMS procurement

6. KEY RISKS AND MITIGATIONS

N/A

7 IMPACT ASSESSMENT

5.1. ***Financial and Resource Implications*** - None known

5.2. ***Quality and Safety Implications*** - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

5.3. ***Equality Implications*** - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

5.4. ***Legal and Policy Implications*** - N/A

Other Implications - N/A

Name: Sue McKie
Job Title: Lay Member for Patient and Public Involvement
Date: 31 January 2019

ATTACHED: none

RELEVANT BACKGROUND PAPERS
NHS Act 2006 (Section 242) – consultation and engagement
NHS Five Year Forward View – Engaging Local people
NHS Constitution 2016 – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)
NHS The General Practice Forward View (GP Forward View), April 2016
NHS Patient and Public Participation in Commissioning health and social care. 2017. PG Ref 06663

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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	Details/ Name	**Date**
Clinical View	**n/a**	
Public / Patient View	**Sue McKie**	**31 January 2019**
Finance Implications discussed with Finance Team	**n/a**	
Quality Implications discussed with Quality and Risk Team	**n/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**n/a**	
Information Governance implications discussed with IG Support Officer	**n/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**n/a**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**n/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**n/a**	
Signed off by Report Owner (Must be completed)	**Sue McKie**	**31 January 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 9th October 2018 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Mike Hastings – Director of Operations
Nicola Hough – Minute Taker – Administrative Officer (PA to Chief Nurse and Director of Quality)
Yvonne Higgins – Deputy Chief Nurse, WCCG
Dr Ankush Mittal – Consultant in Public Health, City of Wolverhampton Council
Sukhdip Parvez – Patient Quality and Safety Manager, WCCG
Sally Roberts – Chief Nurse and Director of Quality, WCCG
Kassie Styche - Quality and Safety Officer

Lay Members:
Jim Oatridge – Deputy Chair - Lay Member
Sue McKie – Patient/Public Involvement – Lay Member
Peter Price – Independent Member – Lay Member

In attendance (part):
Liz Corrigan – Primary Care Quality Assurance and Practice Development Co-ordinator, WCCG
Peter McKenzie – Corporate Operations Manager
Kelly Huckvale – Information Governance Officer, Arden and GEM CSU
Maxine Danks - Head of Individual Care
Phil Strickland - Governance & Risk Coordinator
Vanessa Whatley – Head of Nursing Corporate Services, RWT

APOLOGIES:
Marlene Lambeth – Patient Representative

QSC/18/041 Apologies and Introductions

Apologies were received and noted as above and introductions took place.

QSC/18/042 Declarations of Interest

Ms McKie advised that she is involved with Wolverhampton and Walsall Public Health reviewing Child Deaths and this will be for two days per week.

QSC/18/043 Minutes, Actions and Matters Arising from Previous Meeting

QSC/18/043.1 Minutes from the meeting held on 11th September 2018 (Item 3.1)

The minutes from the meeting which was held on 11th September 2018 were read and agreed as a true record.

QSC/18/043.2 Action Log from meeting held on 11th September 2018 (Item 3.2)

QSC/18/031 - Apologies and Introductions – To discuss the attendance of the secondary care consultant with Mr McKenzie.

Mrs Roberts advised that Ms Hibbs will write to the Secondary Care Consultant.

ACTION: Ms Hibbs

QSC/18/034.1 - Primary Care Report – To provide a Public Health Update at the next meeting.

This item is on the agenda and therefore it was agreed to be **closed** and **removed** from the action plan.

QSC/18/036.1 - Quality Report including Primary Care and Care Home Report: Cancer: To share the IST action plan with the Committee at the next meeting.

Mrs Roberts tabled an updated copy of the action plan and advised that it is updated on a weekly basis and added that there was also a NHSE Assurance meeting taking place.

This action is now **closed** and will be **removed** from the action log.

QSC/18/037.1 - Quality and Safety Risk Register - To meet outside of the meeting with regards to progress the Docman Risk.

It was confirmed that this meeting had taken place.

This action is now **closed** and will be **removed** from the action log.

QSC/18/037.1 - Quality and Safety Risk Register – To provide an update at the next regarding a potential incident around breast cancer screening.

This item is on the agenda and therefore it was agreed to be **closed** and **removed** from the action plan.

QSC/18/025.1 - Quality Report including Primary Care and Care Home Report - Friends and Family Test (FFT) - The maternal rate of smoking; the CCG is working with this and will ask Ms Sandra Smith for an update for the next meeting. To share the LMS 'Saving Babies Care Bundle' action plan.

Ms Higgins advised that this had now been sent to Mrs Hough for her to share with the Committee.

ACTION: Mrs Hough

QSC/18/015.2 - Items for Consideration: CQC update - To check with IT to see if the iPads could be an IT solution to the WHO checklist and report back to the Committee.

This was shared at CQRM and Ms Cannaby agreed to look into it.

This action is now **closed** and will be **removed** from the action log.

QSC/18/015.2 - Items for Consideration: CQC update - To give an update on inspections that had taken place on the VI practices on 5th July 2018 in September 2018.

Ms Higgins advised that of the VI Practices that had been inspected they had been rated 'good'.

Mr Hastings added that there were four practices and confirmed that they were rated 'good'. He stated that there are more VI Practices that are still to be inspected.

This action is now **closed** and will be **removed** from the action log.

QSC/18/015.2 - Items for Consideration: CQC update - Ms Higgins to meet with Ms Tracy Creswell regarding triangulating information for the dashboard.

Ms Higgins confirmed that this meeting had now taken place.

This action is now **closed** and will be **removed** from the action log.

QSC071 - H&S Performance Report: New H&S Provider to look into supporting CCG with H&S requirements.

Mrs Roberts advised that she had been in talks with the University of Wolverhampton for support with this and they had agreed a business case, but unfortunately this option is now not viable due to capacity. However, she is looking at another service at the moment.

ACTION: Mrs Roberts

QSC/18/044 Matters Arising

There were no matters arising.

Dr Rajcholan stated that she wanted to compliment and thank Mrs Hough for her support to this meeting and to herself as the chair.

QSC/18/045 Performance and Assurance Reports

QSC/18/045.1 Quality Report including Primary Care and Care Home Report (Item 5.1)

The above report was previously circulated and noted by the Committee.

Ms Higgins advised that there was more Cancer performance indicators had been added to the dashboard data and it was work in progress. She added that the number of RWT Serious Incidents has decreased over the last month and auditors are currently auditing the Serious Incident management processes within the CCG.

Mr Oatridge commented on the reduction and the correct reporting and wondered if RWT were over-reporting.

Ms Higgins replied that yes they were over-reporting and added that there was a new framework introduced in May 2015.

Mr Parvez commented that there had been discussions with the Head of Governance at RWT and they are now only reporting what meets the latest Serious Incident criteria.

Mr Parvez commented that there were only four overdue of the 60 days Serious Incidents.

Mr Price commented that the report was really helpful and asked if it was possible to see the progress being made.

Mr McKenzie joined the meeting.

Ms Higgins replied that they can outline the actions and maybe add an extra column showing work done this month and last month.

ACTION: Ms Higgins

Mr Hastings commented on the Information Governance (IG) breaches and asked where the VIs get reported.

Mrs Corrigan joined the meeting.

Mr Oatridge confirmed that would be through RWT.

Ms Higgins commented that IG incidents were not always Serious Incidents and added that they had strengthened the process and that Mr McKenzie was now providing expert advice too.

Mr Oatridge commented that at the Governing Body Meeting, it had been agreed that Vocare would be stepped down to business as usual and wondered if it had been agreed to take the same approach at this Committee.

Mrs Roberts replied that it had been agreed to do the same.

Mr Parvez stated that there was an update provided in the main body of the report regarding Vocare.

Ms Higgins advised that Vocare were expecting a CQC review in November.

Cancer (62 and 104 days wait) – Ms Higgins advised that she was more assured relating to the harm review process for 104 day breaches. There were 46 harm reviews undertaken between June, July and August for Urology, Head and Neck and Gynae.

NHSE/I escalation meeting – Mrs Roberts advised that work is taking place around clinical pathways, additional capacity etc. RWT have got more actions around pathways, mainly urology. The system has had a 34% increase of referrals from Walsall to Wolverhampton which is a challenge to the CCG.

STP Stocktake Meeting – Mrs Roberts stated that she had attended this meeting and it had gone well, there were a couple of words that currently define the CCG; mainly Cancer performance, as we are on national escalation and there may be a visit from the national team.

Ms Higgins advised that there was a report going to the Governing Body with regards to Cancer. With regards to the harm reviews; the process will be enhanced by using a GP to further examine the complete pathway.

Ms Higgins commented that the CCG have provided support for the process and that going forward harm reviews will include 62 days breaches.

Dr Rajcholan offered her help with that if needed.

Mr Hastings advised that there were monthly NHSE/I meetings and added that there was a recovery action plan being implemented.

Mrs Roberts commented that they were looking at additional capacity for a CT scanner and they are outsourcing for diagnostics primary care pathways.

Dr Rajcholan commented on the 'one stop urology clinic' and asked if they had got an implementation date.

Mrs Roberts stated that they could ask Ms Whatley when she attends the meeting.

Mortality – Ms Higgins advised that the SHMI has risen to 122 and the HMSR is 133 and they should benchmark at 100. The SJRs have identified key themes for improvement; including end of life, sepsis and the recognition and response for deteriorating patients.

Mrs Roberts advised that with regard to the work that Dr Mittal had undertaken around data for ONS data.

Ms McKie commented that RWT are the second worse SHMI in the country and advised that Patient Groups are now asking about it.

Mrs Roberts stated that she had met with Ms Tracy Creswell (Healthwatch) and she now sits on the Wolverhampton Mortality Improvement Group. She added that there was a Strategic Summit on Friday with Wolverhampton Council to discuss Mortality across the City.

Dr Mittal added that a reassuring report was to be delivered on Friday with regards to City wide death data and advised that NHS Digital was providing data for them. He stated that 40 to 60 year olds were a higher death age in the City and that for older people there were less than expected. Statistics show that half people dying in hospital and half at home.

Mrs Roberts stated that she had been at a meeting where haematology, GI, endocrinology and MAU feedback was shared and the key themes were around coding; where patients had been identified with one illness and dies from that but it could have been another illness.

Dr Mittal commented that there were a small number of deaths that need to have Palliative care assessments for coding reasons.

Ms Higgins stated that a business case has been completed which includes a GP to support for SJRs to ensure system wide learning.

Mrs Roberts advised that Dr Stan Silverman was also working with the Trust

Dr Mittal advised that differential diagnosis and end coding was an issue. He advised that there was going to be a Scrutiny Meeting on Friday which would look at symptom code, the expected death rate might affect the SHMI and analytical data will be seen. The Gold Standard is SJRs and the reviewing of deaths going into the future.

Mrs Roberts stated that the commitment and knowledge came across at the Mortality Review Group Meeting she had attended and added that lots of work is being done. With regards to the wider system work; there is a detailed report going to the Governing Body around Mortality.

Concerns around Sepsis Pathway – Ms Higgins stated that the mortality reviews had identified some issues in relation to sepsis.

Sepsis CQUIN – Ms Higgins advised that RWT were not achieving the CQUIN for Q1.

ED and Inpatient Sepsis –Ms Higgins had met with the sepsis leads at RWT and she felt the methodology for the audit was not as robust as it could be; she has shared methodology from other providers with them. RWT are now looking at a specific team to drive improvements in Sepsis. From January 2019, the electronic observation system will flag sepsis. Quarter 2 data should be available next week but she thinks we will see improvements in Quarter 3 data.

Black Country Partnership – Ms Higgins advised that their vacancy rate, turnover and sickness rates had all increased. A RCA had been undertaken around a patient with challenging behaviour who had now moved to a different provider. The team had undertaken an unannounced visit to the Penrose Unit. On the day of the visit both of the RGN staff were bank nurses.13 HCAs were on duty but only three of them were substantive staff. A Multi-Disciplinary Team (MDT) had been established within the unit and there was a clear vision which was consistently articulated of how things will improve; Ms Higgins had asked the trust for clinical leadership for the unit and there will be more detail on the next report.

ACTION: Quality Report

Mrs Roberts advised that the team will revisit the unit on another unannounced visit.

Ms Higgins stated that Learning Disability nursing recruitment is a national issue.

Ms McKie commented that the client had been moved and enquired as to what was being done differently at the new place.

Ms Higgins replied that they have a different areas, which Penrose didn't have and they are incentivising his behaviour.

Probert Court – Ms Higgins advised that they have moved forward with Probert Court; there is clinical leadership driving improvements.

Mr Parvez stated that the team had undertaken an unannounced visit there yesterday and areas of good practice were identified.

Ms Styche left the meeting.

Mrs Roberts advised that Prof. Cannaby had visited Probert Court and the trust are prepared to support some training for them.

Ms Styche rejoined the meeting and Ms Whatley joined the meeting.

Mr Oatridge asked a question for clarification regarding Caesarean sections as the report states about the threshold and wondered if the two numbers were capable of addition.

Mrs Roberts replied no they couldn't be added together, the elective number was a local measure and the emergency number was a national figure.

Ms McKie commented that handwashing and Infection Prevention had gone red.

Ms Whatley replied that the training requires staff to go onto the computer to do the training; which was proving difficult; they are monitoring it carefully through the Infection Prevention and Control Group meeting which the CCG attend.

Ms Higgins commented that the Trust had another MRSA this month.

Ms Whatley confirmed this and advised that they are doing a RCA.

Primary Care

Flu vaccines – Mrs Corrigan advised that there were six practices who hadn't ordered any trivalent vaccinations for the over 65 year old patients and another practice had under-ordered; she added that they are working together with Public Health and commented that there was a national agreement to move vaccines; they had also identified some Pharmacies too; it is being managed well.

Dr Mittal commented that in London there were 16% of practices without vaccines.

Ms Whatley advised that the Trust had had its first flu case.

Dr Rajcholan commented on the statement that was on the bottom of page 34 of the report:

> *Public Health are working with NHSE to identify ways to order and manage stock where required and contingency plans e.g. priority vaccination (over 75s and care homes, at risk over 65s then healthy over 65s) mutual aid from practices who have over-ordered and diversion of patients to alternative providers such as pharmacies, NHSE will remunerate for letters sent out inviting patients where GPs do not have a TIV vaccine.*

Mrs Corrigan replied that this was for the over 65 year olds.

Practice Issues: Mrs Corrigan advised that they were monitoring the Docman issues.

MGS Medical Practice: They are monitoring the action log for the practice:

- **Incorrect Storage of Records** - They have reviewed patients who have died or have moved practice. There was an issue with PCSE sending labels as they will only accept 50 labels per week that can be returned due to capacity issues, this should be completed by the end of this month.
- **Complaints** – Patients being deregistered from the practice has now been

resolved, no harm and all but one patient has been seen – cardiology issue.

- **Medicines Management Audits** – This is in hand.

Friends and Family Test – The results are good.

Ms McKie advised that she was in attendance at a PPG yesterday and they seem more than pleased with progress back from the practice; patients who are coming in for flu vaccinations are also having their Blood Pressure taken at the same time.

Mr Oatridge commented on Workforce Development and queried whether there were any recruitment issues around GPs.

Ms McKie left the meeting.

Mrs Corrigan commented that there were some retired GPs but they are continuing to work.

Mrs Roberts stated that GPs do not always want to sign up to a partnership.

Dr Rajcholan commented that younger GPs want variation.

Mrs Corrigan left the meeting.

QSC/18/045.2 Infection and Prevention Report (Item 5.6)

The above report was previously circulated and noted by the Committee.

Ms Whatley presented the Infection and Prevention Report and picked out the highlights and advised that it was an improving picture:

- **GP Audit Results** – Four out of five practices were higher than last year.

Themes of non-compliance

- **Water Maintenance** – Providing evidence of Legionella risk assessment & water outlet flushing.
- **Physical Environment** - Some fixtures and fittings that are permeable, for example desks, carpets. Minor wall damage. Non-compliant hand-wash basins.
- **Sharps handling & disposal** – Old stock of non-safe sharps. They have been recommended to dispose of old sharps.

Surveillance Results – C *Diff* infections were below trajectory for the CCG and are marginal for Trust. Treatments were not accessible for a few months; however, they are now back on track.

MRSA – This is a whole concern across the City. There has been an increase across the board. Nationally, there has been a relaxation to screen all patients; but the policy at RWT is to screen all patients. There has been an increase in care homes and will continue to reinforce screening and skin and soft tissue. Ms Whatley advised that there were definitely themes on early identification.

Mrs Roberts commented that it was more concerning around skin and soft tissue and added that there are more patients with Pressure Ulcers (2 MRSA – 1 skin).

Ms Whatley replied that the other was still under investigation, but had had a dermatology screening referral. She added that they are looking at themes over a number of years and they are seeing skin and lack of screening coming through.

Ms Whatley wondered if there were audits being undertaken in the care homes.

Mrs Roberts replied that the QNA will continue this.

Ms Whatley commented that there could be an issue with Council Commissioned Care Homes.

Dr Mittal stated that he might be able to oversee this information.

Ms Higgins commented that they are having system sharing meetings and thought it might help to raise profile there, she added that she would get Ms Henriques-Dillon to send dates to Ms Whatley.

ACTION: Ms Higgins

Gram Negative Bacteraemia – Ms Whatley advised that the numbers are variable, she added that there is work ongoing around catheters, they will re-visit the action plan again.

QSC/18/046 Improvement and Innovation Reports/Policies for Ratification

QSC/18/046.1 Infection and Prevention Strategy (Item 6.1)

The above report was previously circulated and noted by the Committee.

Ms Whatley advised that the strategy had been signed off at RWT Infection Prevention and Control Meeting and that it needed this Committee to sign it off so that it can go on the website, she added that the Council have also agreed it.

The Committee agreed to sign off the policy.

Mr Strickland joined the meeting and Ms Whatley left the meeting.

QSC/18/047 Performance and Assurance Reports

QSC/18/047.1 FOI Report (Item 5.2)

The above report was previously circulated and noted by the Committee.

Mr McKenzie presented the report and advised that the CCG had received 75 requests in last quarter and they were all responded to on time. Although FOI requests may be made by anyone and the CCG response does not differ based on the source of the request, requests have included:-

- Requests from members of the press including national newspapers and Health Service trade journals
- MPs and All Party Parliamentary Group
- Commercial organisations.
- Charities and Pressure Groups

There has also been coverage in the press for uptake of hours in GP practices and Mortality in RWT.

QSC/18/048 Improvement and Innovation Reports/Policies for Ratification

QSC/18/048.1 Information Governance Report including 5 policies (Item 6.3)

The above report was previously circulated and noted by the Committee.

Ms Huckvale presented the quarterly report and advised that five key policies have been extracted out of the staff handbook for easy access. She added that the website has been updated with the new GDPR information and feedback received from NHS Digital.

GDPR training – Ms Huckvale had provided training at the staff forum in August.

GDPR Communications and Awareness Plan – This had been completed and circulated to all staff. Each of the 12 communications will be merged into a PDF/leaflet and circulated to all staff as quick reference guide.

Information Risk Reviews – These will be conducted with IAA/IAOs throughout October to December 2018.

Ms Danks joined the meeting.

IG Incidents - Ms Huckvale advised there had been no incidents reported in Quarter 2.

Caldicott Guardian Log Work Remit 2018/2019 – there were six DPIAs submitted to the IG team for review and comment during the second quarter, most of which relate to commissioned services and the IG implications for the service provider.

Subject Access Requests – There had been two Data Protection Requests in the form of Subject Access Requests during Quarter 1 and 2.

Mr Price commented that the report had identified that the Data Protection Policy (Section 12/13) was overseen by the Audit Committee; however, he could not recall seeing that at the Committee.

Mr McKenzie replied that, that was a typo and it should be this Committee.

QSC/18/048.2 Fair Processing/Privacy Notice (Item 6.4)

The above report was previously circulated and noted by the Committee.

Ms Huckvale presented the Fair Processing/Privacy Notice report and advised that it had referenced the individual rights and that contact details had also been added.

Mr McKenzie commented that this was meant for the public. NHS Digital had asked the CCG to include all of the information; it will hopefully go on the website and people will be able to click on links which will guide you to the detail in the report.

Dr Rajcholan thanked Mr McKenzie and Ms Huckvale for their hard work which was commendable.

Ms Huckvale and Mr McKenzie left the meeting.

QSC/18/049 Performance and Assurance Reports

QSC/18/049.1 Quality Assurance in CHC Report (Item 5.4)

The above report was previously circulated and noted by the Committee.

Ms Danks presented the Quality Assurance in CHC Report and referred the committee to the following table on page 3 of the report. She advised that there had been an increase in Quarter 1 and she was just finalising quarter 2 data now.

Year	Newly Eligible (including Fast Track)	No Longer Eligible (including Fast Track)	Total CHC eligible end of Quarter (including existing pts & Fast Track)	Total FNC eligible
2016/17				
Q1	168	127	501	454
Q2	175	139	535	452
Q3	152	123	544	470
Q4	157	146	563	482
2017/18				
Q1	197	169	591	488
Q2	155	147	603	475
Q3	136	142	612	481
Q4	157	136	639	448
2018/19				
Q1 ***	252	123	699	465

****The benchmarking data has changed and this may assist in explaining the change in numbers.*

Appeals – These were ongoing and there was nothing to report.

Fast Tracks in Wolverhampton –A Task and Finish Group had been established to review fast referral process. All Fast Tracks will come to the CCG as of 1st October 2018 and there will be a clinician available to speak to people to help improve Patient Experience.

Personal Health Budgets – The numbers have increased to 43 and they continue to be under scrutiny.

Step Down – The number of patients in step down average between 30 and 35 per week and patients continue to be monitored by the CCG.

Quality Premiums Targets – This requires 80% of full CHC assessments to be completed within 28 day timescale and less than 15% of CHC full assessments to be completed in an acute setting and they are performing well. .

Risks – Ms Danks advised that there are more complex patients now; they had budget meeting for next year and are currently reviewing processes and communications and she added that they are working with Healthwatch. The team has been restructured and Ms Danks was hopeful that by Christmas all staff will be in post.

Mr Hastings enquired about the STP targets.

Ms Danks replied that the CCG will meet the CHC budget.

Ms Danks left the meeting.

QSC/18/049.2 EPRR Update (Item 5.3)

The above report was previously circulated and noted by the Committee.

Mr Hastings gave an update on EPRR and advised that there was a review of EPRR yearly around approaches for staff and to ensure that the plan is safe and also that the provider is meeting their responsibilities. He referred the Committee to page 75 of the papers where it showed the EPRR self-assessment and the RAG rating; from this they had improved training for the Executive team. There was one amber rated standard and the team are working with NHSE; the Black Country wide training didn't really meet the criteria so was rated amber. Mr Hastings stated that they had presented the self-assessment to NHSE who thought we were being hard on ourselves. Mr Les Trigg (lay member) has the responsibility for EPRR. He added that there would be a full review in the New Year and they are currently planning work ready for next year where they will work with RWT. With regards to the CCG it is down to each department to ensure that they are meeting their responsibilities and added that everybody needs to be comfortable with the actions.

Mr Price asked if this needed to go to Governing body

Mr Hastings replied that yes it did need to go to the Governing Body.

Mr Strickland advised that the Corporate Risk score for this was 6 and asked if that was still appropriate.

Mr Hastings replied that the score was correct.

QSC/18/049.3 Quarterly CQUIN Update (Quarter 1) (Item 5.5)

The above report was previously circulated and noted by the Committee.

Mrs Roberts provided an update on the Quarterly CQUIN Update and advised that Sepsis (2a and 2b) have been rated as amber and that there was an improvement plan in place for RWT. With regards to Tobacco Brief Advice (9b) for BCPFT which had been rated as red and added that this monitored by CQRM.

QSC/18/050 Improvement and Innovation Reports/Policies for Ratification

QSC/18/050.1 NICE Policy (Item 6.2)

The above report was previously circulated and noted by the Committee.

This was received for information it had been updated with a review of the Terms of Reference and some minor amendments made.

QSC/18/051 Risk Review

QSC/18/051.1 Quality and Safety Risk Register (Item 7.1)

The above report was previously circulated and noted by the Committee.

There were no new risks.

Corporate Risks

QS05: Maternity Capacity and Demand – This had been reduced to 4.

Committee Risks

QS08: Probert Court Nursing Home – This had been reduced to 16 and is being monitored weekly.

QS02: Inappropriate Arrangements for a Named Midwife - RWT – They are currently awaiting recruitment checks and Ms Higgins will check on this.

ACTION: Ms Higgins

QS06: RWT are currently not meeting NHS Constitutional Standards for 62 and 104 day Cancer Pathways and QS07: RWT has higher than expected SHMI – These are both due for review this month.

QS09: Potential issue with supply of adjuvented trivalent influenza vaccine (a TIV) for 2018/19 influenza season - Received review of flu vaccinations supply will review this next time.

QS01: Out of Hours Provider - inaccurate reporting of performance data/quality assurance (Vocare) - This had been reviewed and re-rated and reduced to 6, Mr Strickland asked if the committee were happy with it.

Mrs Roberts advised Mr Strickland to keep it as it was for now.

QS05: Maternity Capacity & Demand – Mr Strickland advised that this was rated as 4 and asked if this was to remain.

Mrs Roberts replied that she would take it off; but added that they should await Staffs outcome.

Mr Hastings asked if RWT was going to be removing their cap.

Mrs Roberts replied that they will not remove the cap at the minute because of the issue with Staffs.

Mr Oatridge commented on the closure of A&E overnight at Telford.

Mrs Roberts replied that they are already asking for regular diverts and RWT are saying no; if it had happened that would be an extra four to six ambulances daily diverted to Wolverhampton; she added that RWT are in talks with Shropshire.

Mr Oatridge asked as to what was happening.

Mrs Roberts replied that Telford A&E are going to be closed overnight so they are going to Shrewsbury, Powys and then Wolverhampton and added that RWT are not seeing a major impact at the moment.

Dr Rajcholan commented on the A&E night closure at Staffs and asked if it was temporary.

Mrs Roberts replied that she was not sure at the moment.

QSC/18/051.2 LeDeR Risk Assessment (Item 7.2)

The above report was previously circulated and noted by the Committee.

Mr Strickland advised that from a conversation last month he wondered if the risk for LeDeR was for us or the STP; the highlights risk for the Black Country area and compliance from Wolverhampton, it was bought to the Committee attention and the question was being asked if there was a need for the risk to be put on the Committee Risk Register.

Mrs Roberts replied that we would manage it locally for now.

Mr Strickland left the meeting.

QSC/18/052 Items for Consideration

There were no items for consideration.

QSC/18/053 Feedback from Associated Forums

QSC/18/053.1 Commissioning Committee (Item 9.1)

The Commissioning Committee minutes were received for information/assurance.

QSC/18/053.2 Primary Care Operational Management Group (Item 9.2)

The Primary Care Operational Management Group minutes were received for information/assurance.

QSC/18/053.3 Health and Wellbeing Board (Item 9.3)

The Health and Wellbeing Board minutes were received for information/assurance.

QSC/18/053.4 NICE Group (Item 9.4)

The NICE Group minutes were received for information/assurance.

QSC/18/054 Items for Escalation/Feedback to CCG Governing Body

- Cancer paper
- Mortality paper
- EPRR paper

QSC/18/055 Date of Next Meeting: Tuesday 13th November 2018 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12:38pm

Signed: …… **Date**: ……
Chair

NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 11th December 2018 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Nicola Hough – Minute Taker – Administrative Officer (PA to Chief Nurse and Director of Quality)
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sally Roberts – Chief Nurse and Director of Quality, WCCG
Mike Hastings – Director of Operations, WCCG

Lay Members:
Peter Price – Independent Member – Lay Member
Sue McKie – Patient/Public Involvement – Lay Member

In attendance (part):
Phil Strickland - Governance & Risk Coordinator, WCCG
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Katrina McCormick - Children's SEND Programme Officer, WCCG
Vanessa Whatley - Head of Nursing Corporate Services, WCCG
Danielle Dain – Head of Nursing Corporate Support Services, WCCG
Sam Squire – Mental Health Student Nurse (Shadowing Liz Corrigan), University of Wolverhampton

APOLOGIES:
Jim Oatridge – Deputy Chair - Lay Member
Marlene Lambeth – Patient Representative
Sukvinder Sandhar – Deputy Head of Medicines Optimisation, WCCG

QSC/18/067 Apologies and Introductions

Apologies were received and noted as above and introductions took place.

QSC/18/068 Declarations of Interest

Ms McKie advised that she is involved with Wolverhampton and Walsall Public Health reviewing Child Deaths and this will be for two days per week.

QSC/18/069 Minutes, Actions and Matters Arising from Previous Meeting

QSC/18/069.1 Minutes from the meeting held on 13th November 2018 (Item 3.1)

The minutes from the meeting which was held on 13th November 2018 were read and agreed as a true record.

QSC/18/069.2 Action Log from meeting held on 13th November 2018 (Item 3.2)

QSC/18/060.4 - Safeguarding Adults, Children and Looked After Children Report – To review the contract around School Nurses and would confirm by e-mail.

Mrs Roberts advised that health visiting contracts have been escalated at QSG and added that she would take an action to speak with Dr John Denley around assurance for Health Visiting and School Nursing.

ACTION: Mrs Roberts – February 2019

QSC/18/045.1 - Quality Report: Black Country Partnership – Ms Higgins had asked the trust for assurance of clinical leadership for the unit and there will be more detail on the next report.

Ms Higgins advised that this was for the Penrose Unit and added that the matron is now a clinical leader and they have got a band 7 nurse and the CCG team will repeat the visit February/March 2019 and she is expecting an update at the next Learning Disabilities CQRM.

Mrs Roberts stated that the trust capital request had been supported for inpatient beds from the national monies. Top 4 have been given money which includes: Walsall and Dudley ED, TCP and S&WB Trust (Met Hospital).

Dr Rajcholan commented that she had recently had a problem with one of her patients; they eventually got a bed but in Redditch for a week and half and then they were moved to Penn Hospital.

Ms Higgins advised that there was recently a 12 hour breach in ED, New Cross which was another Mental Health patient. She added that she has got a meeting this week to discuss Mental Health beds locally.

Mr Hastings stated that there is a national issue.

Mrs Roberts advised that she will flag this issue at QSG and ask others about their experiences.

ACTION: Mrs Roberts/Mrs Higgins

Dr Rajcholan asked if we had mental health step down beds.

Ms Higgins replied that she would find out and let Dr Rajcholan know.

ACTION: Ms Higgins

Mrs Corrigan joined the meeting.

QSC/18/031 - Apologies and Introductions – To discuss the attendance of the secondary care consultant with Mr McKenzie. To speak with Dr Hibbs regarding the appointment of another Secondary Care Consultant.

Mrs Roberts advised that they are going back out to advert.

QSC/18/037.1 - Quality and Safety Risk Register - To meet outside of the meeting with regards to progress the Docman Risk.

This action was **complete** and it was **agreed** to remove it off the action plan.

QSC068 - Points raised by the Chair following the presentation of the Quality & Risk Report: A date is to be confirmed on the implementation of the catheter passport.

Ms Higgins advised that there was a bigger piece of work the Trust is working on and the continence team are supporting the community team.

Mrs Roberts stated that because of the challenge she thought it would be best to put it through CQRM. It was agreed this would now be monitored through CQRM and escalated/reported through Q&S if required.

This action was **complete** and it was **agreed** to remove it off the action plan.

QSC071 - H&S Performance Report: New H&S Provider now identified to look into supporting CCG with H&S requirements. To assess as to whether this needs to be a risk at the next meeting.

Mrs Roberts advised that she has put this on the Risk Register she added that they now have an offer and she is meeting them this afternoon.

Mr Hastings stated that the company is RG Consultants Limited and they are based in Wolverhampton.

Ms Higgins advised that there was something that she needs some support with.

Mrs Roberts commented that it could be reduced on the Risk Register from next month.

QSC/18/070 Matters Arising

There were no matters arising.

QSC/18/071 Performance and Assurance Reports

QSC/18/071.1 Quality Report (Item 5.1)

The above report was previously circulated and noted by the Committee.

Cancer – Ms Higgins advised that for the 104 and 62 day cancer waits the CCG continue to monitor and review the recovery plan.

Mr Hastings stated that there is a national escalation meeting taking place on Wednesday and Dr Hibbs will be attending on behalf of the CCG.

Mrs Roberts commented that there will be a walkabout at RWT by NHSI/NHSE and Cancer Alliance colleagues.

Mr Hastings advised that at the last Face to Face meeting with Cancer Alliance and NHSE they were assured of the actions being taken by RWT and CCG and added that the presentation can be shared with the Committee.

ACTION: Mr Hastings

Ms Higgins advised that all visits to GPs have now been undertaken re: cancer peer support, there was no safety net for two week referrals and there was some good practice. For the 104 day reviews this month, there were some patients that had multiple referrals; this was being addressed directly with the referring GP.

Cancer Sharing Event – Ms Higgins advised that there is an event being planned to share good practice. GP feedback is that further work is required to ensure alignment with NICE guidance.

Mrs Roberts added that Simon Gromett (representative from RWT) will be at the event and they are looking to share referral data.

Dr Rajcholan commented on the five fast track referrals mentioned in the report and asked if it was a training practice.

Mrs Roberts replied that she thought it was a training practice.

Dr Rajcholan commented on fast track referrals and she thought it still needed to go through their trainer.

Ms Higgins stated that GPs are not following up on two week wait referrals.

Mrs Roberts added that they are also looking at NFA.

Ms Higgins advised that they now understand the issues and are driving improvement. With regards to the 62 day harm review, the back log has now been completed and RWT have thanked the CCG for their help. Themes that have come out of the reviews are lack of escalation policy, tertiary referral delays, tertiary referral process issues, delays in MDT cases discussion and diagnostic delays.

Ms McKie commented that there was no colour on the RAG rating column.

Ms Higgins replied that it should be red.

Mortality – The Medical Examiners are now in post and the bereavement centre is now open and they are going to include families in the reviews. MJRs continue and learning from these is taken back out into practice.

Death after 30 Days of Discharge – There is some expected deaths and some that are not and they will be reviewed. Mortality strategy now received. Latest SHMI has come down very slightly but this is reflective across the Country.

Mrs Roberts advised that the SHMI has decreased by 0.1.

Mr Price asked when we can expect to see the impact of the work being undertaken on the overall performance of mortality.

Mrs Roberts replied that it was unlikely we would see a large improvement quickly, she had attended a meeting last week with all of the executives at RWT and Stan Silverman and herself as external representatives and this was the mortality review group for the trust. The SJRs around mortality are starting to get some quality reviews done and the Trust is bringing in more external help.

Sepsis Compliance – Ms Higgins advised that the Trust is planning to introduce NEWS2 and a Sepsis Alert within Vital Pac in January 2019 to help with early recognition of Sepsis as well as having Outreach team referrals.

Ms Whatley and Ms Dain joined the meeting.

Ms McKie commented on the bereavement suites and the Child Deaths and advised that the Neo-Natal Unit is trying to get a bereavement room too.

Mrs Roberts advised that she would flag this with Cath Williams, as designated Doctor.

Mr Hastings questioned the quality and appropriateness of data and coding.

Ms Higgins replied that there was a problem with coding and the patient's initial diagnosis.

Mrs Roberts added that there was an issue with FCE coding which was a big finding out of the theming. She added that Nigel Coates; who worked on the Keogh Mortality review has been working with the Trust and was hoping to have his findings in the New Year.

Dr Rajcholan queried whether the SJRs backlog had been done.

Ms Higgins replied that yes the backlog has now been completed.

Dr Rajcholan commented on the care homes deaths and asked if there was any analysis available.

Ms Higgins replied that a lot of the learning will be picked up by the Deterioration project; which is moving forward really well across Walsall and Wolverhampton. She added that Dr Samra is working with the CCG and is looking at three elements in cross system training; frailty, End of Life and the deteriorating patient. NEWS2 is being trialled in two nursing homes; one in Walsall and one in Wolverhampton. They are putting together a

booklet to help with Nursing Homes; Stop and Watch to help recognise the signs of deterioration and if they need to escalate then they will do NEWS2.

Mrs Roberts commented that a standardised frailty tool will be really useful.

Ms Higgins advised that she would bring a synopsis of the work to the Committee in February 2019.

ACTION: Ms Higgins

Maternity Performance – Ms Higgins advised that they are awaiting the RCOG report and added that we are awaiting the trust findings from the C-section rate audit completed by the trust.

12 Hour Breach – There is a meeting this Friday to discuss this and to ensure any learning is captured.

Probert Court – Ms Higgins advised that there is now a plan to support them. She added that the QNA team are going into the home every day and they are interviewing for a clinical lead and RWT are also supporting them by going in weekly. There is a collaborative meeting with RITS team. The staff at the home can also access training at RWT now too and they are accessing the training.

Overdue Serious Incidents – There is one outstanding Serious Incident for BCP.

Mrs Roberts advised that the CCG had been challenged by NHSE about the outstanding Serious Incidents as they had got them down as 21; there were in fact only two outstanding. NHSE have been advised of the error from them.

Ms Higgins added that there is now only one outstanding.

Infection Prevention – With regards to the Gram Negative; we are one of the worse performing CCGs; however, there is a plan on how it can be rectified with a meeting being held at the end of December.

Staff and Turnover Rates – This is really positive.

Mrs Roberts advised that we might see this change as workforce impacts begin to hit, in addition the trust will be reviewing vacancy arrangements as part of their CIP programme.

Children and Young People in Care (CYPiC) - Mr Price asked if they were still unsure about changing the name.

Ms Higgins advised that the children had suggested the new name.

Mrs Roberts confirmed that the change of name had been accepted.

Cancer Waiting Times: 2 Week Wait – Dr Rajcholan commented on '30.1% were due to capacity, 69.9% patient choice' and asked if that was correct.

Ms Higgins replied that it was correct and added that the importance of patients choosing alternative and often longer appointments cannot be stressed enough.

Mr Hastings stated that this time of year patients are being deferred and often this is seasonal, but added we will be reviewing this regularly.

QSC/18/071.4 Infection Prevention Service Update (Item 5.4)

The above report was previously circulated and noted by the Committee.

Care Home Activity – Ms Whatley advised that they are starting to see respiratory

outbreaks; patients are being screened for flu and RSV is circulating, which is a concern.

Audits – This was decommissioned in March, but the CCG and RWT are working on this now.

Infection Prevention Team – The team have been into Probert Court and they are currently writing the report, there were some issues highlighted.

GP Audit Results – There are 11 centres that are audited and the scores are all in the high 90s; but some important issues are being missed. Some of the GP surgeries are old and the hand wash basins need to be reviewed; guidance changed five years ago so might need to consider a Capital bid to get them bought up to the relevant requirements.

Mr Hastings advised that he had asked Gill Shelley to look at past audits and they can look at capital funding from non-recurring money as long as it is spent in a good time frame.

Ms Whatley commented that they could have a Task and Finish Group to discuss this and added that Danielle Dain could sit on the group.

Mrs Roberts agreed that would be a good plan.

Ms Whatley advised that waste bins were also an issue.

Mrs Roberts asked if we change the audit year on year.

Ms Whatley replied that the audit was amended two years ago and added that they only change it if national guidance is received.

Mrs Roberts added that from past experience, if the auditing staff get used to the same audit you don't get fresh eyes on them.

Ms Whatley advised that the Infection Prevention team do the audits not surgery staff.

Mrs Corrigan commented that she went out to do an audit and it was interesting.

Mr Hastings added the need to be wary with regards to the last time it was changed as MCA only review things they have reviewed.

Mr Strickland and Ms McCormick joined the meeting.

Ms Whatley advised that other trusts audits have been weighted and thought it might be worth looking at.

Surveillance Results: C Diff – There were no major concerns around GP surgeries, National guidance on screening changed a few years ago. However, RWT are struggling with compliance and they are having a push in the Trust.

MRSA Bacteraemia – The Trust has had two cases and they are not sure if they were screening correctly as they were outpatients so went on the CCG figures. The team are monitoring it regularly.

Mrs Roberts asked if NHSI have been in touch with the Trust as it had not been flagged with her.

Ms Whatley replied that they had not been in touch with her. She advised that there was an issue with dermatological conditions and the team is working with dermatology.

Mrs Roberts stated that it was good to share the work that is being done by the team.

Ms Whatley advised that the other two cases that occurred in the Trust earlier in the year were not RWT patients.

DRAFT

Gram Negative bacteraemia – Ms Whatley advised that this was an uncontrolled bacteraemia; there is a call on 18th to see what is happening.

Dashboard – Ms Whatley advised that they have been working on an Infection Prevention dashboard which she shared with the Committee as it was only completed on the morning of the meeting. She shared that the microbiologist had commented on it and added that they will develop it and it will change daily.

Safer Sharps - Mrs Corrigan and Ms Whatley has done some work on Safer Sharps and they are planning on putting on an event for GPs in April.

Risks – There is a risk that Wolverhampton will not retain its excellent reputation for the prevention of infection without the sustained input into care homes but they will include Public Health going forward. They are also looking at the National data to keep updated.

MRSA - Care home work needs to keep going and Gram Negative work is also system wide.

Dr Rajcholan commented on the Gram Negative work and asked if there was a target for e-coli.

Ms Whatley replied that there was a national target to reduce e-coli.

Dr Rajcholan commented that it was all increasing in October with dips in July and September.

Ms Higgins replied that it could be to do with dehydration issues during the Summer months.

Ms Whatley stated that they need to have a plan going forward.

Ms Higgins advised that work has been done in the care homes around hydration and oral health.

Ms Dain advised that the team was going to send a poster around to GPs.

Mrs Roberts asked if they could also send the poster to the CCG as well so they could share it with Comms.

Ms Whatley stated that she was getting information about some GPs not giving flu vaccines.

Mrs Corrigan advised that she has got a list and has spoken to Steve Barlow (Public Health) and added that there were some extras in Dudley which Dr Barlow and Mrs Corrigan will collect and distribute accordingly. She added that they had been told that they needed to prioritise care homes which was the protocol from NHSE but it was difficult to police.

Ms Whatley stated that she was concerned about a flu outbreak in a home.

Mrs Roberts replied that there was a plan and she was expecting some information by the end of the week.

Ms McKie commented on dehydration and asked if we could use the voluntary sector too.

Mrs Roberts replied that yes they could and added that they would do comms around it.

Ms Whatley and Ms Dain left the meeting.

QSC/18/071.2 Primary Care Report (Item 5.2)

The above report was previously circulated and noted by the Committee.

Flu – Mrs Corrigan advised that she would update the flu risk to increase the score again. She added that she will review it with Dr Barlow; there is 75% coverage and NHSE do give figures; the problem this year is that there was only one supplier and they were hopeful that there would be more flu vaccines available next year.

Serious Incidents – There are currently no serious incidents being investigated in primary care. However, there have been two incidents relating to incorrect flu vaccines being given where over 65 patients were given the under 65 vaccines.

Quality Matters – This has been monitored; it says there were five SIs but it is now two. The majority were around information governance and patients had been given incorrect blood form.

DocMan – This is now being managed by Mr Ramsey Singh; there are no issues currently.

MGS Practice – These are all in hand and more assurance has been received.

Complaint – Mrs Corrigan is awaiting outcome on this. Should now have DocMan open. One issue is being referred to PEIG; but was unsure whether it would be before or after Christmas; she will chase it up and copy Mrs Roberts into the e-mail.

ACTION: Mrs Corrigan

Friends and Family Test – This had been the best uptake they had ever had, September data which was reported in October was good uptake. The figures are still lower on 'would recommend. There are more people reporting against the national figure. Some practices may only return five FFTs.

Mrs Roberts asked if we were targeting surgeries with no response.

Mrs Corrigan replied that yes they are but added that they are different surgeries each month. Dr Mudigonda's patients are not filling them in; they are also using text messages at Bilston Health Centre.

Mr Hastings advised that this had been discussed but added that the reception areas are all over the place.

Mrs Corrigan added that there are some surgeries with really good uptake.

CQC – There is one new CQC visit (Dr Fowler) who received a really good rating.

Collaborative Practice Visits – Collaborative contracting visits are carried out where appropriate between CCG and Public Health. There were a couple of action plans outstanding.

Workforce – **STP**: Mr Paul Aldridge is working on this.

Mrs Roberts advised that the clinical lead presented at the Members Meeting; it went down really well with six/seven schemes on it.

Mrs Corrigan stated that they will look at a copy for practice nurses.

Apprenticeships – Mrs Corrigan advised that she will look at other pots of funding for this.

Workforce Numbers – They have now got National data figures for Whole Time Equivalent (WTE).

GPN 10 Point Action Plan – This continues to be reviewed; and they are looking at training places for spirometry.

Nurse Training – The digital clinical supervision issue is resolved now.

Project Manager for Training Hub has left and is out for application.

Ms McKie asked if the CCG get cervical screening data.

Mrs Corrigan replied that it now goes to another team and added that they don't always know about breaches.

Mrs Roberts advised that we need to tighten up the links with screening and immunisations.

Mrs Corrigan added that the immunisation meeting now includes screening.

Mr Hastings referred the Committee to page 3 of the report and the Infection Prevention audits and asked if the ones that were failing are all in one group.

Mrs Corrigan replied that yes they are all VIs who have property buildings.

Mrs Corrigan and Student Nurse Squire left the meeting.

QSC/18/071.3 SEND Update (Item 5.3)

The above report was previously circulated and noted by the Committee.

SEND Tribunal National Trial – Ms McCormick advised that there was a key risk around Special School, there is an action plan and asked if the Committee could receive the action plan on a regular basis.

Key Points

- The CCG can be inspected at any time; it will be unannounced; the Local Authority will get informed and they will let us know.
- Increases around Special Schools Places.
- **Joint Inspection** – Co-operation with Local Authority; there will be three primary questions we will get asked. There have been six out of 14 local areas across West Midlands that have been inspected so far.
- **National Trial** – In the past parents and young children could take the LA to tribunal, this has now changed, they could take the CCG too. It is currently being trialled.
- **Special School Placements** – The Council have increased the number of children and young people school places from September 2018. There is an action plan for children's nurses, physiotherapists and paediatrics which Ms McCormick monitors. There are six domains around leadership and governance; they have made good progress and it will come to this committee to make it more robust, work is still being done.
- **Joint Arrangements** – There is a lack of data locally; on a health prospective there are plans in place.
- **Commissioning** – Public Health are leading on this, pathways need redesigning. As yet there has been little take up of Personal Health Budgets for SEND although not for Children's Continuing Care, there is a workstream project in place to develop this.
- **EHC Plans** – We are engaged with this, further work underway to continuously review the quality of both the plans and the process.
- **Engagement** – Some areas need to be strengthened – we need to get hold of data.

The main recommendation is that this comes to this Committee regularly.

Patient and Public View – Parents and children's have been engaged in various workstreams.

Inspections – There is a list of key areas of improvement. In some cases a written statement of action may be required; this is likely to be in relation to either illegal practice or failure to meet the duties under the Act. Ms McCormick advised that she is not seeing many tribunals at moment.

Increases in Special School Places from September – Further difficulty; need to know where parents are placing children won't know until March 2019. Might have reputational risk to the CCG depending on any decisions around future models of care. Ways to mitigate; working with LA for best models. There are resource implications as well as Quality and Safety implications and Equality.

Ms McKie stated that there was a lot of information and was a very robust report.

Mr Price asked if there was any idea as to when the inspections could be.

Mrs Roberts advised that the teams are in Sandwell and Stafford at the moment.

Ms McCormick stated that they only know that it will be within five years and added that there has been a Safeguarding visit already.

Mrs Roberts requested an update to this Committee bi-monthly.

Mr Price added that it should be by exception.

Mr Hastings referred to section 6 of the report and asked if it could be bespoke.

Ms McCormick stated that we are not alone as it is National but added that it would be better if we could do it at a STP level.

Mrs Roberts added that it would be really good to see the STP footprint. With regards to the local offer; we need to review the health offer and advised that they are getting some support to help Ms McCormick with this. In connection with special school placements they have not had a lot of dialogue from the LA, received a letter from them.

Ms McKie left the meeting.

Dr Rajcholan commented about SEND which is from birth to 25 years old and asked if it would continue.

Ms McCormick replied that transition is always the difficult bit.

Ms McCormick left the meeting.

QSC/18/071.5 Equality and Diversity Report (Item 5.5)

The above report was previously circulated and noted by the Committee.

Mrs Roberts advised that the Publication of Standards is now on the website.

RWT – their RAG rating is green now and was amber last year. Started at a difficult position. BCP has not been reviewed since their compliance. All agreed there had been some good positive progress with this work stream.

QSC/18/072 Risk Review

QSC/18/072.1 Quality and Safety Risk Register (Item 6.1)

The above report was previously circulated and noted by the Committee.

Mr Strickland advised that there were no new risks this month.

Risks

CR13: Maternity Services Capacity and Demand – Trust going over 5000 births

Health and Safety – There is a plan for Health and Safety.

SEND – Raise as a risk for Committee.

Mr Price asked if the Committee could see the action plan.

Mr Strickland advised that is was on the Quality Team Risk Register.

Mr Strickland left the meeting.

QSC/18/073 Items for Consideration

There were no items for consideration.

QSC/18/073.1 Internal Audit Report 2018/2019 Quality and Safety – Serious Incident Reporting (Item 7.1)

The above report was previously circulated and noted by the Committee.

Mrs Roberts advised that this report had been to the Audit and Governance Committee. It was a comprehensive review of internal process and there was one advisory action and another that has been actioned already.

A Safeguarding review has also been done and that will come here once it has been to the Audit and Governance Committee.

QSC/18/073.2 Serious Incident Policy (Item 7.2)

The above report was previously circulated and noted by the Committee.

Mrs Roberts advised that there were some minor amendments that had been made.

Mr Price stated that it was helpful to have the tracking on the document to identify the changes easily.

Mrs Roberts added that they have strengthened the processes.

QSC/18/074 Feedback from Associated Forums

QSC/18/074.1 Commissioning Committee (Item 8.1)

The Commissioning Committee minutes were received for information/assurance.

Mrs Roberts commented on the equipment; it was a Quality and Safety issue initially. The procurement will go live on the decision from the Governing Body.

QSC/18/074.2 Primary Care Operational Management Group (Item 8.2)

The Primary Care Operational Management Group minutes were received for information/assurance.

QSC/18/074.3 Health and Wellbeing Board (Item 8.3)

The Health and Wellbeing Board Minutes were received for information/assurance.

QSC/18/074.4 Finance and Performance Report (Item 8.4)

The Finance and Performance Report was received for information/assurance.

QSC/18/075 Items for Escalation/Feedback to CCG Governing Body

- SEND

QSC/18/076 Date of Next Meeting: Tuesday 8th January 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.30pm

Signed: …… **Date**: ……
Chair

DRAFT

Minutes of the Quality & Safety Committee
Tuesday 13th November 2018 at 10.30am in the CCG Main Meeting Room

PRESENT:
Nicola Hough – Minute Taker – Administrative Officer (PA to Chief Nurse and Director of Quality)
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sally Roberts – Chief Nurse and Director of Quality, WCCG

Lay Members:
Jim Oatridge – Deputy Chair - Lay Member
Peter Price – Independent Member – Lay Member

In attendance (part):
Steve Barlow – Principal Public Health Specialist, City of Wolverhampton Council
Fiona Brennan - Designated Nurse for Looked After Children, WCCG
Molly Henriques-Dillon – Quality Nurse Team Leader, WCCG
Annette Lawrence – Designated Adult Safeguarding Lead, WCCG
Lorraine Millard – Designated Senior Nurse for Safeguarding Children, WCCG
Sukvinder Sandhar – Deputy Head of Medicines Optimisation, WCCG
Phil Strickland - Governance & Risk Coordinator

APOLOGIES:
Marlene Lambeth – Patient Representative
Dr R Rajcholan – WCCG Board Member (Chair)
Mike Hastings – Director of Operations
Dr Ankush Mittal – Consultant in Public Health, City of Wolverhampton Council
Sue McKie – Patient/Public Involvement – Lay Member

QSC/18/056 Apologies and Introductions

Apologies were received and noted as above and introductions took place.

QSC/18/057 Declarations of Interest

There were no declarations of interest.

QSC/18/058 Minutes, Actions and Matters Arising from Previous Meeting

QSC/18/058.1 Minutes from the meeting held on 9th October 2018 (Item 3.1)

The minutes from the meeting which was held on 9th October 2018 were read and agreed as a true record.

QSC/18/058.2 Action Log from meeting held on 9th October 2018 (Item 3.2)

QSC/18/045.1 - Quality Report including Primary Care and Care Home Report - To outline the actions and maybe add an extra column showing work done current month and previous month.

This action is now **closed** and will be **removed** from the action log.

QSC/18/045.2 - Infection and Prevention Report - To send dates to Ms Whatley for the system sharing meetings.

This action is now **closed** and will be **removed** from the action log.

QSC/18/031 - Apologies and Introductions – To discuss the attendance of the secondary care consultant with Mr McKenzie. To write to the Secondary Care Consultant.

Mrs Roberts advised that the Secondary Care Consultant has resigned from the CCG.

Mrs Roberts stated that she would speak with Helen Hibbs regarding the appointment of another Secondary Care Consultant.

ACTION: Mrs Roberts

QSC/18/025.1 - Quality Report including Primary Care and Care Home Report - Friends and Family Test (FFT) - To share the LMS 'Saving Babies Care Bundle' action plan.

This action is now **closed** and will be **removed** from the action log.

QSC068 - Points raised by the Chair following the presentation of the Quality & Risk Report: A date is to be confirmed on the implementation of the catheter passport.

Ms Higgins advised that this was to do with catheters generally and also an e-coli case.

QSC071 - H&S Performance Report**:** New H&S Provider to look into supporting CCG with H&S requirements. To assess as to whether this needs to be a risk at the next meeting.

Mrs Roberts advised that a detailed offer had been completed and there were people interested of whom the CCG will liaise with. At present though there is no one formally identified and suggested therefore this should be added to CCG Risk Register.

Action: To be added to Risk Register
Mr Oatridge offered his assistance if required.

Mr Barlow commented that Health and Safety Officer is part of his remit and offered support if needed.

QSC/18/059 Matters Arising

There were no matters arising.

QSC/18/060 Performance and Assurance Reports

QSC/18/060.1 Quality Report (Item 5.1)

The above report was previously circulated and noted by the Committee.

Ms Higgins asked the Committee for feedback on report.

Mr Price stated that the report was really useful and much preferred the new format.

Cancer – Ms Higgins advised that there was a remedial action plan in place with trajectories and the trajectories were being met.

Mrs Roberts stated that although the local trajectories are being met, performance is still a significant challenge. She advised we were expecting a dip in the next few weeks as the trust works through the patient back log, but improvement should be noted after that. There is significant focus to cancer performance, across all levels. The Trust is doing an additional two weekends a month to support the urology pathway.

Mr Oatridge commented on the Trust being on trajectory and asked as to what extent are the Trust putting in place.

Ms Higgins replied that they are working on capacity demand; they are using trackers as well and added that the CCG are supporting the review on the trackers.

Mrs Roberts stated that the IST have reviewed the pathways; urology which we know about and diagnostics (MRI) and added that the Trust are one MRI scanner down; which is well documented; the work is going into the Cancer Alliance and discussions are taking place on demand and capacity. Walsall patients need to have had their MRI done at Walsall before being referred to Wolverhampton. Paul Tulley is working on Cancer in STP.

Ms Higgins advised that the process for 104 days reviews has been refined as well as the 62 day wait.

Mr Barlow stated that with regards to breast screening the letters went out two weeks ago; there had been a timed clinic set up at New Cross on Saturday; he was unsure as to how many ladies had turned up, but there were an additional 28 ladies in clinic with an additional 14 telephone calls.

Mr Oatridge commented on the Trust being placed on national escalation and asked what that meant.

Mrs Roberts replied that this was as a result of escalation following the local NHSI/E escalation meetings and advised that the Trust would have a visit from NHSI Medical Director, date to be advised.

Mr Price asked if they had set a target for the overall cancer performance.

Mrs Roberts replied that there was no target set but added that there are local targets and trajectories for each pathway. She advised that she had attended a Stocktake meeting which was chaired by Dale Bywater and Wolverhampton had been marked for Cancer Performance; it was noted that there needs to be changes in cultural and local systems. She added that primary care for diagnostic capacity was currently being outsourced, to support the trust with more cancer diagnostic capacity.

Mortality – Ms Higgins stated that she had received an update since the report was written; the SHMI was at 1.21 now and work across the system continues with this agenda. She added that a presentation was going to the Governing Board this afternoon. She advised that they are doing system wide mortality reviews within primary care and are looking at approximately 650 deaths that occurred 30 days from discharge.

Ms Sandhar joined the meeting.

Ms Higgins stated that they know where patients were discharged to; they had looked at Nursing Home data but as this was not accurate data from the trust they are working with RWT refining this data. There is separate Nursing Homes and Residential Home data.

Mrs Roberts advised that there were two key emerging themes; FCE and coding related issues ie: the cause of death was being recorded as what the patient was originally admitted for, which was not always correct.

Ms Henriques-Dillon joined the meeting.

Mrs Roberts added that they were not coding later illnesses; i.e. lower respiratory tract, but patient died of pneumonia, the first coding was FCE, the trust are now reviewing this with every speciality where FCE is an issue.
Ms Higgins advised that SJRs were not being done for patients who die out of hospital but they are going to do that now with support from Primary Care.

Mrs Roberts commented that the quality of care does not appear to be flagging; however EOL care is the other key trend emerging, with community patients being admitted repeatedly and discharged and then eventually dying in hospital.

Ms Higgins advised that the system wide work is being presented to the regional

mortality group.

Mr Price queried if coding could be looked at and amended retrospectively.

Mrs Roberts replied no but it will be looked at going forwards. There is also seasonal variation to manage.

Mr Oatridge asked about the relationship between Mrs Roberts and Prof. Cannaby.

Mrs Roberts stated that it was really good, they work well together; she added that it is on a QI approach, which is very different from previous styles.

Sepsis – Ms Higgins advised that she does not understand the data that has been submitted for quarter two results and has therefore asked for further assurance.

Maternity Performance – Ms Higgins advised that there is a high C-section rate; she added that there is a safeguarding person now in post and thought that this risk could be removed off the Risk Register.

Mrs Roberts stated that given some of the IQPR maternity report ratings and on-going capping arrangements that she recommends maternity stays on the Risk Register as amber.

Black Country Partnership (BCP) – Ms Higgins advised that she had asked BCP for a themed review at their CQRM in December and added that we will have better reporting in April going forward. Staffing and capacity is an ongoing issue for the trust which is discussed at every CQRM and will continue to be monitored for improvement.

Probert Court – Ms Higgins stated that the collective work between Accord, RWT and CCG was having a positive impact on the care being delivered The RITS team are reporting different things to what the CCG are finding and so further review is now underway to establish actual findings.

Ms Higgins advised that the team had undertaken an announced visit to Cannock Hospital; it was a really positive visit and outcomes would be shown in the next report.

Mr Price commented that it was really helpful to see the progress being made across the board and asked when it could be shown when issues are likely to be resolved.

Ms Higgins stated that mortality and cancer is going to be ongoing for a while.

ED Performance – Ms Higgins advised that the closure of the SATH hospital is under review with NHSE, it is critical that Wolverhampton assess the potential and impact of this closure for Wolverhampton patients and clearly more significant assurance is required.

Mrs Roberts added that the potential closure was going to be three extra ambulances a day, but could now be significantly more as there has been push back from RWT which is supported by CCG. The closure is being reported as either from 8pm or 10pm but the senate has recently agreed for it to be from 8pm.

Ms Higgins stated that the RWT workforce and staffing report from the trust was really positive.

Ms Lawrence, Ms Brennan and Ms Millard joined the meeting.

Vocare – Have had a visit from CQC; initial feedback showed it was a positive visit. Awaiting final report

QSC/18/060.2 Primary Care Report (Item 5.2)

The above report was previously circulated and noted by the Committee.

Flu Vaccinations – Ms Higgins advised that the uptake was positive and added that some practices hadn't had enough trivalent injections but it was now sorted.

Mr Barlow added that all practices should have received what they had ordered.

Docman – Ms Higgins stated that all reviews have been undertaken and there was no identified harm to any patients as a result of this issue.

Mr Oatridge referred the Committee to page 9 of the report and commented that all deadlines were the 7th August 2018.

Mrs Roberts advised that all actions should now be closed.

FFT – Mr Price referred the Committee to page 15 of the report and commented that the figures were down on West Midlands and England figures.

Mrs Roberts stated that they have struggled with some returns but added that they will focus an improvement plan on it.

Ms Higgins advised that there was some more data on page 16 of the report.

Mr Barlow asked if there was some more in-depth data done around FFT.

Ms Higgins replied that unfortunately, it can't be done through FFT.

Mrs Roberts added that you can triangulate the data with patients' choices and advised that Mrs Corrigan is sharing this information with the PPGs.

Mr Oatridge commented on the workforce activity and the fact some practices have not agreed to share information and asked how we know if they are operating safe staffing and patient care and asked if it was in the contracts; if not could we add it.

Mrs Roberts stated that she thought we needed to ask the question as to why they won't share the information with us and that this is the role of primary commissioning committee too.

QSC/18/060.3 Quality Assurance in Care Home Report (Item 5.3)

The above report was previously circulated and noted by the Committee.

Serious Incidents (SIs) – SIs are relatively low across the Nursing Homes. There were seven reported during Quarter 2 which was a slight increase on Quarter 1.

Performance Data - Chest infections (21) and falls (30) remain the highest reason for attendances at ED in quarter 2. There were 65 ED attendances during Quarter 2 that fell into 'other' category with a multitude of reasons. The team are providing some training with regards to this.

RITS teams – Data can't be triangulated, WMAS data is currently 6 months behind; if they are not using the RITS team are they going to ED or are they managing themselves.

Mrs Roberts commented that falls are difficult for CQC as their expectations are that if a patient falls they go to ED.

Mr Oatridge commented on unscheduled GP visits to homes and asked what was scheduled.

Ms Henriques-Dillon advised that GPs are doing weekly ward rounds to homes and homes are ringing GPs if the patient is poorly on a particular day, there is a lot of pressure on the practice.

Mr Oatridge wondered if that practice had got a regular scheduled day visit.

Ms Henriques-Dillon replied that yes they have but added that there was a new home manager and work is being done to help them

Mr Oatridge asked if homes have a designated practice.

Ms Henriques-Dillon commented that the PIP scheme had looked at through the Enhanced Care Homes.

Mrs Roberts added that this was to do with the primary care remodelling and added that the PIT Scheme evaluation shows it was inconsistent.

Mr Oatridge asked if it had to be a GP or could it be an ANP.

Ms Higgins replied that it could be either.

Mrs Roberts added that it could also be clinical fellows; they need to be sharing staffing with acute and added that she was trying to push this with the Trust.

Mortality - Ms Henriques-Dillon commented that residents who had died in care homes was the preferred place of death for those patients and added that work is being done around this.

Ms Higgins stated that with regards to the End of Life work that is being done, she had met with the MacMillan Nurse and she will bring a report to the Committee in January 2019.

Safety Thermometer - Ms Henriques-Dillon advised that the homes are exceeding the target on this and added that she has seen an improvement in CQC rating in quarter 2.

Safeguarding Referrals – Ms Henriques-Dillon stated that referrals were coming in, in abundance and added that she is doing work with MASH and they are looking for solutions.

Mr Price asked if it was healthy to get so many referrals.

Ms Henriques-Dillon replied that it was a concern and if it is a health element they refer to CCG as a team. Some safeguarding concerns could fall in with the Council.

Mrs Roberts added that reporting numbers are positive.

Ms Lawrence advised that they will look at the conversion rates of Section 42s.

SPACE – Ms Henriques-Dillon advised that the newsletters for the quarter were attached to the report.

Mrs Roberts asked Ms Henriques-Dillon to attend the Chief Nurse Forum to share this positive work.

Ms Henriques-Dillon left the meeting.

QSC/18/060.4 Safeguarding Adults, Children and Looked After Children Report (Item 5.4)

The above report was previously circulated and noted by the Committee.

Ms Lawrence advised that the team has set a training programme for GPs practice staff for coming year and added that it was also available to CCG staff that needs safeguarding training. This is the same with WRAP training for care home staff in

January and added that an e-learning training was also now available. The team provided training for the Board in October, need to pick up on a legal perspective.

Mr Price commented that some members did not attend and added that it will be raised at the Audit committee later.

Mr Oatridge added that it was also time limited.

Mrs Roberts commented that perhaps they could include something at the CCG away day.

Domestic Homicide Review - Ms Lawrence advised that the CCG have got a few of these.

Safeguarding Review – There is one review which is nearing publication; there has been a delay from the family.

Table Top Reviews – There are currently two learning reviews taking place for adults; a self-harm incident and a suicide.

Mr Oatridge stated that the report says nothing about the frequency and there are no figures for this year against last year.

Ms Lawrence stated that figures are usually shown in the annual report.

Ms Millard added that the numbers are increasing for children.

Ms Lawrence advised that there are more SCRs coming through.

Mrs Roberts commented that there are some high profile cases and added that we will have to manage them carefully.

Ms Lawrence stated that there is now new staff within the team; Ms Sharon Fitzgerald (admin support) and MASH Safeguarding administrator starts next week. There is a Band 7 Quality and Safeguarding practitioner who starts in January 2019. NHSE have got £10,000 to share and is to be discussed at the Chief Nurse Forum.

GP Domestic Violence – The team have trained 134 staff to date; which covered 28 GP practices and 7 MARAC referrals have been made by GPs/Practice Nurses.

LeDeR – There were two completed reviews that were submitted by Wolverhampton reviewers in quarter 2. This is a total of four that have been submitted; there are seven in progress and nil outstanding but it is slightly different across the Black Country.

Ms Millard referred the Committee to appendix 1 of the report; the Children's complete self-assessment tool and advised that there were two ambers in place.

Serious Case Reviews (SCR) – There are two reviews ongoing; Child N, which Ms Millard is part of the panel and they have set dates for progression. There is also Child K, there has been a delay in commissioning someone to do this work; there is a 6 month time delay and so are expecting a first draft around December. Working Together 2018 has been published with national as well as local levels. Another SCR was identified as not meeting the criteria and the national panel agreed.

Mrs Roberts commented on the new working together guidance and added that there would be period of transition issues; there will be some significant changes for the children's agenda.

Mr Oatridge asked if this was something for the Risk Register.

Mrs Roberts replied that it is not yet a risk but might be once the work is set in motion.

Ms Millard agreed that she didn't see it as a risk at the moment, within Wolverhampton, the meeting has taken place and there are plans on how to progress this.

Mr Oatridge asked if the Committee will receive further progress update.

Ms Millard replied that it would feature in future reports as it is significant.

Mr Oatridge asked if the Committee could see how the responsibilities are changing in a future report.

Ms Millard suggested that perhaps she could present a separate report to this committee in maybe February 2019. With regards to SCRs there is lots of debate around the table and the national panel has to agree.
Action: MS L Millard

CP-IS (Child Protection – Information Sharing) - The Trust are going live with this on 1st March 2019 which is really good. With regards to the Local Authority, they have met with NHS Digital there has now been agreement on how to progress this within the timescales. There is an issue with Vocare; they are looking at how children who are attending Vocare are being monitored.

Mr Oatridge asked who the employer of the School Nurse was.

Ms Millard replied that they come under the Public Health commission.

Mr Oatridge asked if School Nursing was comprehensive in the public or private sector etc.

Ms Millard commented that this is to do with health education/promotion and they are working with a small number of children and added that they need to move away from that.

Mr Barlow stated that he would review the contract and check it and would confirm by e-mail.

ACTION: Mr Barlow

Mr Oatridge asked who has the responsibility of oversight of the children.

Mrs Roberts stated that this was one to watch; school nurse and health visiting especially given the recent funding restrictions in the council, as these are substantial.

Ms Millard added that it had caused a lot of concern but wanted to reassure the Committee they had supported the change; the process is as safe and robust as it needed to be.

Provider Compliance – Ms Lawrence advised that RWT Safeguarding Adults Level 3 Training Compliance is flagging as red; however, they have done a Training Needs Analysis and have set trajectories of 50% of staff to be trained by December 2018 and full compliance by March 2019. The CCG are monitoring this achievement carefully in line with trajectory set. BCP are all green on their dashboard and the team are supporting their safeguarding functions.

Children and Young People in Care

Ms Brennan advised that she has broken down the data for Children and Young People in Care in Wolverhampton; in 20 50 miles etc. There are 51 Children that are 50 miles plus away (8%) so hopefully this gives the Committee assurance that we have a good oversight; she added that she could safely say that all 51 children are where they should be and letters have been sent out with Ms Brennan's details on.

Mr Oatridge asked if we get a letter of assurance and clarity that health checks are being

complied with.

Ms Brennan replied that yes we do.

Mrs Roberts advised that some of the 51 will be because of specialist provision.

Ms Brennan agreed that the 8% need to be away for their own safety.

Providers – The providers are working really hard with regards to their reporting requirements. Ms Brennan has got a meeting with RWT and added that they rely heavily on the local authority and stated that she has assurance from the teams.

Mrs Roberts advised that the CCG can be more specific next year for framework.

Ms Brennan stated that she had met with BCP yesterday and they never asked for LAC assurance. With regards to information requirements it is really positive.

Joint CYPiC Training Event – Ms Brennan advised that 45 out of the 50 professional that were invited attended the event. The evaluation was really positive.

The Children and Social Work Act 2017– Wolverhampton Council will publish the offer for care leavers in October 2018, providing information about services which could help care leavers in, or in preparing for, adulthood and independent living.

Statutory Health Assessments (BAAF) Forms – A task and finish group have redesigned the forms to make them more children friendly. They will be presented at Octobers regional CYPiC forum and Novembers Children in Care Council.

Mrs Roberts advised that both Ms Lawrence and Mrs Roberts had attended a Counter Terrorism for Health Briefings where Paul Bett presented. From the Wolverhampton CCG perspective we have got some work to do with regard to RESPECT and PREVENT as on high alert across the West Midlands. She added that there are five key elements; mainly ISIS, very right winged, animal rights, Irish, DEBEC. Need more assurance for CCG, will get this and report back.

Mr Oatridge stated that it was an excellent report, it looks much better than other CCG reports.

Ms Higgins, Ms Lawrence, Ms Millard, Ms Brennan and Mr Strickland left the meeting.

QSC/18/060.5 Medicine Optimisation Report (Item 5.5)

The above report was previously circulated and noted by the Committee.

FDB OptimiseRx® Pilot - Wolverhampton CCG has launched FDB OptimiseRx® software across the CCG from 17th September 2018. FDB OptimiseRx® delivers patient-specific prescribing guidance to drive medicines optimisation at the point of care.

The best practice message metrics report for Wolverhampton CCG from 1st October 2018 to 1 November 2018 shows that best practices messages were triggered 1653 times during this timeframe with a current acceptance rate 14.64%. The information only message report for the same time period triggered 699 times; these messages are usually related to drugs that require regular monitoring. With regard to the 1653 messages is higher than the national average but is a best practice message from the safety alert.

Mr Strickland and Ms Higgins rejoined the meeting.

Mr Oatridge asked if he was to visit another hospital would this be flagged.

Mrs Roberts replied that it would not be flagged through Optimise.

Ms Sandhar added that Optimise is more of a messenger software.

Mr Price commented on the 14.6% acceptance rate and asked what that was for.

Ms Sandhar replied that it was to do with the flagged system.

Mr Price asked if it was an aide to the GP.

Ms Sandhar replied that it was hopeful that it would be helpful for GPs.

Mr Oatridge asked if this was for all GPs in Wolverhampton.

Ms Sandhar replied that yes it was and they used to switch which was the old software which had lots of messages.

Gosport Report – Ms Sandhar advised that this report was published on 20th June 2018 into the premature deaths of hundreds of elderly patients at Gosport War Memorial Hospital in Hampshire. The Gosport Independent Panel Report was an in-depth review into an 'institutionalised regime' of prescribing dangerous amounts of opiate painkillers in elderly patients, many of whom died, between 1989 and 2000. She added that electronic prescribing is coming to RWT and advised that they have reviewed the complaints processes too. At Gosport, some complaints were overlooked. Actions have been identified to help with this:

- Opiate reports to include usage data for each ward.
- Medicines Management Group newsletter to highlight link to palliative care prescribing guideline.
- Educational sessions for Nurse, Medical Prescribers & Pharmacy staff regards report findings.
- With regards to the complaints monitoring/processes the following lessons learned/actions have been taken:
    - Procedural/Practice Change Required – Local Level
    - Personal Change Required – Training/Development
    - Report of complaint themes to be shared with the Medication safety officer for triangulation quarterly.

Mrs Roberts stated that these actions also went to Board.

Ms Sandhar advised that they are doing really well on antibiotics; others were also on target and added that this was August data.

Mrs Roberts added that she has recognised the work that the Medicines Management team is doing around Quality and Safety and it is really positive.

QSC/18/061 Improvement and Innovation Reports/Policies for Ratification

QSC/18/061.1 Collaborative Commissioning Policy (IFR) (Item 6.1a) and Collaborating Commissioning Policies (x 10) (Item 6.1b)

The above reports were previously circulated and noted by the Committee.

Mrs Roberts advised that these have worked through IFR process.

Mr Oatridge stated that there had been lots of reports from them.

Mr Price commented that it would have been good to have an amendments list.

Mrs Hough confirmed that there was a list in the report.

Mrs Roberts advised that if there is a robust complaint the processes have been reviewed.

QSC/18/062 Risk Review

QSC/18/062.1 Quality and Safety Risk Register (Item 7.1)

The above report was previously circulated and noted by the Committee.

Committee Risks

QS08: Probert Court – Mr Strickland advised that there had been a reduction in score.

QS02: Maternity – Named Midwife – Mr Strickland commented that the named midwife is now in post, so this can be removed.

QS06: Cancer and QS07: Mortality – These risks are ongoing, so will remain on the Risk Register.

QS09: Flu – Mr Strickland advised that he had received an update from Mrs Corrigan and all practices now have stock.

QS01: Vocare – Mr Strickland stated that they were awaiting the CQC visit and asked if it had taken place yet.

Mrs Roberts replied that the visit had taken place and initial feedback was positive. However, she added that she would like to await the report before it was removed.

QS05: Maternity Capacity and Demand – Mr Strickland commented that this was to do with recruitment and asked if it could be closed.

Ms Higgins and Mrs Roberts advised that this needed to be kept open.

Mrs Roberts stated that they are keeping the cap on at the moment.

Mr Oatridge commented about the Health and Safety update that Mrs Roberts had given at the beginning of the meeting and asked Mr Price; if this had been done appropriately from an Audit perspective.

Mr Price replied that yes it had.

Mrs Roberts asked about it from the commissioning committee perspective and wondered if we look at that.

Mr Strickland replied that he could de-escalate it from the commissioning committee risk register.

QSC/18/063 Items for Consideration

There were no items for consideration.

QSC/18/064 Feedback from Associated Forums

QSC/18/064.1 Commissioning Committee (Item 9.1)

The Commissioning Committee minutes were received for information/assurance.

QSC/18/064.2 Primary Care Operational Management Group (Item 9.2)

The Primary Care Operational Management Group minutes were received for information/assurance.

QSC/18/064.3 CCG Governing Body Minutes (Item 9.3)

The CCG Governing Body Minutes were received for information/assurance.

QSC/18/065 **Items for Escalation/Feedback to CCG Governing Body**

Mortality – This was being presented to the Governing Body today.

SAF and Telford closure.

Maternity – protected by cap.

ED – is one to watch; round table discussion.

Mr Oatridge commented that he was keen to pick up the LAC information and changes.

Mrs Roberts advised that internal audit had looked at the SI process and that would be presented at the next meeting.

QSC/18/066 **Date of Next Meeting:** Tuesday 11th December 2018 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.30pm

Signed: …… **Date**: ……
Chair

DRAFT

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Notes of the meeting of the members of the Finance and Performance Committee held on 30th October 2018Science Park, Wolverhampton

Present:

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Dr D Bush	Governing Body GP, Deputy Finance and Performance Lead

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr V Middlemiss	Head of Contracting and Performance

In attendance

Mr P Strickland	Governance and Risk Coordinator
Ms J Reynolds	Primary Care Development Manager (part meeting)
Mrs H Pidoux	Administrative Team Manager

1. Apologies

Apologies were submitted by Mr Hastings and Mr Marshall

It was noted that the meeting was inquorate.

2. Declarations of Interest

FP.310 There were no declarations of interest.

3. Minutes of the last meetings held on 25th September 2018

FP.311 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.312 Item 132 (FP.292) – Committee Level Risks – FP07 – CHC Budget – narrative to be reviewed to accurately reflect the risk level in respect of 'the significant risk of overspend, however, the risk level is reported as moderate – clarified that whilst there is an overspend in CHC this can be fully mitigated against, therefore, the risk to the CCG is 'Moderate'. Narrative to be amended to reflect this.

Item 133 (FP.304) – Failure to deliver Long Term Financial Strategy – noted that the narrative related to 2018/19 (short term plan) and queried if this was reflected in the reduction of the risk from Very High to Moderate – Mrs Sawrey to liaise with Mr Gallagher to clarify – clarification given that as the CCG is in a position to mitigate against its risks the level of risk had been reduced. Also the proposed Risk Share Agreement with RWT will reduce the financial risk for the CCG. It was highlighted that the CCG is due to be notified of its allocations for the next two years mid to late November which will inform long term plans going forward. The narrative of this risk to be amended to reflect the assurance gained following the discussions at this meeting.

Item 134 (FP.304) – Transforming Care Partnerships – this was queried in the same way as Item 133 (FP.304) – Mrs Sawrey to liaise with Mr Gallagher to clarify – update given as Item 133 (FP.304)

Item 135 (FP.305) – Mrs Sawrey to speak to Mrs Roberts regarding the approach from Liaison to review CHC/FNC payments for inappropriate payments – Mrs Sawrey confirmed that discussions had been held with Mrs Roberts and she was in agreement to move forward with the proposal. Finance to liaise with CHC to take forward – action closed.

Item 136 (FP.307) – New risk to be added to Committee Level risk register relating to GP Premises issues where IAPT services can no longer be delivered – clarified that a new risk had been added to the Risk Log relating to IAPT. The risk was not specific to GP premises issues but was a broader risk around delivery of target. Assurance was given that there was no specific risk around GP practices and a mitigation plan is in place to address this.

5. Matters Arising from the minutes of the meeting held on 25th September 2018

FP.313 There were no matters arising to discuss from the last meeting.

6. Risk Report

FP.314 The Committee considered feedback following a deep dive at SMT into Corporate Risk (CR03) around not meeting NHS Constitutional Targets. It was agreed and confirmed that:

- Based on current performance the risk score of CR03 should remain scored as a High 8.

Committee level risks;

The Committee discussed the need for a committee level risk relating to RTT. TG stated that he would discuss with Mr Hastings whether a committee level risk was required as although the Trust had not met

the Constitutional target they were performing against the recovery trajectory.

- Increased activity FP04 should remain on the risk register given the impact of potential increased activity.
- The Committee acknowledged the new risk FP15 relating to IAPT Access Rate Target (BCPFT).

The Committee;

- noted the current risk levels
- consideration to be given to adding a committee level risk relating to RTT

7. Performance Report

FP. 315 Mr Gallagher the following key points;

Royal Wolverhampton NHS Trust (RWT)

- RTT – achieving month on month improvement towards constitutional standard of 92%. The focus is on reducing the backlog and there is financial flexibility to use other providers.

- A&E – performance had fallen short of achieving the national target of 95% at 93.51%, however, performance had achieved the target of 90.20% agreed with NHSI.

  A decrease in A&E attendances due in part to the CCG and Primary Care's response to demand management in Primary Care. Ambulances conveyances are increasing month on month.

  The winter plan is still to be finalised. This is being overseen by the A&E Delivery Board.

- Cancer waits – there is still a considerable risk to achieving this target. It remains a high profile area which is being closely monitored by NHSE and NHS. The Trust has rebased the activity required to reduce the backlog in the refreshed recovery action plan to support the achievement of the recovery trajectory.

  The Trust had confirmed, following a review of theatre utilisation that an additional dedicated robotics theatre will open in October which will improve performance for Urology and Gynae pathways.

- Delayed Transfers of Care (DToCs) – failed to meet target for all delays and excluding Social Care. This is overseen by the Better Care Fund (BCF) arrangements.

- MRSA and C Diff – there have been no MRSA breaches reported for August, however, the Year End zero threshold has already been

failed with 2 cases in year. There were 5 C Diff breaches during August (against a 3 per month threshold). Learning from these cases have been identified.

- Serious Incident Breaches (SUIs) – 6 breaches were identified for August; there were no reported Never Events in August.

Black Country Partnership NHS Foundation Trust (BCPFT)

- IAPT Access – not meeting target. The CCG is considering investing in increased provision.

The Committee;

- Noted the contents of the report and the actions being undertaken

8. Finance Report

FP.316 Mrs Sawrey introduced the report relating to Month 6, September 2018

The following key points were highlighted and discussed;

- Remain on target to achieve all financial metrics
- Forecasting breakeven
- Agreement has been made with RWT to change the payment day to 3rd day of month to help reduce payment pressures
- Planned same day electives are significantly underperforming - in order to comply with national planning guidance the CCG has commissioned additional activity which is currently not being delivered.
- Elective activity shows an underperformance which gives concern for the achievement of RTT. Winter pressures will have an impact and affect performance
- QIPP is being reported as delivering on plan and any shortfall in delivery is covered by reserves and underspend
- There were no real changes to risk and mitigations and the CCG is reporting full mitigation of known risks.

Mr Trigg raised a query regarding the increased activity at the Nuffield. Clarification was given that these are low risk procedures.

Mr Trigg questioned the current reporting of overspend in the prescribing budget. It was confirmed that this is mainly due to NCSO and a cost pressure relating to Cat M price increases. These are national issues and the CCG is seeking clarity from NHSE regarding whether these pressures are recurrent. The risk of additional NCSO costs are covered although there are no additional allocations.

Medicines Optimisation are working closely with the Finance Team regarding these issues.

The new dashboard and presentation of QIPP as recommended by Auditors was considered. This still includes delivery by Programme Board. The Committee supported the use of the new presentation. It was suggested that the a greater analysis of the risk areas should be identified within the presentation.

The Committee;

- noted the contents of the report

9. Contract and Procurement Report

FP.317 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

- At the last Contract Review Meeting RWT shared the forecast to year end. This did not include specifics these will be shared after the next Board Meeting has been held.
- Activity is being queried in 3 areas;
    - Phlebotomy – there had been a significant stepped change in increasing numbers at the hospital and the Trust is not able to confirm the reason for this and, therefore, remains on the query log.
    - Community Service – assessing the value of the service line and how money is proportioned and applied against services
    - Children's Nursing Teams – relating to special schools, there is over-performance in the number of follow ups and this is being reviewed. A meeting is to be held between the Trust and CCG in November.
- Dermatology – a response had been received to the CCG's letter regarding the current acute provision of this service, with regards to the sustainability of dermatology provision in light of workforce issues. However this response had not answered the CCG's queries relating to;
    - which elements of acute activity they would wish to retain
    - which elements to transfer into the community
    - which areas to work on collaboratively

  The Trust intentions are unclear and this will be pushed back. The robustness of the community services to deal with more complex cases was queried and it was clarified that this would be considered before any reprocurement took place.

- 2019/20 Planning Round – the first meeting had taken place and had been positive with good discussions. It is now known that the

publication of 2019/20 operational planning guidance is expected in early December, following the release of national letter on 16th October. This will be followed in mid-December by the publication of CCG allocations, final 19/20 prices, contract guidance, technical guidance and templates. The deadline for contract signature is stated as 21 March 2019.

Black Country Partnership Foundation Trust (BCPFT)

Planning round 2019/20 – A meeting is due to be held mid-November and as previously will be carried out jointly with Sandwell and West Birmingham CCG. A similar approach will be undertaken as for RWT. The main difference being that an outcomes based contracting approach will form the basis of negotiations for 2019/20, rather than a block contract. The CCG has developed a draft set of outcome measures. Next steps include an intention to hold a joint workshop involving BCP clinicians to help refine and further develop the draft.

WMAS – Non-emergency Patient Transport Service (NEPTS)

The Provider had previously experienced issues with quality and performance. Overall there had now been improvement in the performance of key performance indicators of this contact. There is an option to extend this contract for 2 years after October 2019 if the CCG is confident in the performance of the current provider and the provider wishes to accept.

Urgent Care

Following a recent contract review meeting held with Vocare it was reported that positive improvement against quality metrics had been seen. The A&E four hour waiting time target had been achieved in 3 of the 5 months of the year and the two months when this was not achieved performance was above 94%. Triage performance had improved from 40% last year to 90% this year.

It was reported that a new management team had been put in place by Vocare and joint working was showing improvement in performance. Concerns were raised that the activity levels are lower than anticipated and the CCG would like to see this increase with a high level of monitoring to ensure quality and performance is maintained.

A block agreement has now been agreed and signed for a one year period.

Other Contracts

Marie Stopes International – Termination of Pregnancy Service

It was brought to the Committee for information at this stage that at a Commissioners Meeting a potential one year contract extension was

discussed. The current contract was for 5 years to run until March 2020 with an option to extend for 12 months to March 2021. The Provider had indicated that the current fees they receive are not sustainable. At the meeting there was discussion around the contract prices submitted as part of the procurement process. The proposed increase put forward by the provider would give a large tariff uplift which would have an approximate £240k impact for the CCG. Agreement was reached that the Provider would write to the co-ordinating Commissioner Sandwell and West Birmingham CCG setting out their proposed pricing.

The alternative to extending the contract would be to reprocure. It would be expected that the costs of the service would increase if reprocured. Further discussions with the Commissioner would take place.

The Committee;

- noted the contents of the report and the actions being taken

10. Additions/updates to Risk Register

FP. 318 There were no additions or updates to be made to the Risk Register other than those discussed under item FP.314 Risk Report.

The Committee;

- noted that there were no additions or updates to be made other than those discussed under item FP.314 Risk Report

11. International General Practitioner Recruitment Scheme

FP.319 Ms Reynolds updated the Committee in relation to the application the CCG had made for this scheme. This is part of the workforce work on retention carried out at an STP level across the Black Country Footprint. The application was supported by the Commissioning Committee and had been approved by NHSE earlier this year. The application is currently being refreshed in preparation for a readiness assessment being undertaken by NHSE before the end of December 2018.

Confirmation was given that the STP had chosen not to underwrite any of these appointments and, therefore, there is no financial risk to the CCGs across the Black Country. NHSE had confirmed that they will fund up to the first 12 months of employment. The practices will be responsible for the costs for the remaining 2 years. Practices who have expressed an interest and progress to the point of offering employment will be required to offer a 3 year contract to each individual GP they appoint.

The STP will receive an allocation of £2,500 per GP recruited to the Black Country. These funds will be utilised to fund a Local Integration Team who will be required to facilitate the programme locally.

Clarification was given that this approach had not been done before for GP recruitment. It is anticipated that recruitment will commence in January 2019.

The Committee;

- noted the update provided
- took assurance that there was no financial risk to the CCG

12. Aligned Incentives Agreement

FP.320 Mr Gallagher informed the meeting that the CCG and RWT had been discussing innovative contract arrangements for the last 12 months. The approach presented had been agreed by Executive Teams at both organisations and by RWT's Finance and Performance Committee. It was being taken to the RWT Board meeting on 5th November for approval and, if recommended for approved by this Committee, would go to the CCG's Governing Body meeting on 13th November.

The aim of the agreement is to have an Aligned Incentive Contract which can form a basis for contractual management arrangements in the future. The principles take into account the move towards an integrated care system, acknowledging that financial risk will be shared across the parties recognising the financial challenges present across the health economies.

It was acknowledged that there is a need to be transparent and to manageme demand to develop a clinically sustainable model with a focus on moving to community/primary care services where agreed, supported by the transfer of funding.

The governance process will be retained. The A&E Delivery Board (AEDB) will be an important part of this with an oversight of winter planning. The AEDB will provide the governance structure to direct the investment of MRET and readmissions funds to support the development of the winter plan.

The agreement covers all points of delivery related to planned care and a cap and collar, between 95% to 105% would be in place. The rationale and infrastructure was considered and it was confirmed that the Trust is currently operating within the parameters of the cap and collar arrangements.

Cost reductions covering drugs, devices and step down pass through costs have an indicative plan. However, various ad hoc gain share arrangements are applied to certain high cost drugs due to national directives and as a consequence the current arrangements will remain to enable both parties to respond flexibly to national directives.

A block value had been agreed for unplanned care. The utilisation of the readmission funds of £850k will be directed to the AEDB to support the funding of the system wide winter plan and is ring fenced to support the Trust element of the system plan. In addition MRET funding of £371k had

been identified which will also be directed to the AEDB to support the funding of the system-wide winter plan.

It was highlighted that the new model around frailty is yet to be agreed and, therefore, will sit outside this agreement.

Community services segment will run as normal with a cap and collar of +/- 2.5% on the bottom line overall financial value excluding CQUIN. Should the cap or collar be invoked then the CCG will only reimburse at 60% thus retaining 40% the marginal rate. The exception to this is CQUIN which is fixed at 90%.

The 2017/19 contract earmarked £1,107.000 to be made available in each of the two years to support fixed costs that cannot be avoided as the Trust supports out of hospital care models.

If the proposal is agreed by both parties a Transformation Board will be established to oversee the process.

A query was raised as to whether the cap and collar is set for the following year or would it be revised based on the previous year. It was noted that this would be considered jointly and would require joint agreement for any amendments. It was reiterated that this is an agreement for this year which will inform arrangements going forward.

The members of the Committee;

- recommended that the Governing Body approve the adoption of the proposed risk share arrangements with Royal Wolverhampton Trust for 2018/19.

13. Any other Business

FP.321 There were no items to discuss under any other business.

14. Date and time of next meeting

FP.322 Tuesday 27th November 2018 at 3.15pm

Signed:

Dated:

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 27th November 2018
Science Park, Wolverhampton

Present:

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Dr D Bush	Governing Body GP, Finance and Performance Lead
Mr M Hastings	Director of Operations

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr V Middlemiss	Head of Contracting and Performance

In attendance

Mrs G Moon	Business Operations Manager
Mrs H Pidoux	Business Operations Support Manager

1. Apologies

Apologies were submitted by Mr Marshall

2. Declarations of Interest

FP.323 There were no declarations of interest.

3. Minutes of the last meetings held on 30th October 2018

FP.324 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.325 Item 132 (FP.292) – Committee Level Risks – FP07 – CHC Budget – narrative to be reviewed to accurately reflect the risk level in respect of 'the significant risk of overspend, however, the risk level is reported as moderate – clarified that whilst there is an overspend in CHC this can be fully mitigated against, therefore, the risk to the CCG is 'Moderate'. Narrative to be amended to reflect this – action closed

Item 133 (FP.304) – Failure to deliver Long Term Financial Strategy – noted that the narrative related to 2018/19 (short term plan) and queried if this was reflected in the reduction of the risk from Very High to Moderate –

Mrs Sawrey to liaise with Mr Gallagher to clarify – clarification given that as the CCG is in a position to mitigate against its risks the level of risk had been reduced. Also the proposed Risk Share Agreement with RWT will reduce the financial risk for the CCG. It was highlighted that the CCG is due to be notified of its allocations for the next two years mid to late December which will inform long term plans going forward. The narrative of this risk to be amended to reflect the assurance gained following the discussions at this meeting – action closed

Item 134 (FP.304) – Transforming Care Partnerships – this was queried in the same way as Item 133 (FP.304) – Mrs Sawrey to liaise with Mr Gallagher to clarify – update given as Item 133 (FP.304) – action closed

Item 137 (FP.314) - Risk Report – consideration to be given to adding a Committee level risk relating to the RTT – an overarching constitutional risk for each area to be added – action closed

Item 138 (FP.320) – Aligned Incentives Agreement – Recommendation to be made to the Governing Body that the proposed risk share agreements with RWT for 2018/19 are adopted – recommendation made and accepted at the Governing Body meeting held on 13th November 2018 – action closed.

5. Matters Arising from the minutes of the meeting held on 30th October 2018

FP.326 There were no matters arising to discuss from the last meeting.

6. Risk Report

FP.327 The Risk Report was considered as follows;

Corporate – Organisational Risks:

- CR18 Failure to Deliver Long Term Financial Strategy – The risk assessment applies to the Long Term Financial Plan 2018/19. The CCG in accordance with national guidance will produce a revised Long Term Financial Plan for the period 2019-20 to 2024-25 which will go to the Governing Body for consideration by March 2019.

Committee Level Risks

- FP07 CHC Budget – The risk is mitigated through reserves and non-recurrent slippage. The recurrent implications are considered as part of the long term financial plans.

- FP14 Transforming Care Partnership – Financial impact - The CCG is able to mitigate the non-recurrent financial risk through the application of reserves.

Resolved: The Committee noted the updates.

7. Performance Report

FP. 328 Mr Hastings the following key points;

Royal Wolverhampton NHS Trust (RWT)

- RTT – validated NHS performance for September was confirmed as 90.82%. October figures are indicating that the Trust was very close to meeting target, achieving 91.98%. This is a focus area for regulators particularly that the waiting list does not go above the March 2018 baseline and RWT is on target to achieve this.

  Zero 52 week waiters had been reported by the Trust, however, there are 3 Wolverhampton patients elsewhere who remain waiting over 52 weeks; 2 at The Royal Orthopaedic and 1 at Bart's Health NHS Trust. Since the report had been written the patient at Bart's Health NHS Trust awaiting a cosmetic procedure had been removed from the list as it had not been possible to contact the patient.
- Urgent Care – the Trust achieved the local target but failed to achieve the national target. The issue with ambulance handovers is due to the high number of conveyances. Wolverhampton patient attendees is slightly below plan, however, there is no drop in attendance from surrounding areas.

  Issues with patient flow within the hospital is impacting on achieving this target because the patient waits in A&E if there are no beds available. It was requested that the conversion rates from arrival to decision to admit or treatment are checked.
- Electronic Discharge Summary – performance for Assessment Units has consistently failed to meet target for the last 12 months. This is a Local Quality Requirement and a review is to be undertaken to address if the target is still valid and realistic.
- Delayed Transfer of Care (DToC) – target was achieved in October.

- Cancer waits – the September validated national performance for 62 Day from the referral to 1st definitive treatment had been confirmed as 56.88% (based on 47 breaches out of 109, with 18 patients at 104+ days). This placed RWT at the bottom of the national table for 62 day performance. Additional funding is available, including local investment from the Cancer Alliance above and beyond national funding. An agreement needs to be reached with RWT as to how this will br invested as there is a need for sufficient capacity in surgery, staffing and diagnostics.

  The National Cancer Team will be visiting on 4th December to work with RWT. The Trust had requested that the CCG be represented during the visit, it was to be agreed who this should be.

  The Trust is working towards the rebased activity of 118 patients per month (from the original 105) in order to reduce the waiting list.

  A review of the Urology pathway at the Trust had taken place and progress had been made in reducing the diagnostic pathway. RWT are confident this can be achieved. The revised trajectory is awaited and will be included in the report for the Committee.

  Tertiary referrals are reviewed each week. The impact of other providers submitting late referrals is being collated and this will be shared with other CCGs.

  Mrs Moon commented that October performance in this area is looking positive with performance above 70%. In November a large backlog will be seen, the focus will be on breach patients, and therefore performance will go back down. However, clearing the backlog will help going forward. It was clarified that additional sessions are planned to reduce waiting lists.

  Current performance will be reflected in both the Committee and Governing Body Risk Registers.

  RTT performance was discussed. Mr Middlemiss highlighted that October performance was just below 92% for CCG performance at RWT. Performance for September across all providers was 91.46%. It was confirmed that activity at Nuffield would have the biggest impact as other providers have minimal patient numbers. Nuffield to be challenged on their reporting as currently this is at 100%. It was noted that 83.7% is the national performance level for Trusts who are meeting target and RWT performance is in the top quartile in the country.

- IAPT Access – the 2018/19 in month target of 1.58% with 1.59% was achieved September for the first time in 2018/19, however the Year to Date remains below the cumulative target.

  Additional rooms are being investigated at the Gem (Children and Young Person Centre) to increase session availability.

  The Trust is to submit a plan for increasing staffing levels and had identified training courses for new staff. Following one week's induction, new staff activity will then be included as part of the IAPT Access performance.

  Discussions are on-going with the Trust including the use of none NHS organisations. Commissioned to deliver the previous year's target 16.8%, however the CCG target is 19%. Additional investment is required to close this gap. An urgent meeting is to be held to move forward and clearly define the next steps. It was clarified that there is no recurrent funding available.

  The Quality Premium was discussed and it was confirmed that the summary for 2017/18 had been finalised. It was agreed to circulate this to the Committee members.

Resolved: The Committee;

- Noted the contents of the report and the actions being undertaken
- The conversion rates from arrival to decision to admit or treatment to be checked.
- Quality Premium summary for 2017/18 to be circulated

8. Finance Report

FP.329 Mrs Sawrey introduced the report relating to Month 6 September 2018

The following key points were highlighted and discussed;

- No material changes and remain on target to achieve all financial metrics
- Reporting a surplus in non-recurrent resources. Working to identify non recurrent investments in the health economy to support providers i.e. RTT, winter pressures and cancer
- Leads are reporting that QIPP is off target by approximately £5m. There are flexibilities to cover this in reserves and this had been planned for.
- RWT underperforming significantly in electives which is down to planning rather than activity issues. 92% has been contracted.
- The number of GP and Consultant to Consultant referrals are increasing dramatically. It was considered whether the switch off

for paper referrals had impacted, however, this was felt to be unlikely

- The year to date Prescribing budget is reporting an overspend mainly due to Category M drugs and NCSO. The CCG had been informed by NHSE that with effect from November data there will be a significant reduction in the price of Cat M drugs which will alleviate the financial pressures on the prescribing budget. This has not yet been factored into the position and the impact will be evaluated.

Resolved: The Committee

- noted the contents of the report

9. Contract and Procurement Report

FP.330 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

Dermatology – a letter had been issued to the Trust to formally issue notice on this service. The letter advised decommissioning of the service with the exception of Cancer 2 Week Waits, Red Flags and Complex Biologics. The end date of the notice period is 30th November 2019, which aligns with the end date of the contract with Concordia for current community service provision. A meeting is to be held with Trust colleagues, including clinicians, to ensure that both parties have a shared understanding of the activity data/patient co-horts that will be shifted into the community versus activity data/patient co-horts which will remain in the Trust.

E-Referrals – A response to a letter sent to RWT regarding concerns about electronic referrals had been received, however, this did not provide any specifics. The national target for all referrals to be done electronically was 1st October 2018. The Trust is still accepting some papers referrals and has been asked to clarify these areas and to provide justification as to why this needs to be. Exemptions are possible, however, these should be applied sparingly and for strong justifiable reasons. A meeting has been requested with the Trust to discuss. It was suggested that NHS Digital were contact to support with advice and guidance.

Mr Middlemiss agreed to carry out a risk assessment to ascertain if this should be added to the Committee Risk Register.

2019/20 Planning round – work had commenced on the planning round. The Risk Share Agreement will form the basis of negotiations. Sub groups are being set up for Finance and Activity, Commissioning and Information and

Quality. National planning guidance is anticipated to be published in December. It had been agreed at Officers meeting that month 6 figures will be used as a baseline for tariff modelling.

Black Country Partnership Foundation Trust (BCPFT)

A similar approach will be taken for the 2019/20 planning round as to RWT. This will be done jointly with Sandwell and West Birmingham CCG. The main difference is that an outcomes based contracting approach will form the basis of negotiations for 2019/20, rather than a risk/gain share approach. Sub groups will also be set up. As this is a tripartite agreement discussions are more difficult, however, both CCGs have agreed to work together towards aligning contract with BCPFT where possible.

Nuffield

The planning process for 2019/20 had commenced and a response had not been received from the provider with any specifics. A significant change to the current contract is not expected.

Marie Stopes International – Termination of Pregnancy Service

Following the Provider advising the CCG that a substantial increase in fees is required for them to continue with the contract. The optionis to either extend the current contract or to carry out a procurement exercise. Financial modelling had been undertaken and CSU Procurement had produced a procurement options paper. This will be taken to the Commissioning Committee in January and will include recommendations.

Connect Health Limited

This is a 5 year contract which has over performed in the first year. An increased Year 2 contract value had been recommended and agreed by the Commissioning Committeee. tThis more accurately reflected the anticipated activity increase. There is an existing Risk Share Agreement in the contract which will continue for Year 2.

Resolved: The Committee

- noted the contents of the report and the actions being taken
- Risk assessment to be undertaken relating to E-referral issues

10. Additions/updates to Risk Register

FP. 331 There were no additions or amendments to be added to the Risk Register.

Resolved: The Committee noted;

- that there were no additions or updates to be made.

11. **Any other Business**

FP.332 There were no items to discuss under any other business.

12. Date and time of next meeting

FP.333 December meeting virtual meeting

Signed:

Dated:

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 2nd October 2018 at 2.00pm
PC108, Creative Industries Building, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	No
Tony Gallagher	Chief Finance Officer	No
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
John Denley	Director of Public Health (WCCG)	No
Liz Corrigan	Primary Care Quality Assurance Coordinator (WCCG)	Yes
Kassandra Styche	Quality and Safety Officer	Yes
Steve Barlow	Public Health Specialist	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcome and Introductions

WPCC365 Ms McKie welcomed attendees to the meeting and introductions took place.

Apologies

WPCC366 Apologies were submitted on behalf of Mr J Blankley, Dr H Hibbs, Mr J John Denley.

Declarations of Interest

WPCC367 Dr Bush and Dr Kainth declared that, as GPs they have a standing interest in all items relating to Primary Care.

Dr Reehana declared that as a GP she had a standing interest in all the items relating to primary care. She also declared that, as her practice was named as one of the participants in the pilot project she had a conflict of interest in the item on the Home Visiting Service.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting held on the 4th September 2018

WPCC368 The minutes from the meeting held on the 4th September 2018 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC369 There were no matters arising from the minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC370 **Minute Number WPCC320 – Primary Care Assurance Report**
It was noted the next Primary Care Assurance Report is not due until November. Agreed to close the action.

Minute Number WPCC343 – Primary Care Quality Report
Ms Corrigan noted that she had spoken to Ms Reynolds and conflict resolution training has been scoped, a training provider has been identified. Agreed to close the action

Minute Number WPCC344 – Update report following the retirement of Dr Mudigonda
Ms Shelley to confirm the supervision process of the GP registrars.

Minute Number WPCC348 – Influenza Vaccination Programme
A report has been provided for the Private agenda. Agreed to close the action.

Dr Reehana entered the meeting.

Primary Care Quality Report

WPCC371 Ms Corrigan presented to the Committee the monthly Primary Care Quality Report and highlighted the following key points:

- Quality Matters – continue to be monitored, and all Primary Care incidents have been forwarded to the relevant practices and to NHSE where appropriate. Practices are asked to provide evidence of investigation and learning from these incidents and this is provided to NHSE who will then escalate accordingly and feedback to the CCG.
- Complaints – there have been 36 complaints received from NHS England since the new process began on the 1st November 2017
- Friends and Family Test – There were improvements in all areas of submission for the month and the overall response rate has increased slightly at 1.8%. This is significantly better than both regional and national averages.
- Workforce Development – a GP retention scheme has been agreed across the Black Country at an event held on the 25th September 2018. The plan will look at ways to maintain GPS in post but increase options to work across primary and secondary care and take up leadership roles. It was noted that a physician's associate internship programme is due to start with three practices expressing an interest.

RESOLVED: That the above is noted.

Ms Corrigan left the meeting

Primary Care Operational Management Group Update

WPCC372 Mr Hastings advised the Committee of the discussions which took place at the Primary Care Operational Management Group Meeting, the following points were noted:

- The MGS Medical Practice Transition Meetings are progress well and as a result have moved to monthly instead of fortnightly.
- The practice migration onto EMIS web is Dr Bilas, which is currently on target to complete.
- There are two practices which have gone through ETTF, and work has commenced on builds at Newbridge and East Park.
- Dr Whitehouse surgery had issues with their current lease, this has now been resolved.
- Contract Monitoring Annual Practice Declaration Template was agreed by the Group.

- The Practice Groups are now hitting their 100% for Improved Access target set by NHS England. The Practice groups are now open seven days a week offering 6pm – 8.00pm in the evening and additional Saturday and Sunday access.
- The query raised by the Primary Care Commissioning Committee regarding single hander practices. It was agreed single hander practices were not considered a significate risk to be added on to the risk register.
- The CQG reported a number of visits to GP Practice have been undertaken and the results have been positive.

RESOLVED: That the above is noted.

Home Visiting Service

WPCC373 Mrs Southall presented to the Committee a revised business case for a GP Home Visiting Service project which has been previously approved by the Committee. The project is currently being mobilised and is due to commence in December 2018. Following discussions with the practices and the provider (Royal Wolverhampton NHS Trust) the business case has been updated to request for a healthcare assistant to undertake some of the routine activity as set out in the service model.

The Committee were asked to approve the funding for the Healthcare assistant for the six month period of the pilot project at an additional cost of £13,094. The changes to the business case were highlighted within the report.

The Committee reviewed the changes and queried the role and function of the healthcare assistant. The Committee requested further clarification on the role and purpose as it was not clear within the business case. It was agreed a virtual e-mail would be sent to the Committee outlining the healthcare assistant role, however due to timescales a decision would need to be made via e-mail to approve or not approve the funding.

RESOLUTION: Mrs Southall to provide clarification on the healthcare assistant role to the Committee via e-mail and seek approval of funding.

Primary Care Workforce – New Roles and GP Retention

WPCC374 Mrs Southall gave the Committee an update on the GP workforce position and projects that are underway locally and across the STP footprint to address recruitment and retention of GPs. Mrs Southall highlighted the following key points from the report:

- GP Workforce in Wolverhampton - based on available data from NHS Digital there are currently 142 GPs (FTEs) working across 42 practices in Wolverhampton, who are either employed as partners or salaried GPs. The age profile of our GPs demonstrates that 21% of GPs are of an age where they may choose to retire.
- STP initiatives – The Black Country STP has in place a Primary Care Workforce Strategy, which acknowledges that there are many challenges across the STP footprint.

- Intensive Support Site – The Black Country have been identified as an Intensive Support Site (ISS) for GP retention. Through having the ISS status dedicated funding has been allocated to invest in a series of projects until the end of March 2019.
- Schemes – There are four schemes that have been produced in liaison with GPs across the STP, which are due to be launched in October 2018 for GPs from across the Black Country to consider/access. The schemes are as follows:
    - Incentivising Portfolio Careers
    - Retention of Newly Qualified and GP Trainees
    - Peer Mentoring Network
    - Pre-retirement Coaching

Dr Reehana noted in terms of GP retention to review the possibility of involving Vocational Training Scheme (VTC) as they offer a lot of support to GPs. Mrs Southall agreed to review VTC and their programme.

A discussion took place around international recruitment, GP retirement and potential CCG funding pressures. It was noted that the CCG need to consider the risk associated of the funding initiatives on the wider footprint and build this into future financial planning for next year.

RESOLVED: That the above is noted.

Any Other Business

WPCC375 Promotion of Primary Care Commissioning Committee

Ms McKie informed the Committee that she has agreed to share the public meeting dates with the PPG Chairs and Citizens Forum to encourage attendance of the public to future meetings.

Date of Next Meeting

WPCC376 Tuesday 6th November 2018 at 2.00pm in the Stephenson Room, Technology Centre, Wolverhampton Science Park

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 6 October 2018 at 2.00pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	No
Dr Manjit Kainth	Locality Chair / GP	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Tony Gallagher	Chief Finance Officer	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Coordinator (WCCG)	Yes
Jo Reynolds	Primary Care Development Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG – minutes)	Yes

DRAFT

Welcome and Introductions

WPCC400 Ms McKie welcomed attendees to the meeting and introductions took place.

Apologies

WPCC401 Apologies were submitted on behalf of Dr D Bush, Ms S Southall and Ms S Gaytten.

Declarations of Interest

WPCC402 Dr Kainth declared that, as a GP he has a standing interest in all items relating to Primary Care.

Dr Reehana declared that as a GP she had a standing interest in all the items relating to primary care.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting held on the 2 October 2018

WPCC403 The minutes from the meeting held on the 2 October 2018 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC404 There were no matters arising from the minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC405 **Minute Number WPCC320 – Primary Care Assurance Report**
It was noted that the report is included within the agenda for this meeting.

Minute Number WPCC373 – Home Visiting Service
It was confirmed that the clarification on the Healthcare Assistant role was shared with the Committee via email by Ms Southall and therefore approved. Agreed to close the action.

Quarterly Finance Report

WPCC406 Mr Gallagher presented a report to the Committee outlining the financial position at the end of Month 6 (September 2018). It was noted that the delegated primary care allocation for 2018/19 as at month 6 is £36.267m and the forecast outturn is £36.267m delivering a breakeven position.

RESOLVED: That the above is noted.

Primary Care Quality Report

WPCC407 Ms Corrigan presented the monthly Primary Care Quality Report to the Committee and highlighted the following key points:

- Ms Corrigan has met with the Infection Prevention Team regarding safer sharps and an action plan is now in place to raise awareness in Practices.
- There are no Serious Incidents to report at present.
- 36 complaints have been received since 1 November 2017 of which 28 are now closed and 8 remain under investigation.
- Friends and Family Test results remain stable with a 1.8% uptake for the population in Wolverhampton.
- A GP Retention Scheme has been agreed across the Black Country. A co-design event was held on 25 September 2018 where the following areas of focus were identified:
  - Portfolio careers
  - Peer mentoring support
  - Pre-retirement coaching

Ms Roberts joined the Meeting

RESOLVED: That the above is noted.

Quarterly Primary Care Assurance Report

WPCC408 Ms Reynolds provided an overview of the activity taking place from the work programmes within the GP Forward View work and Primary Care Strategy.

The following areas were highlighted:

- QOF+ has been launched with 100% of practices signed up.
- Extended Access is fully in place, with 100% coverage of the requirement for an additional 30 minutes across Wolverhampton.
- Online consultation and triage pilots have been launched in this quarter.
- Care Navigation cohort 2 has been launched.

Discussion took place around the plans for evaluation of the work undertaken so far and Ms Reynolds confirmed that the Primary Care Team are working with Business Intelligence at the CCG to evaluate data.

A point was made around the need for a refresh of the Primary Care Strategy. It

was noted that GP Networks will be a focus going forward and it is vital that the CCG evaluate the work currently being undertaken as part of this exercise.

RESOLVED: That the above is noted.

Primary Care Operational Management Group Update

WPCC409 Mr Hastings advised the Committee of the discussions which took place at the Primary Care Operational Management Group Meeting, the following points were noted:

- The Project Group Meetings for the Health and Beyond mergers are now underway.
- Estates work in Wolverhampton has a Bilston focus particularly around the utilisation of buildings in that area. There is also ongoing discussion regarding a potential new build for a hub building. A meeting with GP Partners is being scheduled to discuss these plans.

RESOLUTION: That the above is noted.

Primary Care Contracting Update

WPCC410 Ms Shelley provided an update on primary care contracting to the Committee and highlighted the following:

Alternative Provider Medical Contracts Procurement
The advertisement has been live throughout October 2018 and the evaluation and moderation is currently underway with a view of bringing a report to the December 2018 Committee Meeting outlining the outcome of the procurement exercise and preferred bidders.

Post Payment Verification (PPV) of the Quality and Outcome Framework (QOF)
NHS England is supporting the CCG with this piece of work. A Practice from each model of care group has been chosen at random by the Local Medical Committee and will be visited throughout November and December 2018.

Post Payment Verification (PPV) of Local Enhanced Services (LES)
NHS England is supporting the CCG with this piece of work. The chosen areas to be reviewed are ear syringing and simple and complex dressings.

RESOLVED: That the above is noted.

Healthwatch Wolverhampton: GP Communication Report

WPCC411 Ms Reynolds provided an update on the report recently published by Healthwatch Wolverhampton regarding a survey that focussed on how much communication patients receive from their GP practice and what levels of awareness and involvement there is with Patient and Participation Groups.

A query was raised by the Committee around page 3 of the report where the following statement was made, ‘There were a number of respondents who said that they did not want to have any communication from their practice on any

subject'. Ms Cresswell agreed to confirm what percentage of the respondents expressed this opinion and update the Committee.

RESOLVED: That the above is noted. Ms Cresswell to provide clarification on the percentage of respondents who stated that they do not want to have any communication from their practice.

Thrive into Work Specification

WPCC412 Ms Reynolds updated the Committee around a service specification that has been developed in partnership with the Thrive into Work Programme. It was noted that the CCGs Clinical Reference Group have also considered the content of the specification. The purpose of the programme is to enable a targeted approach to recruitment which encourages practices to contact patients who meet the participation criteria to take part in the research programme. Ms Reynolds confirmed that the Local Medical Committee have had the opportunity to comment on this service specification.

RESOLVED: That the above is noted.

Any Other Business

WPCC413 **General Practice Awards 2015/2019 (for information)**
Ms Reynolds provided an update around a letter received from NHS England regarding the General Practice Pay Awards 2018/19. The letter noted that the additional 1% which has been referred to by Dr Richard Vautrey, Chair of the General Practitioners Committee of the BMA, is conditional to the ongoing contract negotiations and, if agreed, would only be payable from 1 April 2019.

WPC414 Ms McKie informed the Committee that Laura Russell had moved onto a new role and would no longer be supporting the Committee going forward. The Committee thanked Laura for all her hard work.

Date of Next Meeting

WPCC415 Tuesday 4 December 2018 at 2.00pm in the PC108, Creative Industries Building, Wolverhampton Science Park

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 4 December 2018 at 2.00pm
PA108, Creative Industries Building, Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

Name	Position	Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	No
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	No
Sally Roberts	Chief Nurse	No
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	No

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Coordinator (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Ramsey Singh	IM&T Project Manager (Infrastructure) (WCCG)	Yes
Sam Squire	Student Nurse (WCCG/UoW)	Yes
Diane North	PMO Administrator (WCCG – minutes)	Yes
Janette Rawlinson	Chair of SWB PCCC – Lay Person	Yes

Welcome and Introductions

WPCC431 Ms McKie welcomed attendees to the meeting and introductions took place. Diane North was welcomed as the new PMO Administrator responsible for the administration of the meeting.

Apologies

WPCC432 Apologies were submitted on behalf of Ms H Hibbs, Ms S Roberts, Dr Kainth, Ms S Gaytten, Dr D Bush, Mr S Marshall and B Dhami.

Declarations of Interest

WPCC433 Dr Reehana declared that as a GP she had a standing interest in all the items relating to primary care.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting held on the 6 November 2018

WPCC434 The minutes from the meeting held on the 6 November 2018 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC435 There were no matters arising from the minutes.

RESOLVED: That the update was noted.

Committee Action Points

WPCC436 **Minute Number WPCC411 – Healthwatch Wolverhampton: GP Communication Report**

Following a query at the previous meeting, it was clarified that 9 out of 506 (1.78%) patients surveyed has stated that they did not want to have communication from their Practice.

It was also noted that the recommendations in the report would be considered by the Primary Care Operations Management Group to inform a report from the Primary Care Team on the CCG's response to the Healthwatch Recommendations.

Primary Care Quality Report

WPCC437 Mrs Corrigan presented the monthly Primary Care Quality Report to the Committee and highlighted the following key points:

- Mrs Corrigan had shadowed the Infection Prevention (IP) nurses on a Practice visit. This had provided useful insights into the processes. There had been a query about whether the recommendations made following the visit were monitored. Mrs Corrigan advised that, other than for more significant recommendations (that were monitored by exception), an annual follow up was made.
- It was reported that the uptake of flu jabs was increasing week on week following the slow start. The issue of low stock had been resolved by rules around moving stock between Practices being relaxed. The Committee was assured that Practices were not moving vaccines themselves, rather the CCG and Public Health were coordinating the transfer of stock safely between Practices to maintain the cold chain. The Primary Care Flu group are planning to meet again in January 2019 to review this year's flu activity and in March 2019 to plan for next year.
- No new serious incidents had occurred and those being monitored had been resolved. There is one new performer issue, which will be reviewed by the NHS England Practice Performer Intelligence Gathering Group (PPIGG) in the coming week. No new complaints data had been received from NHS England.
- Friends and Family Test (FFT) uptake had seen the best results so far in September 2018 at 2.1% an increase of 0.7% since April for the population in Wolverhampton. It was noted that the comparative figures in the table did not add up to 100% as they were based on averages and therefore subject to rounding. Practices that had not submitted their data were being monitored in line with the FFT policy. In response to a query it was confirmed that some Practices have had issues submitting reports which is monitored on a monthly basis. Although the data shows high levels of "other" being recorded as a method of response, anecdotal evidence shows that these are, in fact, responses through check-in screens that Practices are unsure how to categorise.
- It was reported in reference to Workforce Development that work continues to promote student placements and apprenticeships and a new reporting tool would be used to present figures in a revised format from 2019 onwards.
- A Practice Nurse Strategy was being developed at STP level which focussed on retention in particular. It was clarified that the reference to first 5s' related to newly qualified GPs in their first five years of practice.
- It was reported that an issue with the Digital Clinical Supervision pilot usage of Skype was being resolved. Mr Hastings advised the CCG has worked with the IT Service provider to develop a policy for Skype and he can assist in resolving the issue if user names could be supplied.

RESOLVED: That the update was noted.

Primary Care Operational Management Group Update

WPCC438 Mr Hastings presented the Primary Care Operational Management Group Update, highlighting that matters discussed included: -

- An update on the transition work with MGS Medical Centre. This was winding down as the only issues outstanding related to transferring patient records, as Primary Care Support England (PCSE) were only able to process a limited amount at a time.
- Discussions continued around Primary Care Estates work in Bilston. A recent meeting with a number of practices and the Local Authority had been very positive. There are opportunities for improvements as a result of plans to build new houses in the Willenhall to Walsall corridor starting initially with 450 houses in Bilston and work has been undertaken to develop a feasibility study and options appraisal.
- An update on work to support the mergers of Health and Beyond Practices had been considered and discussed. Clinical system mergers had now taken place.

RESOLVED: That the update is noted.

Primary Care Contracting Update

WPCC439 Ms Shelley provided an update on primary care contracting to the committee

The report highlighted a number of variations to General Medical Services (GMS) contracts. This included various variations to contracts at Penn Manor Medical Centre, Woden Road Surgery, Bradley Medical, Church Street, Tettenhall Medical Practice, Warstones Medical Practice and Grove Medical (Health & Beyond). In response to a query, Ms Shelley confirmed that the contract changes at Woden Road would not cause an issue with clinical cover as the practice had recruited additional salaried GPs.

It was also reported that a Quality Outcomes Framework (QOF) Post Payment verification process, supported by NHS England, was due to take place at the end of February with practices being given two weeks' notice of the visit. A Practice from each model of care group has been chosen at random by the Local Medical Committee to participate.

RESOLVED: That the update was noted.

Enhanced Services (November 2018-March 2018)

WPCC439 Ms Southall presented the report on behalf of Ms Reynolds following a discussion at the previous meeting of the committee on time limited enhanced services designed to improve performance in meeting a number of NHS Constitutional Standards.

The Committee had agreed to approve the service specification in principle at its last meeting due to the need to commence the service, subject to circulation of

the full specification. Clinical input had been sought from the CCG Chair and Accountable Officer and further minor changes had been made to the specification and it was agreed that the final version would be shared.
It was noted that there was occasionally need for urgent decision making of this type by the Committee and there was a discussion about how to effectively progress this. It was agreed that the Primary Care Operational Management Group would develop a process that would ensure robust decision making, with appropriate clinical input into developing service specifications.

RESOLVED:

1) **That the final version of the Service Specification be circulated to Committee members.**
2) **A process for urgent approvals be developed by the Primary Care Operational Management Group.**
3) **That the update was noted.**

Unprocessed Files associated with Docman

WPCC440 Mr Singh presented the report, which provided an update on the impact of a national issue with the Docman Document Management system used by GP Practices.

It was highlighted that the issue, which had resulted in a large number of documents sent to practices by providers not being processed by the system. This had first come to light in August 2018 following a communication from NHS England and that, as directed by NHS Digital, individual CCGs have taken ownership of the local response. The CCG had worked with individual Practices to collate the information to understand the volume of affected documents and then put a plan in place to review them. It was agreed the CCG would financially support Practices to undertake the additional work involved. The majority of outstanding documents had now been reviewed, the vast majority had been duplicate copies of documents already in the system and to date no significant impact to patient care had come to light.

The report also gave details of work to identify possible contributing factors to the issue which had included:

- Inefficient knowledge and skills transfer to staff as the system had been installed a number of years ago. This meant alerts & error messages for unprocessed documents were not always picked up by users.
- The file path to unprocessed documents was long and difficult to locate and not advised to users on installation.
- A lack of communication from Docman who felt that the system was working as designed.
- The version of the Docman software used by the majority of practices is dependent on another piece of software to work effectively and Clinical correspondence had been received in incompatible files formats.
- The increased complexity of the health economy meant that new services and providers used the system.
- A number of PCs had been replaced in Primary Care through the CCG's hardware replacement programme. This had resulted in the loss of some local configuration settings.

Recommendations for work to respond to these issues included contacting service providers to remind them to send correspondence in compatible formats and to prioritise the rollout of the upgraded version of Docman. This is a 'hosted solution', that will ensure that responsibility for addressing issues with the processing of documents would fall to the supplier rather than individual practices. It was proposed to start this work in January 2019, completing by the end of March 2019.

During the discussion it was queried whether investing further in the system was a good idea, given the issues experienced. In response, the concerns were noted but it was highlighted that, as a health economy, there had been significant investment in the system which helped to ensure that document management in Primary Care and Acute Care would be as seamless as possible.

It was acknowledged that alternatives were available and that, although the upgraded Docman 10 was an improvement, there were still some issues in using it. It was noted that a new healthcare standard for document exchange was being developed which could impact on the use of Docman across the health economy. The Primary Care Operations Management Group was asked to review the potential to use alternative systems.

A question was raised about the total cost to the CCG of supporting practices to review and action the unprocessed documents. . It was reported that some claims were still being received and, once they were all received this would be reported to the committee.
Dr Reehana highlighted that the response to the issue by the CCG's Information Management and Technology and Primary Care Teams had been excellent and appreciated by practices.

RESOLVED:

1) **That the Primary Care Operations Management Group review whether alternatives to Docman could be utilised.**
2) **That, when confirmed, the total cost to the CCG of supporting practices to review documents be reported.**
3) **That the update be noted.**

Any Other Business

WPCC441 **Next Meeting**
It was agreed that due to the short timescale for submission of papers because of the Christmas and New Year holiday that the meeting of 8th January 2019 would be cancelled.

Date of Next Meeting

WPCC442 Tuesday 5 February 2019 at 2.00pm in the PA125 Stephenson Room, Technology Centre, Wolverhampton Science Park

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 25 October 2018 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~ **Present**

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	No

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Sally Roberts	Chief Nurse & Director of Quality	Yes
Sarah Smith	Head of Commissioning - WCC	Yes

In Attendance ~

Alison Lake	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Philip Strickland	Governance and Risk Coordinator	Yes (Part)
Sharon Nisbet	Assist Development Manager	Yes (Part)

Apologies for absence

None

Declarations of Interest

CCM745 None.

RESOLVED: That the above is noted.

Minutes

CCM746 The minutes of the last Committee meeting, which took place on 27 September 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM747 None to review

RESOLVED: That the above is noted.

Committee Action Points

CCM748 None to review

RESOLVED: That the above is noted and agreed

Sharon Nesbett joined the meeting

Community Dermatology Service

CCM749 The Committee was presented with a report to re-procure the current Community Dermatology Contract which ceases in December 2019.

The commissioning of the Community Dermatology Service is in line with strategic objectives.

It should be noted that the Royal Wolverhampton Trust are currently facing workforce challenges in this speciality and discussions have taken place regarding the sustainability of the workforce provision. If the Royal Wolverhampton Trust inform the CCG they are giving notice that results in the reduction of acute provision commencing prior to the expanded Community Dermatology Service being commissioned, then patients in Wolverhampton will be referred to other secondary care providers due to the gap in service locally.

RESOLVED: That the above is noted and agreed expansion and re-procurement of the service

Phillip Strickland joined the meeting
Vic Middlemiss joined the meeting

CCM750 **Contracting Update Report**

The Committee was presented with an update on the current contracting overview –

Contract Performance (activity and finance)

The latest key points presented at the CRM meeting earlier today -

The Trust's position at the end of the financial year is currently awaiting confirmation. The Trust Board meet on the 5 November 2018 following which, Commissioners will be informed of the most recent Trust position.

Cancer – A positive position for this service was reported, the 62 day service however, is proving to be a challenging area, and the Trust has enlisted the services of a private provider for ad hoc sessions to help with the backlog of patient.

E- Referrals

The CCG has forwarded a letter to RWT to seek clarification and justification for the exclusions of service areas that will not be progessing to use this process. Clarity and rational has been requested to enable an agreement to be made by both RWT and the CCG.

Risk/gain and share agreement

This agreement is currently at the stage of being presented to the governance processes within each organisation. When guidance is available it may impact and negotiations will continued.

UHB Urology Tertiary referrals

The current update on this service is that only Burton and Derby will be effected at this time, discussions are continuing, however at this time there is no risk to Wolverhampton patients.

Ambulance referrals

This service has been in high demand over the last month and it has been confirmed that this is only confined to the Wolverhampton area, a major contribution to this demand are areas with high numbers of Care Homes. Patient triage may be a way forward to reduce demand.

The Walk In Centres are reporting a high turnover of patients within the last month.

Telford Hospital

Telford Princess Royal Hospital may be closing its A&E Department at 10.00 pm from the 18 December 2018, RWT will be remodelling their service to accommodate the extra demand this may bring

Delayed transfer of care

This is currently above target by 0.5% which stands at 3.5%. There is no breakdown of patient intake demand available in areas, it is however noted that Walsall and Staffordshire have the largest number of patient for delayed transfer of Care.

Diagnostics

RWT has been performing well in this area until October 2018, there is a deep dive investigation being carried out to try and find the reason increased demand in this service.

Black Country Partnership Foundation Trust (BCPFT)

Performance Quality Issues

A draft measure for Mental Health indicators has now been completed and will be shared with RWT. Further discussions will follow if needed.

Marie Stopes International – Termination of Pregnancy Service

The Provider has requested an increase to their current tariff. The CCG is an associate to this contract and is currently collaborating with the main contract holder to determine the next steps; extension of the current contract is on hold if outcomes are not agreed a possibility of re-procurement for this service may be considered.

RESOLVED: That the above is noted.

Review of Risks

CCM 751 Corporate Organisational Risks

The Committee was advised that no change has been made to the current Corporate Risk Register.

A quality review of the currently corporate risks has been carried out.

Committee Level Risks

CC10 – is still an outstanding risk of staff workforce issues across the BCF programme office. This issue is currently under discussion with the Local Council members for additional support.

Dermatology timescales for procurement was highlighted as a future low risk for the Committee. It was agreed that an assessment will be needed for clarification.

RESOLVED: That the above is noted

Philip Strickland left the meeting

Any Other Business

CCM752 None

RESOLVED: That the above is noted

Date, Time and Venue of Next Meeting

CCM753 Thursday 29th November 2018 at 1pm in the CCG Main Meeting Room

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 29th November 2018 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~ **Present**

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	Yes

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Sally Roberts	Chief Nurse & Director of Quality	No
Sarah Smith	Head of Commissioning - WCC	Yes

In Attendance ~

Alison Lake	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Phil Strickland	Governance & Risk Coordinator	Yes (Part)

Apologies for absence

Apologies were submitted on behalf of Sally Roberts.

Declarations of Interest

CCM754 None.

RESOLVED: That the above is noted.

Minutes

CCM755 The minutes of the last Committee meeting, which took place on 29th November 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM756 None

RESOLVED: That the above is noted.

Committee Action Points

CCM757 None to review.

RESOLVED: That the above is noted.

Contracting Update

CCM758 **Royal Wolverhampton NHS Trust**

Activity

The committee was presented with the key points of the latest CRM meeting.

The expectation for the Trust's position for end of year is currently awaiting confirmation. The Trust Board paper which will be presented at the 5 December 2018 Trust Board meeting will provide details. Commissioners will then be updated.

Cancer – A positive position for this service was reported, improvement trajectories are being reached. The 62 day target is however proving to be a challenging area with a back log of patients. The Trust confirmed that to improve further and reduce the back log of this service they have enlisted the services of a private provider for ad hoc sessions.

E- Referrals
The CCG has forwarded a letter to RWT to seek clarification and justification for the exclusions of service areas.

Risk/gain and share agreement

This agreement is progressing and is currently at the stage of going through governance in each organisation after which sign off will follow

UHB Urology Tertiary referrals

It is expected that only Burton and Derby will be affected at this time, and no impact is expected on other CCGs. Further discussions will be taking place. At this time there is no risk to Wolverhampton patients.

Ambulance referrals

It has been reported that this service has been in high demand over the last month and but it remains to be established if this solely due to 06A patients. There is a number of suppositions i.e. a high concentration of elderly care homes. The Committee raised the point that WMAS need to be approached regarding patient triage to help reduce service demand.

The Committee was advised that the Walk In Centre is also reporting high turnover of patients within the last month.

Telford Hospital

It has been informally reported, though remains to be formally confirmed that Telford Princess Royal Hospital will now be closing its A&E Department at 10.00 pm from the 18 December 2018, RWT will be remodelling their service to accommodate the extra demand.

Delayed transfer of care

This is currently above target by 0.5% which currently stands at 3.5%, (due to LA challenges). Walsall and Staffordshire patients are noted to be the highest majority of the current percentage. Meetings have been taking place to help reduce the impact on this service.

Diagnostics

RWT has been performed well until October 2018, but have failed with scans, this is due to high demand. This is being managed by a private provider by way of ad hoc sessions to alleviate the current pressure. GI referrals may be the major cause of the impact on this service. A deep dive investigation is currently being carried out determine the reason behind the sudden high demand.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

Discussions are currently ongoing for delivery of core services and budget; this may identify the need for further funding if required.

A draft measure for Mental Health indicators has now been completed and will be shared with RWT.

Marie Stopes International – Termination of Pregnancy Service

The Provider has forwarded written evidence of the financial unsustainability of this service. The CCG are now awaiting the new tariff increase proposal. It is believed that this may be over the acceptable limit of 10%, when received this will be shared with other CCG commissioners who are involved in this procurement agreement. If the increase is as expected above 10% then procurement may need to be followed.

The extension of the current contract is on hold until the new proposal has been submitted.

RESOLVED: That the above is noted.

Review of Risks

CCM758 Corporate level risks – there were no issues to bring to the Committee's attention.

Committee level risks:

CR10 is still an outstanding risk for staff workforce issues across the Better Care Fund programme office. This is currently under discussion with the Local Authority.

Dermatology timescales for procurement were highlighted as a future low risk for the Committee. It was agreed that an assessment will needed to be carried out for clarification of this action.

RESOLVED: That the above is noted

Any Other Business

CCM762 None

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM763 Thursday 31st January 2019 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

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NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 31 July 2018 commencing at 10.00am
In Brindley Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman/Governing Body Member
Mr D Cullis	Independent Lay Member
Mr J Oatridge	Deputy Chair of the Governing Body and Audit and Governance Committee
Mr L Trigg	Lay Member/Governing Body Member

In Regular Attendance:

Mr P McKenzie	Corporate Operations Manager, WCCG
Miss M Patel	Administrative Support Officer, WCCG (minute taker)

In Attendance:

Ms R Bajaj	Internal Audit Manager, PwC
Ms A Breedan	Partner, PwC
Mr T Gallagher	Chief Finance Officer, WCCG and Walsall CCG
Mr J McLarnon	Manager, External Audit, Grant Thornton
Mr N Mohan	Senior Manager and LCFS, PwC

Apologies for attendance:

AGC/18/72 Apologies were received from Dr H Hibbs, Dr S Reehana, Ms M Tonge, Ms J Watson, Mr M Stocks

Declarations of Interest

AGC/18/73 There were no declarations of interest.

Minutes of the last meeting held on 22 May 2018

AGC/18/74 The minutes of the last meeting were agreed as a true record.

Matters arising (not on resolution log)

AGC/18/75 Mr Price asked if his query to Ms Watson around risk being addressed in the Draft Internal Audit Annual Report had been acknowledged.. Ms Bajaj advised that this would be picked up within the reports already on the agenda.

Resolution Log

AGC/18/76 The resolution log was discussed as follows;

- Item 120 (AGC/18/40) - Informing the Audit Risk Assessment - Results from the mapping exercise around the National Standard Contracts to be brought to the next meeting – In terms of 2018/2019 there were only 5 contracts outstanding out of over 100 contracts. Going forward Providers would be asked to report back on compliance on a regular basis.
- Item 121 – (AGC/18/64) – Draft Internal Audit Plan 2018/19 – Ms Watson to provide further information around the areas of risk that have been identified – this would be discussed on the agenda.

Internal Audit Progress Report

AGC/18/77 Ms Bajaj presented the Internal Audit Progress Report to the Committee which updated them on activity since the last meeting and against the key recommendations and when they were due.

Mr Oatridge asked if 2018/2019 reports could be produced before year end in order for outcomes to be fed into the annual statement and governance report. Mr Oatridge advised that he was aware that this would depend on receiving the management opinion.

Mr Price asked if there were more or less reports in Quarter 4 which Ms Breedan advised that there were more reports. Ms Breedan asked if management could look into avoiding deferring items as this did impact the production of reports.

Mr Price commented on outstanding actions which had due date slippage as to how an end date could be finalised. Ms Bajaj said that Internal Audit were trying to chase the owners of the actions in order to ascertain this.

RESOLUTION: The Committee:

- Noted and accepted the report.
- That the Internal Audit Team would look to produce reports in time for the production of the annual statement and governance report dependent on receiving the management opinion.

Internal Audit Report – QIPP 2017/2018

AGC/18/78 Ms Bajaj presented the QIPP report for 2017/2018.

Three medium risks had been identified:

- Potential QIPP Opportunities
- Papers for the QIPP Programme Board
- Reporting QIPP Performance

Mr Gallagher advised that he had been working with Mr Marshall to look at the identified risks. Mr Marshall had put in place the recommendations and that Finance and Performance were more sighted on delivery and non-delivery of QIPP. The Executive Team were supportive of the report.

Mr Trigg praised the layout of the dashboard.

Mr Oatridge asked Mr Gallagher if there was a group that looked at the in year delivery and drove the performance. Mr Gallagher said there were detailed reports and PMO played a key role in this. The emphasis needed to be changed to look at QIPP opportunities. He felt that a lot of future arrangements around integrated systems and that more transparency was needed.

Mr Price said that the report was very helpful.

RESOLUTION: The Committee:

- Noted and accepted the report.

Internal Audit Report 2017/2018 Governance Arrangements Relating To The Better Care Fund

AGC/18/79 Internal Audit Report 2017/2018 Governance Arrangements Relating To The Better Care Fund had identified one risk that stipulated that although the Better Care Fund was referenced in Governing Body papers a dedicated paper to this area was not presented.

The recommendation was that the Better Care Fund report which was presented at the Health and Wellbeing Board could be shared with the Governing Body Members.

The risk rating for this had been assessed as low as the Governing Body were kept informed about the subject area.

RESOLUTION: The Committee:

- Accepted the report and its findings. It was agreed to provide a formal paper to the Governing Body in future.

Internal Audit Report – 2017/2018 Primary Care Commissioning

AGC/18/80 The Internal Audit Report on 2017/2018 Primary Care Commissioning had identified 4 low rated risks:

- Primary Care Commissioning Committee (PCCC) control design
- Financial reporting updates to the PCCC
- Clinical performance monitoring
- Contract management KPIs

The report felt that the focus seemed to be more around operational work rather than strategic work.

Mr Trigg asked what route the report would take to be fedback to the PCCC. Mr McKenzie advised that it had been discussed at the PCCC last month and at the August Primary Care Operations Management Group and an action plan had been devised. Audit Reports should be sent back to the PCCC following this.

Mr Price asked if this route would be the same to other Committees and asked Mr McKenzie to pick this up as an action to ensure that this took place.

Mr Price enquired if there was a forum for strategic decision making. Mr McKenzie said a report had been taken to the last PCCC and the Governing Body. In the first formation of the PCCC it was more operationally focused in order for the CCG to gain delegated access. A Primary Care Strategy Committee was established to address this but as this became 'business as usual' the meeting had now become the Milestone Review Board.

The new governance around the Primary Care Committee would look at the Primary Care Strategy going forward.

Mr Oatridge highlighted that the importance of Conflicts of Interest being addressed at the Committee.

RESOLUTION: The Committee:

- Accepted the report and its recommendations.
- Mr McKenzie to ensure that audit finding reports were taken back to the relevant committees.
- That Conflicts of Interest was highlighted as a top priority at the PCCC.

Internal Audit Charter - Revisions

AGC/18/81 The Internal Audit Charter outlined the responsibilities of the Internal Audit function for the year.

Mr Cullis noted that there was no reference in the document to the Head of Internal Audit Opinion and asked that this was added.

RESOLUTION: The Committee:

- Noted the report.
- That the Head of Internal Audit opinion was added to the Internal Audit Charter.

Internal Audit Recommendations

AGC/18/82 This agenda item was covered in the progress reports.

Annual Audit Letter

AGC/18/83 Mr Mclarnan presented the Annual Audit Letter which was not dissimilar to the audit findings report but was a document that was more public facing report. It was issued as an unqualified report. One risk was identified at a local STP level.

Mr Oatridge highlighted that the internal audit progress report had included a benchmarking report from the Financial Reporting Council (FRC) which had identified that 2 of the 8 Grant Thornton audits inspected had required 'significant improvements'. Mr Mclarnan advised that he was not able to comment on the specific information required or the audit work it related to. Mr Oatridge asked Ms Breedan if this related to internal and external audit work or just external work. Ms Breedan confirmed that it was external audits which fell in the remit of an Audit Quality Review (AQR) inspection.

Mr Cullis asked Mr McLarnon what internal quality reviews were undertaken. Mr McLarnon explained that there was a robust process in place. Mr Oatridge asked if there was a public internal quality report produced around process and regulations as an independent piece of governance. Mr McLarnon said he would look into this and bring back a report if it was available.

RESOLUTION: The Committee:

- Noted the report.
- Mr McLarnon to check if there was an internal quality report for Grant Thornton which could be shared with the Committee.

Risk Register Reporting/Board Assurance Framework

AGC/18/84 Mr McKenzie presented the report on the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.

Risk around VOCARE and the Improvement Board was moving more to 'business as usual'. Performance against Cancer standards continues to be concern and is monitored through Quality and Safety Committee and through Finance and Performance Committee.

No new strategic risks had been identified. Constitutional targets were not being met and were discussed at Finance and Performance Committee following discussions and Senior Management Team (SMT).

Last year's review had identified that SMT should be conducting quarterly deep dive reviews around risk. Mr Price asked if a summary would be received by the committee and Mr McKenzie confirmed that it would.

Mr McKenzie assured the Committee that continuous improvement and risk management continued to be high priority. A Governing Body Development Session had been utilised to discussed risk and its discussions on agendas.

Mr Oatridge asked about the potential staff capacity changes due to possible changes and how they would be addressed. Mr Gallagher said that this had been noted and that risk was at the forefront of the organisation and managing risks. The STP was trying to ensure that there was a more streamlined process so there was no duplication of work. Mr Oatridge felt that there was no process in place to pull organisation effectiveness together. Mr Gallagher felt that the corporate risk register was a way of addressing this. Overall it was the Accountable Officers responsibility to look at this and Mr Oatridge felt that this should be addressed in the Chief Executives Report around organisational resilience to the Governing Body.

Mr Price had a query around process/assurance where there were risks in 2016/2017 that were still open and if there was an end date. Mr McKenzie said he would be working with the Governance and Risk Coordinator to look at this.

RESOLUTION: The Committee:

- Noted the report and its recommendations.
- Mr McKenzie to report at next Audit and Governance Committee on end dates for risks where appropriate.

Review of Performance against Whistleblowing Policy

AGC/18/85 Mr McKenzie presented the report on the review of performance against the whistleblowing policy. The report was an annual assessment of the policy and that no disclosures had been made. The Speak up Guardian for the CCG could act on behalf of practices if they wanted.

Generally across the NHS whistleblowing remained high on the national agenda.

Mr Trigg said that as there had been no reported whistleblowing incidents reported and how could the committee be reassured that the policy was effective if there had not been any incidents reported because it wasn't effective or if it was effective. Mr Cullis asked if Mr McKenzie had asked managers if anything had been raised. Mr McKenzie advised that he hadn't been approached.

There was a discussion between the committee about how far the whistleblowing policy extended out to stakeholder organisations and how assurance was in place.

RESOLUTION: The Committee:

- Approved the report with some potential amendments in the future.
- Mr Oatridge and Mr McKenzie to meet outside of committee meeting to discuss policy further. Mr McKenzie to take to Executive Team meeting and bring to Audit and Governance Committee.

Feedback to and From the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

AGC/18/86 Mr Price reported that more assurance had been received regarding VOCARE and the Governing Body were happy to deescalate to the Quality and Safety Committee.

Mr Oatridge updated that the Black Country Joint Governance Forum (BCJGF) had not met as there had been ongoing discussions around the uniform reporting of risks. The templates had now been approved at the Black Country Joint Commissioning Committee and that himself and Mr Maubauch would be meeting to populate the Risk Register. Mr Oatridge suggested that he meet with Mr McKenzie to find a suitable date for another BCJGF. Mr McKenzie also updated that Dr Helen Hibbs was now the Black Country STP SRO there was a change in the direction of travel and a new STP PMO office was being established including the appointment of the STP Portfolio Director in the coming weeks.

RESOLUTION: The Committee:

- Approved the report.
- Mr Oatridge and Mr McKenzie to liaise and arrange another date for the BCJGF.

Losses and Compensation Payments – Quarter 1 2018/2019

AGC/18/87 Mr Gallagher presented this report and advised the Committee that there were no loses or special payments for the period ending 30 June 2018.

RESOLUTION: The Committee:

- Noted the above.

Suspension, Waiver and Breaches of SO/PFPS

AGC/18/88 Mr Gallagher noted the below in quarter 1 of 2018/19:

- During quarter 1 of 2017/18 there were 24 invoices in breach of PFPs (5.30% of all invoices paid);
- 17 waivers were raised during quarter 1;
- 10 non-healthcare invoices were paid without a purchase order being raised during quarters 1.
- Assured the Committee that the Finance department liaised with individuals where invoices were paid without a Purchase Order.

Mr Price asked Mr Gallagher if a report could be brought to the next meeting showing trends against performance last year with regards to non-purchase order.

RESOLUTION: The Committee:

- Noted the above.
- Mr Gallagher to bring a year on year trend report to next Audit and Governance Committee.

Receivable/Payable Greater than £10,000 and over 6 months old

AGC/18/89 The Committee noted that as at 30 June 2018 there were:

- No sales invoice greater than 10k and over 6 months old.
- 21 purchase ledger invoices greater than £10k and over 6 months old.

RESOLUTION: The Committee:

- Noted the above.

Counter Fraud Progress Report

AGC/18/90 Mr Mohan reported that a new Fraud Risk Group Meeting had been arranged. All plans were on target and no referrals had been made.

RESOLUTION: The Committee:

- Accepted the report.

Any Other Business

AGC/18/91 There were no items to be discussed under this agenda item.

Date and time of next meeting

AGC/18/92 Tuesday 13 November 2018 at 11am at Wolverhampton Science

Park

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Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 11th October 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG's
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Mike Abel – Lay Member, Walsall CCG
Alastair McIntyre – Portfolio Director, Black Country and West Birmingham STP

In Attendance:
Charlotte Harris – Note Taker, NHS England
Jonathan Fellows – Black Country STP Independent Chair
Laura Broster – Director of Communications and Public Insight

Apologies:
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Peter Price – Lay Member, Wolverhampton CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. Prof Nick Harding informed he had declared an interest in the Clinical Leadership Group Chair position.

1.4 The minutes of the meeting held on the 13th September were agreed as an accurate record. The minutes of the meeting held on the 9th August were agreed as an accurate record and signed off today as the previous meeting was not quorate.

1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 In regards to 091, it was informed the Clinical Strategy would be presented to the Clinical Leadership Group (CLG) later that evening. This will be brought back in December.

1.7 In regards to 114, it had been agreed that the Black Country STP will not be doing the review for Kiran Patel but will be carrying out a review on Provider Sustainability. It is also part of action 102.

1.8 In regards to 124, it has been impossible to convene all three applicants on one date. There have been three dates provided for applicants to attend.

2. MATTERS OF COMMON INTEREST

2.1 Place Based Commissioning Update – Dudley

2.1.1 Paul Maubach informed there has been a joint conference call with NHS England (NHSE) and NHS Improvement (NHSI). They have agreed and outlined a timetable with the regulators. They have agreed with the regulators to submit the commissioning components of checkpoint two of the ISAP process following the Governing Body meeting in November. The NHSI assurance process is that they will then need to take the providers through in order to develop the MCP. This is going to be a lengthy process to write the strategic pace for the MCP in the context of the Dudley system and what it means for providers in the system. They will require two produce LTFMs; one for Dudley Acute and one for the MCP. The mobilisation process for creating the MCP can then start. The whole process can take at least a year. The timeframe for establishing the MCP properly are aiming for January 2020, ready for April 2020. It was noted, if this had been a joint venture between the NHS provider and the GPs, the MCP would be place by now. However, this had higher risks. The levels of assurance in the chosen process have elongated the completion. There have been no applications to split a Foundation Trust before.

2.1.2 There were questions raised regarding the impact on Commissioning Intentions. Paul Maubach confirmed the contract cannot be awarded in April 2019 as previously intended. The Transition Board for MCP has been established which will bring all the partners together to manage the situation during the transition period. This will have to run for at least 18 months. A lot of work is required when creating an organisation. The biggest concern is that the General Practice will become frustrated with the long process as 93% have signed up to the creation of the MCP. The council will be equally exercised in regards to the timeframe.

2.1.3 Dr David Hegarty discussed the fact the MCP is the system solution to the problem with Dudley Emergency Department. In previous discussions, it was confirmed everyone wanted something done. There is an issue regarding how the system survives until the MCP is in place. There needs to be a workforce solution and a better relationship developed with the third sector.

2.1.4 Paul Maubach noted it would be beneficial to have collective support from the committee and the STP for the MCP model. There has been extensive consultations and questions raised but with no solution offered. If there is a consensus across the STP, it will make the case for the MCP stronger. There were discussions on the sustainability of Primary Care and the risk around this. The MCP can make a substantial difference to the population around outcomes. They can evidence where there will be improvements in specific areas but more can be done.

2.1.5 It was confirmed the time delays with procurement will not have an impact on the MCP. Workforce is an issue with each CCG. There needs to be some better solutions as the problem could develop before the MCP is in place. It was agreed the Workforce Strategy would be produced alongside the Clinical Strategy. There is a need to understand how far away the STP is from tipping point in Primary Care to try and prevent this from occurring.

Mike Abel suggested there are additional pressures on Primary Care that will need to be reviewed.

Action: An extended discussion to be arranged regarding the MCP and Primary Workforce Retention.

2.2 **Clinical Leadership Group Update**

2.2.1 The CLG is meeting later today to discuss the Clinical Strategy and Primary Care Networks.

2.3 **Performance**

2.3.1 Alastair McIntyre presented performance on a page for the Black Country. The information only runs until June 2018. The CSU tool is being developed and will be presented when available. There has been an improvement in RTT but there are 24 52 week waits that need to be reduced. In regards to the waiting list reduction to 0, this has been requested from NHSI. The CSU tool will allow a narrative for actions in regards to red ratings. With dementia, NHSE has escalation meetings with Sandwell & West Birmingham. IAP is improving. There was an assurance statement released yesterday; there is general improvement. There are some issues in Mental Health.

2.4 **Risk Register**

2.4.1 Paul Maubach, Jim Oatridge and Alastair McIntyre presented the first draft for the risk register. They have focused on risks that are relevant to the committee and would not be on the CCG risk register. The next step would be to review mitigating actions to deal with those presented. The list consisted of:

BC001 – the delegation to the committee is not legally sound
BC002 – West Birmingham is out of scope for the BC JCC in terms of matters for delegation
BC003 – there is confusion in decision making/delegation in relation to the BC JCC or that matters are not sufficiently clear as to be understood
BC004 – it is not clear on the agreed method of delivery or of assurance for such services as included in the joint commissioning intentions
BC005 – not all CCG Governing Bodies agree the proposed model of funding for TCP
BC006 – the different models for commissioning place based models of care impact on CCG ability to delegate to the JCC
BC007 – the BC JCC does not have legitimacy in the STP or with CCGs unless the governance and delegation are clarified

It was suggested that BC003 be re-worded to reflect that the committee will become irrelevant if noting substantial is delegated to it. It was noted with BC005, the funding for TCP has been agreed by the CCGs. This is still waiting agreement from the councils. There was a suggestion to re-word this to reflect a general risk around funding. Jim Oatridge noted a lot of these are easy to address; the committee would need to be disciplined.

2.5 **Sandwell & West Birmingham and Wolverhampton Integrated Care System and Financial Risk Discussion**

2.5.1 Matthew Hartland gave a recap from the previous meeting. The request had surfaced regarding any initial risks of the MCP on Dudley Group, place based models and future financial flows. For Dudley, half of the services would be subcontracted back to existing providers. Therefore, the impact is less material. There is limited impact on Dudley Group and Dudley and Walsall Mental Health Trust. For Black Country Partnership, there are more services contracted back so they will be less affected.

2.5.2 Paul Maubach informed the clinical model for the MCP was designed to reduce the risk to existing providers. There were questions raised whether this would jeopardise any long term outcomes. As a CCG, they will need to ensure the MCP collaboration is real. It was confirmed there are clauses in the contract to allow mutually agreed negotiation should there be a need to increase resource in the community services. As a commissioner, they are moving away from what service they want to what outcomes they require. There are mitigations should outcomes go the wrong way.

2.5.3 For Walsall, there is a similar process, with the need to define what is in and out of scope. They are not establishing a new organisation. There will be a lead provider. Everything in Walsall Manor will be in scope except the Emergency Department which is being reviewed. The plan is to be in shadow form by 2019/20 onwards.

2.5.4 With Wolverhampton, everything will be in scope under the alliance model. They are reviewing the boundary issues. This encompasses the entire economy and ensures financial transparency. There were discussions over GMS contracts within Wolverhampton. The partners are directly employed by the trust and hold themselves to account. The GPs are able to work across more than one practice.

2.5.5 The approach for Sandwell & West Birmingham will be different. As it stands, all will be in scope. There will be two alliance partnerships; one for Sandwell and one for Western Birmingham. These could be subcontracted down. They are not assuming double delegation and have kept GP contracts out. The Better Care Funds are a difficult element, and are currently split between the two. They are talking with West Birmingham colleagues about the approach.

2.5.6 It was suggested that the activity should be presented in the same way. It was suggested this could be presented as year one with additional information and changes for the future. There needs to be a consistent approach for the STP. It was suggested there is a need to understand the provider view and other areas of commissioning to have the totality of each provider to understand their full resilience.

2.5.7 Paul Maubach suggested the full picture is not being presented. The differences and gaps between numbers will need to be addressed. There needs to be a look at the whole system. It was noted that the provider landscape is changing which could change the financial flows. There is also a difficult position with the Local Authorities which could have an impact on health. This has revealed there is more work to be done to clarify approached and review where differences are.

Action: The financial analysis for each place to be updated to be presented in the same way with a year one position with additional information and changes in the future.

2.6 **JCC Executive Development Session Review**

2.6.1 There was good attendance and the session went well. Joint Commissioning Intentions was an action from the session; these were presented at the STP Stocktake meeting. It was suggested these need to go to individual Governing Bodies for sign off. An important piece of work that was identified was the need to commission West Midlands Ambulance Service (WMAS) differently. The trusts are under pressure; Russell Hall's had 30 ambulances arrive within one hour. The performance standards for WMAS are the best in the country but this is not working in the way the system needs. There is a need to support the work being done by Rachael Ellis. It was noted that Rachael Ellis will be attending on Monday's Partnership Board to present the information to the partners.

2.7 **Latest Service Change List**

2.7.1 Alastair McIntyre presented the latest service change list for the Black Country. At the next Accountable Officers meeting on 06 November, they will run through the timescales. NHSI will have conversations regarding the transactional process. There is a meeting with Specialised Commissioning later that day. It was noted that the Active Services Change Group review services changes brought to attention of NHSE. It was suggested, for the presentation to remove the word "Active" and change it to "Service Changes Being Considered". Cancer and Specialised Commissioned are being narrowed down.

3. FORMAL DELEGATION

3.1 **Risk Register**

3.1.1 This was discussed in 2.4.

3.2 **Transforming Care Partnership (TCP)**

3.2.1 Dr Helen Hibbs presented a report on TCP. The numbers are not good but discharges are being achieved. However, there are still admissions occurring. There was a meeting with Ray James where it was commented there are "green shoots of recovery". The provider model is mainly operational. The focus is to avoid admissions. There is work being carried out with the Care and Support Programme. There were discussions regarding a recent programme around this area which involved a patient from St. Andrews Hospital. The difficult process has helped lay a firm foundation for the Black Country.

3.2.2 Paul Maubach reflected on the Walsall case where the patient was being commissioned by Specialised Commissioning. From the Walsall CCG perspective, the CCG could have been more proactive. Dr Helen Hibbs discussed the lack of coordination between the CCG and Specialised Commissioning. Specialised Commissioning has high caseloads. Resource was offered to get additional support but they failed to recruit for case management.

Mike Abel left the meeting.

3.2.3 Laura Broster informed that the TCP public involvement is due to commence in November. They are undertaking the involvement exercise to seek public views on the community model, the reduction of inpatient beds and to influence the future location of the Assessment and Treatment Beds in the Black Country.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 **CCG Collaboration – Areas for Consideration for Delegation to the JCC**

4.1.2 It was suggested there needs to be a clear paper, such as the CAMHS paper for areas that are being worked on. It was suggested that each area be worked up on and brought the committee so there can be a review for options to discuss possible delegation.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 **Response to Alison Tonge Letter of 28th September**

5.1.1 Dr Helen Hibbs informed this letter was sent to all CCGs in the Midlands and North. This was around learning from the CCG merger for Birmingham and Solihull and the time taken to do so. It is a helpful document for those that are considering merging as it highlights the

steps needed and the issues with governance. It was agreed there would be a collective response from the Black Country to note they are not considering CCG mergers.

5.2 **STP Diabetes Prevention Programme**

5.2.1 Alastair McIntyre informed there was a webinar earlier in the week which noted that there needs to be a draft prospectus for the STP Diabetes Prevention Programme submitted by the 19 October. The new contracts will be on a STP footprint. Therefore a lead will need to be identified. Laura Broster noted there are experts available with Public Health colleagues. This will be presented at the STP Partnership Board on 15 October.

5.3 **Stroke Review**

5.3.1 Prof Nick Harding suggestions the Stroke Review comes to the committee for understanding. It was noted that the CSU can attend in November to give a presentation on Stroke Data.

5.4 **Meeting of Accountable Officers and Clinical Chairs**

5.4.1 Dr Helen Hibbs informed that it is not possible to organise a meeting between the Accountable Officers and Clinical Chairs before the meeting with Alison Tonge in November due to annual leave commitments and availability.

6. DATE OF NEXT MEETING

Thursday 8th November, 10:00-12:00, Stephenson Room, Wolverhampton CCG, Wolverhampton Science Park, Glaisher Drive, Wolverhampton, WV10 9RU

JCC Action Log

No.	Date	Action	Lead	Status Update
091	22nd Mar 2018	Clinical chairs to discuss CLG links into workstreams and the PMO to ensure there is no duplication of work.	Dr Anand Rischie	11/10/18 The Clinical Strategy is to be signed off. This will be brought back in December. The PMO will be in place by then.
097	10th Apr 2018	Local Authority representatives to be invited to the Clinical Leadership Group meetings.	Charlotte Harris	11/10/18 The Terms of Reference of the CLG is to be signed off.
102	10th Apr 2018	Prof Nick Harding to include clinically based commissioning for outcomes as an agenda item for the Clinical Leadership Group.	Nick Harding	13/09/18 This will be pending CLG approval and appointment of Chair
126	11th Oct 2018	An extended discussion to be arranged regarding the MCP and Primary Workforce Retention.	Paul Maubach	
127	11th Oct 2018	The financial analysis for each place to be updated to be presented in the same way with a year one position with additional information and changes in the future.	James Green and Matthew Hartland	

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Health and Wellbeing Together
Minutes - 17 October 2018

Attendance

Members of Health and Wellbeing Together

Councillor Roger Lawrence	Leader of the Council (Chair)
Dr Helen Hibbs	Chief Officer, Wolverhampton CCG
Emma Bennett	Director of Children's Services
Brendan Clifford	Service Director - City Health
John Denley	Director of Public Health
Ben Diamond	West Midlands Fire Service
Dr Helen Hibbs	Chief Officer, Wolverhampton CCG
Councillor Roger Lawrence	Leader of the Council
Councillor Hazel Malcolm	Cabinet Member for Public Health and Wellbeing
Steven Marshall	Director of Strategy & Information, Wolverhampton CCG
Councillor Sandra Samuels OBE	Cabinet Member for Adult Services
Linda Sanders	Independent Chair of Adults' and Children's Safeguarding Board
Sarah Smith	Head of Strategic Commissioning
Councillor Paul Sweet	Cabinet Member for Children and Young People
Meredith Teasdale	Director of Education
Councillor Wendy Thompson	Conservative Party Leader
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
David Watts	Director of Adult Services

Employees

Madeleine Freewood	Development Manager
Neeraj Malhotra	Consultant in Public Health
Parpinder Singh	Senior Public Health Specialist
Shelley Humphries	Democratic Services Officer

In attendance

Margaret Courts	Children's Commissioning Manager, Wolverhampton CCG
Dana Tooby	Healthwatch Wolverhampton

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence were received from Councillor Jasbir Jaspal, Chief Superintendent Andy Beard, Tracy Cresswell, Dr Alexandra Hopkins, David Loughton CBE and Lesley Writtle.

2 **Notification of substitute members (if any)**
Inspector Tracey Packham attended on behalf of Chief Superintendent Andy Beard, Dr Ranjit Khutan attended on behalf of Dr Alexandra Hopkins, Chris Masikane attended on behalf of Lesley Writtle and Elizabeth Learoyd attended on behalf of Tracy Cresswell.

3 **Declarations of interest (if any)**
There were no declarations of interest made.

4 **Minutes of the previous meeting**
Resolved:

That the minutes of the meeting held on 11 July 2018 be approved as a correct record and signed by the Chair.

5 **Matters arising**
The Chair opened the meeting by announcing the new name of the board as Health and Wellbeing Together.

6 **Health and Wellbeing Board Forward Plan 2016-2017**
Resolved:

That the Forward Plan be noted.

7 **Public Questions**
There were no public questions to consider.

8 **Child and Adolescent Mental Health Services (CAMHS) Transformation Plan Refresh 2017-2020**
Margaret Courts, Children's Commissioning, Wolverhampton CCG presented the report on the CAMHS Transformation Plan Refresh **2017-2020**. The Board was asked to consider and accept the refreshed version of the Plan, which was last presented to the Board in 2015. The report detailed the funding available from the Clinical Commissioning Group and the intentions for investment of this funding in 2021 – 22. She informed the Board that the report was currently in its draft form and a further revised version would be produced.

In addition to the information contained within the report:

- It was noted that it was beneficial that Speech and Language Therapy (SALT) and the Youth Offending Team (YOT) were included.

- In response to a query about performance indicators and how a link could be forged with the Citywide Strategy, it was noted that the 32% diagnosis target had not been reached, however the Black Country Partnership had achieved 19%.

- It was noted that, with regard to access to services for young people with eating disorders, the seven-day target for urgent cases was being met, while the four-week target for non-urgent cases was not. This was thought to be due to parents not keeping appointments.

- It was noted as important to establish the journey of the young service users and discover the impact in addition to looking at contact figures.

- It was explained that there had been challenges with regard to workforce, however the training was almost ready; it was felt the problems related to ensuring the right people had the right qualifications rather than a shortage of staff.

- It was explained that there were dedicated services within the Council for Children in Need and child protection, including children and young people in care and that work was being carried out in partnership with the CCG to explore ways of bridging the Tier 2 gap.

- With regard to waiting times, particularly pertaining to children who had suffered abuse, the Board were advised there was a sexual abuse referral centre with its own counselling services. There had usually been a quick turnaround here and young people were referred back to CAMHS if their case could not be resolved. It was noted that the centre wasn't commissioned by the CCG and was not under the Authority's jurisdiction.

- It was suggested that partners work together to explore pathways the impact that mental health resilience in children has on elements such as community cohesion, policing, etc.

Resolved:

That the report be endorsed.

9 **Adults' and Children's Safeguarding Board Annual Report**

Linda Sanders, Independent Chair of Wolverhampton Adults' and Children's Safeguarding Board presented the **Adults' and Children's Safeguarding Board Annual** Report. It was explained that there was a new, integrated Safeguarding Board with a comprehensive agenda and the combined report was intended to inform Health and Wellbeing Together of progress made over the past year and the four key priorities of the Board were highlighted.

The report was welcomed by Councillor Sandra Samuels OBE and the work of the Wolverhampton Safeguarding Board referred to in Priority 4 was praised for successful community engagement and delivery, particularly in respect of the Orange Wolverhampton Campaign, throughout the 12 months covered.

Councillor Hazel Malcolm added that there needed to be some alignment with emerging issues such as gang and gun violence, county line issues and exploitation of young people and requested that these be considered for the next time.

Dana Tooby, Healthwatch Wolverhampton, added that work was being undertaken to ensure that faith groups were included to ensure the requirements set out by the Charity Commission are met. There were partnership meetings and continual engagement with the faith sector was being carried out with a Faith Engagement Worker being funded by the board to carry this out.

Resolved:

That the report be noted.

10 **People with No Recourse to Public Funds (NRPF) Draft Multi-Agency Protocol**
Neeraj Malhotra, Public Health Consultant and Seeta Wakefield, Public Health Registrar presented the report on **People with No Recourse to Public Funds (NRPF) Draft Multi-Agency Protocol**. The aim of the protocol was to act as an informative document on what support could be accessed and to dispel the myth that the term 'no recourse to public funding' meant no access to support at all.

It was suggested there was a need to clarify that there were NRPF people living in Wolverhampton who were being supported by other local authorities and therefore were not under Wolverhampton's scope of responsibility. It was requested that the checklist in the multi-agency protocol included questions on what support was being received from another local authority.

With regard to the training referenced in point 3.6 of the report, Councillor Samuels OBE requested that this be rolled out to elected members, as they may come into contact with people NRPF during their surgeries and it would be useful to direct them straight towards the help they need.

It was requested by Councillor Wendy Thompson that the protocol also be followed up with a data 'snapshot' with numbers of NRPF within Wolverhampton. It was agreed that this could be done to a degree, however there were people who either did not self-identify or require any services who could not be accounted for. It was also noted that when people achieved immigration status, they were no longer considered to be NRPF.

The Chair commended the protocol agreeing that it was important to gain a better understanding of the wide range of services available to people.

Neeraj Malhotra acknowledged the contributions made by partners to the protocol. She closed the presentation with a mention of correspondence sent by the Chair to other local authorities requesting notification of people coming across borders from other authorities to ours and that she was in the process of tracking this and chasing those authorities who hadn't responded as yet.

Resolved:

1. That the protocol be endorsed.
2. That a report containing data on NRPF within the City be added to the Forward Plan for consideration at a future meeting.

11 **Update on Suicide Prevention**
Neeraj Malhotra, Public Health Consultant presented the report on **Suicide Prevention.** An update on the work carried out by the Suicide Prevention Forum was provided and the Board was advised that the last update was submitted two and a half years ago.

In support, Parpinder Singh, Senior Public Health Specialist, delivered a visual presentation which provided the background on Wolverhampton statistics compared with national trends and a more in-depth overview on the progress of the Forum.

It was highlighted that 2017 figures showed the lowest rates of death by suicide in the UK since 1981 and, since this date, it was recorded that two thirds of people taking their own life were men around the ages of 45 - 49. It was noted that research

suggests more women attempt suicide but do not complete. This could have been partly attributed to the fact that women generally used less fatalistic methods such as overdoses, whereas men would use hanging as the most common method.

It was noted that there had been a steady downward trend for suicides in Wolverhampton with some fluctuation and the gender split locally was very similar to the national figure.

Work being done with Black Country Coroners had provided some useful data with a deeper delve into demographics. Out of 31 cases scrutinised for suicides registered in 2015-16, 77% were found to be males, the youngest being 23.

There had been reported a rise in teenage suicides between 2010 – 2017 which was around 47% nationally. However, suicide amongst children and young people in Wolverhampton was reported to be very low.

Linda Sanders, Independent Chair of Wolverhampton Adults' and Children's Safeguarding Board, queried the prioritisation of adult males as, based on statistics, suicide or self-harm with intent to cause death in 10 to 19-year-olds accounted for 14% of deaths nationally. It was noted that there was a suicide prevention sub-group established under the main suicide prevention forum with a focus on children and young people. As part of the group's current focus, it was noted that data around self-harm would be reviewed, that policy and guidance was being developed for schools and the opportunities to raise awareness would continue to be explored.

With regard to General Practitioner (GP) training, following case studies highlighted by THRIVE West Midlands in which people sought help, in two thirds of cases a family member was approached for help as professionals were thought to be dismissive in some instances. It was considered whether GP training was the issue or the time restraints put on GPs to keep appointments to a minimum.

It was agreed that it was important to raise awareness of identifying key signs that someone may be at risk of taking their life by suicide, particularly in schools where either bullying or social isolation were often contributing factors, so appropriate action could be taken. It was highlighted that early intervention was vital and Dr Helen Hibbs noted that statistics showed 28% of people had been in contact with mental health services in the year prior to death and it would be interesting to know if they had been in contact with any other services at that time.

In response to Brendan Clifford's query whether there had been any data analysis by postcode and if individuals in prison were included in the figures, Parpinder Singh, Senior Public Health Specialist advised the Board that a map would be circulated with postcode data provided by the Coroner. It had also been noted that there had been a link found to areas of deprivation. A report had been released regarding suicide in prisons. Self-harm in particular was a key concern within prisons. There were varying initiatives that take place within prisons to support individuals, this includes The Samaritans who provide an independent listening and support service.

In respect of the Zero Suicide Alliance's e-learning package, it was requested that a link be forwarded to elected members on the Board with a view to completing the training and forwarding on to all elected members once approved.

It was suggested by the Chair that a link be made with the local transport and planning departments with a view to designing out means of attempting suicide within the transport network.

Resolved:

1. That the key areas of action be endorsed.
2. That children and young people be included in the suicide prevention action plan.
3. That the link to the Zero Suicide Alliance e-learning be forwarded to elected members of Health and Wellbeing Together with a view to cascading to all elected members.
4. That the Suicide Prevention Forum liaise with planning and transport departments regarding suicide within the transport network.
5. That a postcode map with suicide statistics be circulated to the Board.

12 **Draft Joint Health & Wellbeing Strategy 2018-2023 - Self-Assessment**

John Denley, Director for Public Health introduced and led an interactive self-assessment on how the Board felt it was performing against the following areas in each of the seven priorities (Early Years, Children & Young People's Mental Wellbeing and Resilience, Workforce, City Centre, Embedding Prevention Across the System, Integrated Care; Frailty & End of Life and Dementia Friendly City).

- Buy in at all levels of the organisations
- A clear shared goal for the next 3-5 years
- An evaluation framework based on long term outcomes
- Public and/or patients engaged and involved
- Appropriate resources and capacity allocated
- A thorough understanding of the issue from a long-term perspective

The Board were asked to vote using a bespoke online survey using a sliding scale of 1 - 5, 5 being the highest score and 1 being the lowest.

Resolved:

1. That the Early Years Strategy be brought to a future meeting to open up discussion.
2. That the results of the survey and responses received from the Board be taken into consideration when delivering the Joint Health and Wellbeing Strategy.