NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 9 April 2019 commencing at 1.00 pm

at Stephenson Room - Wolverhampton Science Park

A G E N D A

		1	Apologies for absence		
		2	Declarations of Interest		
		3	Matters arising from the minutes		
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		8	Dementia Strategy	Ms S Fellows	Report to follow
			Committee Reports		
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		24	Any Other Business		
		25	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 14 May 2019 – Governing Body Board Meeting		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 26 March 2019
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~	
Dr S Reehana	Chair
Clinical	
Dr D Bush	Board Member
Dr R Gulati	Board Member
Dr M Kainth	Board Member
Dr J Parkes	Board Member
Dr R Rajcholan	Board Member
Management	
Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Mr M Hastings	Director of Operations
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 H Cook	Engagement, Communications and Engagement Manager
Ms K Garbutt	Administrative Officer
Mr P McKenzie	Corporate Operations Manager

Apologies for absence

Apologies were received from Mr J Denley, Dr D Watts, and Ms S Gill

Declarations of Interest

WCCG.2309 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.2310 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group (WCCG) Governing Body meeting held on the 12 February 2019 be approved as a correct record.

Matters arising from the Minutes

WCCG.2311 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2312 Dr S Reehana stated action WCCG.2279 will be actioned in April 2019.

RESOLVED: That the above is noted.

Budgets sign off

WCCG.2313 Mr T Gallagher presented the report to the Governing Body for Budget sign off. He referred to page 3 of the report. In early January 2019 NHS England issued Clinical Commissioning Groups (CCGs) with their allocations for 5 years from 2019/30. Allocations were designated as confirmed for 2019-22 and indicative thereafter as detailed in the table on page 3.

He pointed out the revised planning guidance which confirms the key elements and requirements for CCG plans outlined in 3.1 on page 4 of the report. In additional to these requirements there have been considerable changes to the National tariff such as ~

- Revision to Market Forces Factor to be phased over 3 years.
- Greater granularity in coding for Maternity and deliveries.
- Incorporation of Marginal Rate Emergency Threshold and Readmissions into tariff.
- Incorporation of 1.25% of Commissioning for Quality and Innovation (CQUIN) into tariff, leaving 1.25% for schemes to be specified.
- A new blended payment for Emergency care.

For planning purposes the CCG's Long Term Financial Model has applied the overall growth in line with the Business Rules and growth, inflation and efficiency assumptions as identified in the tables on page 5.

In order to submit a balanced, assured plan for 2019/20 the CCG has included a Quality, Innovation, Productivity and Prevention (QIPP) programme of £13.5m, 3.2% of its allocation. This is an extremely stretching target. Delivery of the portfolio of QIPP schemes presents a significant challenge and risk to the CCG and the Programme Boards continue to develop and agree schemes to deliver the target. The level of unidentified QIPP is 2.3% of the overall QIPP programme. The CCG has benefited from most of the "quick win" schemes and has now to be creative in developing solutions to bridge the gap. This will be challenging and although difficult is considered achievable.

Dr Reehana pointed out the revised guidance on allocation sent recently to reflect budget adjustment around primary care network. Mr Gallagher confirmed he is aware and will be incorporated in the future pending further guidance.

Mr Gallagher stated the next stage we need to submit a further financial plan to NHS England which incorporates contracts which have been agreed.

A discussion took place regarding running costs and the requirement to reduce this in readiness for the planned reduction in 20/21 .

RESOLVED: That the Governing Body agreed to sign off the 2019/20 budgets.

Wolverhampton Clinical Commissioning Group Operating Plan sign off

WCCG.2314 Mr M Hastings gave an overview of the report. He stated that originally the CCG was told that we needed to submit a 12 month Operating Plan for the CCG however, this guidance then changed nationally. The CCG is now only obliged to contribute towards a Sustainability and Transformation Plan (STP) wide 12 month Operating Plan which is attached. The Executive Team took the decision to develop a local operating plan for our own local requirements to assist in planning for 2019/20. Both of these reports are attached.

Dr R Rajcholan arrived

Mr Hastings stated the reports are for information, however if anybody has any issues, changes or suggestions to let him know. Dr J Parkes asked if

the Primary care networks are based around the current localities and whether this is already agreed. Mr Hastings confirmed that this work is ongoing and discussions with our GP practices and community services are still taking place.

Dr R Gulati pointed out the reference in the Operational Plan 2019/20 on page 91 stating "resignation of the chair…" Mr S Marshall stated this referred to last year and will be amended.

RESOLVED: That the above is noted.

Any Other Business

WCCG.2315 RESOLVED: That the above is noted.

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

WCCG.2316 There were no questions.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2317 The Board noted that the next meeting was due to be held on **Tuesday 9 April 2019** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 1.30 pm

Chair..……..

Date ……

Wolverhampton Clinical Commissioning Group Governing Body

Action List

9 April 2019

Date of meeting	Minute Number	Action	By When	By Whom	Status
12.2.19	WCCG.2279	Quality and Safety – The mortality plan is discussed at a Governing Body Development Session	March/April	Sally Roberts	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
9 April 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 System change NHS England (NHSE) / NHS Improvement (NHSI)

2.1.1 The new Regional Director for the West Midlands region is Dale Bywater and he starts formally in post on 1 April 2019. He is currently recruiting to his new team. This marks the beginning of a new way of working with NHSI and NHSE having a joint Chief Executive and working more as one single organisation.

2.2 Sustainability and Transformation Plan (STP)

2.2.1 The STP continues to work to develop as a system to enable it to move to become an Integrated Care System from 2021 in line with the commitments in the long-term plan. Increasingly, the commissioners in the Black Country are working more closely together to enable delivery of a range of transformation plans which are driven by NHSE.

2.3 GP Networks

2.3.1 As we continue to strengthen service delivery in primary care the formation of Primary Care Networks is actively underway. Our initial focus is on practice configurations that are geographically aligned at neighbourhood level giving patients better access to services within their local communities. There will be some overlap between networks, this is fine. Discussions with health / social care partners are also taking place to ensure networks are functional. Applications from groups of practices to formalise their groups as primary care networks will be agreed by May 2019.

2.4 IMT Developments

2.4.1 Wolverhampton CCG have started the migration of our operating system from Windows 7 to Windows 10 and this will be completed by January 2020, we are also looking to upgrade the existing office software used within the CCG to Microsoft Office 2019. To ensure that the GP's within the CCG benefit from the latest innovations we are migrating our Docman software (Clinical documents system) to a new cloud based version that will support the GP's working at scale across the CCG.

2.5 Wolverhampton Integrated Care Alliance (ICA)

2.5.1 The ICA has two overarching groups – ICA Governance Group co-chaired by Steven Marshall and Sultan Mahmud and the Clinical Priorities Group co-chaired by Dr J Odum and Dr S Reehana. Beneath these groups sit a number of sub-groups, for Governance there is Outcomes, Information Governance / Information Technology / Business Intelligence, and Commissioning and Contracting group and there are four clinical

sub groups reviewing and redesigning pathways for Frailty, End of Life, Children and Young People and Mental Health.

2.5.2 Each group has representation from key partners across the City. This development stage is looking at the pathways in scope to determine the best delivery model for care for patients and then to determine how we enable that to happen across partners with activity and resource allocated across the system.

2.6 **CCG Assurance Meeting**

2.6.1 The CCG end of year assurance meeting took place on 27 March 2019. The outcome of this will be subject to regional and national moderation and we will not know our rating until later in the summer.

2.7 **EU Exit**

2.7.1 The CCG Senior Responsible Officer for EU Exit, Director of Operations continues to fulfil the CCG requirements for planning and preparedness. Daily sitreps are now being sent in to NHS England with an additional weekly Monday sitrep to report on weekend impact. To date there has been no requirement to report anything untoward and the planning and process put in place satisfies our responsibilities. A press release and website update has been published to assure the public around the supply of medicines, with assurance gained from the Local Pharmaceutical Committee. The Executive Team and staff members have been briefed on planning and a city-wide health and social care EU Exit group is holding regular update calls.

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 March 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**	**29/03/19**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
9 April 2019

Agenda item 7

TITLE OF REPORT:	Better Care Fund Programme Planning
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning
MANAGEMENT LEAD:	Steven Marshall
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:	• The current BCF plan runs from 21017-2019 • Future planning guidance has not yet been published and subsequently there is no known planning submission date. • The BCF Plan requires sign off from all key organisations and from Health and WellBeing Board • This report requests that in the event of publication of the planning guidance and a submission date that does not align to WCCG Governing Body or Health and WellBeing Board meetings that delegated authority for approval be given. to Dr Salma Reehana, Governing Body Chair, WCCG on behalf of Wolverhampton CCG and Dr R Lawrence, Chair of Health and Well Being Board on behalf of the Health and WellBeing Board
RECOMMENDATION:	That delegated authority is for approval of the BCF Plan post March 2019 is given to:- • Dr S Reehana on behalf of Wolverhampton CCG • Cllr R Lawrence (or Deputy) on behalf of Wolverhampton Health and WellBeing Board
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	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current

commission	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

N.B. Please divide the rest of the report into Paragraphs, using numbering for easier referencing.

1. BACKGROUND AND CURRENT SITUATION

1.1. The current BCF Plan covers the period 2017-2019. Future planning guidance has not yet been published and as such a submission date is unknown.

1.2. Previous years have demonstrated a short turnround time from the publication of the planning guidance and submission of local plans. The timeframes do not always allow for plans to be presented through the appropriate governance approval processes. .

1.3. In previous years delegated authority for approval has been given to senior indiviuals to allow for timely submission of the local plan.

1.4. This report is a request for delegated authority to again be given in the event that the publication of planning guidance and submission date does not align with the Governing Body or Health and Wellbeing Board meetings.

1.5. Delegated authority for approval is requested for:-

- Dr S Reehana, Chair WCCG on behalf of WCCG
- Cllr R Lawrence (or Deputy), Chair Health and WellBeing Board on behalf of Wolverhampton Health and WellBeing Board

1.6 In the event that delegated approval is actioned, the BCF Plan submission will be presented to the next meeting of the Governing Body and Health and WellBeing Board following the submission date for ratification.

.

2. CLINICAL VIEW

2.1. Clinicians and Professionals are involved in the programme at a Workstream level being involved from the outset in redesign of pathways.

3. PATIENT AND PUBLIC VIEW

3.1. Patients and public are engaged at a workstream level.

4. KEY RISKS AND MITIGATIONS

4.1. Dependent upon the nationally mandated deadlines the BCF plan may be submitted prior to formal approval by WCCG Governing Body and Health and WellBeing Board.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. Financial and resource implications will be defined within the Local plan. The content of the Pooled budget is currently being considered and will be agreed by Directors of Finance from both WCCG and City of Wolverhampton Council, before submission of the plan..

Quality and Safety Implications

5.2. Quality and Safety implications will be defined within the local plan.

Equality Implications

5.3. If required, and Equality Impact Assessment will be undertaken for the local plan. In previous years this has been undertaken on individual projects within the plan.

Legal and Policy Implications

5.4. The Better Care fund programme is underpinned by a Section 75 agreement. Work is underway to determine the content of the Pooled budget and the subsequent Section 75 agreement.

Other Implications

5.5. All other implications will be detailed within the local plan.

Name: Andrea Smith
Job Title: Head of Integrated Commissioning
Date: 4th March 2019

ATTACHED:

N/A

RELEVANT BACKGROUND PAPERS
N/A

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	**Tony Gallagher**	
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	**Peter McKenzie**	
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

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
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WOLVERHAMPTON CCG

Governing Body
9 April 2019

Agenda item 9

TITLE OF REPORT:	**Commissioning Committee – February 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 February 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 February 2019 meeting.

2. MAIN BODY OF REPORT

2.1 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

The Community Phlebotomy service continues to over perform, Rheumatology patients referred into RWT Community and may be contributing to the rise in demand, and activity is appropriately planned for 19/20.

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

The CCG is investing additional funding in the IAPT service to ensure delivery of the Access and Recovery targets. The Trust is currently in the process of recruiting additional staff and sourcing training.

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.

Other contracts

AQP Audiology

The contact for this service is due to expire at the end of June 2019 however due to service specification changes being agreed, an extension of 3 months was requested to allow for re-procurement process. The service will continue to be procured collaboratively.

DIEP Flap Breast Reconstruction

UHB Trust has served notice on this service and an alternative provider is currently being sought, a recent benchmarking being undertaken revealed that the price paid for this service is well in excess of the national tariff).

The committee noted the above update and approval was given for a 3 month extension requested for AQP.

Action - The Governing Body notes the updates and the decision made by the committee

2.2 Dementia Strategy

The Committee was presented with a report to a report on a joint Dementia strategy for Wolverhampton. The collaboration with the Local Authority, Public health and Wolverhampton CCG aims to ensure support to dementia diagnosis.

The Committee noted the above and approval was given.

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

2.3 Social Prescribing Report

The Committee was presented with an evaluation report of the pilot scheme launched in 2017. While the non-financial benefits of the service are clear, a request was made that

additional research take place to quantify the financial consequences, in particular a reduction in GP demand loads.

The Committee noted the above and assurance was given with update in 6 month.

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

2.4 Medicines Optimisation QIPP 2019/20 – Prescribing Incentive Scheme

The Committee was presented with a report to approve amendments of the current scheme for continued support to GP practices.

The Committee noted the above and approval was given.

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

2.5 Healthy Ageing Co-ordinator

The Committee was presented with a scheme for patients with frailty. A coordinator will assess the level of frailty of patients by undertaking a health ageing check using an assessment tool and identify the best support to improve their independent living standards.

The Committee noted the above, assurance and approval was given with a request for a 6 monthly reviews.

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

2.6 Review of Risks

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

The committee noted the update report

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: **28 February 2019**

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NHS
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WOLVERHAMPTON CCG

Governing Body
9 April 2019

Agenda item 9

TITLE OF REPORT:	**Commissioning Committee – March 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 March 2019
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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 February and March 2019 meeting.

2. MAIN BODY OF REPORT

2.1 Diagnostic Pathway for Autistic Spectrum

The committee noted that the report was originally presented at February 2019 committee for assurance and that it was being resubmitted for a decision.

The Committee noted the above and approval was given.

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

2.2 Contracting update

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

The Community Phlebotomy service experienced an over performance of approximately 25%. Upon raising this with the Trust, the CCG learned that patients seen in Acute Rheumatology are now being referred to RWT Community. Consequently, this has been raised as a counting and coding challenge with the Trust.

Dermatology

Work continues on a project to re-procure community dermatology services which involves movement of some activity out of RWT i.e. complex/cancer activity remaining at the Trust. The provider was advised to respond to the CCG on the 15th March 19 and formally advice

of the activity cohort the trust wished to remain with the Acute contract. This response remains outstanding and consequently an escalation letter will be send to the Trust.

2019/20 Planning Round

Discussions are continuing to reach an agreed position, whilst Finances position between RWT and WCCG has been agreed, associates and in particular South Staffs CCGs remain outstanding. Further meeting will take place in March 2019.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

Improving Access to IAPT

The CCG has commissioned the Big White Wall (BWW) to help deliver the IAPT service and increase access rates, communication is being increased to GPs and circulating market information to help achieve the 19% Target (presently at 18%).

Data Quality Improvement Plan (DQIP)

The new RIO system implementation has been delayed due to the Dudley and Walsall MHT merge and the alignment of their systems. Updates on progress will be forthcoming.

2019/20 Planning Rounds

There is a signed contract in place for the 19/20 Contract with the mental health provider.

Vocare – Urgent Care Centre

Discussions are currently ongoing with the provider, a proposal for 2019/20 contract has been received which is circa £3m and is significantly higher than the 18/19 £2.6m contract. Negotiations are ongoing and the CCG are optimistic of reaching a conclusion to the 19/20 contract settlement.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

The CCG has received a Contract Extension Proposal from WMAS which requests a significant increase in funding. Commissioners have been unable to agree financial terms for a two year extension. An alternative of a six month extension is being considered which will give a 12 month allowance to conduct a re-procurement process for this service.

The committee noted the update

Action - The Governing Body notes the updates provided

2.3 Review of Risks

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

The committee noted the update

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: **28 March 2019**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY MEETING
9th April 2019

Agenda item 10

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 significantly challenged • Mortality indicators remain above national rates relating to SHMI and require ongoing understanding and assurance. • Maternity performance issues continue to show improvement. • An action plan is in place regarding the amber risk around concerns 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 February 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.	Overall cancer performance at Royal Wolverhampton Hospital Trust (RWT) remains challenged. Performance of all cancer targets has deteriorated in January. There has been a further decline to 80% in the 2 week wait target and particular concern highlighted for performance relating to 2 week wait Breast Symptomatic in February, this is unprecedented. Key areas of concern, along with breast, are Urology, Upper GI, Dermatology and Head & Neck. Assurance is now provided relating to the actual or potential impact of harm to patients as a result of the delay. **Risk Mitigation:** • Trust is continuously receiving support from Intensive Support Team. • System wide work continues to impact the quality and timeframe of tertiary referrals. • STP cancer lead is fully briefed on the deteriorating performance on the 2 week wait and Wolves CCG have requested additional system support re additional capacity. • WCCG continue to engage with GP's to improve cancer referrals into the trust and a collaborative event to further support this work is planned. • Wolves CCG have requested NHSI support to identify any additional activity that could be potentially outsourced from RWT. • Cancer performance trajectories for year 2019/2020 are currently being discussed. • 15 patient pathways were reviewed within the 104 day harm reviews for December; no harm was identified as a result of the prolonged delay for these patients. • Weekly system wide assurance calls continue to provide updates on current cancer performance. • Referral activity is unprecedented for breast symptomatic pathway, CCG have requested PH analysis of this unprecedented demand, this is awaited.	
Mortality: RWT is currently reporting the highest Standardised Hospital Mortality	RWT is currently reporting the highest Standardised Hospital Mortality Index in the country. The SHMI for October 2017 to September 2018 is 1.21, which is a slight increase on the previous 1.20. The SHMI is rated red and the banding still remains higher than expected. The crude mortality rate for January has risen slightly to 3.44% compared to 3.13% in December; recognition there will be seasonal variation. RWT has a high percentage of in-hospital deaths for the local health economy	

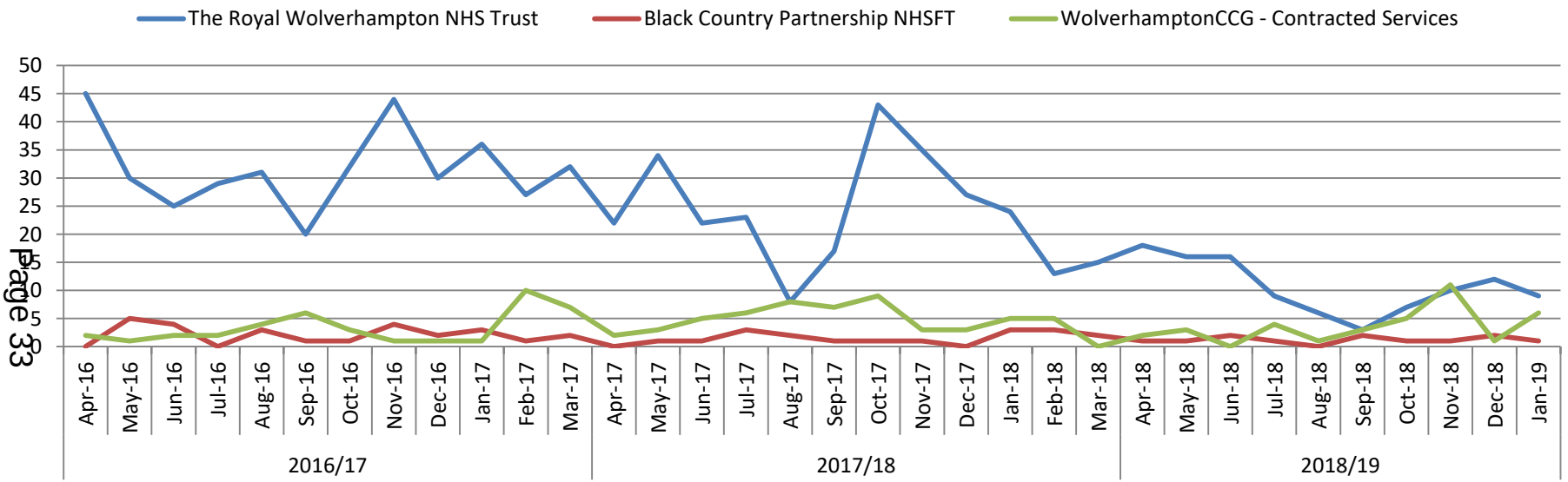
Key issue	Comments	RAG
Index in the country	compared with the national mean. **Risk Mitigation:** • The Trust mortality strategy 2019-2022 has been launched with a focus on ensuring that the organisation is learning though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care. • External review of mortality data has identified that not all co-morbidities are accurately captured within patient coding. This will potentially have a significant impact on expected death rates. Work is ongoing to accurately capture both secondary and subsequent consultant care episodes and appropriate depth of co-morbidity data. • The Trust continue implementation of the mortality improvement action plan which looks to address issues with clinical documentation, coding, and clinical analysis and associated learning. Quality improvement to clinical pathways continues following mortality review recommendations and additional workforce has been identified for some key pathways to support avoidable mortality eg: sepsis, EOL and deterioration. Action plan progress is monitored via CQRM. • A third audit of deceased patient records following death from sepsis or pneumonia has been undertaken and fed back to MRG. • Further challenge has been raised relating to outcomes of care from SJR2s and correlation of reported serious incidents. Confirmation is awaited.	
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:** • Trust has confirmed that Sepsis nurses are in post and currently working on key improvement initiatives to improve sepsis screening and administration of IVAB within 1 hour. • A revised ward quality audit system is in the final stages of development and will include sepsis and recognition of deterioration. When implemented CCG clinical team will attend the audit to gain assurance relating to processes • CCG have conducted a deep dive review into serious incidents relating to sub-optimal care of deteriorating patient. The review has identified failure to recognise and escalate deteriorating patients as a key theme but no particular theme around sepsis management.	
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:** • BCPFT have agreed to revised CQRM processes to enable further assurance to be gained. Strengthened	

Key issue	Comments	RAG
	reports, focusing on outcomes and actions, will be produced from April's data onwards. • BCPFT vacancy rate remains static in January but remains red rated against the target. Turnover remains within the target range • Performance against annual and 3 yearly mandatory training also improved during January. • Work continues in relation to improving MH bed capacity issues.	
Quality concerns identified at a Nursing Home providing discharge to access (D2A) provision could potentially impact on the quality and safety of care provided and also on the urgent care system within Wolverhampton	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:** • CCG's QNA Team will continue to support the care home manager with quality improvement initiatives and in particular the newly appointed clinical lead and senior nurse. • Progress against the improvement plan continues with support from QNA team. • Thematic review of falls to be undertaken following an identification of an increased number of falls incidents involving harm. • Further falls training being scheduled for April 2019 to incorporate lessons learnt from incidents. • Sustained improvement and monitoring visits to be continued by QNA team. • Care Home identified to participate in next wave of deterioration project. • Quality team are working with contracts team to consider the sustainability of provision for this provider.	
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:** • The Community Continence Service has commenced reviewing patients from VI practices who were discharged with a urinary catheter. Numbers of patients discharged with indwelling catheters are starting to reduce. • System wide engagement continues. Detailed plans are being developed and initial actions implemented. Plans are monitored at the 6 weekly E.coli system wide meetings.	

2. PATIENT SAFETY

2.1 Serious Incidents

Chart 1: Serious Incidents Reported by Month



In total 16 Serious Incidents (SIs) were reported in January 2019 which is a slight increase compared to 15 SI's reported in December 2018. There were 9 SI's reported by RWT, 1 SI reported for BCPFT and 6 SI's 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 January 2019

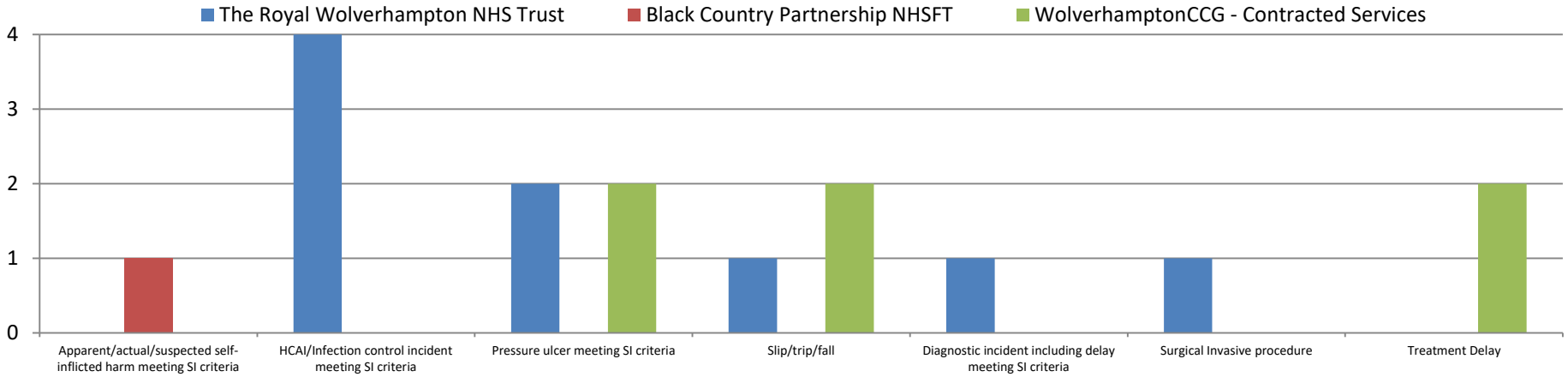


Chart 2 shows the breakdown of serious incident types reported by each provider for January 2019. RWT was the highest reporting provider (9).

Assurance

- A WCCG representative attends multiple review groups to provide assurance that serious incidents are being appropriately identified.
- WCCG is currently undertaking a thematic analysis of all suboptimal care, diagnostic delay and treatment delays SI's to establish whether there are any service related themes or wider issues or links recurring across these serious incidents.
- 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.

RWT Pressure Injuries Scrutiny meeting Update

RWT Adult Community Services have not reported any pressure injury related serious incident since 04.06.18, and recurrently report good quality actions particularly in extreme complex cases. In addition, there is significant reduction seen in number of pressure injury SI's reported by the inpatient areas for this financial year to date. WCCG attends weekly pressure injury scrutiny meetings to seek assurance, to identify any themes or trends and to challenge poor practice. In February 2019, there was 3 device related pressure injuries reported as an emerging theme, on investigation there were no omissions in care but some learning was identified for each area. The trust is looking into raising issues with the manufacturer. The learning from these incidents will be shared across the trust through "Making it Better" newsletter.

2.2 Never Events

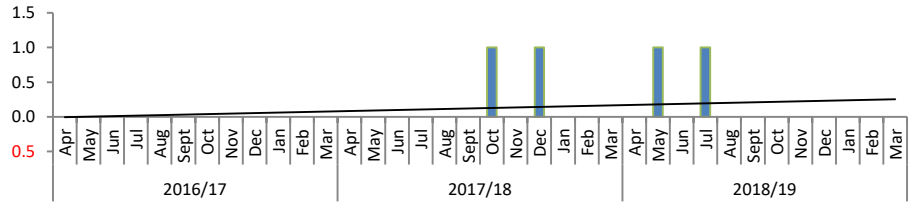
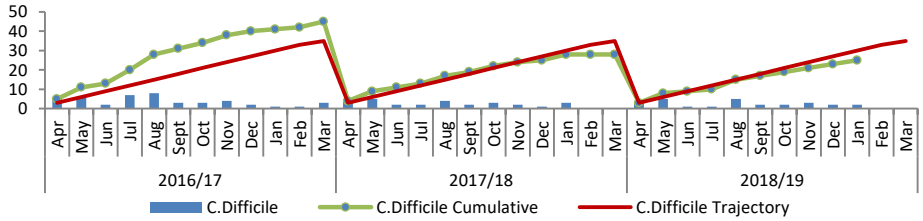
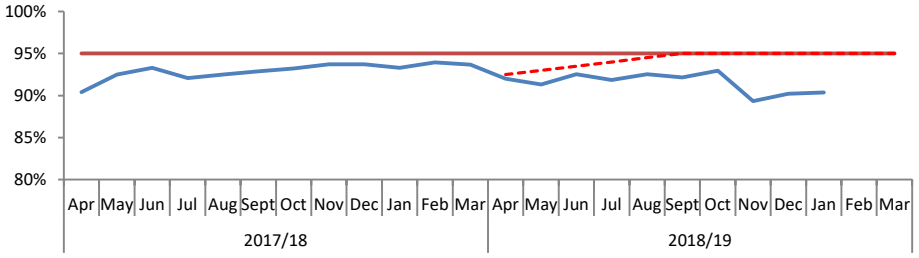
Table 1: Reported Never Events

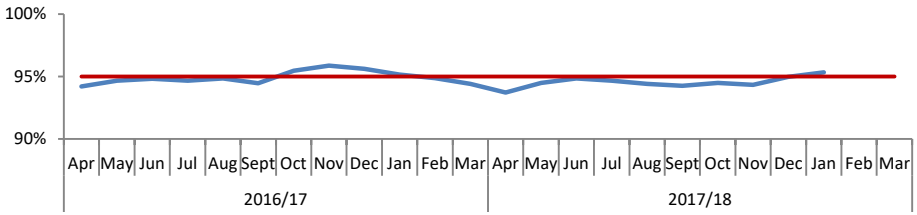
	Yr 16-17	Yr 17-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Yr to date
Royal Wolverhampton	**5**	**4**	2	0	2	0	0	0	0	0	0	0			**4**
Black Country Partnership	**0**	**0**	0	0	0	0	0	0	0	0	0	0			**0**
Other providers	**0**	**1**	0	0	0	0	0	0	0	0	0	0			**0**
Total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

There were no Never Events reported in December 2018 and January 2019.

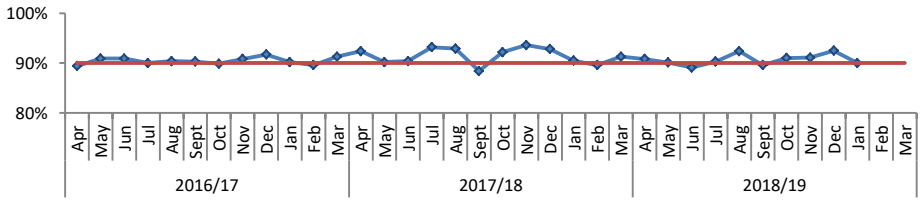
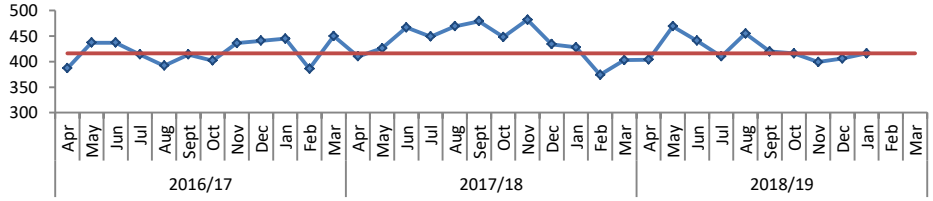
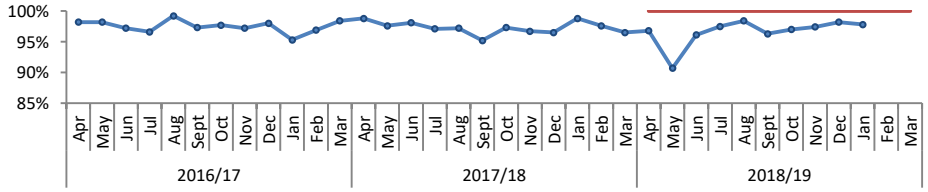
3. ROYAL WOLVERHAMPTON HOSPITAL TRUST

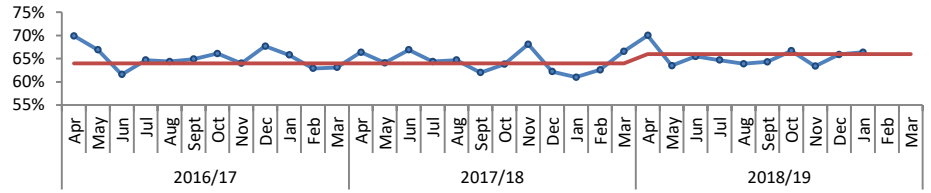
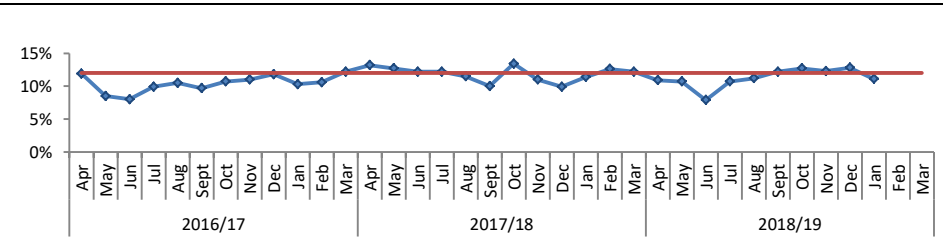
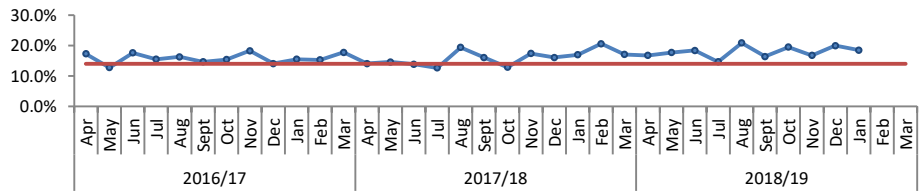
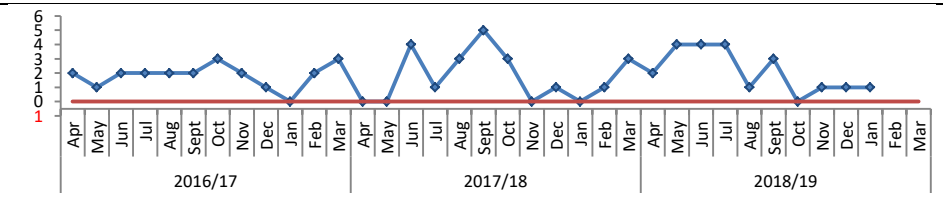
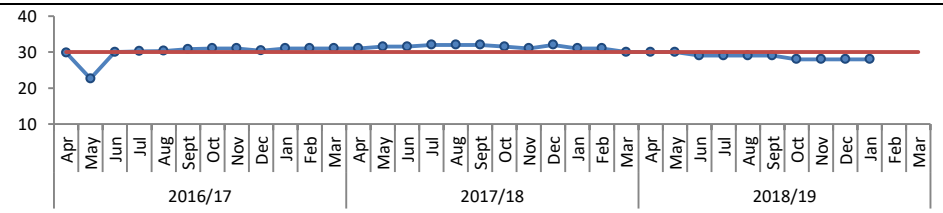
3.1 Infection Prevention

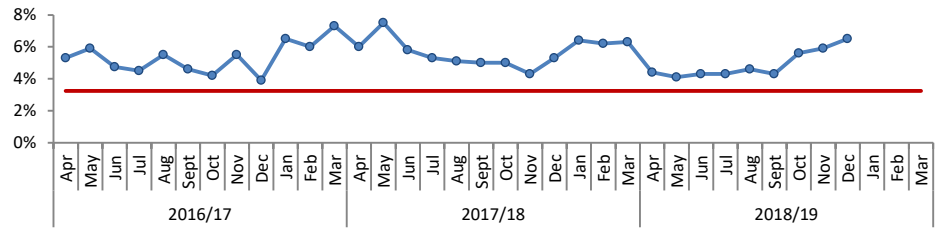
Measure	Trend	Target	Assurance/Analysis
MRSA		**0**	No new MRSA cases reported in January 2019.
C. Diff		**<35**	The Trust continues to remain below the monthly trajectory for 2018/19. A combination of antibiotic diversity, attendance at ward huddles and strong environmental controls is thought to have contributed. Two C. Difficile cases were reported for January 2019. 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 January increased slightly to 90.36% (December 90.22%). The Trust continues to take 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 January is 95.33% and has met the national standard of 95% for the second consecutive month since July 2018. 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.

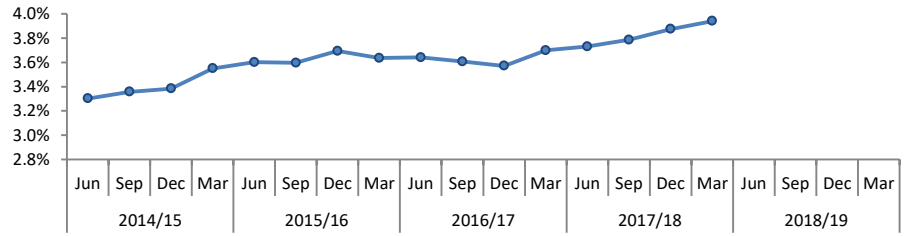
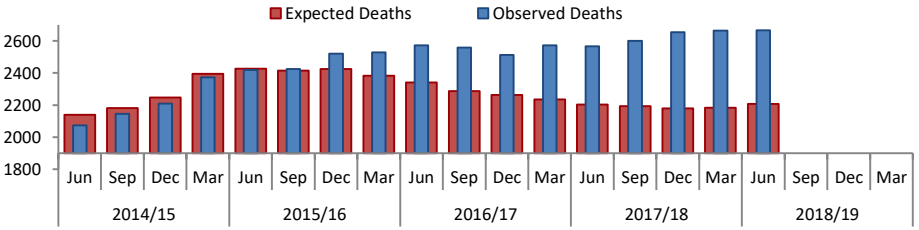
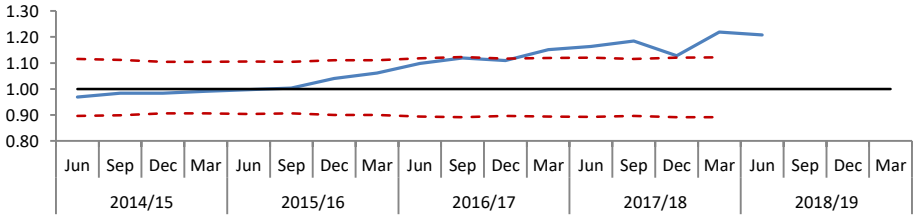
3.2 Maternity

Measure	Trend	Target	Assurance/Analysis
Bookings at 12+6 weeks		>90%	Monitoring of booking numbers continues with a review on booking restrictions in the spring. The figure for January decreased to 90% from 92.5% in December 2018.
Number of Deliveries (mothers delivered)		<416	The number of deliveries increased slightly to 416 (target) in January 2019 from 406 in December.
One to One care in established labour		100%	Ongoing recruitment of Midwives continues, with a number commencing in post shortly. One to one care in established labour decreased slightly in January 2019 to 97.8% from 98.2% in December.

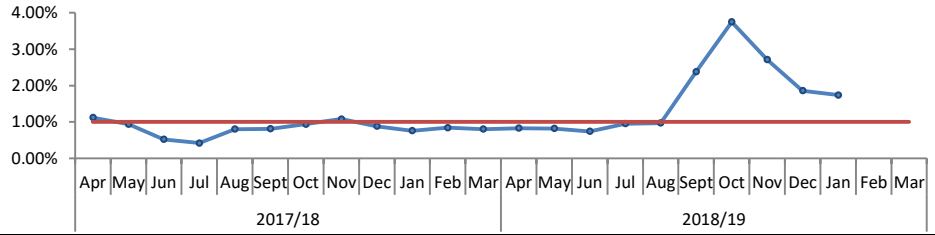
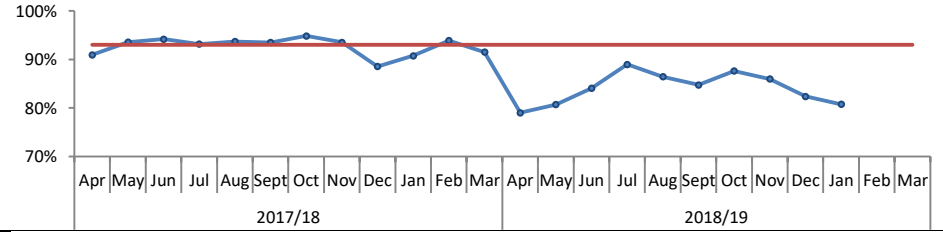
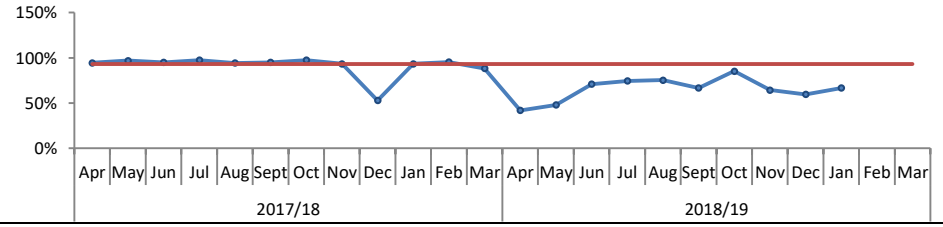
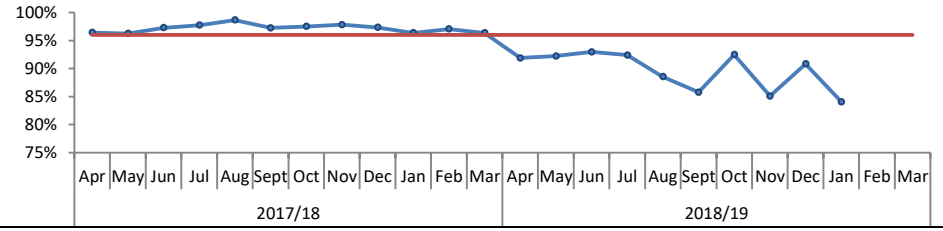
Measure	Trend	Target	Assurance/Analysis
Breastfeeding (initiated within 48 hours)		>=66%	The rate of breast feeding initiation in January 2019 met the threshold at 66.4%.
C-Section - Elective (Births)		<12%	The elective rate for elective C-Sections was 11.10% for January 2019, slightly below the 12% threshold.
C-Section - Emergency (Births)		<14%	Emergency C-section case rate decreased to 18.5% in January 2019, from 20% in December 2018. The Trust has undertaken a C-section audit following concerns relating to a rise in C-section rates and the audit findings has indicated that RWT is not an outlier in terms of national total rates.
Admission of full term babies to Neonatal Unit		0	One full term baby was admitted to neonatal unit during January 2019.
Midwife to Birth Ratio (Worked)		<=30	The Midwife to birth ratio has seen significant improvement over the last 8 months and currently stands at 1:28 and is within national standards.

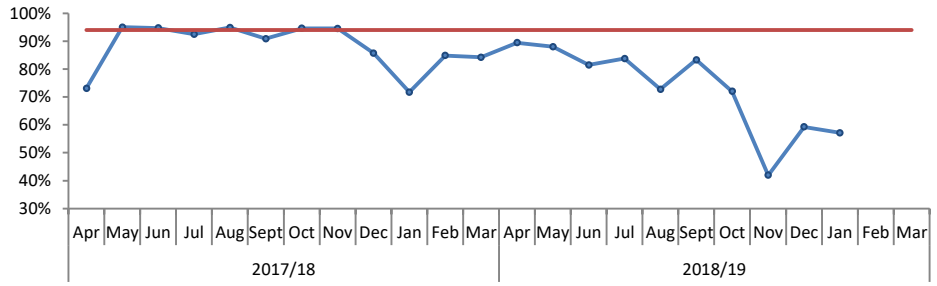
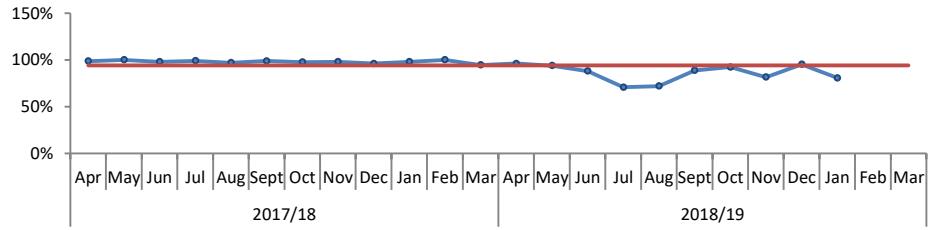
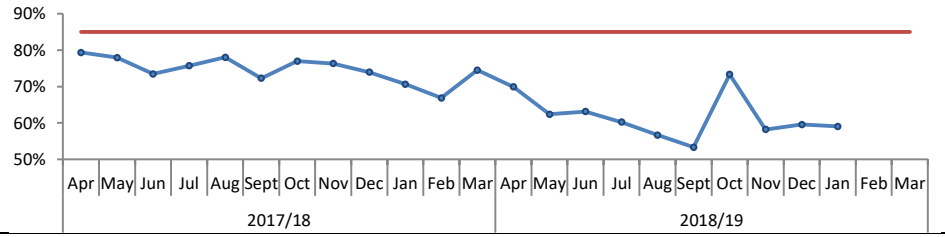
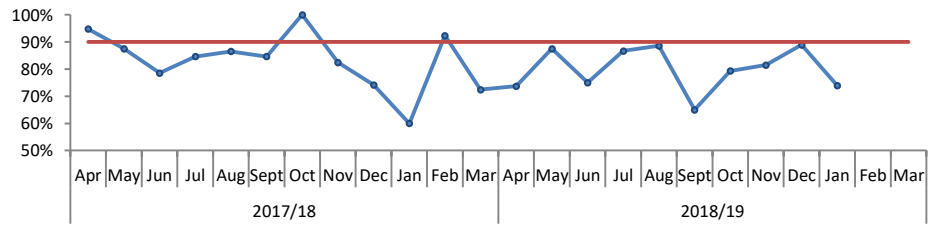
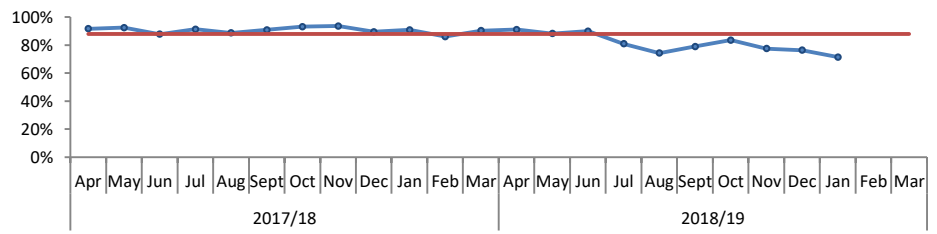
Measure	Trend	Target	Assurance/Analysis
Maternity - Sickness Absence		<3.25%	Maternity Sickness Absence saw an increase in December (reported one month behind) to 6.5%. November figure 5.9%, October figure 5.6%.

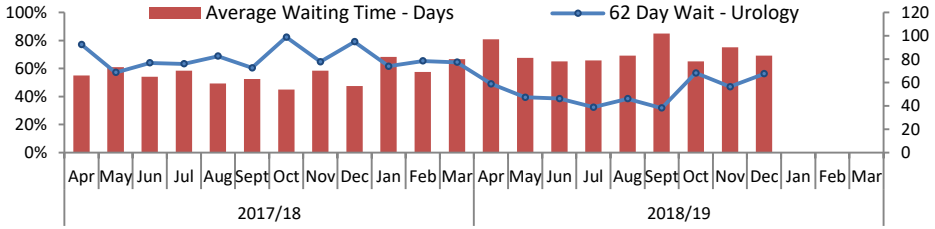
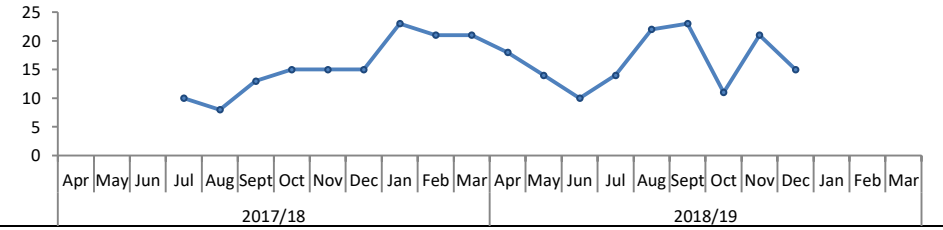
3.3 Mortality

Measure	Trend	Target	Assurance/Analysis
Mortality – Inpatient deaths		**N/A**	The SHMI for October 2017 to September 2018 is 1.21 and has been rated red and the banding still remains higher than expected. RWT remains a national outlier for this performance. The crude mortality rate for January has risen slightly to 3.44% compared to 3.13% in December. The trust has developed mortality strategy 2019-2022 to ensure that the organisation is learning from mortality though the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care. Trust is making good progress on the mortality improvement action plan which looks to address the governance arrangements, a city wide approach, clinical documentation, coding, clinical analysis and associated learning and overarching staffing. WCCG monitors this action plan via the monthly CQRM.
Mortality - SHMI Observed vs. Expected Deaths		**N/A**	
Mortality - SHMI		**N/A**	

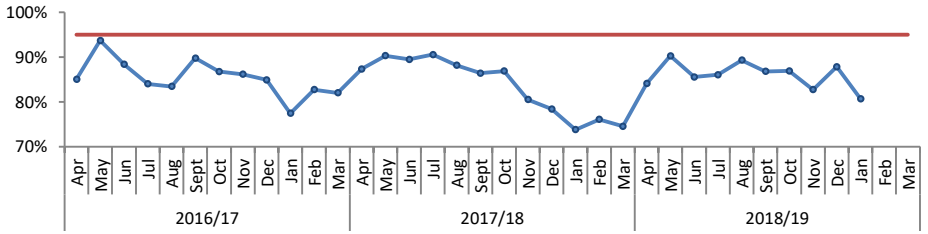
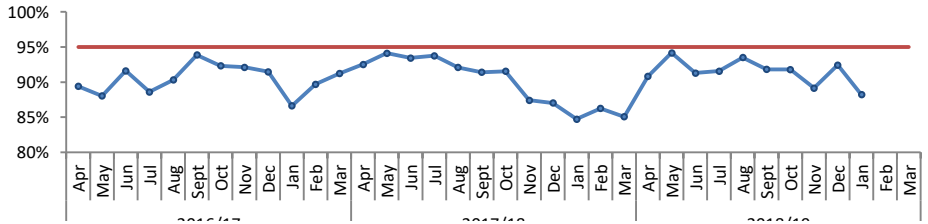
3.4 Cancer Waiting Times

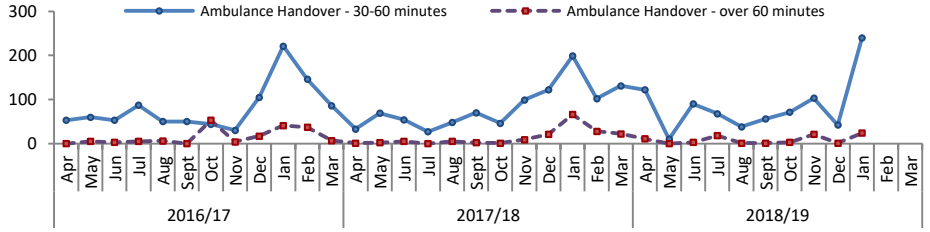
Measure	Trend	Target	Assurance/Analysis
6 Week Diagnostic Test		**<1%**	KPI remains red at 1.74% in January.
2 Week Wait Cancer		**93%**	The 2 week wait cancer performance position declined for the third consecutive month in January 2019 to 80.77% and remains below target. 75.9% Were due to capacity, 23.4% were Patient initiated, 0.77% were admin error.
2 Week Wait Breast Symptomatic		**93%**	January 2019 saw a slight improvement to 66.67% from 59.65% in December.1 patient initiated, 5 capacity.
31 Day to First Treatment		**96%**	The trust has not achieved this target for this financial year. The figure for January 2019 dropped to 84.04%. 31 Day to treatment – 78.9% Capacity, 21.1% Complex cases.

Measure	Trend	Target	Assurance/Analysis
31 Day Sub Treatment - Surgery		**94%**	The figure for January 2019 was 57.14%. 47.1% Capacity, 11.8% complex, 41.2% Tertiary referrals received between days 27 and 221.
31 Day Sub Treatment - Radiotherapy		**94%**	31 day sub treatment radiotherapy saw a decrease to 80.62% in January 2019 from 95.28% in December.
62 Day Wait for First Treatment		**85%**	Performance remained steady in January 2019 at 59.02%. 15 Capacity, 3 patient initiated, 12 complex, 17 tertiary referrals received between days 12 and 160.
62 Day Wait - Screening		**90%**	62-day wait screening target decreased significantly in January 2019 to 73.91% from 90% in December. 3 Patient initiated, 1 complex, 1 capacity
62 Day Wait - Consultant Upgrade (local target)		**88%**	The 62-day wait consultant upgrade (local target) performance for January 2019 saw another slight decline to 71.43% (76.32% in December).45.8% Capacity, 41.7% Complex, 12.5% Patient initiated.

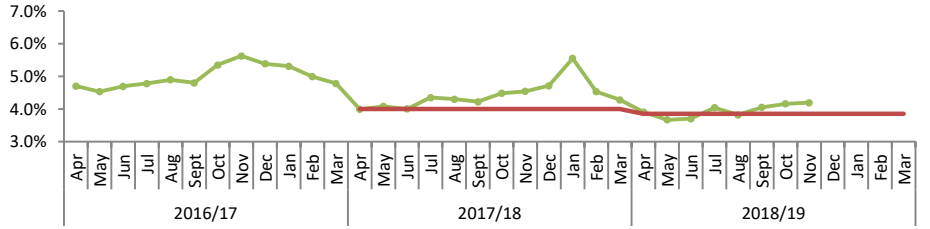
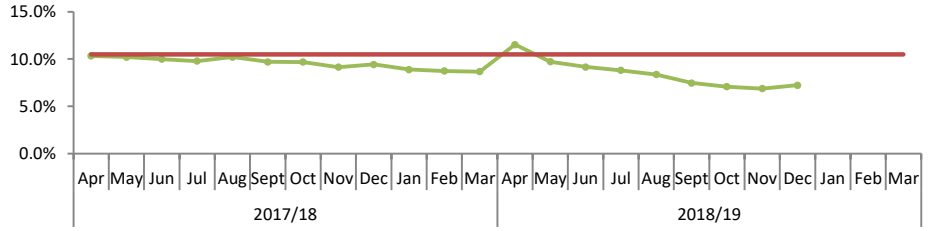
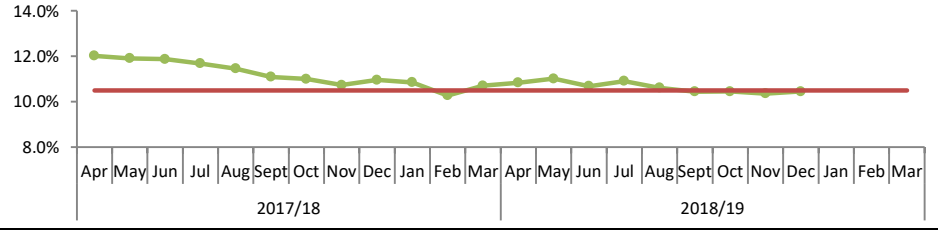
Measure	Trend	Target	Assurance/Analysis
62 Day Wait - Urology		**85%**	The average waiting time decreased to 83 in December.Performance for Urology in December was 56.14%.
Patients over 104 days		**N/A**	15 patients identified over 104 days in December 2018 compared to 21 in November. All of these patients had a harm review and no harm was identified.

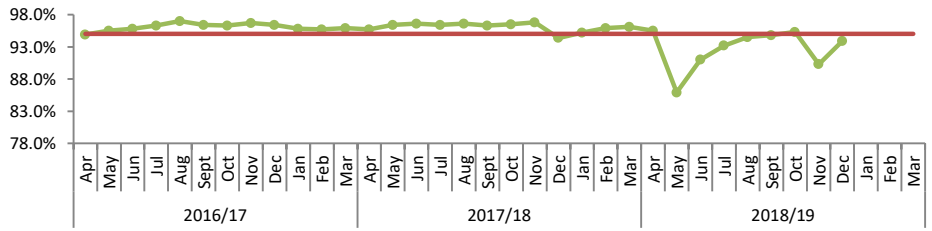
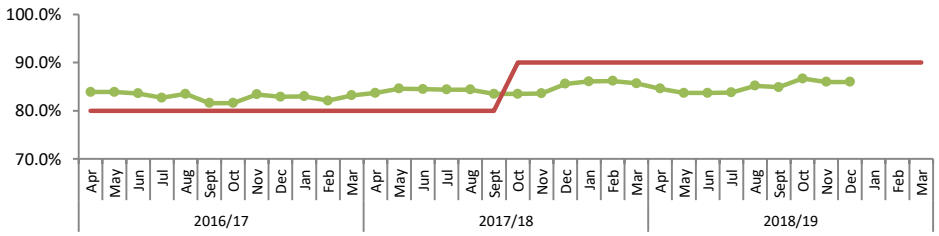
35 Total Time Spent in Emergency Department (4 hours)

Measure	Trend	Target	Assurance/Analysis
Time Spent in ED (4 hours) - New Cross		**92%**	Performance for New Cross declined in January to 80.69% and remains below target, however performance is the 27th best in the Country. 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 January 2018; overall performance declined to 88.23% compared to the previous month of 92.44%.

Measure	Trend	Target	Assurance/Analysis
Ambulance Handover		**N/A**	December saw a dramatic increase in ambulance handover 30-60 minutes, from 42 in November to 240 in December.24 ambulances breached the 60 minute handover in December compared with 1 in November.

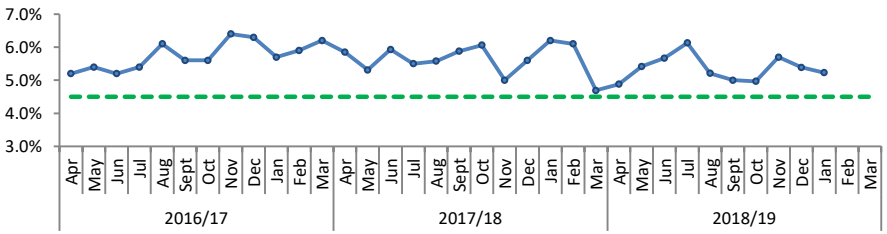
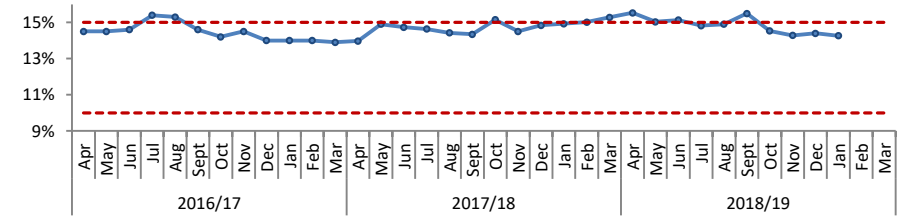
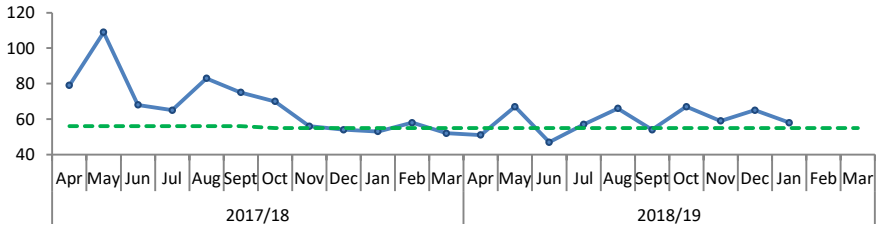
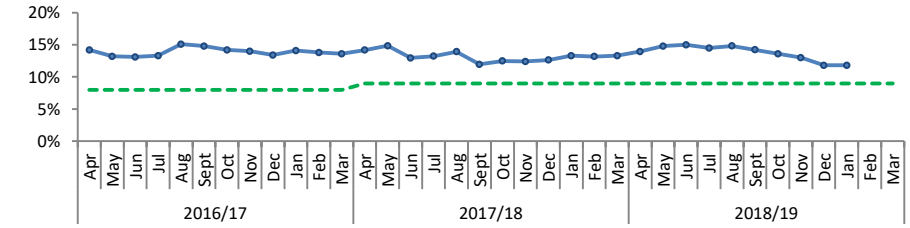
3.6 Workforce and Staffing

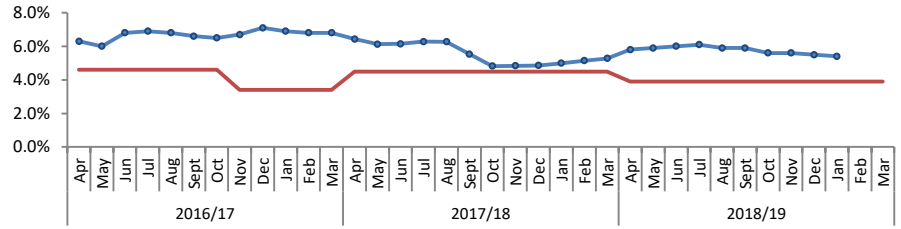
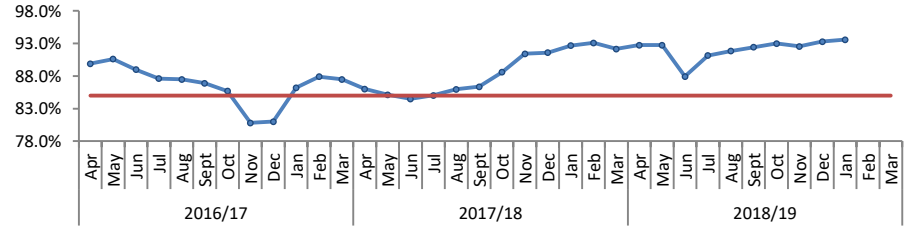
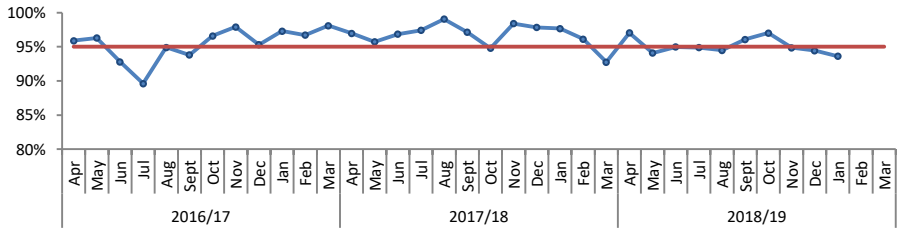
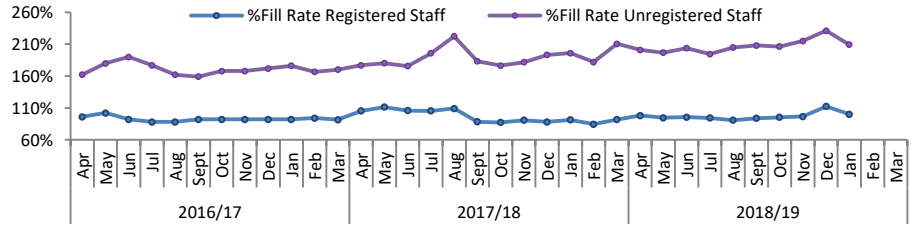
Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**3.85%**	Reported one month in arrears. Attendance levels have improved when considered over the rolling 12 month period despite the slightly worsened performance September to November 2018, driven primarily by an increase in seasonal absence. Actions to build on this improvement include continued focus particularly on long term absence, monthly sickness absence workshops in the divisions and a long term sickness absence tracker in Division 1.
Vacancy Rates (%)		**10.5%**	The vacancy rate has diminished slightly, driven by a slight reduction in the number of staff in post and a more significant increase in the budget WTE.
Staff Turnover Rates (%)		**10.5%**	Staff turnover for December 2018 remains steady at 10.45%.

Measure	Trend	Target	Assurance/Analysis
Mandatory Training Rate (%)		**95%**	Mandatory training (generic) compliance rates have improved in month with all Divisions now meeting the target of 95%. There is further work to do in BCPS and in sustaining these levels of performance to deliver compliance against the 95% target.
Appraisal Rate (%)		**90%**	Appraisal compliance remains below target, but has maintained 86% over the month of December. This is being closely monitored in the Divisions.

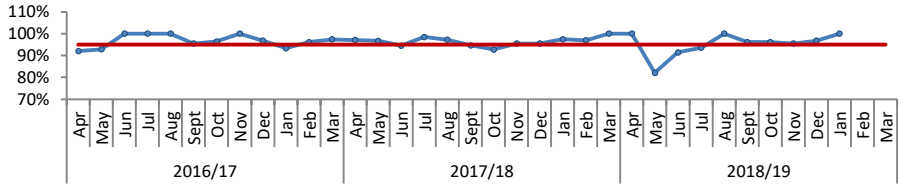
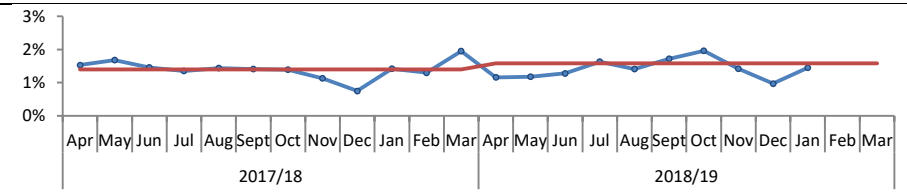
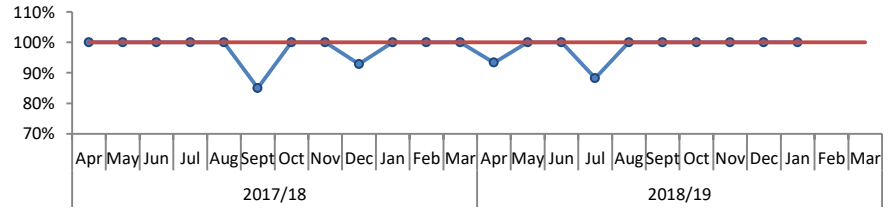
4. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

4.1 Workforce and Staffing

Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**<4.5%**	Sickness rate reduced further in January to 5.23% however, KPI remains red rated against a target of 4.5%.
Staff Turnover Rates (%)		**10-15%**	Turnover rate reduced slightly and remains within the target range.
Average Time to Recruit		**55**	Average time to recruit KPI improved to 58 working days in January slightly above the 55 working day target.
Overall vacancy rate		**<9%**	There was a small reduction in vacancy rate which reduced from 11.83% in December to 11.79% in January and remains red rated against the target.

Measure	Trend	Target	Assurance/Analysis
Agency Usage (%)		**<3.9%**	Agency usage continues to remain above target at 5.4% for January 2019.
Mandatory Training Rate (%)		**85%**	Performance against annual and 3 yearly mandatory training improved during January.
% of Shifts filled (Bank and Rostered)		**95%**	Work continues to monitor safe staffing. The Trust is planning to implement the safe care tool on allocate which will support the data collection process. It will also enable them to utilise the acuity tool to support safe staffing.
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 – January = 100%.
% of people with anxiety or depression entering treatment		**1.40%**	This indicator improved in January 2019, up to 1.58% from 0.97% in December.
% of inpatients with Crisis Management plan on discharge from secondary care		**100%**	Trust continues to achieve target of 100% for January 2019.

5.0 PRIVATE SECTOR PROVIDERS

5.1 Vocare

There are currently no quality issues or concerns and no serious incidents have been reported for January 2019. Vocare was rated “Inadequate” and “Requires Improvement” in their last two CQC inspections. However, a re-inspection of Wolverhampton Urgent Care Centre undertaken on 8th November 2018 has resulted in the service being rated as “good” in all areas and “good” overall. Vocare continues to achieve key performance targets month on month, there have been no quality matters raised recently. A permanent advanced lead practitioner/ manager will commence in April 2019. Assistant Operational Manager and Advanced Lead Practitioner are directly supported by the Regional Director, Assistant Director, Medical Director and Clinical Director: SMT meetings have been held weekly throughout January. Local Vocare is now an integral part of the Central Region and therefore also supported by clinical governance, safeguarding and pharmacy teams.

6.0 SAFEGUARDING

6.1 Safeguarding Children

- Work is progressing in regards to the development of a Black Country CDOP. The Designated Doctor (DD) and Deputy Designated Nurse Safeguarding Children (DDNSC) attended a further Steering Group meeting. The meeting reviewed the outcome of the stakeholder event that was held in November 18, clarified additional work that is needed to occur in regards to the 2 operational CDOP's that are in place (Wolverhampton / Walsall and Sandwell / Dudley), and a decision was made for the work to continue under the Terms of Reference of a shadow Black Country CDOP until the changes are officially in place in relation to the new Child Death Arrangements.

- The DDNSC held a meeting with Public Health; commissioners for the HV/SN service, the Head of Service for 0-19 and a member of RWT safeguarding team. This was to review and agree the processes and procedures that are in place in relation to the actions that occur when any notifications are received by the 0-19 service from A+E, hospital services and the Urgent Care Centre (provided by VoCare). Two processes were agreed on; one to use for paper records, and one to use when the records are to become electronic. A review of the quality and content of the notifications from VoCare is also going to occur with the support from the DDSNC

- The DDSCN and DD had a meeting with the new social worker team manager for MASH. This meeting was to discuss health's role and input in to strategy meetings and how to ensure that this can occur as effectively as possible. A process was agreed for the MASH professionals to follow to be able to access essential child protection paediatrician involvement at strategy meetings. A proposal was discussed in regards to direct input from HV and SN in to strategy meetings. The DDSNC to discuss and agree this proposal with RWT and the 0-19 services.

6.2 Safeguarding Adults

- Safeguarding Adult Review (SAR) scoping exercise has been carried out for a person who was found deceased at home, the decision is awaited as to whether this will proceed to a SAR
- The first meeting with the SAR author took place for another review following a death where neglect is suspected. WCCG is represented on the Panel by the Designated Adult Safeguarding Lead
- WCCG's Designated Adult Safeguarding Lead attended a Heath Education England Workshop in London to develop a blended learning package for Safeguarding Adults Level 3 training. Further workshop to take place in the summer
- LeDeR: 5 reviews have been submitted to Bristol. 2 further reviews almost complete. BCPFT LeDeR Reviewer is now in post and is supporting reviews across the Black Country. Black Country STP (ICS) LeDeR Learning Event is planned for later in the year.
- The newly appointed WCCG Quality and Safeguarding Adults Practitioner commenced in post in January 2019.
- A Review of the Wolverhampton Safeguarding Children's Board continues, in line with the new Working Together 2018. An independent reviewer has been commissioned by the Wolverhampton Safeguarding Board, with oversight from the 3 Statutory Partners (CWC, WCCG and the Police).
- Wolverhampton Safeguarding Board carried out a Parents with Disability Audit in January 2019, the results are awaited.
- A new Domestic Homicide Review notification was received in January 2019 (DHR 11). A scoping exercise is being carried out to determine the need for a full DHR.

6.3 Children and Young People in Care (CYPiC)

- The final task and finish group was held at WCCG in January, attended by Named and Designated professionals across the region, in order to finalise amendments to the current form, making them more child focused. Wolverhampton is piloting the forms with excellent feedback from children, Carers and professionals. It is anticipated that they will be adopted both regionally and nationally.

- 50 mile plus cohort; Whilst considerable work has been done to build and strengthen working relationships with the Provider Trust (RWT), it is unfortunate that issues arose around the sharing of information (from Trust to CCG) for this small cohort. This was internally escalated in January within WCCG and addressed accordingly. A review of the current commissioning arrangements is to be considered moving forward to ensure more timely access to relevant data.

6.4 Care Homes

There have been no acquired pressure injuries reported from care homes who participate in the Care Home Quality Improvement questionnaire for three consecutive months.

Use of the RITs team within Care Homes increased during January 2019 to 69, up from 44 in December.

Mortality data continues to show that the majority of nursing home residents are dying in care homes rather than in hospital (75% January 2019).

Of the 40 deaths in January, 30 died in nursing homes, 10 in hospital. 27 residents died in their preferred place of care (67.5%) with 25 of them having an EOL/Advanced Care Pathway (62.5%).

7.0 PRIMARY CARE QUALITY DASHBOARD

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

Issue	Concern	RAG rating
Infection Prevention	Three IP audit have been undertaken so far in February– the overall average rating is silver. The flu vaccination programme continues and stock of all vaccines is available across the city, some flu outbreaks have been noted in care homes. Work continues to drive the improvement in the management of sepsis in primary care.	1b
MHRA	Since 1st April 2018 • 44 weekly field safety bulletins with all medical device information included. • 5 device alerts/recalls • 15 drug alerts/recalls	1a
Serious Incidents	One serious incident currently under investigation at the practice	1b
Quality Matters	Currently up to date: 9 open 2 of these are overdue	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	No new complaints to report	1a
FFT	In January • 2 practices did not submit • 2 submitted fewer than 5 responses (supressed data)	1a
NICE Assurance	NICE assurance is now linked to GP Peer Review system – last meeting in early November	1a
CQC	One practice currently have a Requires Improvement rating and is 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	Spirometry training, Nursing Associate and HCA apprenticeship business case are currently being finalised. 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 the risk around this has been reviewed. HEE have been reviewing the role and function of the Training Hubs in light of the re-procurement process.	2

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GOVERNING BODY

Agenda item 11

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 26th February 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	£421.747m	£421.747m	Nil	G
Revenue Administration Resource not exceeded	£5.560m	£5.460m	£0.100m	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£370k	£354k	(£16k)	G
Maximum closing cash balance %	1.25%	1.20%	(0.05%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£11.538m	£11.538m	Nil	G
Programme Cost *	£336,897k	£339,056k	£2,159k	G
Reserves *	£2,070k	£0k	(£2,070k)	G
Running Cost *	£4,633k	£4,543k	(£90k)	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) M9 data indicates a financial under performance.
- The CCG is reporting a forecast underspend of £1m to £1.4m within Delegated Primary Care as claims in respect of QOF, maternity and sickness claims and developments are less than planned.
- 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;

	Annual Budget £'000	YTD Performance M10						
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)
Acute Services	200,692	167,243	167,813	571	0.3%	201,445	753	0.4%
Mental Health Services	39,877	33,235	33,562	328	1.0%	40,234	357	0.9%
Community Services	40,802	34,009	34,033	24	0.1%	40,894	92	0.2%
Continuing Care	15,107	12,589	12,486	(103)	(0.8%)	14,980	(127)	(0.8%)
Primary Care Services	53,632	44,694	44,833	139	0.3%	53,813	180	0.3%
Delegated Primary Care	36,023	30,019	29,309	(710)	(2.4%)	34,623	(1,400)	(3.9%)
Other Programme	17,585	15,108	17,020	1,911	12.7%	19,763	2,178	12.4%
Total Programme	**403,718**	**336,897**	**339,056**	**2,159**	**0.6%**	**405,753**	**2,035**	**0.5%**
Running Costs	5,560	4,633	4,543	(90)	(1.9%)	5,460	(100)	(1.8%)
Reserves	2,483	2,070	0	(2,070)	(100.0%)	548	(1,935)	(77.9%)
Total Mandate	**411,761**	**343,599**	**343,599**	**(0)**	(0.0%)	**411,761**	**(0)**	**(0.0%)**
Target Surplus	9,986	8,322	0	(8,322)	(100.0%)	0	(9,986)	(100.0%)
Total	**421,747**	**351,921**	**343,599**	**(8,322)**	(2.4%)	**411,761**	**(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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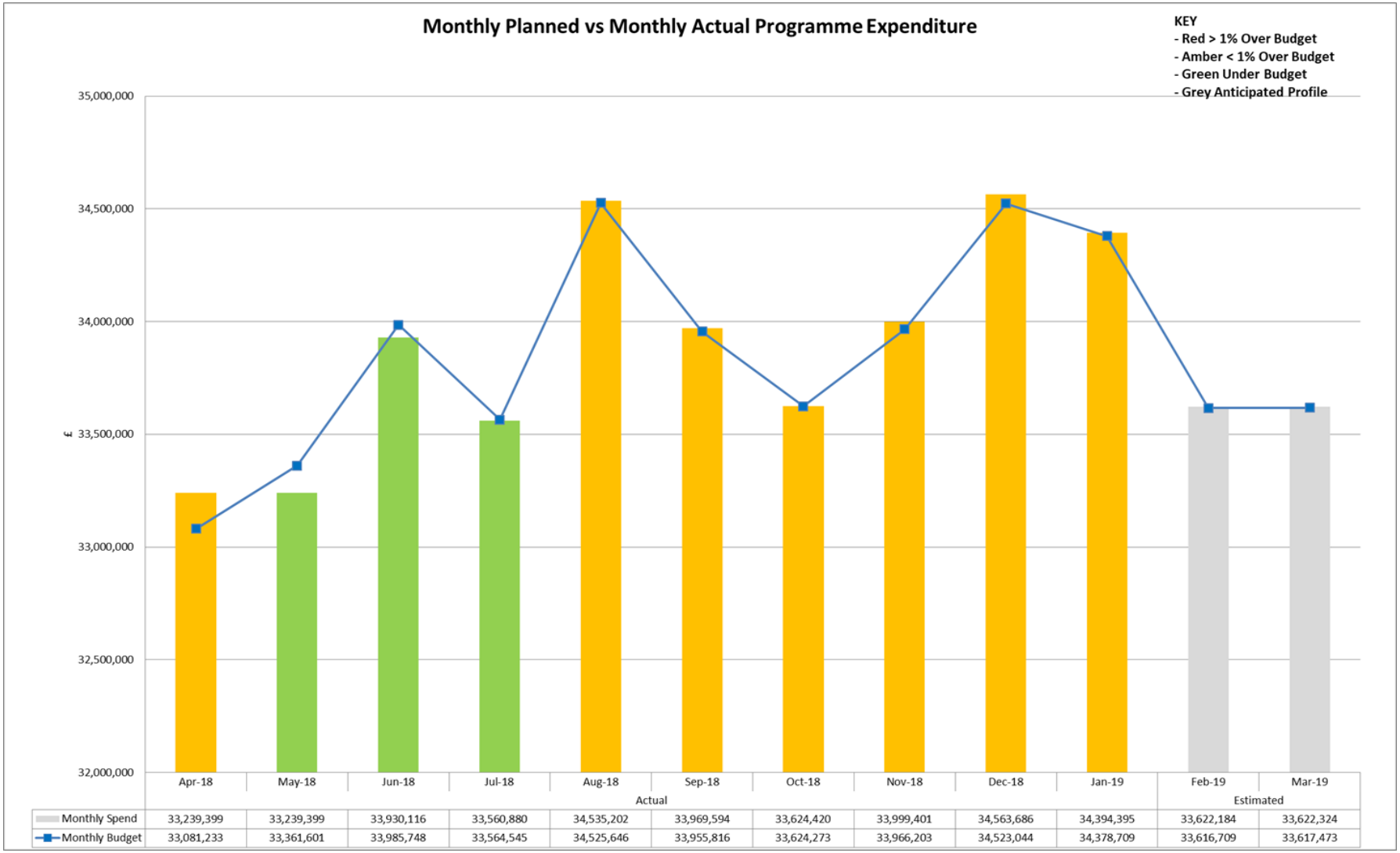
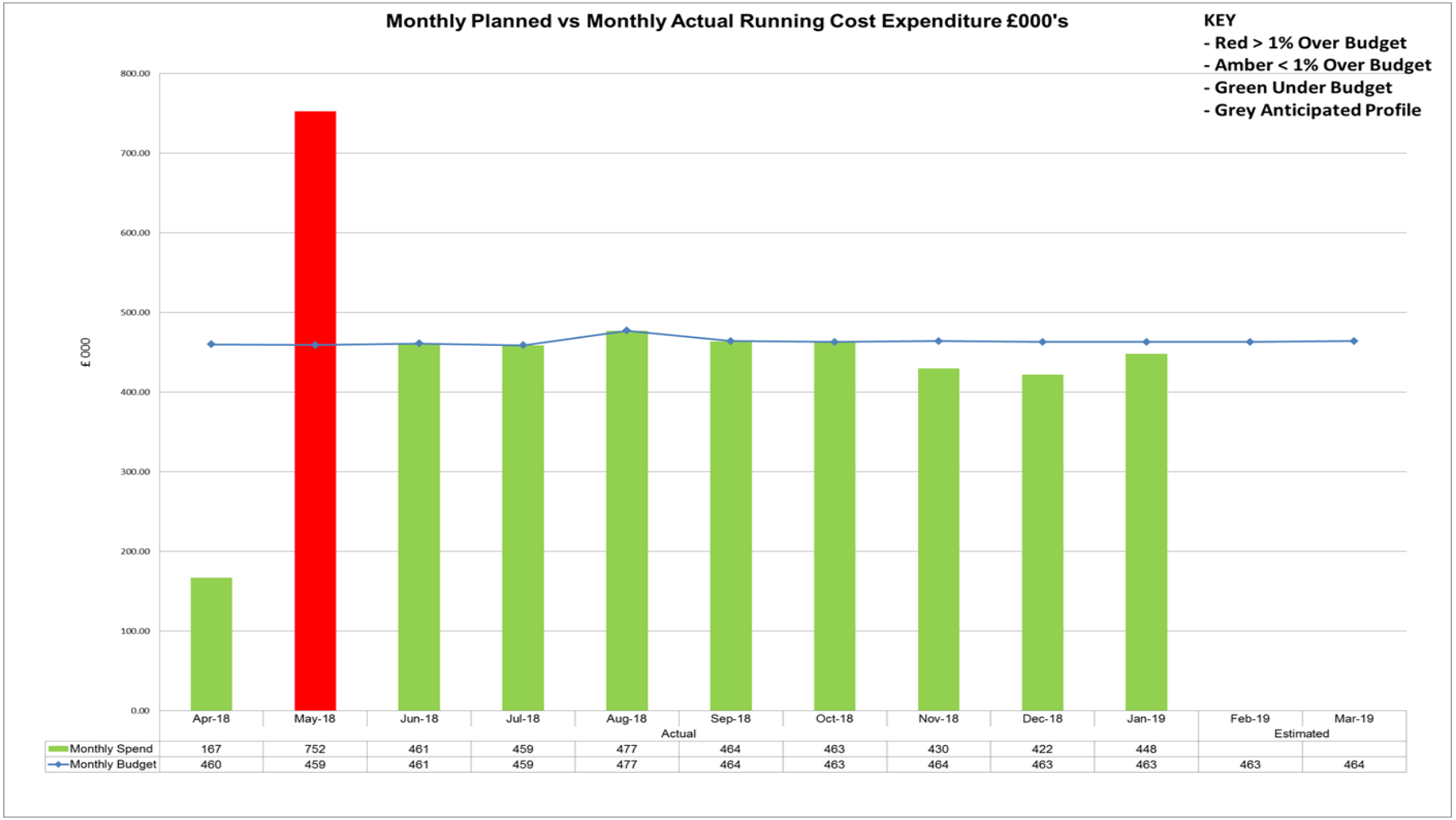
CCG UNDERLYING POSITION	Forecast Net Expenditure				Remove Non Recurrent Items				Part/Full Year Effects		2018/19 Underlying Position
	Plan £m	Actual £m	Variance £m	Variance %	NR Allocations & Matched Expenditure £m	NR QIPP Benefit £m	Contingency £m	Other NR Spend / Income £m	QIPP £m	Other £m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	411.761				(9.495)						402.266
Acute Services	200.692	201.445	(0.753)	(0.4%)	(1.244)	-		(6.729)			193.471
Mental Health Services	39.877	40.234	(0.357)	(0.9%)	(2.726)	-		(0.766)			36.743
Community Health Services	40.802	40.894	(0.092)	(0.2%)	-	-		0.247			41.141
Continuing Care Services	15.107	14.980	0.127	0.8%	-	-		(0.173)			14.808
Primary Care Services	53.632	53.813	(0.180)	(0.3%)	(2.151)	-		0.512			52.174
Primary Care Co-Commissioning	36.571	35.171	1.400	3.8%	0.285	-		1.096			36.552
Other Programme Services	19.520	19.763	(0.243)	(1.2%)	(3.617)	-	(2.021)	0.216			14.341
Commissioning Services Total	406.201	406.301	(0.100)	(0.0%)	(9.453)	-	(2.021)	(5.597)	-	-	389.230
Running Costs	5.560	5.460	0.100	1.8%	(0.042)	-		0.097			5.515
TOTAL CCG NET EXPENDITURE	411.761	411.761	0.000	0.0%	(9.495)	-	(2.021)	(5.500)	-	-	394.745
IN YEAR UNDERSPEND / (DEFICIT)	-	0.000	0.000	0.0%							

Underlying Underspend / (Deficit)	7.521
% 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	34,563,686	34,394,395	33,622,184	33,622,324
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	34,378,709	33,616,709	33,617,473


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
800.00
700.00
600.00
500.00
400.00
300.00
200.00
100.00
0.00
Actual
Estimated
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19
Monthly Spend 167 752 461 459 477 464 463 430 422 448
Monthly Budget 460 459 461 459 477 464 463 464 463 463 463 464

DELEGATED PRIMARY CARE

- Delegated Primary Care allocations for 2018/19 as at M10 are £36.571m. The forecast outturn is £35.171m delivering a forecast underspend position of £1.4m.
- In 17/18 the CCG assumed responsibility for Primary Care Co-Commissioning budget, now referred to as Delegated Primary Care, from NHSE. At the end of the financial year 17/18 included an accrual for £3.4m which was for any expenditure relating to 17/18 which would not be claimed until 18/19. This expenditure included QOF, developments and general expenditure such as sickness/maternity claims. The actual level of claims received is less than anticipated and although the CCG has explored options to bring forward planned developments it has been unable to do so and as a consequence at this stage is forecasting an underspend of £1.4m.
- The 0.5% contingency and 1% reserves are showing an underspend year to date but the expendiutre is sitting on other GP services and will be fully utilised by year end. In line with NHSE planning matrics no expenditure should be shown on the 0.5% contingency and 1% reserves
- The table below shows the outturn for month 10:

	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	18,591	18,852	262	22,309	22,309	0		0	0
General Practice PMS	1,597	1,256	(341)	1,916	1,916	0		0	0
Other List Based Services APMS incl	2,027	2,374	347	2,433	2,433	0		0	0
Premises	2,348	2,091	(257)	2,817	2,817	0		0	0
Premises Other	79	50	(29)	94	94	0		0	0
Enhanced services Delegated	739	640	(99)	887	887	0		0	0
QOF	3,168	3,075	(93)	3,802	3,802	0		0	0
Other GP Services	1,471	970	(500)	1,765	365	(1,400)		(1,400)	0
Delegated Contingency reserve	152	0	(152)	183	183	0		0	0
Delegated Primary Care 1% reserve	305	0	(305)	366	366	0		0	0
Total	**30,476**	**29,309**	**(1,167)**	**36,571**	**35,171**	**(1,400)**		**(1,400)**	**0**

2018/19 forecast figures have been updated on quarter 4 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 Month10 QIPP is being reported as delivering on plan supported through the application of reserves and underspends in the overall position.

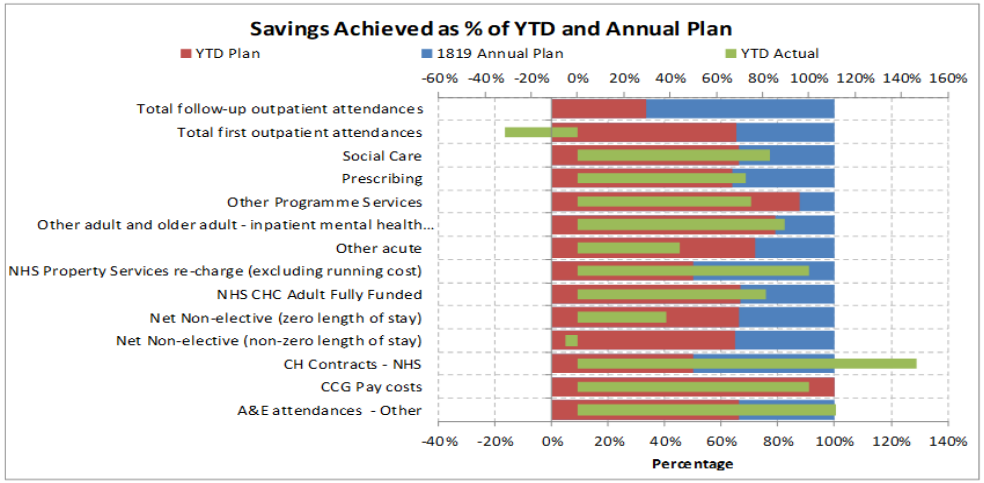
NHS
Wolverhampton
Clinical Commissioning Group

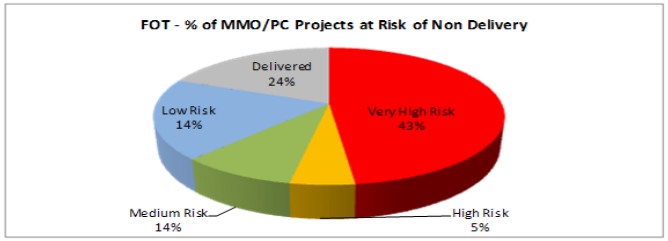
QIPP Programme Delivery Board

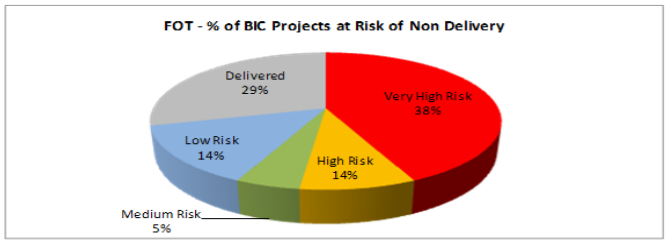
Mth 10 - Jan 18/19

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

Area of Spend Category	Annual Plan	April to Jan (YTD) Plan	YTD (Non ISFE)	Variance from Plan (YTD)	FOT (Non ISFE)	FOT Variance from Annual Plan	Jan (YTD) Prog Brd diff from Plan	Jan (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	-270	-319
Net Non-elective (non-zero length of stay)	4921	3199	3199	0	4921	0	3460	4553
Net Non-elective (zero length of stay)	1618	1072	1072	0	1618	0	447	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	100
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	-100	0
Other Programme Services	160	140	140	0	160	0	20	40
Prescribing	2507	1603	1603	0	2507	0	-221	159
Social Care	500	332	332	0	500	0	-84	0
Total first outpatient attendances	718	468	468	0	718	0	694	718
Total follow-up outpatient attendances	221	74	74	0	221	0	74	221
Grand Total	13947	9248	9248	0	13947	0	4172	6114



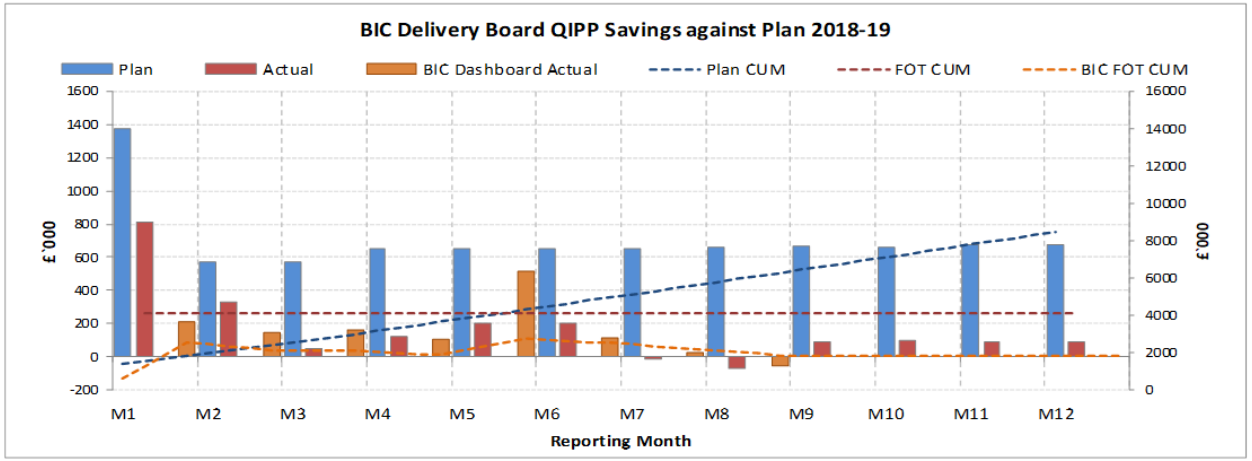


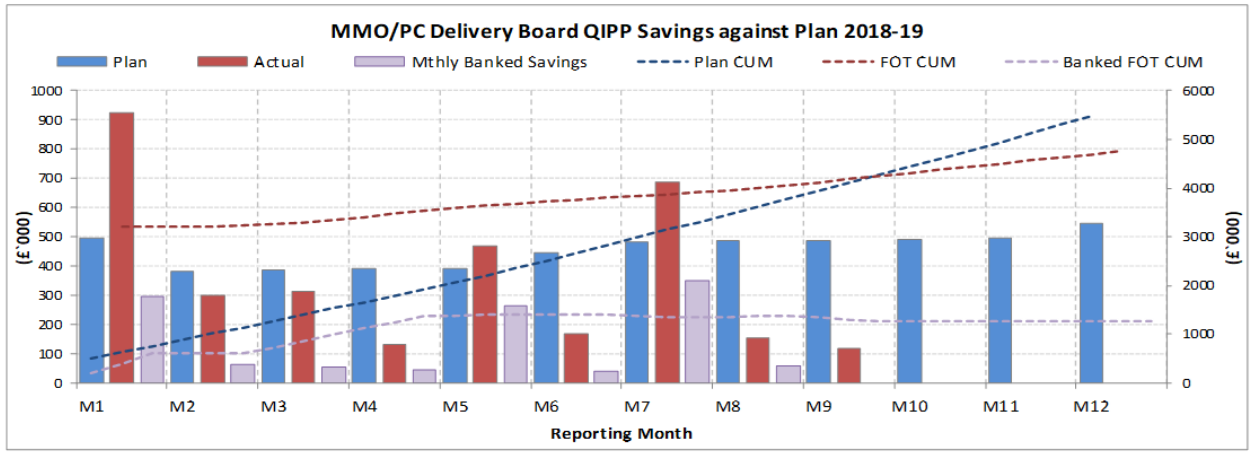


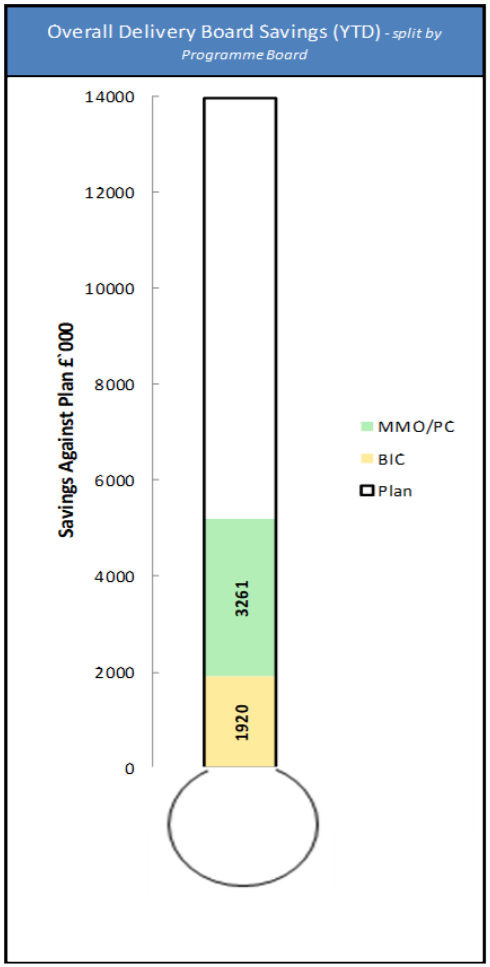
QIPP Programme Delivery Board

Mth 10 - Jan 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 31st January 2019 is shown below:

	31 January '19 £'000		31 December '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	2,212		2,803	3	-590
Cash and Cash Equivalents	355		132	4	222
	2,567		2,935		
Total Assets	**2,567**		**2,935**		
Current Liabilities					
Trade and Other Payables	-42,917		-43,210	5	293
	-42,917		-43,210		
Total Assets less Current Liabilities	**-40,350**		**-40,275**		
TOTAL ASSETS EMPLOYED	**-40,350**		**-40,275**		
Financed by:					
TAXPAYERS EQUITY					
General Fund	40,350		40,275	6	75
TOTAL	**40,350**		**40,275**		

Key points to note from the SoFP are:

- The cash target for month 10 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);

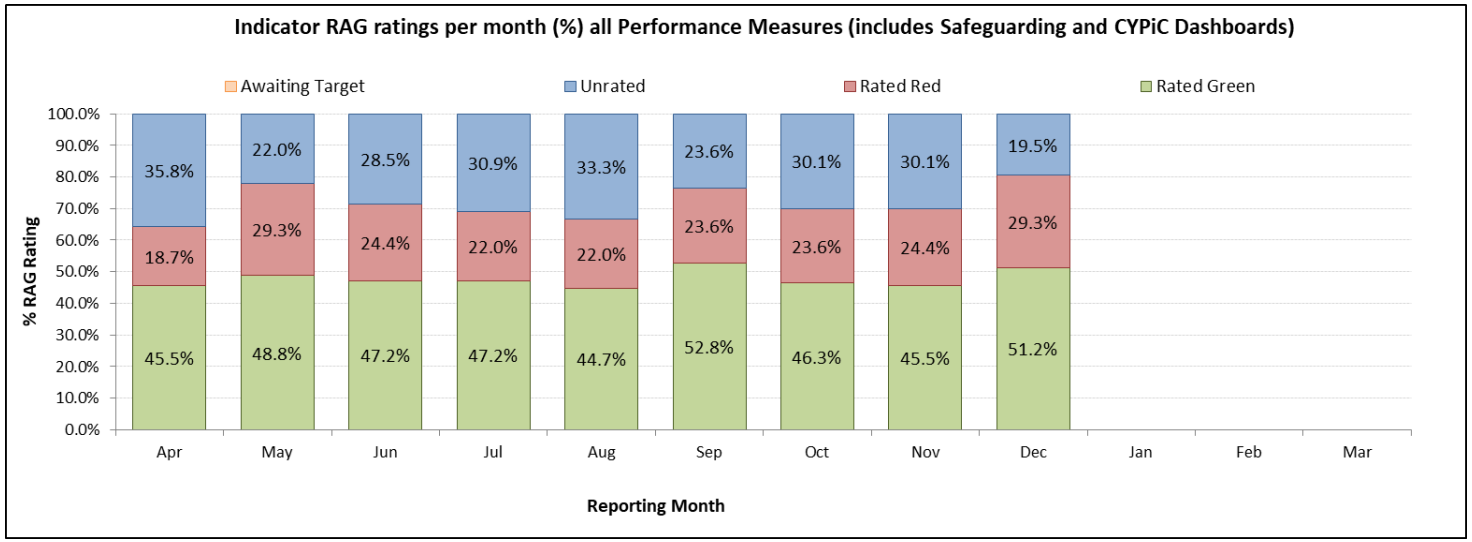
- **PERFORMANCE**

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

Executive Summary - Overview

Dec-18

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	8	8	14	15	2	1	0	0	**24**
Outcomes Framework	8	7	7	8	11	11	0	0	**26**
Mental Health	24	30	3	6	14	5	0	0	**41**
Sub Totals	***40***	***45***	***24***	***29***	***27***	***17***	***0***	***0***	***91***
RWT - Safeguarding	6	4	3	3	3	6	0	0	**13**
RWT - Children & Young People in Care (CYPiC)	0	4	0	2	6	0	0	0	**6**
BCP - Safeguarding	10	10	2	2	1	1	0	0	**13**
Dashboard Totals	***16***	***18***	***5***	***7***	***10***	***7***	***0***	***0***	***32***
Grand Total	**56**	**63**	**29**	**36**	**37**	**24**	**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

RTT data measures waiting times from referral to the start of first definitive treatment in weeks at treatment speciality level. The length of the RTT period is reported for patients whose RTT clock stopped during the month, and those who are waiting to start treatment at the end of the month.

- The Trust's verified performance for December was 90.7% with an average (median) waiting time of 6.8 weeks and 92% patients waiting 19 weeks to start treatment.
- M9 in-year trajectory (as agreed with NHSI) of 91.2% has not been achieved, however performance is better than the national position of 86.6% (down from 87.3% in November).

- Trust had been achieving the national requirement to sustain or reduce RTT waiting list size against the March 18 baseline of 33,858; however for the first time in 2018/19 the list size in December exceeds this position at 34,998.
- December performance has been affected by patients choosing to wait until post-Christmas to commence treatment.
- Increased referrals have continued for Gastroscopy, Colonoscopy and Flexible Sigmoidoscopy, this is directly linked to the increase in 2ww referrals.
- Additionally it would appear that there is a national issue with increase in referrals following paper switch off in October, the Trust is meeting with CCG colleagues and NHS Digital to explore the reasons for this and to identify any actions to resolve this.
- Zero 52 week waiters have been reported by the Trust. The November patient waiting over 52 weeks at The Royal Orthopaedic Hospital NHS Foundation Trust (T&O) has been removed from the waiting list.
- The % of patients waiting 6 weeks (or more) for diagnostic tests has not achieved the national target of 99% with performance in December at 98.14%.
- Performance has been steadily improving since October and the Trust have confirmed that performance is improving and issues have been resolved with Neurophysiology, Endoscopy and Flexible Sigmoidoscopy anticipated to return to achieving the 99% standard in January.
  Capacity remains an issue in cardiac MRI, however, the Trust reports that performance should return to standard February.

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

- 92.4% of A&E attendances were admitted, transferred or discharged within 4 Hours in December; achieving the monthly PSF trajectory target of 90.2%.
- Although the Trust fell short of the national target of 95%, nationally only 11 acute trusts out of 136 achieved the national standard with RWT ranked at 28th.
- NHS England performance was 86.4% and the Black Country STP achieved 82.73%.
- No patient breached the 12 hour decision to admit target.

3.1.3. Cancer 2WW, 31 Day and 62 Day

- December validated national performance for the 62 Day from referral to 1st definitive treatment has been confirmed as 67.02% (based on 31 breaches out of 94, with 9.5 patients at 104+ days).
- The Trust has once again achieved the agreed recovery trajectory which was 63% for December.
- All 104+ patients had a harm review and no harm was identified.
- The Trust received 13 Tertiary Referrals in December; only 5 were received by the standard of day 38, 6 by day 62, 2 had already breached 104 days at d138 (UGI from Sandwell) and d176 (Urology from Heartlands Hospital).
- The increase in Breast cancer referrals following Breast Cancer Awareness Campaign has continued in to December, January and February shows no signs of abating. It is suspected that this is reflected nationally and NHSI are currently investigating further as there is no obvious cause of the sustained increase in level of referrals.
- Current performance levels :

Ref	Indicator	Target	Dec18	YTD
EB6	2 Week Wait (2WW)	93%	81.69%	84.30%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	46.00%	63.24%
EB8	31 Day (1st Treatment)	96%	88.42%	89.39%
EB9	31 Day (Surgery)	94%	51.72%	73.12%
EB10	31 Day (anti-cancer drug)	98%	90.70%	97.02%
EB11	31 Day (radiotherapy)	94%	95.33%	88.39%
EB12	62 Day (1st Treatment)	M8=57.6% (Recovery) 85% (National)	61.14%	61.48%
EB13	62 Day (Screening)	90%	88.89%	81.20%

The Trust have 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 96.5% (against a 95% target).
  - Assessment Units which is currently showing as failing (89.58%) 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 contract target figures are in discussion as the CCG base performance against the 17/18 yearend target of 92.5%. The Trust have submitted an exception report indicating reasons for underperformance as :
- No overnight ward clerk support, regular attenders and the clerking of patients onto the system.
- Actions have been identified which include an approved business case for a 24 hour ward clerk.

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 = 1.10% against a 2.00% target) and all delays (including social care of 2.79% based on 17/18 threshold of 3.5%)
- The Trust have identified that the main areas of delays remain :
  - Further Non Acute NHS (top NHS delay = 2.42 average bed day delay)
  - Care Packages in Home (top Social Care delay = 7.0 average bed day delay, additional NHS element of 0.4 average bed day)
- The proportion of Staffordshire patient delays at the Trust during November has been confirmed as 41.44% of the total delays (Wolverhampton patients = 48.01%).

3.1.6. Serious Incident Breaches (SUIs) - RWT

- 1 breach was identified for December (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	*Dec18*	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*	26

3.1.7. Safeguarding

- 8 out of the 19 Safeguarding and Young People in Care (CYPiC, formally known as LAC) indicators were reported as achieving targets for December 2018 (and 6 non submissions).
- ***Children:*** Exception reports have been received for 2 CYPiC assessment indicators which identify staff capacity as an issue, with the Paediatric Advance Nurse Practitioner booking additional clinics throughout Quarter 4 to support the service.

3.1.8. Infection Prevention

- Hand Hygiene compliance has seen an increase in December but remains below the 95% target at 90.22%.
  - Trust Actions: to gain assurance from each directorate that an effective process for 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).
  - Discussions on how best to enforce this mandatory training will be undertaken in the New Year.
- Infection Prevention Training (Level 2) has seen an increase in December and close to the 95% target at 94.96%.
  - Infection prevention compliance is discussed monthly with directorates with non-compliant staff names raised with line managers.

3.1.9. CHC Checklist (LQR11)

- The performance for the Continuing Health Care checklist has seen an increase in performance during December to 96.00%.
- Breach reasons have been confirmed as templates not being completed in full (unsigned and not dated).

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 MHMDS is subject to a publication data lag, with latest data confirming 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)

- December failed to achieve the 2018/19 in-month target of 1.58% with 0.97%, this has impacted on the Year to Date which remains below the cumulative target (YTD= 12.94% against an YTD target of 14.25%); performance is measured against the Year End target of 19%. Based on the December data, subsequent months will need to achieve 2.02% (an additional 131 patients per month) to meet the year end 19% target.
- Two trainees commenced posts in January and Coventry University have confirmed that three successful PWP trainees will commence in March 2019.
- The CCG are exploring the use of Serenity (local counselling service) and IESO (national electronic -on-line therapy) to support access rates. 3rd party providers (The What! Centre and WPH) have supplied files for upload to the Mental Health Minimum Data Set (MHMDS) to support STP performance. However, initial uploads have been declined by the national system due to file errors.

3.2.3. Safeguarding

- 10 out of the 13 Safeguarding indicators were reported as achieving targets for December 2018 (and 1 non submission).
- The 2 failing indicators both relate to Level 1 training (1 x Children, 1 x Adults). Issues with the ESR e-learning tool prevented staff from accessing the relevant training, which has had a subsequent impact on the performance for both indicators. As the system was unavailable until 11th January 2019, it is expected that the M10 compliance will also see an impact.

3.3. Other Providers :

3.3.1. Referral to Treatment Time (18weeks) – Nuffield Wolverhampton

- The performance for the Nuffield (Wolverhampton) has previously been included within this report due to a discrepancy in reported numbers. National publications have confirmed the December performance as below target at 87.95% (with the Wolverhampton element at 87.47%).
- 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 18/19 SQPR has since been updated to Wolverhampton only totals – with discussions for Provider total performance on-going.
- Following the RTT national reporting queries, the December Monthly Activity Report (MAR) commissioner submission was initially highlighted as a null submission from the Nuffield, however has since been updated. The National Reporting process and timeliness of submissions is to be raised via the Contract Review Meeting.

3.3.2. Serious Incident Breaches (SIs) – Compton Care

- 1 breach was identified for December, which relates to a Slip/Trip/Fall meeting Serious Incident Criteria.

4. RISK and MITIGATION

The CCG submitted a M10 position which included 0.6m risk which has been fully mitigated. There is no change from the previous month.

.

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 Plan.

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

6. Budget 19/20

The Committee received a paper regarding the Budget for 19/20 demonstrating the one year financial plan, as required by NHSE, meets all planning metrics and delivers a balanced budget. The high level planning metrics are:

- Tariff inflation 3.8%
- Tariff efficiency (1.1)%
- Application of Ambulance specific allocation of £366k
- Minimum cumulative historic underspend to be 1%
- Local contingency to be a minimum 0.5%
- Minimum in-year position is break even prior to agreement of drawdown of historic underspend
- Admin costs to remain within allocation
- MHIS (Mental Health Investment Standard) to be delivered including the additional 0.7% growth
- Better Care Fund minimum contribution must be complied with
- Drawdown only with permission of NHSE

Removal of the requirement for any portion of the allocation to be spent non recurrently. Although there is no requirement for the CCG to spend recurrent resource non recurrently (previously 1% reserve) although NHSE have advised the CCG should maintain 1% underlying surplus.

	£'000	£'000	£'000	£'000	£'000	£'000
Allocations	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Core CCG	360,146	382,540	400,035	417,446	434,477	450,910
Delegated PC	36,552	39,275	41,204	43,576	45,484	47,448
Programme total	396,698	421,815	441,239	461,022	479,961	498,358
RC	5515	5,516	4,865	4,865	4,865	4,865
CCG Total	**402,213**	**427,331**	**446,104**	**465,887**	**484,826**	**503,223**
Core %		6.22%	4.57%	4.35%	4.08%	3.78%
Delegated %		7.45%	4.91%	5.76%	4.38%	4.32%
overall Programme%		6.33%	4.60%	4.48%	4.11%	3.83%
RC %		0.02%	-11.80%	0.00%	0.00%	0.00%

Growth has been based on two elements, demographic (ONS) projections as provided by Public Health, and non ONS projections derived from trend analysis. The table below details the impact on each component of the CCGs allocation following the adoption of these assumptions.

	b/f recurrent	Inflation	Efficiency	ONS Growth	Non ONS growth	Developments	QIPP	Total 19/20
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Programme costs	360,146	12,266	- 3,738	2,005	9,251	15,247	- 12,435	382,742
Delegated Primary Care	36,552	1,243	- 402	212	336	2,069	- 735	39,275
Running Costs	5,515	-	-	-	104	-	- 305	5,314
Total as per LTFM M9v5	**402,213**	**13,509**	**- 4,140**	**2,217**	**9,691**	**17,316**	**- 13,475**	**427,331**

In order to submit a balanced, assured plan for 19/20 the CCG has included a QIPP programme of £13.5m, 3.2% of its allocation. This is an extremely stretching target. The table below summarises the CCG QIPP challenge

	£'000	%
Acute Services	7,865	58.4%
Mental Health	1,564	11.6%
Community	-	0.0%
CHC/FNC	375	2.8%
Prescribing	2,323	17.2%
Co Commissioning	735	5.5%
Running Costs	305	2.3%
Total allocated	**13,167**	**97.7%**
Unallocated	309	2.3%
Total	**13,476**	**100.0%**

The CCG has identified risks included within the 2019/20 budgets which total £3.05m. The key risks are as follows:

- £750k relates to potential level of overspend in the Acute Sector, a somewhat lower figure than 18/19 in anticipation of the agreement of an Aligned Incentives contract.
- £500k in relation to the volatility of Mental Health services particularly individual cases and NCAs.
- £500k associated with Prescribing and the volatility within this budget particularly around NCSO and QIPP
- £200k in relation to the uncertainty around Other Programme Services such as NHSPS.
- £1.1m potential slippage in QIPP schemes

The CCG has identified mitigations for risks as detailed below.

- £1.95m - as in 2018/19 the CCG will utilise all of the Contingency reserve to offset overspends if they arise.
- £1.1m of further efficiency extensions.

2019/20		RISKS (enter negative values only)						MITIGATIONS (enter positive values only)									
CCG RISKS & MITIGATIONS	Plan	Contract	Efficiency	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investments Uncommitted	Further Efficiency Extension	Non-Recurrent Measures	Delay / Reduce Investment Plans	Other Mitigations	Potential Funding	TOTAL MITIGATIONS	TOTAL NET (RISK) / MITIGATION	Of Which: RECURRENT
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
REVENUE RESOURCE LIMIT (IN YEAR)	427,154																	
REVENUE RESOURCE LIMIT (CUMULATIVE)	437,140																	
Acute Services	206,290	(750)	(1,000)	0			(1,750)	750			1,000					1,750	0	500
Mental Health services	40,106	0	(100)	0		(500)	(600)	500			100					600	0	500
Community Health Services	44,899	0	0	0			0				0					0	0	
Continuing Care Services	15,743	0	0	0			0				0					0	0	
Primary Care Services	56,831	0	0	0	(500)		(500)	500			0					500	0	
Primary Care Co-Commissioning	39,275	0	0	0			0				0					0	0	
Other Programme Services	16,509	0	0	0		(200)	(200)	200			0					200	0	
Commissioning Services Total	419,653	(750)	(1,100)	0	(500)	(700)	(3,050)	1,950	0	0	1,100	0	0	0	0	3,050	0	1,000
Running Costs	5,316	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0
Unidentified QIPP			0				0				0					0	0	
TOTAL CCG NET EXPENDITURE	424,969	(750)	(1,100)	0	(500)	(700)	(3,050)	1,950	0	0	1,100	0	0	0	0	3,050	0	1,000
Contingency	2,186																	
IN YEAR UNDERSPEND / (DEFICIT)	0																	
CUMULATIVE UNDERSPEND / (DEFICIT)	9,986																	

As a consequence of the risks and mitigations the CCG starts 2019/20 with nil net risk.

7. RISK REVIEW

The Committee conducted a review of the Committee risk profile with an emphasis on whether each risk should either continue to be Treated or the residual level of risk be Tolerated. The Committee also considered if any of the risks had been mitigated enough to bring about closure or whether they can be de-escalated to be managed as business as usual.

8. CCG FINANCE PLAN AND BUDGET FOR 2019/20

The Committee noted the 2019/20 planning submissions made by the CCG. Assurance was taken from the quality and financial considerations which have been taken into account during the planning round.

The Committee recommends to the Governing Body that it signs off the budget, noting the inherent risk.

9. 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.

10. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Financial Officer**
Date: **27th February 2019**

NHS
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Performance Indicators 18/19

Current Month: Dec-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%	98.14%	98.31%	↓	
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%	92.44%	91.84%	↑	
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%	81.69%	84.38%	↑	
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%	46.00%	61.76%	↑	
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%	88.42%	89.36%	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94.0%	51.72%	74.45%	↓	
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%	90.70%	96.95%	↓	
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%	95.33%	87.92%	↑	
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%	61.14%	61.31%	↓	
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%	88.89%	81.25%	↑	
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	1	23	↑	
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	42	600	↑	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	0	1	59	↑	
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%	93.03%	92.77%	↑	
RWTCB_S10B	Duty of candour (Note : Yes = Compliance, No = Breach)	Yes	No	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%	99.92%	99.89%	↑	

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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%	98.82%	98.66%	⇩		
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	95.0%	96.55%	95.81%	⇧		
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%	89.58%	84.85%	⇧		
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	2.0%	1.10%	1.03%	⇩		
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	26	⇧		
RWT_LQR7	Number of cancelled operations - % of electives	0.8%	0.44%	0.47%	⇩		
RWT_LQR10	DToC – compliance with checklist *awaiting confirmation of removal to Schedule 6	95.0%	72.22%	66.96%			
RWT_LQR11	% Completion of electronic CHC Checklist	98.0%	96.00%	88.65%	⇧		
RWT_LQR12	E-Referral - ASI rates	10.0%	No Data	25.06%			
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	90.0%	No Data	90.55%			
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	80.0%	96.59%	91.22%	⇧		
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	60.0%	87.10%	85.54%	⇧		
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	92.5%	99.67%	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			

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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
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%	90.22%	91.62%	↓	
RWT_LQR29	Infection Prevention Training Level 2	95.0%	94.96%	94.46%	↑	
BCP_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	92.00%	95.69%	96.45%	↓	
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	9		
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	99.89%		
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	95.80%		
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%	No Data	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%	78.48%	84.69%	↓	
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%	100.00%	98.92%	↑	
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%	16.81%	12.37%		
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%	100.00%	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%	100.00%	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%	100.00%	84.62%		
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%	100.00%	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%	96.77%	94.98%	↓	
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%	100.00%	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%	97.99%	↑	
BCP_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	80.00%	93.02%	94.49%		
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%	88.20%	85.76%		

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%	96.21%	96.80%	↓	
BCP_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	95.00%	100.00%	99.55%	→	
BCP_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	7.50%	0.00%	1.26%	↑	
BCP_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	95.00%	97.39%	99.34%	↓	
BCP_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	85.00%	97.30%	95.65%	↓	
BCP_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	85.00%	97.58%	98.89%	↓	
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%	63.64%	→	
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%	61.54%	58.81%	↑	
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%	78.48%	84.69%	↓	
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%	100.00%	98.92%	↑	
BCP_LQIA04	Percentage achievement in data validity across all IAPT submissions on final data validity report [Target - >80%, Sanction: GC9]	80.00%	No Data	92.87%		
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%	0.97%	12.98%	↓	
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	12.94%	12.94%	↑	
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%	96.83%	↑	
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%	100.00%	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

Agenda item 11

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 26th March 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.

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	£422.588m	£412.602m	(£9.986m)	G
Revenue Administration Resource not exceeded	£5.560m	£5.460m	(£0.100m)	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£403k	£54k	(£349k)	G
Maximum closing cash balance %	1.25%	0.18%	(1.07%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£12.716m	£12.716m	Nil	G
Programme Cost *	£370,940k	£373,426k	£2,486k	G
Reserves *	£2,414k	£0k	(£2,414k)	G
Running Cost *	£5,096k	£5,024k	(£72k)	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) M10 data indicates a financial under performance.
- The CCG is reporting underspend of £970k within Delegated Primary Care as claims in respect of QOF, maternity and sickness claims and developments are less than planned offset by the requirement for a provision in respect of an on-going issue relating to PMS/GMS.
- 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 M11						
	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	201,410	184,625	185,385	759	0.4%	202,468	1,059	0.5%
Mental Health Services	39,843	36,525	37,113	588	1.6%	40,500	657	1.6%
Community Services	40,882	37,479	37,497	19	0.1%	40,931	49	0.1%
Continuing Care	15,114	13,855	13,530	(325)	(2.3%)	14,809	(305)	(2.0%)
Primary Care Services	53,702	49,227	49,271	43	0.1%	53,752	50	0.1%
Delegated Primary Care	36,023	33,021	32,634	(387)	(1.2%)	35,053	(970)	(2.7%)
Other Programme	17,435	16,209	17,997	1,787	11.0%	19,081	1,646	9.4%
Total Programme	**404,409**	**370,940**	**373,426**	**2,486**	**0.7%**	**406,594**	**2,185**	**0.5%**
Running Costs	5,560	5,096	5,024	(72)	(1.4%)	5,460	(100)	(1.8%)
Reserves	2,633	2,414	0	(2,414)	(100.0%)	548	(2,085)	(79.2%)
Total Mandate	**412,602**	**378,450**	**378,450**	**(0)**	(0.0%)	**412,602**	**(0)**	**(0.0%)**
Target Surplus	9,986	9,154	0	(9,154)	(100.0%)	0	(9,986)	(100.0%)
Total	**422,588**	**387,604**	**378,450**	**(9,154)**	(2.4%)	**412,602**	**(9,986)**	(2.4%)

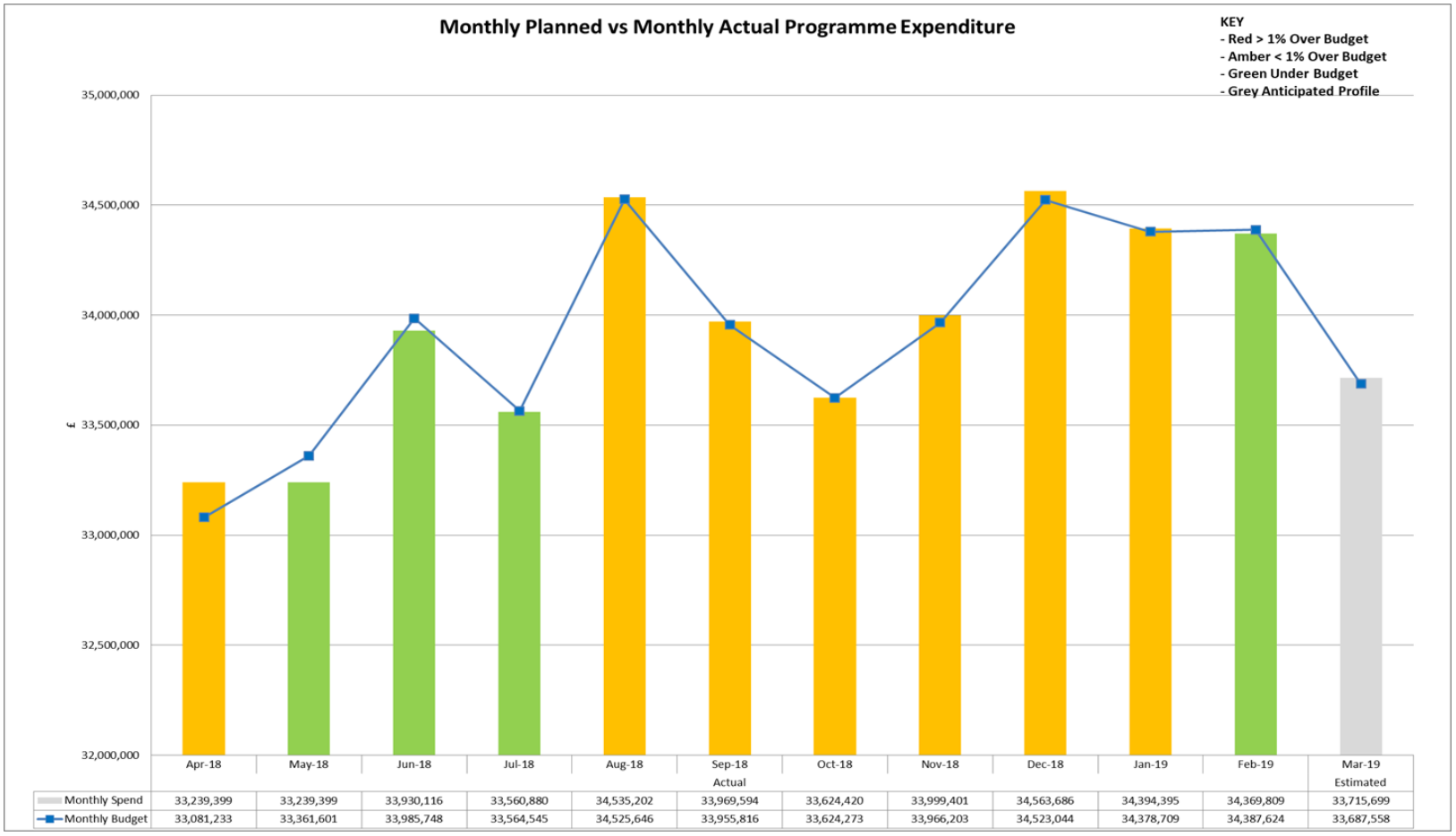
- Within the Forecast out turn there is a commitment of £1.107m of non recurrent investment to support the RWT transformational agenda.

- 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 M11 non ISFE demonstrates the CCG is on plan, achieving 1.9% recurrent underlying surplus.

CCG UNDERLYING POSITION	Forecast Net Expenditure				Remove Non Recurrent Items				Part/Full Year Effects		2018/19 Underlying Position
	Plan £m	Actual £m	Variance £m	Variance %	NR Allocations & Matched Expenditure £m	NR QIPP Benefit £m	Contingency £m	Other NR Spend / Income £m	QIPP £m	Other £m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	412.602				(10.336)						402.266
Acute Services	201.410	202.468	(1.059)	(0.5%)	(2.026)	-		(7.035)			193.407
Mental Health Services	39.843	40.500	(0.657)	(1.6%)	(2.692)	-		(0.945)			36.863
Community Health Services	40.882	40.931	(0.049)	(0.1%)	-	-		0.266			41.197
Continuing Care Services	15.114	14.809	0.305	2.0%	-	-		0.087			14.896
Primary Care Services	53.702	53.752	(0.050)	(0.1%)	(2.204)	-		0.484			52.032
Primary Care Co-Commissioning	36.571	35.601	0.970	2.7%	0.285	-		0.666			36.552
Other Programme Services	19.520	19.081	0.440	2.3%	(3.657)	-	(2.021)	0.838			14.241
Commissioning Services Total	407.042	407.142	(0.100)	(0.0%)	(10.294)	-	(2.021)	(5.639)	-	-	389.188
Running Costs	5.560	5.460	0.100	1.8%	(0.042)	-		0.097			5.515
TOTAL CCG NET EXPENDITURE	412.602	412.602	0.000	0.0%	(10.336)	-	(2.021)	(5.542)	-	-	394.703
IN YEAR UNDERSPEND / (DEFICIT)	-	0.000	0.000	0.0%							
									Underlying Underspend / (Deficit)		7.563
									% RRL		1.9 %



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18 Actual	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19 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	34,563,686	34,394,395	34,369,809	33,715,699
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	34,378,709	34,387,624	33,687,558

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18 Actual	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19 Estimated
Monthly Spend	167	752	461	459	477	464	463	430	422	448	481	
Monthly Budget	460	459	461	459	477	464	463	464	463	463	463	464

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DELEGATED PRIMARY CARE

- Delegated Primary Care allocations for 2018/19 as at M11 are £36.571m. The forecast outturn is £35.171m delivering an underspend position of £0.970m.
- Further to last month when a £1.4m underspend was reported the CCG has identified potential expenditure relating to costs for NHS Health Checks and a provision for an ongoing issue relating to PMS/GMS. This has reduced the forecast underspend to £970k.
- The 0.5% contingency and 1% reserves are showing an underspend year to date with an expectation of full utilisation by year end. In line with NHSE planning metrics no expenditure should be shown on the 0.5% contingency and 1% reserves.
- The table below shows the outturn for month 11:

	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	20,450	20,738	288	22,309	22,309	0		0	0
General Practice PMS	1,756	1,382	(375)	1,916	1,916	0		0	0
Other List Based Services APMS incl	2,230	2,612	381	2,433	2,433	0		0	0
Premises	2,582	2,300	(282)	2,817	2,817	0		0	0
Premises Other	87	55	(32)	94	94	0		0	0
Enhanced services Delegated	813	704	(109)	887	887	0		0	0
QOF	3,485	3,383	(102)	3,802	3,802	0		0	0
Other GP Services	1,618	1,462	(156)	1,765	795	(970)		(970)	0
Delegated Contingency reserve	168	0	(168)	183	183	0		0	0
Delegated Primary Care 1% reserve	335	0	(335)	366	366	0		0	0
Total	**33,523**	**32,634**	**(889)**	**36,571**	**35,601**	**(970)**		**(970)**	**0**

2018/19 forecast figures have been updated on quarter 4 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 Month11 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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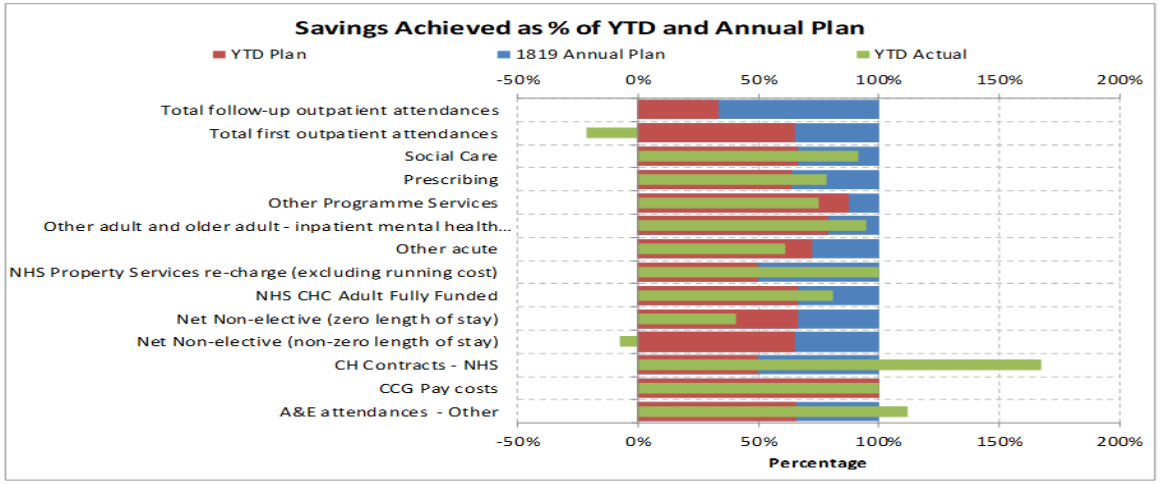
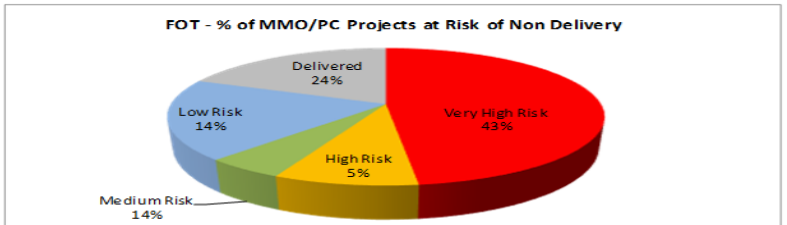
QIPP Programme Delivery Board

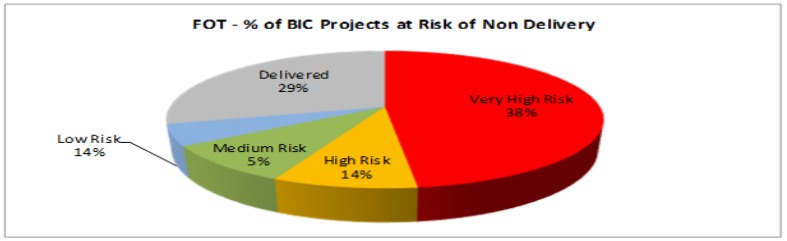
Mth 11 - Feb 18/19

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

Area of Spend Category	Annual Plan	April to Feb (YTD) Plan	YTD (Non ISFE)	Variance from Plan (YTD)	FOT (Non ISFE)	FOT Variance from Annual Plan	Feb (YTD) Prog Brd diff from Plan	Feb (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	-330	-419
Net Non-elective (non-zero length of stay)	4921	3199	3199	0	4921	0	3557	4638
Net Non-elective (zero length of stay)	1618	1072	1072	0	1618	0	415	758
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	100
Other acute	1256	906	906	0	1256	0	135	33
Other adult and older adult - inpatient mental health (excluding dementia)	950	750	750	0	950	0	-150	0
Other Programme Services	160	140	140	0	160	0	20	40
Prescribing	2507	1603	1603	0	2507	0	-362	159
Social Care	500	332	332	0	500	0	-126	0
Total first outpatient attendances	718	468	468	0	718	0	622	718
Total follow-up outpatient attendances	221	74	74	0	221	0	74	221
Grand Total	13947	9248	9248	0	13947	0	3654	6299







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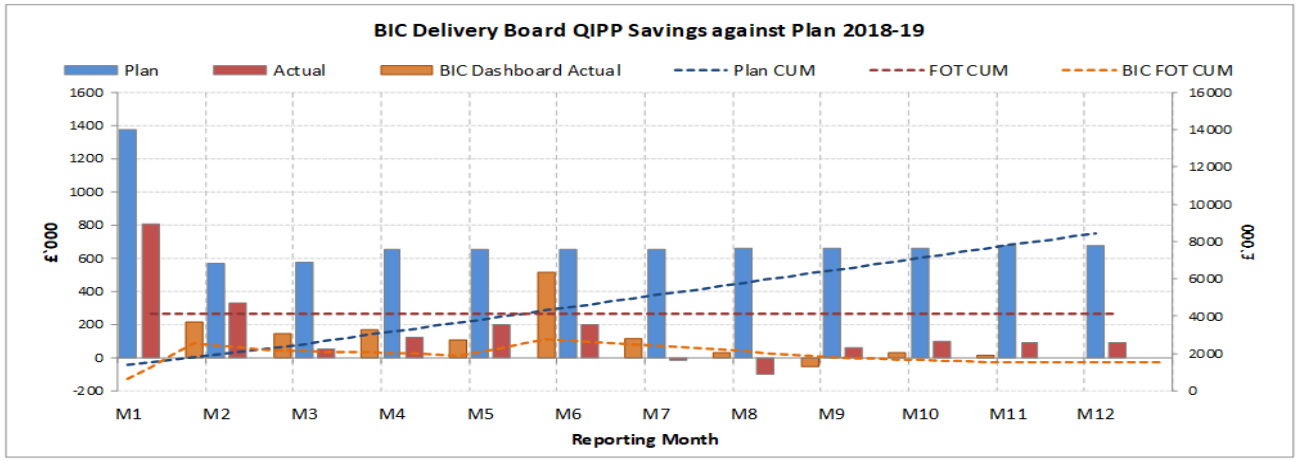
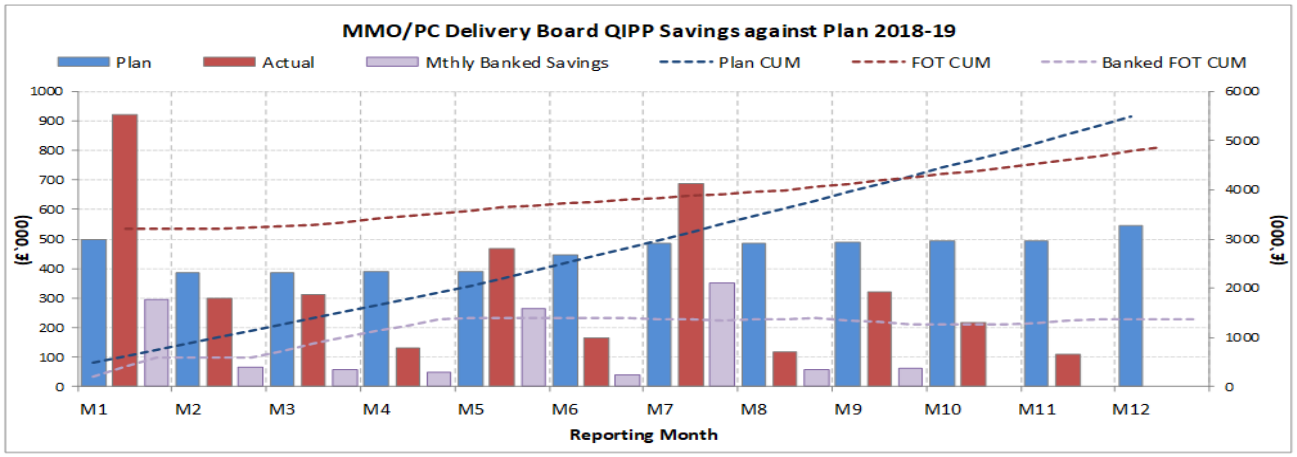
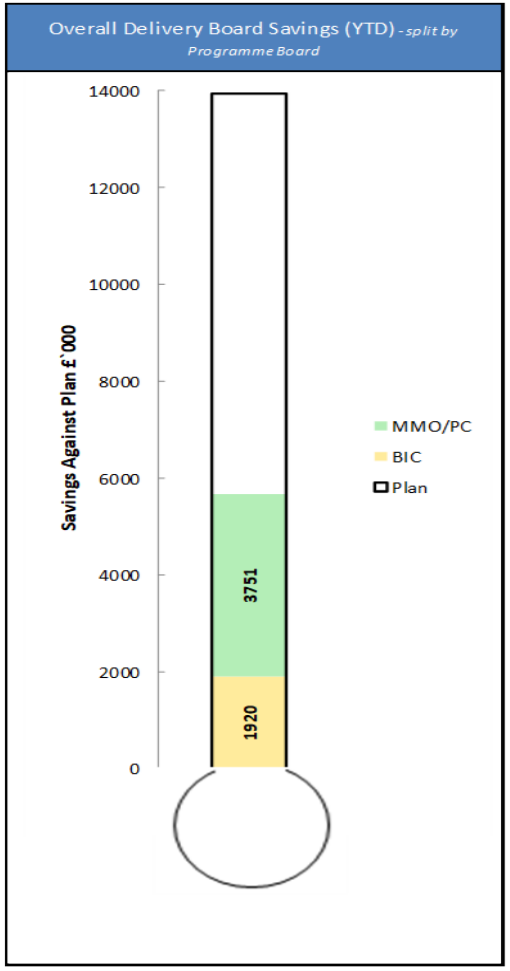
QIPP Programme Delivery Board

Mth 11 - Feb 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 28th February 2019 is shown below:

	28 February '19 £'000		31 January '19 £'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	4,309		2,212	3	2,097
Cash and Cash Equivalents	54		355	4	-301
	4,363		2,567		
Total Assets	**4,363**		**2,567**		
Current Liabilities					
Trade and Other Payables	-43,847		-42,917	5	-930
	-43,847		-42,917		
Total Assets less Current Liabilities	**-39,485**		**-40,350**		
TOTAL ASSETS EMPLOYED	**-39,485**		**-40,350**		
Financed by:					
TAXPAYERS EQUITY					
General Fund	39,485		40,350	6	-866
TOTAL	**39,485**		**40,350**		

Key points to note from the SoFP are:

- The cash target for month 11 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);

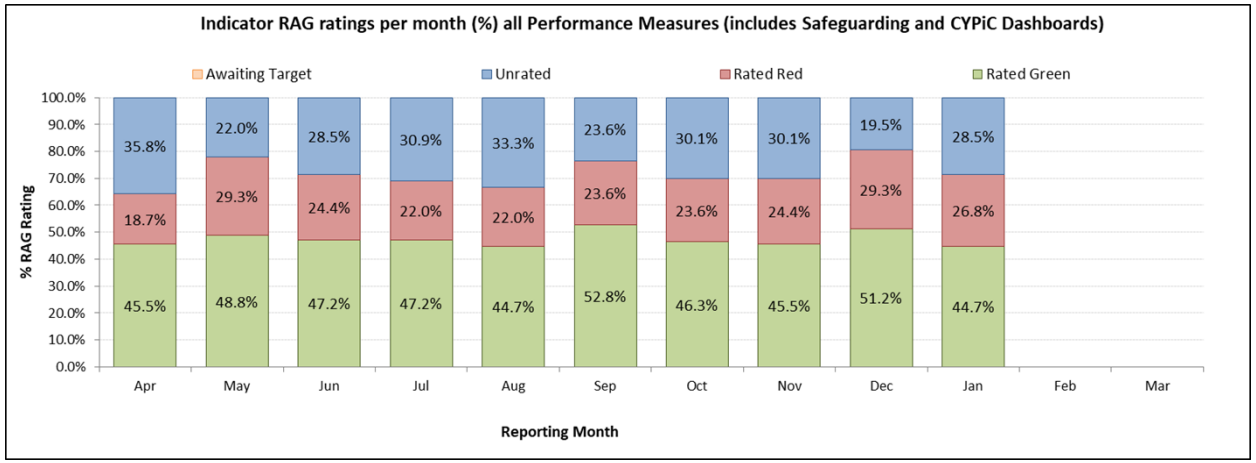
4. PERFORMANCE

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

Executive Summary - Overview

Jan-19

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	8	8	15	15	1	1	0	0	**24**
Outcomes Framework	7	8	8	7	11	11	0	0	**26**
Mental Health	30	24	6	4	5	13	0	0	**41**
Sub Totals	***45***	***40***	***29***	***26***	***17***	***25***	***0***	***0***	***91***
RWT - Safeguarding	4	4	6	6	6	3	0	0	**13**
RWT - Children & Young People in Care (CYPiC)	4	0	2	0	0	6	0	0	**6**
BCP - Safeguarding	10	11	2	1	1	1	0	0	**13**
Dashboard Totals	***18***	***15***	***10***	***7***	***7***	***10***	***0***	***0***	***32***
Grand Total	**63**	**55**	**39**	**33**	**24**	**35**	**0**	**0**	**123**



Exception highlights were as follows;

4.1. **Royal Wolverhampton NHS Trust (RWT)**

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

RTT data measures waiting times from referral to the start of first definitive treatment in weeks at treatment speciality level. The length of the RTT period is reported for patients whose RTT clock stopped during the month, and those who are waiting to start treatment at the end of the month.

- The Trust's performance for January was 90.1% against the national target of 92%
- 48% of patients on the Incompletes waiting list are currently waiting less than 7 weeks and 92% patients are waiting less than 19 weeks to start treatment.
- M10 in-year trajectory (as agreed with NHSI) of 91.39% has not been achieved, however performance is once again better than the national position of 86.7%

- The Trust had been on track to achieve the national requirement to sustain or reduce RTT waiting list size against the March 18 baseline of 33,858; however for the list size in January exceeds this position at 34,855. The increases to list sizes since December follows discussions with the Trust regarding the inclusion of e-Referral Service (eRS) Appointment Slot Issue (ASI) patients as part of the incomplete waiting list.
- The Trust is currently forecasting that it is unlikely to be able to reduce the list size to March levels before the year end.
- The Trust is providing exception reports which are discussed at the monthly CRM and a recovery trajectory is currently in discussion.
- The CCG's performance was 91.5%, England 86.7% & Region 87.3%
- There are no patients waiting 52+ weeks at the Trust. However there are two Wolverhampton patients waiting over 52 weeks at other providers (see section 4.3.4).

4.1.2. EB4 – Percentage of Service Users Waiting 6 weeks or more from Referral for a Diagnostic Test.

- The % of patients waiting 6 weeks (or more) for diagnostic tests at the Trust is 98.26% in January. The CCG's performance for January was 98.24%.
- Performance has been steadily improving since October and the Trust have confirmed that issues have been resolved with Neurophysiology, Endoscopy and Flexible Sigmoidoscopy, this is confirmed by the national data for January.
- Performance issues remain for MRI and CT in January in particular cardiac MRI however the Trust reports confidence in performance returning to standard by the end of March 19.

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

- 88.23% of A&E attendances were admitted, transferred or discharged within 4 Hours in January.
- The January PSF trajectory target of 90.2% was not achieved; this was only the 2nd time in 2018/19 that the target has not been met with continued winter pressures effecting performance.
- Although the Trust fell short of the national target of 95%, nationally only 6 acute trusts out of 136 achieved the national standard with RWT ranked at 43rd.

- NHS England performance was 84.38% and the Black Country STP achieved 83.2%.
- The Trust reported a12 hour decision to admit target breach which related to a paediatric patient awaiting a PICU bed. Patient was unstable and unable to be transferred within target. The patient was transferred to Sheffield and sadly passed away.

4.1.4. Cancer 2WW, 31 Day and 62 Day

- January validated national performance for the 62 Day from referral to 1st definitive treatment has been confirmed as 60.99% (based on 35.5 breaches out of 91, with 7 of those patients at 104+ days).
- As forecast the Trust has not achieved the agreed recovery trajectory which was 66.7% for January.
- All 104+ patients had a harm review and no harm was identified.
- The Trust received 22 Tertiary Referrals in January; only 8 were received by the standard of day 38, 6 by day 62, 8 post day 62 and no 104+All 104+ patients had a harm review and no harm was identified.
- The increase in Breast cancer referrals following Breast Cancer Awareness Campaign has continued in to December, January and February shows no signs of abating. A comparison of referral numbers to the previous year shows an average increase in referrals of 11%.
- NHSI confirms that this is reflected regionally and nationally and as of yet there is no obvious cause of the sustained increase in level of referrals.

Ref	Indicator	Target	Jan19	YTD
EB6	2 Week Wait (2WW)	93%	84.26%	84.29%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	38.32%	60.74%
EB8	31 Day (1st Treatment)	96%	85.31%	88.99%
EB9	31 Day (Surgery)	94%	56.82%	71.49%
EB10	31 Day (anti-cancer drug)	98%	98.08%	97.13%
EB11	31 Day (radiotherapy)	94%	80.60%	87.61%
EB12	62 Day (1st Treatment)	M9=63% (Recovery)	59.89%	61.32%

		85% (National)		
EB13	62 Day (Screening)	90%	88.89%	81.20%

The Trust have 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.

4.1.5. Electronic Discharge Summary

- Performance for the Electronic discharge summary is divided into 2 sections :
    - Excluding Assessment Units which has seen a decrease in performance however is achieving 95.42% (against a 95% target).
    - Assessment Units which has seen an increase in performance, however is currently showing as failing (90.78%) 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 contract target figures are in discussion as the CCG base performance against the 17/18 yearend target of 92.5%. The Trust have submitted an exception report indicating reasons for underperformance as :
    - No overnight ward clerk support, regular attenders and the clerking of patients onto the system.
- Actions have been identified which include a weekly performance report distributed every Tuesday and allows specialties to view and raise discrepancies for investigation.

4.1.6. Delayed Transfers of Care

- Delays for the Royal Wolverhampton NHS Trust in January have achieved both the NHS delays (excluding Social Care = 1.06% against a 2.00% target) and all delays (including social care of 2.90% based on 17/18 threshold of 3.5%)
- The Trust have identified that the main areas of delays remain :
    - Completion of Assessment (top NHS delay = 3.29 average bed day delay)

- Care Packages in Home (top Social Care delay = 5.70 average bed day delay)

- The proportion of Staffordshire patient delays at the Trust during January has been confirmed as 54.81% of the total delays (Wolverhampton patients = 23.43%).

4.1.7. Serious Incident Breaches (SUIs) - RWT

- No breaches were identified for January (see table below), there have been no reported Never Events for January; 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	*Jan19*	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	*0*	26

4.1.8. Safeguarding (LQR21)

- 4 out of the 19 Safeguarding indicators for Children and Young People in Care (CYPiC, formally known as LAC) indicators were reported as achieving targets for January 2019 (and 9 non submissions – however, 6 of the CYPiC indicators have transferred to Quarterly reporting and updates will be available in the March submission).

4.1.9. Infection Prevention

- Hand Hygiene compliance has seen an increase in January but remains below the 95% target at 90.36%.
  - Trust Actions: monthly reporting to line managers of non-compliant staff and to gain assurance that each directorate has an effective process of non-compliance/holding staff to account and staff awareness, with discussions at IPCG every month (chaired by Executive Directors).

- Development of an online submission form/app for Hand Hygiene competence, to prevent the delay in returning papers forms for upload which was due for completion in December 2018, however the app requires some improvements following a trial on mobile devices and requires a desktop based format.

- Infection Prevention Training (Level 2) has seen an increase in January and achieved the 95% target for the first time during 2018/19 at 94.96%.

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4.1.10. CHC Checklist (LQR11)

- The performance for the Continuing Health Care checklist has seen an increase in performance during January to 97.62%.
- The January breach relates to 1 patients CHC template not being completed in full (information not appropriate).
- Early indications are that the February performance has achieved 100%.

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

4.2.1. % 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 MHMDS is subject to a publication data lag, with latest data confirming achievement of the 50% target performance for the 4th consecutive month during 2018/19 in November with 51.47%.

4.2.2. IAPT Access (LQIA05)

- The percentage of Service Users experiencing a first episode of psychosis who commenced a NICE concordant package of care with 2 weeks of referral has breached the 53% target for the first time since April 2018.
- The 0% performance breach relates to an individual patient who did not attend scheduled appointments due to incorrect contact details.
- Early Intervention staff has been reminded to confirm address details prior to appointments being sent.

4.2.3. CYP Receiving Treatment from NHS Funded Community Services (EH9)

- This is a quarterly submission from the Trust however; National monthly reporting confirms the CCG YTD performance for January 2019 26.21% and the YTD as 23.70% against the 32% target.

4.2.4. IAPT Access (LQIA05)

- January failed to achieve the 2018/19 in-month target of 1.58% with 1.45%, this has impacted on the Year to Date which remains below the cumulative target (YTD= 14.39% against a YTD target of 15.83%); performance is measured against the Year End target of 19%. Based on the January data, subsequent months will need to achieve 2.31% (692 Patients per month - an additional 216 patients above original planning trajectories) to meet the year end 19% target.
- Two trainees commenced posts in January and Coventry University have confirmed that three successful PWP trainees will commence in March 2019. The service is currently supported by agency staff and offers of overtime to substantive staff however 1 x Agency staff has left which leaves 30 appointments that the service is attempting to distribute amongst remaining staff.
- The CCG have explored the use of external counselling services however Serenity (local counselling service) have confirmed that they have lost their accommodation and are currently unable to accept referrals. Big White Wall (online therapy) have been contracted to treat 100 patients from 11th February 2019 to support access rates to the end of March 2019.
- As an organisation we need to be assured that there is sufficient capacity within the treatment services to accommodate meeting the increased access targets, maintaining quality of provision for those patients within the system. The Trust has confirmed that they are currently at 18% (as at 21st March) and have multiple community activities booked to take place during the remainder of the month.

4.2.5. Safeguarding

- 11 out of the 13 Safeguarding indicators were reported as achieving targets for January 2019 (with 1 non submission).
- The breach relates to the PREVENT e-learning compliance with January seeing a decline in compliance (116 non-compliant staff).

4.3. **Other Providers :**

4.3.1. Referral to Treatment Time (18weeks) – Nuffield Wolverhampton

- The Nuffield submit an SQPR direct to the CCG on a quarterly basis with the January submission report achieving the 92% target at 96.17%.
- The performance for the Nuffield (Wolverhampton) has previously been included within this report due to a discrepancy in reported numbers. National publications have confirmed the January performance as above target at 96.35% (with the Wolverhampton element at 96.33% and therefore also GREEN).

4.3.2. Serious Incident Breaches (SIs) – Compton Care

- 1 breach was identified for January (carried over from December breaches), which related to a Slip/Trip/Fall meeting Serious Incident Criteria. The Root Cause Analysis report has since been received by the CCG.

4.3.3. Commissioner Mixed Sex Accommodation Breaches (EBS1)

- 4 breaches were identified for the CCG during January 2019 at Sandwell and West Birmingham Hospital (out of 1123 breaches for the Trust during January).
- Following discussions with the lead commissioner (Sandwell CCG) it has been confirmed that the Trust had previously incorrectly reported data to the national collection. The Trust have now rectified this following advice from NHS Improvement that national policy and guidance should be followed and a recovery trajectory has been agreed with the Trust (with an expectation to report zero cases by end of March..
- The Commissioner year to date total is 6 breaches.

4.3.4. Referral to Treatment (18 Weeks) – 52 Week Breaches

- 2 breaches were identified for the CCG during January 2019

- 1 x Guys & St Thomas' NHS FT (Other)
- 1 x Imperial College Health care NHS Trust (Ophthalmology)

- This brings the Commissioner year to date total to 27 breaches.

5. RISK and MITIGATION

The CCG submitted a M11 position which included 0.6m risk which has been fully mitigated. There is no change from the previous month.

.

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	CIPP	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investments Uncommitted	Further CIPP 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

6. 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.

7. COMMITTEE ANNUAL REPORT 2018/19

The Committee received the draft report for consideration and took assurance that it has discharged it's duties as set out in its terms of reference

8. RISK REPORT

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

9. 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.

10. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **27th March 2019**

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Performance Indicators 18/19

Current Month: Jan-19

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
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%	98.26%	98.31%	↑	
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%	88.23%	91.45%	↓	
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%	84.26%	84.37%	↑	
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%	38.32%	58.98%	↓	
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%	85.31%	88.97%	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94.0%	56.82%	72.33%	↑	
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%	98.08%	97.09%	↑	
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%	80.60%	87.06%	↓	
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%	59.89%	61.18%	↓	
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%	73.91%	80.29%	↓	
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	2	25	↓	
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	240	840	↓	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	0	24	83	↓	
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	0	1	6	↓	
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%	93.05%	92.80%	↑	
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%	99.87%	99.89%	↓	

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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	
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%	98.73%	98.67%	↓		
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	95.0%	95.42%	95.77%	↓		
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%	90.78%	85.45%	↑		
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	2.0%	1.06%	1.03%	↑		
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	0	26	↑		
RWT_LQR7	Number of cancelled operations - % of electives	0.8%	0.59%	0.49%	↓		
RWT_LQR10	DToC – compliance with checklist *awaiting confirmation of removal to Schedule 6	95.0%	No Data	66.96%			
RWT_LQR11	% Completion of electronic CHC Checklist	98.0%	97.62%	89.67%	↑		
RWT_LQR12	E-Referral - ASI rates	10.0%	No Data	24.46%			
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	90.0%	90.00%	90.69%	↓		
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	80.0%	98.65%	92.11%	↑		
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	60.0%	97.20%	86.91%	↑		
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	92.5%	99.67%	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	10			
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			

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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
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%	90.36%	91.48%	⇧	
RWT_LQR29	Infection Prevention Training Level 2	95.0%	95.33%	94.55%	⇧	
BCP_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	92.00%	96.81%	96.48%	⇧	
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	10	⇨	
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	99.89%		
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	95.84%		
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%	0.00%	70.83%		
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%	79.81%	84.20%	⇧	
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%	100.00%	99.02%	⇨	
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	9.28%		
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	84.62%		
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%	100.00%	95.50%	⇧	
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%	98.19%	⇨	
BCP_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	80.00%	No Data	94.49%		
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	85.76%		

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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
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%	95.41%	96.65%	↓	
BCP_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	95.00%	100.00%	99.60%	→	
BCP_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	7.50%	0.00%	1.13%	→	
BCP_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	95.00%	100.00%	99.40%	↑	
BCP_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	85.00%	100.00%	96.06%	↑	
BCP_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	85.00%	97.56%	98.72%	↓	
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%	66.67%	→	
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%	60.61%	58.99%	↓	
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%	79.81%	84.20%	↑	
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%	100.00%	99.02%	→	
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%	1.45%	14.43%	↑	
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%	97.05%	→	
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
9 APRIL 2019

Agenda item 12

TITLE OF REPORT:	Summary – Remuneration Committee – 19 February 2019
AUTHOR(s) OF REPORT:	Peter Price – Remuneration Committee Chairman
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	To provide an update of key discussions and decisions made at the Remuneration Committee to the Governing Body.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	The Committee discussed the following points • Arrangement for Senior Management Recruitment and Retention • CCG Human Resources Support Services • Performance and Development Review Policy
RECOMMENDATION:	That the Governing Body receive and note the contents of this report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Remuneration Committee is responsible for ensuring that the CCG has appropriate Human Resources Policies and Procedures in place to deliver statutory responsibilities as an employer.

1. BACKGROUND AND CURRENT SITUATION

1.1 This report gives details of the issues discussed and decisions made at the meeting of the Remuneration Committee on 19 February 2019.

2. ITEMS CONSIDERED BY THE COMMITTEE

2.1. Senior Management Recruitment and Retention

The Committee agreed arrangements to support the continuation of the CCG's high performing management team. This included entering into an arrangement for the Chief Finance Officer from Sandwell and West Birmingham CCG to become the CCG's statutory Chief Finance Officer until June 2020 with the support of the existing Chief Finance Officer in a part time role as Director of Finance. The Committee also agreed actions to ensure the CCG's Executive team are all employed on consistent terms and conditions.

2.2. Human Resources (HR) Support Arrangements

The committee were updated on the CCG's work to bring HR support arrangements in house from the current service provided by Arden and GEM CSU. These arrangements would be supported by network working across the HR functions of Black Country CCGs to provide resilience.

2.3 Human Resource Policies – Performance Development and Review Policy

The committee considered and approved a revised policy\ for staff Performance and Development Reviews which reflected the development of CCG Staff values that are now embedded in the performance review process.

3. CLINICAL VIEW

3.1. There are clinical members who contribute fully to its deliberations.

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. The costs associated with the issues outlined in this report are being met from within existing pay budgets.

Quality and Safety Implications

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

Equality Implications

6.3. There are no equality implications associated with this report.

Legal and Policy Implications

6.4. Changes were made to Human Resources Policies as outlined in the paper.

Other Implications

6.5. There are no specific Human Resources implications arising from this report. The Committee receives Human Resources advice when required.

Name	Peter Price
Job Title	Remuneration Committee Chair
Date:	February 2019

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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)	**Peter Price**	**28/02/19**

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Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
9 April 2019

Agenda item 13

TITLE OF REPORT:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 13 November 2018**
AUTHOR(s) OF REPORT:	Peter Price – 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	n/a

financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1 Internal Audit Progress Report
The Internal Audit team updated the Committee on activity since the last meeting. This includedreports from the reviews of Corporate Governance Primary Care Strategy (to include GP Five Year Forward View), Risk Management, Finance, Safeguarding, Quality and Safety, Provider and Stakeholder Engagement, Information Governance, Audit Follow Up and Delegated Commissioning. The committee noted and accepted the report.

1.2 Safeguarding Report
The committee noted that the outcome of the review of Safeguarding was extremely positive, with only one low risk finding.

1.3 Follow Up Report
The Report was presented to the Committee giving details of actions agreed from completed audit reviews.

1.4 Primary Care Strategy and GP 5 Year Forward View
The report was a review focusing on Primary Care Healthcare and progress with implementing the CCG's Primary Care Strategy and the GP Forward View. The committee asked for this report to be circulated to the Primary Care Commissioning Committee.

1.5 External Audit Plan
External Audit presented the External Audit Plan and the planned scope and timing of work. Areas identified were Significant risks, Materiality, Value for Money arrangements, Audit Logistics and Independence. Highlighted was the current work undertaken by the CCG on mortality.

1.6 NHS Wolverhampton CCG 2018/2019 – Informing the audit risk assessment
This report was a two-way conversation with External Audit and the Audit and Governance Committee. Areas covered were Fraud, Laws and Regulations, Going concern and Accounting estimates.

1.7 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 Governing Body. The Corporate Governance Manager also updated about contingency planning regarding Brexit and a potential no-deal and the corporate risk around maternity. The Committee noted the report.

1.8 Governance Statement

The Corporate Operations Manager talked about the governance statement which had been drafted with the template issued from NHSE. The committee were asked to note the UK Corporate Governance Code which the CCG used as a point of reference for best practice, had been updated since the last Governance statement had been submitted.

1.9 Feedback to and from the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

The Chair advised that Governing Body members had been informed that there had been improvements made at VOCARE and that their rating had been moved to a 'good' rating from 'requires improvement'. Brexit had also been discussed.

1.10 Counter Fraud Progress Report

The first draft of the Counter Fraud Progress report was presented to the Audit and Governance Committee.

1.11 Draft Counter Fraud Plan

The Draft Counter Fraud Plan was presented to the committee. The plan was similar to previous years. The plan was accepted with some changes that had been flagged by the committee.

1.12 Final Accounts and their preparation plan including update on submission of Month 9 accounts

Month 9 had been submitted ahead of the deadline. NHSE have not supplied a template for the final accounts so they had not been submitted yet.

The CCG had corroborated with the CSU on month 9 working. There had been two new standards and the CCG was on track to submit the accounts on the 29 May 2019. The committee noted the report.

1.13 Losses and Compensation Payments – Quarter 3 2019/2020

There were no losses or special payments were reported in quarter 3 2019/20

1.14 Suspensions, Waiver and Breaches of SO/PFPS

There were 10 breaches of PFPs in quarter 3 2019/2020. During the same period 12 waivers were raised and 52 non-healthcare invoices were paid with a purchase order numbers being raised.

1.15 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 February 2019

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
9 APRIL 2019

Agenda item 14

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 5 February and 5 March 2019
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 5 February and 5 March 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	Primary Care Networks (PCNs) The Head of Primary Care presented a report which provided an introductory outline of requirements for GP practices to establish formal PCNs from May 2019. It was noted that practices were required to establish PCNs to support the delivery of services at scale and to facilitate measures to support developments in the skill mix of the Primary Care workforce and leadership in Primary Care.
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	Primary Care issues are managed to enable Primary Care Strategy delivery.

delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Commissioning Committee met on 5 February and 5 March 2019. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Commissioning Committee – 5 February 2019

2.1 Finance Position – Month 9 Update

2.1.1 The Deputy Chief Finance Officer (WCCG), Lesley Sawrey, presented the report on behalf of the Chief financial Officer (WCCG), which gave a summary of the regular quarterly update on Primary Care finances. It was noted that, in response to previous feedback from the Committee, the report not only gave details of financial performance in relation to NHS England delegated budgets but also funding from the CCG's own allocation used to fund Primary Care Services.

2.1.2 Ms Sawrey advised that at Month 9 the delegated budget was forecasted to breakeven and to meet the required financial metrics set by NHS England, including achieving a 1% level of contingency. It was advised that the budget position included an additional uplift of £304,000 to provide for changes in the global sum based on Quarter 3 list sizes across the CCG.

2.2 Primary Care Operational Management Group Update

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

- Work to plan for the mobilisation of the Alternative Primary Medical Service (APMS) contracts awarded at the last meeting was now underway.
- Discussion had taken place with NHS England around the support provided via the Primary Care Hub. It was confirmed that the Hub would continue to provide equivalent support to that currently available.
- Work continues to develop options to deliver improvements in Primary Care estates, including the Bilston and Oxley areas.

2.3 Primary Care Contracting Update

2.3.1 The Primary Care Contracts Manager (WCCG), Gill Shelley, provided an update on primary care contracting and noted that the Quality Outcomes Framework (QOF) Post Payment Verification (PPV) process reported to the last meeting of the Committee would take place in February 2019.

2.4 **Primary Care Strategy Quarterly Assurance Update**

2.4.1 The Head of Primary Care (WCCG), Sarah Southall, presented the report on behalf of the Primary Care Transformation Manager, giving an update on the implementation of the CCG's Primary Care Strategy and GP Forward View (GPFV) programmes of work.

2.4.2 The report included highlights of the work of each of the individual workstreams associated with both the strategy and GPFV, which it was advised would be combined into a single Primary Care work programme aligned with STP priorities for 2019/20 onwards. The following key points were also highlighted:

- The referral rates for both social prescribing and the Primary Care Counselling Service had been discussed in detail. A number of actions had been agreed with the providers of these services to continue to improve usage rates.
- A programme of training for administrative and reception staff in GP practices on key areas of work had now commenced.
- Work was underway to consider enhancements to the Quality Outcomes Framework (QOF+) scheme for 2019/20 following successful sign up across practices for 2018/19.

2.5 **Primary Care Quality Report**

2.5.1 The Chief Nurse and Director of Quality (WCCG), Sally Roberts, presented the report on behalf of the Primary Care Quality Assurance Co-ordinator (WCCG) and 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.

2.5.2 In relation to a question relating to following up patients with flu jabs, raised as a result of patient feedback to Healthwatch, it was confirmed that lessons learned associated with the experience with flu vaccine would be incorporated into planning for 2019/20.

2.6 **Minor Surgery Enhanced Service**

2.6.1 The Head of Primary Care, Sarah Southall, presented a report on the behalf of the Group Manager (WCCG) which set out a revised service specification for an enhanced service for minor surgery which had previously been commissioned by NHS England as a Directed Enhanced Service and would now be commissioned as a Local Enhanced Service by the CCG.

2.6.2 The Committee noted that, due to the urgency, the decision relating to this report had been taken virtually and that the service specification had been agreed.

2.7 **Pharmacy First Scheme**

2.7.1 The Head of Primary Care, Sarah Southall, introduced the report which set out a proposal to continue commissioning a Pharmacy First Scheme for minor ailments. The report set out that, following a decision by NHS England to cease commissioning the Pharmacy First Scheme in 2018, the CCG had commissioned an equivalent service.

2.7.2 The Committee approved the decision for the Pharmacy First Scheme to be re-commissioned for 2019/20.

2.8 **Primary Care Commissioning Committee (Private) – 5 February 2019**

2.8.1 The Committee met in private to receive updates on feedback from the recent Local Medical Committee meeting, changes to enhanced services, Infection Prevention – Estates improvement, Patient Participation Group (PPG) Chairs Forum and the closure of a Wolverhampton Practice.

Primary Care Commissioning Committee – 5 March 2019

2.9 **Primary Care Quality Report**

2.9.1 The Primary Care Quality Assurance Co-ordinator (WCCG), Liz Corrigan, updated the Committee around primary care quality, providing an overview of quality improvement in primary care. The report gave detail around a number of issues including infection prevention, flu vaccination programmes, serious incidents, friends and family test responses and workforce development in primary care.

2.9.2 The rates of flu vaccination was discussed, in particular the low rates amongst pregnant women. Ms Corrigan advised that the CCG's overall rate was lower than other areas in the STP, partially as a result of issues with vaccine supply for practices. A de-brief meeting to ensure lessons were learned for future flu seasons was planned.

2.10 **Primary Care Operational Management Group Meeting Update**

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

- Following discussion at the last Primary Care Commissioning Committee, the Group was working with practices and NHS Property Services to understand the impact of changes in service charges for practices.

- An outline business case for estates improvements in the Bilston area was being produced and would be shared with the Committee in April or May 2019.
- A GP Practice Nursing Strategy was being produced as part of the CCG's Workforce Task and Finish Group.

2.11 **Primary Care Contracting Update**

2.11.1 The Primary Care Contracts Manager, Gill Shelley, provided an update on primary care contracting. The report highlighted the work that was underway with both the exiting and incoming providers to mobilise the contracts that had been awarded for the two APMS practices.

2.11.2 The report also outlined details of changes in General Medical Services (GMS) contracts from April 2019. This included emphasis on building Primary Care Networks to provide support for general practice through expanding and diversifying the primary care workforce, retaining GPs and investing in digital solutions for patient care.

2.12 **Corporate Governance – Primary Care Strategy: Audit Recommendations**

2.12.1 The Head of Primary Care presented the report which introduced the outcomes of an internal audit review into the development and implementation of the CCG's Primary Care Strategy. The report highlighted that since the Strategy had been written, a number of developments had occurred including establishment of the primary care groupings and publication of the NHS England GP Forward View. The recommendations highlighted the need to update the Strategy to reflect these developments and an action plan had been produced to respond to them. It was noted that an update to the Strategy will be received by the Committee in May 2019.

2.13 **GP Forward View – Extended Assurance Visit: Audit Recommendations**

2.13.1 The Head of Primary Care presented a report which outlined the outcome of the NHS England Assurance visit into the CCG's work to commission extended access to primary care. The report highlighted that the CCG had been assessed as fully or partially compliant against all of the relevant components and made a number of recommendations to support achieving full compliance. An action plan was now in place to respond to all recommendations which included work around developing website advertising and access to wider services.

2.14 **Primary Care Networks**

2.14.1 The Head of Primary Care presented a report which provided an introductory outline of requirements for GP practices to establish formal Primary Care Networks (PCNs) from May 2019.

2.14.2 The report highlighted that, in line with the NHS Long Term Plan and the General Medical Services (GMS) contract for 2019/20, practices were required to establish PCNs to support the delivery of services at scale and to facilitate measures to support developments in the skill mix of the Primary Care workforce and leadership in Primary Care. PCNs were required to serve a list size of between 30,000 and 50,000 patients, designate a clinical director and develop a work agreement amongst the constituent practices. Funding to support this development was being made available through a Directed Enhanced Service (DES) at Network level. Further guidance on the establishment of PCNs, along with the Network DES were expected at the end of March 2019.

2.14.3 The report also highlighted that, in order to identify PCNs in Wolverhampton, the CCG was working with the existing practice groupings to ensure that this development built on the work undertaken to establish these groups over the previous two years.

2.14.4 It was noted that the Committee will receive a further update on the development of Primary Care Networks when further guidance has become available.

Primary Care Commissioning Committee (Private) – 5 March 2019

2.15.1 The Committee met in private to receive updates on Sound Doctor, Extended Access 2019/20 Report and Service and Specification, Nursing Associate Apprenticeship Support Programme and information around the closure of a Wolverhampton Practice branch site.

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: 19 March 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)	**Sue McKie**	**19/03/19**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
09 April 2019

Agenda item 15

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 during February and March 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 **Help us help you – Winter campaign** 2.2.1 **Share your views on skin (Dermatology) service** 2.2.2 **We want to hear your views on community care for people with learning disabilities** 5.2 **Patient and Community Engagement Indicator' - 2018/19 CCG IAF**
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 February and March 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 Help Us, Help You

The Help Us, Help You Pharmacy Advice campaign launched nationally in early February until end of March 2019. It aimed to increase people's use of community pharmacy services, by encouraging them to access clinical advice and support from their local pharmacy team and thus reduce pressure on both primary and secondary care by sign-posting to pharmacy services

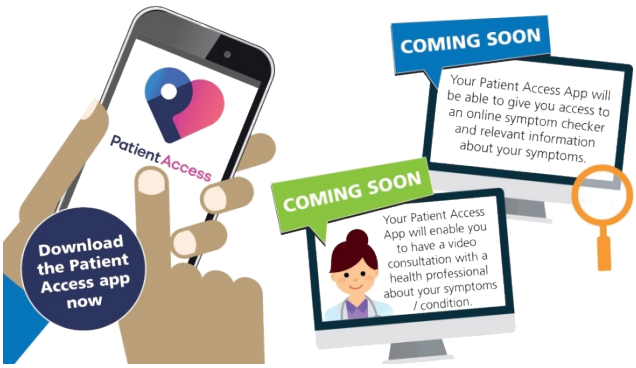
The primary audience for this campaign was all adults who are suffering minor health conditions – such as coughs, colds, tummy troubles and aches and pains – that do not require a GP appointment, with a secondary focus on parents and carers of children. The campaign raised awareness that community pharmacists are qualified healthcare professionals and that local pharmacy teams offer a fast and convenient clinical service for minor health concerns with no appointment needed.

Towards the end of February and into early March we saw promotion also for NHS111, along with Veggie Month, World Kidney Day and No Smoking Day.

Locally, we have continued our bus campaign on both the rear of buses and on the inside of buses to promote GP extended hours across the city.

We continue to promote extended GP appointments online through AdMessenger, which links to our extended hours page. https://wolverhamptonccg.nhs.uk/primary-care/gp-extended-opening-hours.

2.1.2 **Patient Access App**



Promotion of the Patient Access App has continued on a variety of media and sites. These include social media, promotion at Molineux Stadium digitally, printed, printed materials and online.

2.1.3 **Press Releases**

Press releases since the last meeting have included:

February 2019

- Keep children well this half term
- Sock it to Eating Disorders and seek treatment
- Spread love, not infections this valentines
- It's Time to Talk about mental health

March 2019

- Reinforce, Focus and Energise – Nutrition and Hydration Week 2019
- Smear tests don't detect ovarian cancer
- Spring into action for better health
- Patients in Wolverhampton invited to attend diabetes awareness event
- Can you help transform care for people with learning disabilities?

2.2. Communication & Engagement with members and stakeholders

2.2.1 **Share your views on skin (Dermatology) service**

We asked the public and our stakeholders from 14 January to 24 February 2019 about their views on improving skin (Dermatology) services for the residents of Wolverhampton. This was an opportunity for public and stakeholders to have their say and help shape the future design of community dermatology services.

We had 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 two public focus groups planned for the 4 and 18 February.

2.2.2. **We want to hear your views on community care for people with learning disabilities**

We have been working with the other CCGs and LAs in the Black Country and with Black Country Partnership Foundation Trust as the Transforming Care Partnership to develop a model of community care for people with learning disabilities. This supports this vulnerable group of people to stay close to their families and friends and will reduce the number of inappropriate, often long-term, hospital admissions.

The partnership has developed the new community model in collaboration with service users and their families and carers. Now it wants to give local people the opportunity to feedback their views on new community services for people with learning disabilities by attending events in Dudley, Sandwell, Walsall and Wolverhampton, or by completing an online survey.

The engagement period runs from **Thursday 21 March to Thursday 23 May 2019**

To find out more visit: https://wolverhamptonccg.nhs.uk/your-health-services/learning-disabilities/transforming-community-services where you can read the engagement document and complete the online questionnaire:

We are also running a local drop in event **Tuesday 9 April 2019 at Molineux stadium, Waterloo Road, Wolverhampton, WV1 4QR, between 10am – 12pm**

2.2.3 **Annual Report**
We have started collation of our Annual Report ready for submission to NHS England.

2.2.4 **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 *March* edition of the Practice Nurse Bulletin included the following topics:

- New Chairman announced at RWT
- The Charlie Waller Memorial Trust Project Grant for GP nurses 19/20
- GP retention intensive support site (GPRISS) survey
- Practice vacancies
- Malicious email attachment warning
- Reminder around ear irrigation
- FGM conviction nationally
- Compliments and complaints processes for 111 and 999
- Health champion programme 19/20
- Residents programme 2019
- LD Mortality Review bulletin
- 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 meeting took place in March with attendance remaining low, nine GP practices were represented and two Citizen Forums. The group provided feedback on their various practice and group activity.

Following a member query regarding the Shingles vaccination Dr Ankush Mittal attended to provide a Public Health overview of the national shingles vaccination programme.

In light of falling attendance much of the meeting was dedicated to providing an update on the changes relating to Primary Care Networks (PCNs) and the potential opportunities for developing and enhancing the Communications and Engagement Strategy.

The emergence of PCNs was seen as a positive move from members of the group and it was made clear that this joint forum would need change to adapt to the new working arrangements.

5. LAY MEMBER MEETINGS – attended:

5.1 Primary Care Commissioning
CCG Governing Body Development
Strategic communications
Joint Engagement Assurance Group
1:1 to review the IAF submission

5.2 **Patient and Community Engagement Indicator' - 2018/19 CCG Improvement and Assessment Framework**

The PPI Lay Member worked with the Comms & Engagement Team, Governance Team and Equalities Team to complete the submission to NHSE for our Patient and Public engagement activities this year.

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: 26 March 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

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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	**Sue McKie**	**26 Mar 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**	**26 Mar 2019**

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Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
9 April 2019

Agenda item 16

TITLE OF REPORT:	CCG Annual Equality Report
AUTHOR(s) OF REPORT:	David King, EIHR Manager
MANAGEMENT LEAD:	Sally Roberts
PURPOSE OF REPORT:	Report presents the CCG's WRES action plan for assurance.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• CCG Annual Equality Report provides updates on progress in line with. • Public Sector Equality Duty • Equality Delivery System 2 • Including the CCG's Equality Objectives
RECOMMENDATION:	GB are asked to: • Note for assurance
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	Equality, Inclusion and Human Rights (EIHR) are key to the three strategic aims of the CCG in delivering quality services to patients
1. Improving the quality and safety of the services we commission	<u>Ensure on-going safety and performance in the system</u> 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	<u>Improve and develop primary care in Wolverhampton</u> 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.

	<u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> 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	<u>Proactively drive our contribution to the Black Country STP</u> 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. <u>Greater integration of health and social care services across Wolverhampton</u> 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.' <u>Continue to meet our Statutory Duties and responsibilities</u> 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. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> 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.

1. BACKGROUND AND CURRENT SITUATION

1.1. This report includes the relevant information for the CCG to meet its publication duty, this report has previously been approved by QSC and published. It includes a full EDS2 report and details of the CCG's new Equality Objectives. It also summarises a review of progress and key focuses for the coming year.

2. NEXT HEADING

The report is divided into the following sections:

- **Foreword**
- **EDS2**
- **Equality Objectives**

3. CLINICAL VIEW

N / A

4. PATIENT AND PUBLIC VIEW

4.1. Public engagement is planned on the EDS2 outcomes during 2018.

5. KEY RISKS AND MITIGATIONS

5.1. No risks have been identified in the report, though failure to publish by 30th March would be a risk since the CCG would not have met its legal duty to publish.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. N/A

Quality and Safety Implications

6.2. There are no implications within the report since it is retrospective and no issues have been identified.

Equality Implications

6.3. No negative impacts are identified and the report showcases the work done.

Legal and Policy Implications

6.4. Publication is a legal requirement.

Other Implications

6.5. N / A

Name: **David King**
Job Title: **EIHR Manager**
Date: **4/3/19**

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	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)	N/A	

Wolverhampton
Clinical Commissioning Group

Equality & Inclusion Annual Report

2018 – 2019

David King
EIHR Manager
March 2018

Foreword

This report has been produced to set out a summary of the activity Wolverhampton Clinical Commissioning Group (CCG) has undertaken during the 2018/19 financial year with regard to Equality, Inclusion and Human Rights (EIHR). This report includes details of how the CCG has met its obligations under the Equality Act 2010 and the Public Sector Equality Duty, including the specific publication duties.
This report has been produced by the Arden & Greater East Midlands Commissioning Support Unit EIHR team on behalf of the CCG.
The report is split into the following sections:

- An overview of the CCG's approach to Equality
- The CCG's NHS Equality Delivery System 2 (EDS2) template update
- An update on the CCG's newly adopted Equality Objectives

Included within the CCG's EDS2 template is an overview of the population the CCG serves and relevant health inequalities that exist for the CCG's patients.
Additional information and reports can be found via the following link:
https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018

This includes the CCG's NHS Workforce Race Equality Standard (WRES) publication history.

'Wolverhampton Clinical Commissioning Group is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity'

Wolverhampton Clinical Commissioning Group (WCCG) believes that equality and diversity should include addressing health inequalities as well as being embedded into all commissioning activity. Equality and diversity are central to commissioning plans, where everyone has the opportunity to fulfill their full potential. WCCG also believes that equality is about creating a fairer society and diversity is about recognising and valuing difference in its broadest sense.
Forty six GP practices in the city are members of the CCG and this provides us with the opportunity to work with our patients to improve services and the overall health of the city. Our GP practice membership will ensure the needs and priorities of our population are clearly identified and addressed by delivering the right care in the right place, at the right time by the right people.
This annual report sets out how the Clinical Commissioning Group has performed in meeting its legal duties set out in the Equality Act 2010 and the Human Rights Act 1998.

Summary of Progress

While the report and EDS2 table sets out in detail the CCG's activity and demonstrates that it is meeting its legal duties, this section highlights areas of particular good practice. The CCG's progress is in line with other CCGs and has fully met the requirements of the Public Sector Equality Duty in ensuring services are delivered equitably. The CCG has self-assessed its progress as a mix of developing and achieving, in line with the principles of the EDS2 framework. It is intended that the CCG will seek review of the relevant evidence and outcomes during 2018 with a view to gaining independent / public feedback. NHS England has announced a full review of EDS2 and the CCG will thus have due regard to the outcome of these changes in further work. The CCG's Equality Objectives are interlinked with the EDS2 and set out key areas of focus for the CCG however these areas can be set out as follows:

- Enhancing access to services for vulnerable groups
    - Homeless people
    - Those with language or communication support needs
- Ensuring that patient's transition between services including between NHS and Local Authority support is seamless and effective
- Robust assurance around Equality, Inclusion and Human Rights from those who provide services on the CCG's behalf
    - Access to services
    - Information for patients – provide in appropriate formats
    - Services are available when needed
    - Complaints / concerns are identified and lessons learned are acted on
- CCG staff are engaged, supported and protected
- The CCG is a visible system leader within the Black Country, setting best practice and ensuring the best outcomes for patients.

As a key foundation in delivering these areas of work, the CCG has established a strong robust Equality Analysis process that ensures that all decisions made by the CCG are undertaken with all the information, relevant impacts understood and any negative impact is mitigated where possible. This places the CCG in a strong position to ensure equitable high quality services for all patients. Evidence of this best practice approach can be seen in the published Equality Impact Assessments on the CCGs website. Further examples of specific services can be found in this report (EDS2 section) and previous reports, demonstrating year on year improvement.

The CCG is also pleased to note the positive feedback from staff received in the annual staff survey, the CCG has built a positive culture, with visible accessible leaders and supportive policies as showcased under Goal 3 and 4 of the EDS2 section. This combined with the findings of the NHS Workforce Race Equality Standard illustrate that the CCG's Organisational focused activity on Equality is to continue the current approach as there are no key issues outstanding.

EQUALITY DELIVERY SYSTEM 2 (EDS2)

- Introduction to EDS2
- Overview of CCG population information
- Overview of CCG health inequalities
- CCG approach to Equality

If you require this document in an alternative version such as 'Easy to read', Large print, Braille or help in understanding it in your community language please email us at:

NHS
Wolverhampton
Clinical Commissioning Group

Evidence portfolio

Date of publication

30/03/19

Arden&GEM

Introduction to the Equality Delivery System2 (EDS2)

The EDS2 was first launched by the NHS Equality and Diversity Council in 2011 and was refreshed as EDS2 in November 2013. Although it is not a legal requirement, EDS2 allows the CCG to clearly evidence what actions they are taking as a commissioning organisation to address equality and health inequality issues which are part of the responsibilities under the Health and Social Care Act 2012. Also, it is expected by NHS England (NHSE) that all CCGs will continue to implement it as a mandatory requirement. From April 2015, EDS2 implementation by NHS organisations was made mandatory in the NHS standard contract.

There are four sections: population health outcomes, individual patient experience, supported workforce and inclusive leadership. The key role of CCGs is to work with partners to improve the health and well-being of its population. Over time, the various improvements in health care services, social care, public health, wider environmental and economic factors have served to significantly improve the population's life expectancy and health status. This subsequently means that CCGs as commissioners of health care services have statutory and moral responsibility to put in place measures to improve potential patient and patient experience and satisfaction levels with, the healthcare services they commission for them.

The EDS2 framework was designed by the NHS to support NHS commissioners and providers to meet their duties under the Equality Act. The EDS2 has four goals, supported by 18 outcomes as detailed in the table below. NHS Wolverhampton CCG has used the EDS2 as a tool kit to meet the requirements (Public Sector Equality Duty) under the Equality Act 2010 and in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. Furthermore we have linked the EDS2 to Human Rights, listed below are the Articles.

The **Equality Act 2010** requires all Clinical Commissioning Groups (CCGs) to annually publish information which demonstrates their performance and progress against the requirements of the Public Sector Equality Duty (PSED), for people with characteristics protected by the Equality Act 2010. The nine characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race (national and ethnic origin)
- Religion or belief
- Sex
- Sexual orientation

Other disadvantaged groups include people who are:

- Homeless
- Live in poverty
- Stigmatised groups i.e. prostitution
- Misuse drugs
- Geographically isolated

The EDS2 was developed by the NHS for the NHS to help NHS organisations, in discussion with their local partners and local people, review and improve their performance in respect of people with a protected characteristic.

The **EDS2 framework** identifies four over-arching goals with 18 outcomes.

- Better health outcomes for all
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership.

Human Rights

Human rights and principles of equality should never be a secondary consideration in the provision of NHS services or in the development of the workforce. The five principles are referred to as FREDA:

Fairness – at the heart of recruitment and selection processes (Goal 3)

Respect – making sure complaints are dealt with respectfully (Goal 2)

Equality – underpins commissioning (Goal 1)

Dignity – core part of patient care and the treatment of staff (Goal 2 & 3)

Autonomy – people should be involved as they wish to be in decisions about their care (Goal 2)

(Goal 4 would be a golden thread as part of all outcomes)

These have been developed to provide general principles that NHS should aspire to.

The Public Sector Equality Duty (PSED)

Using the EDS2 will help organisations respond to the PSED, and demonstrate their continued activities to meet the requirements to:

eliminate unlawful discrimination;

advance equality of opportunity between different groups and;

foster good relations between different groups;

The goals and outcomes of *EDS2*		
Goal	**Number**	**Description of outcome**
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Articles of the European Convention on Human Rights

The key human rights articles have been considered:

- Article 2 Right to life
- Article 3 Freedom from torture and inhuman or degrading treatment
- Article 4 Freedom from slavery and forced labour
- Article 5 Right to liberty and security
- Article 6 Right to a fair trial
- Article 7 No punishment without law
- Article 8 Respect for your private and family life, home and correspondence
- Article 9 Freedom of thought, belief and religion
- Article 10 Freedom of expression
- Article 11 Freedom of assembly and association
- Article 12 Right to marry and start a family

- Article 14 Protection from discrimination in respect of these rights and freedoms

- Protocol 1, Article 1 Right to peaceful enjoyment of your property
- Protocol 1, Article 2 Right to education
- Protocol 1, Article 3 Right to participate in free elections

- Protocol 13, Article 1 Abolition of the death penalty

Wolverhampton CCG Equality Objectives

1. The CCG to work towards a comprehensive understanding of the barriers to accessing services experience by patients. To work to reduce the barriers identified with partner organisations and stakeholders.
2. The organisation will ensure that Due Regard is given to the needs of the CCG's population during service change, including vulnerable groups, through effective engagement focused to the profile of the population affected by particular changes.
3. The organisation will use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive supportive values and competencies across the workforce.
4. The CCG's Leadership will, as system leaders continue to visibly champion improved outcomes for vulnerable groups and tackling health inequalities across Wolverhampton and the Black Country.

Vision

"Our vision is to provide the right care in the right place at the right time for all of our population. Our patients will experience seamless care, integrated around their needs and they will live longer with an improved quality of life"

Wolverhampton CCG wants everybody to receive the highest quality and appropriate care for their needs, delivered from the right service, when the patient needs it. The CCG have a range of strategies to help us achieve this. Some might mean the CCG look to change how services work in order to meet the current needs and expectations of local patients. Others, for example, will look to help patients make the right decisions about getting care. An example of this is the CCG's 'choose well' campaign, which you may have seen on buses and in newspapers. This aims to inform patients of all the urgent and emergency care options available to them.

CCG region

Overview of CCG population information

Wolverhampton CCG is committed to design and implement policies, procedures and commission services that meet the diverse needs of the local population and workforce, ensuring that none are placed at a disadvantage over others. As the leader of the local NHS, Wolverhampton CCG, are responsible for spending almost £1m a day on healthcare for the city's 262,000 registered patients. The CCG commission (buy and monitor) everything from emergency/A&E care, routine operations, community clinics, health tests and checks, nursing homes, mental health and learning disability services. As a commissioner, it is the role of the CCG to ensure that the services brought from the many providers of care, including The Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust is of the highest quality and appropriate for the health needs of our city. Wolverhampton CCG, are a clinically-led organisation comprising of 46 member GP practices within the city. This means that local family doctors can use all their experience of the needs and wishes of local patients to make decisions about local health services.

Wolverhampton is one of the four local authorities in the Black Country sub-region. Wolverhampton has a documented history dating back to 985AD. In 2000, Wolverhampton was granted city status. The first Census in 1801 shows Wolverhampton's population as 12,500, in 1901 94,187 and by 1951 the population stood at 162,672. Wolverhampton is now one of the most densely populated local authority areas in England, with a population of 249,470 people (Census 2011) living in its 26.8 square miles, equating to a population density of 3,447 per square kilometre. The latest Indices of Deprivation (2010) indicates that Wolverhampton is more deprived than it was three years ago and represents a relative decline, from the 28th most deprived to the 20th most deprived local authority (out of 326 local authorities). The equalities profile of the borough focuses on the following:

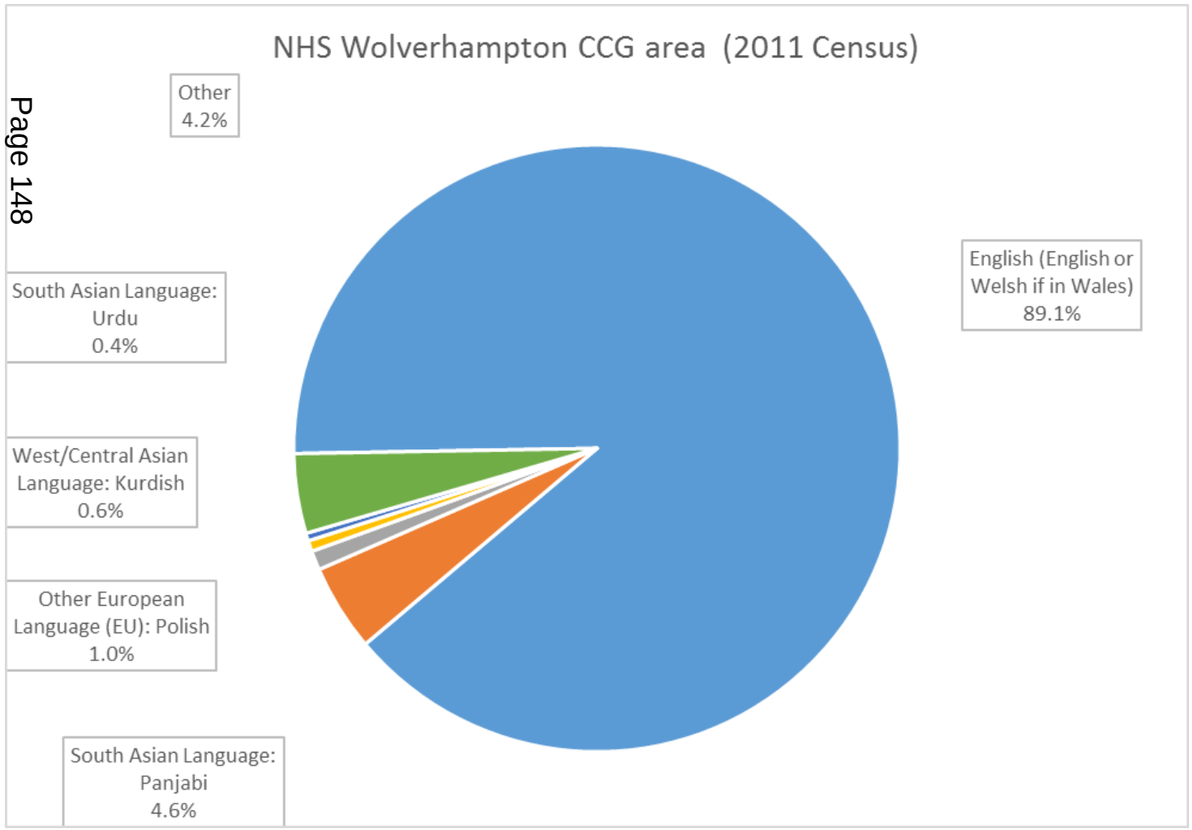
Table 1: The ethnicity profiles of England and NHS Wolverhampton CCG's area based on the 2011 Census (all usual residents)

Ethnicity	England		NHS Wolverhampton CCG	
	n	%	n	%
White	45281142	85.42%	169682	68.02%
Asian British	4143403	7.82%	44960	18.02%
Black British	1846614	3.48%	17309	6.94%
Mixed	1192879	2.25%	12784	5.12%
Other	548418	1.03%	4735	1.90%
Total	**53012456**	**100.00%**	**249470**	**100.00%**

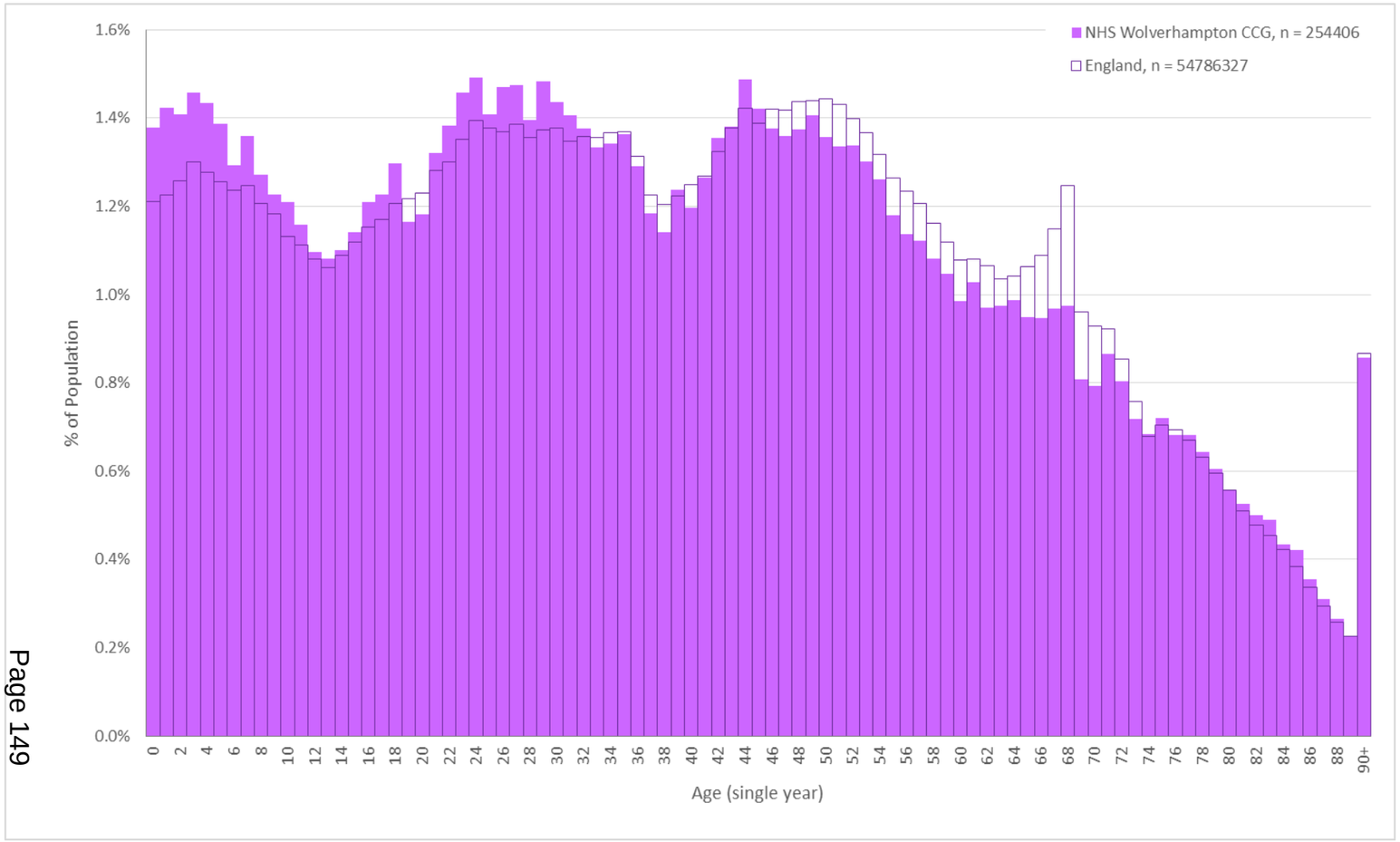
Table 2: The disability profiles of England and NHS Wolverhampton CCG's area based Census (all usual residents)

Disability	England		NHS Wo	
	n	%	n	
Day-to-day activities not limited	43659870	82.36%	196226	
Day-to-day activities limited a little	4947192	9.33%	25381	
Day-to-day activities limited a lot	4405394	8.31%	23919	9.74%
Total	**53012456**	**100.00%**	**245526**	**100.00%**

Language profile of the CCG based on 2011 Census:



Age range of CCG population – 2015 ONS data:



All information is based on the last census in 2011 but provides a clear picture of the diverse community that Wolverhampton CCG serves.
Population Projections estimate the city's population will be 273,300 by 2037, an 8.9% rise from their baseline 2012 figure of 251,000. The balance of the population will change: an increase in the number of children, but fewer working-age people, and elderly. Slightly increasing birth rates, and inflow of migration greater than outflow, are important aspects of population growth, but decreasing mortality rates and longer life expectancies point to a steadily aging population overall. Services need to be planned to meet future need.

Overview of CCG health inequalities

A focus on reducing health inequalities

Unacceptable gaps in health exist across Wolverhampton. A baby born today in Bilston can expect to live seven years less than somebody born in Tettenhall. Improving the health of the entire city and reducing health inequalities is very important. The NHS has a key role to play in both treating people when they are ill or injured, and keeping people healthy. In partnership the CCG work with the Public Health team, who are within the City of Wolverhampton Council and together they work hard to promote healthy lifestyles and commission services that help people to make healthier lifestyle choices.
In order for Wolverhampton CCG to tackle the biggest health challenges in the city, three priorities have been identified which are:

1. Dementia – The CCG aim to increase the numbers of dementia patients who are able to stay at home for longer, keeping them out of hospital.
2. Diabetes – The CCG aim to reduce the number of avoidable admissions to A&E.
3. Urgent Care – The CCG want to increase the number of people with the condition who are able to manage their conditions themselves – at home.

Wolverhampton CCG believe by improving outcomes for people in these areas, we will have the best chance at improving the city's health overall and reducing the health inequalities that remain.

"No decision about you, without you"

When the NHS changes were announced by the government in 2010, a key commitment was made to patients in Wolverhampton. This was that the local NHS would make decisions that were informed by the views of local people. This means the NHS has to get much better at listening to patients' views and using these to influence the decisions it makes. The CCG have a comprehensive engagement framework that enables us to talk and listen to local patient and community groups. We value the time people take to tell us their views and we use the information we gather to help us:

- determine the heath needs and wishes of local people;
- decide how we spend our money – including what we need to start and stop doing;
- monitor the quality of the services we commission;
- investigate concerns that people have raised through using services;
- ensure there are a range of ways patients can get involved;

Statement of commitment from the CCG

The CCG believes that equality and diversity should include addressing health inequalities as well as being embedded into all commissioning activity. Equality and diversity are central to commissioning plans, where everyone has the opportunity to fulfill their full potential. The CCG also believes that equality is about creating a fairer society and diversity is about recognising and valuing difference in its broadest sense.
46 GP practices in the city are members of the CCG and this provides the CCG with the opportunity to work with our patients to improve services and the overall health of the city. The CCG's GP practice membership will ensure the needs and priorities of our population are clearly identified and addressed by delivering the right care in the right place, at the right time by the right people.

"Right care, right place, right time within our financial envelope"

CCG Approach to equality

Wolverhampton CCG has committed to have due regard to the Workforce Race Equality Standard (WRES) and use it as a force for driving change, both as an employer and as a commissioner of services.

The CCG will demonstrate its due regard using a combination of activities. Due regard means that the CCG has given consideration to issues of equality and discrimination in any decision that may be affected by them. This is a valuable requirement that is seen as an integral and important part of the mechanisms for ensuring the fulfillment of the aims of anti-discrimination legislation set out in the Equality Act 2010.
Firstly, through its contracts with its providers, the CCG will seek assurance that there is evidenced compliance to Equality Act 2010 legislation. This is mainly achieved by Service Condition Section 13 of the NHS Standard Contracts, which sets out the requirements according to organisation type. Using Clinical Quality Review Meetings (CQRM) for larger organisations, the provider submits appropriate and relevant evidence that ensures assurance for the CCG. All providers are expected to demonstrate they understand their service users, workforce and race profile and have self-assessed against the WRES standards, the CCG will wish to see how the providers intend to implement the standard and what the impact will be on any key disproportionate representations of their service users and workforce.

Overarching activities of the CCG
Operating Plan

In 2014, along with our partners, the CCG established our five year strategy for the Wolverhampton Health Economy. This set out our vision to commission the **right care, in the right place at the right time** based on improving outcomes for our population by:-

- Decreasing potential years lost to ill health;
- Improving health for those with Long Term Conditions;
- Reducing avoidable admissions to hospital;
- Increasing the number of older people who are supported to live independently at home;
- Improving people's experience of receiving health care; and
- Ensuring consistent outcomes, seven days a week.

This ambitious strategy was and continues to be supported by clear delivery priorities around the development of primary care, continued integration with social care, reconfiguration of urgent and emergency care and the continued improvement of mental health services underpinned by a focus on reducing health inequalities across the population. These priorities were translated into Operational plans, refreshed on an annual basis.

Planning Guidance for 2016/17 introduced the requirement for NHS Organisations to come together with Local Authorities to develop Sustainability and Transformation Plans (STPs) across the footprint of a health and social care economy up to 2021. Wolverhampton is part of the Black Country STP footprint and our Operational Plan for 2017/19 outlines how the CCG will contribute to the delivery of plans across the Black Country. The STP, agreed in November 2016 aims to **materially improve the health, wellbeing and prosperity of the population through providing standardised, streamlined and more efficient services.** It identifies many of the key challenges and priorities we set out to build on in our five-year strategy and provides a clear programme of action across the Black Country based around the following priorities: -

- Implementing local place-based models of care that deliver improved access to better coordinated community and primary care that provides greater continuity for patients who can and should receive integrated services in an out of hospital setting;
- Extending Collaboration between Acute service providers to create a coordinated system of care across the Black Country to reduce variation, improve quality and deliver organisational efficiencies;
- Building on existing plans to transform mental health and learning disability services;
- Addressing the significant challenges faced in maternal and infant health through the development of a single maternity plan;
- Working together on key enablers such as digital infrastructure, public sector estate utilisation and workforce transformation to deliver modern patient centred services and commissioning functions; and
- Acting in partnership with the West Midlands Combined Authority and other partners to address the wider determinants of health including employment, education and housing. Wolverhampton Clinical Commissioning Group 3

The STP will build on existing plans and strategies by recognising both opportunities for organisations to work more closely together to deliver benefits for patients and where local action is most appropriate. There is a clear focus on innovation, particularly where it supports collaboration to reduce variation. This plan outlines the areas Wolverhampton CCG will focus on during 2017/18 and 18/19 to deliver our organisational vision through the broader aims of the STP and the Black Country Footprint.

Governing Body

The CCG aims to commission the highest quality, evidence-based care on behalf of its patients by investing in skills available locally and otherwise to design new and improved care pathways. The mission of the CCG is:
"We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality sustainable services for all our population."

Quality and Safety Committee

The Quality and Safety Committee (QSC) is established in accordance with paragraph 6.9.5(c) of NHS Wolverhampton Clinical Commissioning Group's constitution, standing orders and scheme of delegation. The QSC is accountable to the governing body and its remit is to provide the governing body with assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them. The QSC has specific duties that include monitoring the group's delivery of the public sector equality duty (constitution 5.1.2(b)).

Equality Analysis (formerly Equality Impact Assessments)

Delivering on equality and embracing diversity is only possible if the impact of services, policies, functions and decisions on the community and staff is analysed. Under the Public Sector Equality Duty of the Equality Act 2010, public services are required to analyse the impact on equality when exercising its functions. The equality analysis is important in order to consider the effect on different groups when decisions are made and identify practical steps to tackle any negative impact. The analysis helps public services to pay due regard to the need to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it
- Foster good relations between persons who share a relevant characteristic and those who do not share it

An EA should be carried out from the earliest stages of consideration by the CCG to make any changes. It enables managers to address fundamental questions in considering and understanding how a proposal for healthcare changes and can help them to meet all customer requirements. It specifically seeks to address the following issues:

- Is there any direct discrimination?
- Is there any potential for indirect discrimination?
- What engagement has been carried out and who with?
- What was the outcome of any engagement and how has this informed the decisions made?
- Is any group disproportionately affected?
- What are the potential adverse impacts?
- What actions will be taken to mitigate any adverse impact?

This process has been embedded within the CCG's policy, practice and procedures from the scoping stage of commissioning. It has been and will be embedded in our work throughout 2015-17, so the CCG can scrutinise key changes in healthcare for any adverse impacts on local protected groups (both patients and staff). The CCG understands that EIAs support them to consider protected groups in all of its planning and decision making processes, as required by the Equality Act 2010. The CCG undertake more detailed work to promote the use of EIAs for commissioned services, supported by relevant Health Impact Assessments and Health Equity Audits.

Equality Strategy and Equality Objectives

Equality and Diversity is central to commissioning plans, where everyone has the opportunity to fulfill their potential. The CCG strongly believes Equality is about creating a fairer society and Diversity is about recognising and valuing difference in its broadest sense. This covers the relationships with service users, staff, and with other stakeholders. It builds upon the strong foundation for equality, diversity and human rights in the constitution and governance arrangements, it is key to how the CCG make decisions and how a contribution to strategic planning with partners is made. It sets out how the CCG will ensure equality considerations and valuing difference so that it becomes a systematic part of thinking, tone and approach. The CCG's approach to equality and diversity will directly influence the relationships and transactions with individuals, groups and local communities; the way in which the CCG collects, analyses and interprets information and evidence; the collaborative arrangements with provider organisations; and finally the discipline adopted to reflect and consider if the CCG truly understand the consequences of their actions from the different perspectives of the community. This will apply particularly to those who are disadvantaged, vulnerable because of social determinants or ill-health. The current Equality objectives which inform the CCG's strategic direction can be found on page 3 of this document.

Procurement

The CCG procures services from a range of providers. Contracts vary from small one-off purchases to large works or service contracts. Whilst procuring services, the CCG ensure fair opportunity, competition and value for money. The form of procurement used varies depending on the nature of the product or service being procured but can include Any Qualified Provider (AQP) competitive and non-competitive tendering. The CCG follow public procurement regulations and guidelines when determining the form of procurement and approach. The regulations mean the CCG cannot favour providers simply because they are already in contract with the CCG, an NHS organisation, located in the area, or employing local people. The CCG operate procurements in a fair and transparent way in accordance with the Principles and Rules of Co-operation and Competition published by the Department of Health. In line with the requirements set out in the Statutory Guidance for CCGs on managing conflicts of interest in CCGs published in July 2016 by NHS England, the CCG maintain a register of procurement decisions taken, which includes:

- the details of the decision;
- who was involved in making the decision;
- a summary of how any conflicts of interest in relation to the decision have been managed;

This enables the CCG to demonstrate that it is acting fairly and transparently and in the best interest of patients across Wolverhampton

Equality Delivery System 2 (EDS2) Evidence Portfolio

1. Better health outcomes

The NHS should achieve improvements in patient health, patient safety and public health for all, based on comprehensive evidence of needs and results

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities

How does the CCG design/procure/commission services which are appropriate to its local population? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact

Age
Disability
Gender Re-assignment
Marriage & Civil Partnership
Pregnancy & Maternity
Race
Religion or belief
Sex
Sexual Orientation
	Objective 1
	Objective 2
	Objective 3
	Objective 4
		Article 2
		Article 3
		Article 5
		Article 8
		Article 14
			Wolverhampton CCG aim to provide more personalised care, closer to people's homes. To achieve this, the CCG has set out an ambitious five year strategy to modernise care and look at different ways to deliver services for less. It may take time to bring about this change.
			
			Key priorities identified within the CCG's Operational Plan include the following – illustrating how meeting the needs of vulnerable groups is prioritized.
			• Improving Mental Health and Learning Disability support
			  ○ Maximise regional, system wide approach.
			  ○ Improve bed utilisation and stop out of area bed use
			• Improving Maternal and Infant Health, to achieve a sustainable model of maternal and neonatal care, improving outcomes for mothers and babies across the Black Country
			
			We recognise that in order to deliver our ambitious strategic plans, we will need to ensure that key enablers, including the use of technology, how we use our estate and the skills of our workforce are all aligned to our delivery plans. Our vision to commission the right care in the right place at the right time will only be possible if we deliver our plans to ensure that we have the most appropriately skilled people available to deliver care in high quality, accessible locations using the technology available to them in the right way. We will continue to work to ensure that these key enablers are in place throughout 2017/18 and 2018/19.
			
			The CCG's **Commissioning Intentions** (CI) The Commissioning Intentions report highlights the engagement findings and recommendations during four public CI engagement events which took place during June 2017, on the CCG's proposals to develop, inform and guide Wolverhampton Clinical Commissioning Group (WCCG) CI 2018/19.
			
			The 'You said we did' demonstrates how the CCG involve and listen to the community - https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did
			
			Skin (Dermatology) services in Wolverhampton - 2019
			We are currently asking for Wolverhampton residents' views about dermatology (skin) services. This is an opportunity for you to have your say and help shape the future design of community dermatology services in Wolverhampton.
			You can have your say by completing the survey: https://www.surveymonkey.co.uk/r/WGZY2BK or attending our focus group. The survey will close on Sunday 24 February 2019.
			We will use the feedback we receive to inform the decisions we make on how community dermatology services are provided in Wolverhampton.
			More information can be found here.
			
			Prescribing over the counter medicines - 2018
			In August 2018 we engaged with members of the public on reducing prescribing of over the counter medicines for minor, short-term health conditions.
			We set up a survey to ask people their views on whether medications that are available to buy over the counter should continue to be available on prescription. We promoted the survey via our online channels and attended two groups across the city to do some targeted engagement.
			180 people completed the survey. You can read the summary report pdf here (402 KB)
			
			To support and implement the changes, we have distributed posters and leaflets to GP practices to be displayed in their waiting areas. You can also view them here: pdf leaflet (162 KB) image poster (160 KB)
				By ensuring that a joined up approach is used in the commissioning of services the CCG ensures that services do meet the needs of the local population. The CCGs use a robust Equality Analysis process to ensure that service design, commissioning and redesign take account of the needs of the population.
				
				• Transforming Care Partnership
				• Transforming Care Together
				• MERIT vanguard
				• Better Births
				• Healthy Pregnancy Pathway
				• Neo-natal care pathway
				• Maternal mental health pathway
				
				To ensure the views of the population it serves is taken into account the CCG undertake very comprehensive engagement initiatives. Because of how the engagement is carried out specific views are taken into account and provide focus for key actions.
				
				By adopting a more integrated approach it is aimed to prevent people having unnecessary stays in hospital.
				
				The CCG are working with all providers to strengthen the service user and carers' voice across service re-design and delivery including evaluation of initiatives across the life span to develop self-efficacy and quality of life.

Medicines of Limited Clinical Value - 2018
In August 2018 we asked for your views about the future of medicines with limited clinical value.
We created a survey and attended two groups across the city to do some targeted engagement with people who are already on long term medication of some description, to understand their views.
93 people completed the survey. You can read the summary report pdf here (223 KB)

Sickle Cell and Thalassemia
The survey closed on 21 August 2017. Thank you to all who participated in our engagement exercise.
Some of the help and support for Sickle Cell and Thalassemia is paid for by the CCG. Some of it is paid for by other NHS organisations. We asked you about the help and support that the CCG may need to pay for. We asked for your views (via a survey) as patients and members of the public about the following:

- The information that is available to the public about Sickle Cell and Thalassemia.
- The advice and counselling that parents are offered as part of the screening process
- The long-term support offered to people with the conditions

We also asked people who are affected by Sickle Cell and Thalassemia what they think is important to help them keep healthy and how that support could be provided. Some will have used the services which are available or know someone who has. We would like you to tell us your views about those services to help us decide which ones work best.
For more information click here.

The key objectives are:

- To promote (along with other communications plans) the WCCG as an effective custodian of the local NHS that makes decisions in the best interests of local people.
- Inform commissioning decisions using the engagement cycle and CCG Communications and Participation Strategy, to ensure they are focussed on the needs of service users and communities
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health
- To define and provide a range of communications and participation products and methods to help people to:
    - learn about proposals in detail in to help them form an opinion, and know how they can feedback,
    - to share their opinion with us.

A thorough communications and participation plan was put together and monitored by the Commissioning Intentions Group to inform clinicians and staff within our organisations, partner organisations, patient/community groups and the public about the engagement exercise and how to get involved to share with us their views.

The Commissioning Dept were asked to provide key themes for discussion with the stakeholders.

Communications and Participation approach
A variety of engagement methods were used to share information about the CCG CI and encourage people to share their feedback. Below details each method:
2.1 Scheduled CCG meetings

Date/time	Meeting
06 October 2016	Planning
03 November 2016	Planning
17 January 2017	Planning
06 April 2017	Planning
25 July 2017	Planning
07 September 2017	Planning

Public events

Date/time	Venue	Present
Wednesday 14 June, 9am – 3.30pm	Asda, Molineux Way, Jack Hayward Way, WV1 4DE	public and interested stakeholders
Thursday 15 June, 9am – 3.30pm	Morrisons, Black Country Route, Bilston, WV14 0DZ	public and interested stakeholders
Friday 16 June, morning	Sainsbury's Superstore, Rookery Street, Wednesfield, WV11 1UP	public and interested stakeholders
Friday 16 June, afternoon	Co-op, Low Hill. WV10 9UN	public and interested stakeholders

Direct messages (electronic and paper based)

Type	Date	Reach
Advertise events – emails, press release, web, social media	May/June 2017	To patient partners, PPG Chairs, stakeholders and Citizens Forum, public

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Commissioning decisions and activity are informed by patient and public insight, experience and involvement in order to reduce health inequality and to drive improvement. The CCG's *Communications and Engagement strategy* is available to all staff and is used to inform commissioning work. For primary care specifically, public and patient insight is sought and used through the work of an operational group to support both the work of the *Joint Commissioning Committee* and to support the CCG's broader role in supporting quality improvement in Primary Care. This work is underpinned by patient feedback (range of sources i.e. surveys, expert patients, PPGs, complaints, compliments, engagement events) that is used to drive improvement. The CCG's approach is based on proactive engagement on a routine basis rather than as an afterthought. At present, further work needs to be done to link this work to health inequalities and this will continue as the CCG moves towards delegated commissioning. a) The Governing Body receive a report on patient insight activity each meeting and all reports include details of patient and public involvement. Specific reports relating to individual pieces of work are presented as and when they take place. b) Patient and Public insight has been used to develop the Primary Care Strategy and is reported through formal processes including the *Joint Assurance and Engagement Group* and *PPG Chairs meetings*, *Patient Partners forums* and *quality review work*. The CCG are seeking to move to greater involvement for patients in our operational work through the development of a *Patient Reviewers programme* who will support our work monitoring quality. c) The CCG works closely with Public Health to develop an overall understanding of population needs and health inequalities via the JSNA. This includes evaluation of patient and public insight but not necessarily in a structured way. d) Specific work has taken place to understand access to Primary Care through a structured survey. This formed part of the wider engagement work on the Primary Care Strategy which focusses heavily on population need i.e. health information, feedback from the community and practice understanding of need resulting in care closer to home, in the right place at the right time. e) The CCG works closely with Primary Care to develop mechanisms to gather patient feedback. In particular, the CCG supports the collection of data through the Friends and Family Test and is working closely with New Models of Primary Care delivery to ensure patient needs are at the heart of services. The CCG supports the development and effective operation of Patient and Participation Groups across Primary Care and has encouraged their involvement in the development of new services. Further work will be undertaken to understand and evaluate how effectively this is operating. https://wolverhamptonccg.nhs.uk/publications/corporate-policies-1/493-communications-and-engagement-strategy-1	Commissioners understand their organisation's strategic approach and therefore how and why the use of patient and public insight, experience and involvement reduces health inequality and drives improvement. Commissioners seek and gather patient and public insight and experience data in order to inform their commissioning decisions, activity and evaluation. Commissioners use patient and public insight, experience and involvement to identify and fully understand all health inequalities and inequities. Commissioners use patient and public insight, experience and involvement to inform the development of possible solutions, decisions and activity, in order to reduce health inequality and drive improvement.

			The CCG has put in place a range of contract monitoring requirements to ensure that services are delivered on its behalf in a way that genuinely meets the needs of diverse communities. These contract requirements are set out in sections 1.2 and 2.1. By doing so the CCG ensures that local accountability is maintained and that patients can access services in an equitable manner.	
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The CCG's **Commissioning Committee (CC)** was established by the Governing Body, who supports them to discharge their respective responsibilities when commissioning services, according to NHS Wolverhampton Clinical Commissioning group constitution paragraph 6.4.1/6.4.2. https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf - Appendix H5 This also includes terms of reference for the various committees. The CC is accountable to the governing body and its remit is to provide the governing body, Director of Strategy and Solutions and Executive Nurse with support in meeting the duties and responsibilities of the group as a commissioner of healthcare services, specifically: • acting consistently with the promotion of a comprehensive health service and the mandate issued for each financial year by the Secretary of State to the NHS Commissioning Board, for which the CC will develop a Commissioning Policy (constitution 5.1.2(a)); • securing continuous improvement in the quality of services (constitution 5.2.4); • coordinating the work of the group as appropriate with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, local authorities, patients and their carers, the voluntary sector and others to develop robust commissioning plans (Prime Financial Policies 14.1);	A consistent way to deliver commissioning duties by developing and delivering annual work programmes giving appropriate focus to the following: • develop the commissioning strategy, commissioning plans and annual commissioning intentions, (https://wolverhamptonccg.nhs.uk/about-us/the-governing-body/board-papers/2014-1/november-1/1000-k-agenda-item-10c-gb-report-commissioning-intentions-register-2015-16-11-november-2014-1/file • anticipating and adapting as required for national and international policy, the group's safeguarding and other statutory responsibilities, local and national requirements and patient expectations; • oversee the annual contracting processes and any other programmes of healthcare service procurement; • review of commissioning policies; • develop service specifications for the commissioning of healthcare services; • consider service and system reviews and develop appropriate strategies across the health and social care economy to address any identified issues; • review progress against commissioning strategies and plans to ensure achievement of objectives within agreed timescales; • make recommendations as necessary to the governing body on the remedial actions to be taken with regard to key risks and issues associated with the commissioning portfolio;
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The CCG has now published new Equality Objectives for the period 2018-2021, these help set the direction for the next three years. Updates will be published on progress made against them on the CCG's website. https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2016 As part of the development of these objectives the CCG engaged with its Patient Participation Group network to gain further feedback on the approach. As a result the CCG has ensured that these are inclusive of patient feedback.	Targeted action to improve outcomes for patients and maintain a supported diverse workforce.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Equality Analysis** is an integral part of the commissioning process from the earliest point. Public services are required to **analyse the impact on equality** when exercising its functions. The equality analysis is important in order to consider the effect on different groups when decisions are made and identify practical steps to tackle any negative impact. The analysis helps public services to pay **due regard** to the need to: • Eliminate discrimination, harassment and victimisation • Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it • Foster good relations between persons who share a relevant characteristic and those who do not share it Equality triggers have been embedded into the project process from the scoping stage. The strategic process inclusive of equality is well documented and shared with all relevant staff. An operational process map is being documented for approval, to ensure clarity by all.	Equality and Inclusion is an integral and embedded part of the Equality Analysis and all staff including staff at senior Management levels knows what they should be doing when commissioning services and discharging its duty. It provides assurances to the CCG that this process/procedure supports meeting their legal and moral obligations as outlined in the Equality Act 2010.

			There has been refresher training for relevant staff and a coaching approach was used in an effort to develop an understanding of; • Why Equality Impact and Risk Analysis are important • Better understanding • Responsibilities	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The CCG has articulated the local need for children and young people in their commissioning plan. Although this does not specifically state **Special Educational Needs and/or Disabilities (SEND),** commissioning children and young people's services in a more effective and efficient way will have a positive impact on children and young people with SEND. The review of community health local offer will ensure that services for this group fully meet the needs of this patient cohort. The involvement of patients from this group in this review is key to ensure that their views are heard and appropriate services commissioned. As part of this involvement the CCG will work with patients from this group in a range of settings and forums including; Voice for Parents (Parent and Carer forum), Change in our Lives (Young people forum – which includes a range of patients with physical difficulties, learning disabilities and mental health conditions), in schools and within the trust setting. .	The CCG understand the local SEND population and services are commissioned appropriately to ensure needs are met. As a result outcomes improve for this group and Due Regard is given to the needs of this group of patients across services.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The Mental Health Commissioning Strategy sets out five key priorities as set out below: •Integration of mental and physical health - closing the mortality gap •Improving access to the quality and evidence base and improving access to and responsiveness of services, referral to treatment and waiting times - closing the treatment gap •Improving Data Quality – closing the data quality gap •CCGs commitment to Mental Health Investment Standard - closing the parity of esteem / funding gap •Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap	There is a focus upon transition from CAMHS to AMHS and AMHS to Older Adults There is a focus upon those with a physical health and mental health disability / difficulty (including a learning difficulty) to improve the mental health and self-efficacy of this cohort There is a focus upon those who are transgender and / or LGBT + to improve the mental health and self-efficacy of this cohort There is a focus upon perinatal mental in line with the Five Year Forward View for Mental Health deliverables including a focus on reducing suicide and mental health related deaths as outlined in Better Births There is a focus upon building cultural competence of services and targeting over representation of BAME groups in some mental health services by improving early intervention and prevention and reducing detention of Black males There is a focus upon building cultural competence of services working with faith based community groups to build resilience of individuals families and communities There is a focus upon those who are transgender and / or LGBT + to improve the mental health and self-efficacy of this cohort. Interventions will be gender sensitive ie responsive to the needs of people in relation to gender
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Wolverhampton Clinical Commissioning Group (CCG), in collaboration with Wolverhampton Voluntary Sector Council (WVSC), launched a social prescribing pilot service in April 2017, including three link workers located across the City. The social prescribing service provides a link between primary care services and the voluntary and community sector, and aims to help people with non-clinical needs access a wide variety of services and activities in Wolverhampton to support their health and wellbeing. The Institute for Community Research and Development was commissioned to undertake an independent evaluation of the service. The evaluation took a mixed-methods approach to review the current delivery, evidence impact and provide recommendations for future service provision. Quantitative analysis of routine monitoring data, including measures of wellbeing and loneliness, and NHS use data examined the impact of the service. This was complemented by focus groups and interviews conducted with service users, referrers and providers to understand their experiences.	The service has ensured that patients have access to additional support that helps provide a route to ensure all patients needs are met not just those medically treatable. With the current pressure to local authority and voluntary sector budgets the need for additional support is increased. In addition it assists GPs in navigating the complex and changing landscape of support which might otherwise limit their ability to address patient's non-medical needs.

			Key findings • The service received 676 referrals (64% female; mean age 66.4 years) between May 2017 and December 2018 • The most common reasons for referral were loneliness and low-level mental health conditions • Link workers made onward referrals to over 150 groups/services • There was a statistically significant improvement in service users' reported wellbeing following contact with the social prescribing service • Service users reported a statistically significant decrease in feelings of loneliness following contact with the service • A reduction in primary care health use was statistically significant for those service-users who were the highest utilisers of GP/practice nurse appointments (6+ appointments in six months) • The estimated Return on Investment means that for every £1 spent on the social prescribing intervention, there will be a saving of £0.15 for primary care services. This is a conservative estimate considering the data limitations described in the report • Qualitative findings support the quantitative findings. The service is highly regarded by referrers, providers, and service-users. In addition to improved wellbeing and loneliness, respondents discussed improved mental health, confidence, self-esteem, and in some cases improved physical health. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. WV Social Prescribing Link Workers do? • Accept referrals from GPs and other professionals within the GP practice • Build relationships with a range of health workers and voluntary and community sector providers; • Support people to connect with alternative sources of social and emotional support within their locality • Work with health teams to identify common issues that can be supported by the voluntary and community sector • Provide a holistic and integrated approach to support vulnerable individuals to improve their health and wellbeing This service can support: • Patients with long term conditions that could benefit from individualised support • Patients who are lonely • Patients who show mild symptoms of anxiety and/or depression • Circumstances where a medical solution or intervention is unlikely to be successful or satisfactory. • Patients who frequently access NHS services for non medical reasons • Who this service is unable to support: o Patients under the age of 18 o Patients for whom a medical intervention is required	
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	An all age **Autism Spectrum Condition Strategy** has been developed in conjunction with the City of Wolverhampton Council and NHS Wolverhampton CCG. The CCG is involved in the development of an implementation plan with the focus on health specifics of the strategy across CYP and adults. This service is specifically aimed at those children and young people, their families and carers who are under the age of 18 who have been referred into services to undertake assessments for an autistic spectrum condition The areas of the strategy which the CCG is focusing on are as follows: Diagnostic pathways: From July 2016 the CCG commissioned a new diagnosis, assessment, treatment, review and support care pathway from Dudley and Walsall Mental Health Partnership Trust for adults. This has resulted in increased numbers of assessments, reduced waiting times and improved satisfaction from service users. For children and young people under the age of 18, the CCG has started work to review the diagnostic pathway, and are working with key stakeholders, including parents, to develop a new pathway, which will be implemented by April 2019. Participating in Care, Education and Treatment Reviews: The development of the neurodevelopmental conditions strategy and subsequent workstreams will impact on children and young people who either are going through or have been through a diagnostic process for neurodevelopmental	The intended benefit of this review is that the ASC diagnostic services will be secure and will reduce health inequalities for CYP in the city ensuring good patient and carer experience. This review and service change will benefit those CYP who are being referred into services due to concerns that they may have an ASC diagnosis. This ensures the services are able to provide exactly what the Child or young person and their families/carers need as and when they need it. It will also ensure the pathways are clear for all to understand with clear timescales. Easier access to ASC diagnostic services with clear information provided to parents/carers and the children and young people about the process involved in the

			conditions as well as their parents and carers, staff who are involved in the care of this group of children and young people including those in acute, community, education and social care. Currently the diagnostic pathways rely on the goodwill of the services involved in the multi-agency pathway to undertake the assessment. As services have become pressured to achieve activity targets they are withdrawing their expertise from the panel as no activity is counted from the panel. A service specification will be drawn up to ensure that services are commissioned to deliver a NICE compliant service for diagnosis of neurodevelopmental services. These services will be multi-agency and so the service specification will need to be jointly commissioned.	diagnosis.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The review and implementation of an Arterial Fribulation pathway across both primary and secondary care will facilitate the identification of currently undiagnosed patients who have AF; offering them anticoagulant medication, and secondly by identifying patients on practice AF registers who are not currently receiving anticoagulants and offering them that medication. The estimated numbers in each group are: Prevalence data suggests that there are 2,300 undiagnosed patients across the CCG (NHSE 2015 and Stroke Association) Improved access to diagnostic and treatment options as a result of improved an atrial fibrillation pathway Improve the identification/diagnosis of patients over 65 who have AF Improve the health outcomes and medicine optimisation for patients who have an atrial fibrillation diagnosis. Provision of lifestyle information to reduce stroke risk as per local and national guidelines Enhanced GP/practice confidence in the management of stroke risk in AF Disease register validation with potential to improve atrial fibrillation prevalence Thorough clinical assessment of patients using structured care pathways and integration tools Risk stratification of patients using CHA2DS2-VASc which also supports optimal achievements within the AF QOF indicators Facilitating practice achievement of indicator points within the Atrial Fibrillation QOF clinical domain NHSE estimates suggest that of those patients who have been identified to have AF over half are untreated or poorly controlled. **The project includes due regard to interpreting and translation requirements.** **Carers may benefit from the preventative and treatment intervention preventing potential stoke and disability since it will improve the support / health of the patient they support**	Enhancing the quality of life for people with long term conditions, improving the health related quality of life for people with long term conditions. An improvement in both the health and wellbeing, quality of life and the healthy life expectancy of patients with AF who are currently either not diagnosed or not receiving anticoagulant treatment. A reduction in the number of people experiencing a stroke and TIA associated with AF. A reduction in the number of deaths arising from AF-related stroke. Stroke is a major cause of death in the older population and AF-related stroke is considered to have much higher mortality.

1.2 Individual people's health needs are assessed and met in appropriate and effective ways

How does the CCG ensure individual health needs are met effectively? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The Joint Strategic Needs Analysis (JSNA) supports the CCG to understand the make-up, health needs and health inequalities of the population its serves. This work stream within Wolverhampton develops two kinds of JSNA Products – JSNA Overview Report and Topic specific JSNAs. The topic specific JSNAs aim to establish the current and future health and social care needs of the local community for that topic. It provides an overview of services currently in place to meet those needs and helps to identify the gaps and actions which partners may need to take to improve the outcomes for that particular topic.	The JSNA provides the CCG with baseline data that allows it to review the population profile and take due regard to health inequalities in its decision making.

Sexual Orientation			An important part of the JSNA process in Wolverhampton is to identify and prioritise topics which are of utmost importance to stakeholders as well as the public to develop the topic-specific JSNAs. We would like to invite you to complete this survey to help us understand which topics are important to you. http://www.wolverhampton.gov.uk/jsna	
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**You said we did** - Demonstrates what the CCG have done following engagement or consultation work. Listening and acting upon the feedback that patients and the public have taken time and effort to share is very important to the CCG. Examples have been set out previously in this report. Wolverhampton CCG want to show how the CCG's decision-making has been enhanced by talking and listening to local people. https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did - Also linked to outcome 1.1	By publishing this document the CCG demonstrates that it is taking account of feedback and how it has been used in the decision making. As a result those engaged with can feel more confident that their opinions are listened to and influence decision making.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Commissioning decisions** and activity are informed by patient and public insight, experience and involvement in order to reduce health inequality and to drive improvement. The CCG monitors Secondary Care Providers in line with national contract obligations and their work to gather and use patient insight and this is regularly discussed through Quality Review Meetings and reported to the Governing Body via Quality and Safety Committee. Patient engagement in secondary care settings i.e. acute and mental health is improving and where possible joint working between the CCG and providers is encouraged. Significant issues are escalated as appropriate, but more work is required to explicitly link to health inequalities. The CCG applies the following contractual requirements around E and D to ensure that the needs of individual patients are met appropriately. 1. Equality and Diversity Compliance: a) Demonstrate full compliance with Equality and Human Rights Legislation <u>in line with the EIHR protocol.</u> *(Detail set out in requirements 1, 2, 4 and 6 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).* i. Equality Act 2010 ii. Public Sector Equality Duty (PSED), including the duty to publish information in relation to the equality profiles of service users and the workforce. iii. <u>Evidence of Equality Analysis and Due Regard processes.</u> iv. Action plans and progress in addressing issues identified. *b)* Demonstrate compliance with NHS Contractual requirements *(requirements 3, 5, and 7 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).* i. Equality Delivery System2 (EDS2) ii. Workforce Race Equality Standard (WRES) iii. Workforce Disability Equality Standard (WDES) Action plans and <u>an update on progress</u> in addressing issues identified. These contractual requirements ensure that providers are required to evidence to the CCG how they are meeting their legal duty and are delivering the best possible outcomes for all patients. In particular the provider must satisfy the CCG that vulnerable group's needs are met and that access to services is equitable. Further work is required to link health inequalities specifically to Clinical Quality Review Meetings (CQRMS), and the contracting mechanism. https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf - Quality and Safety Committee Appendix H3	The contract requirements ensure that a diverse range of patients can access services. For example providers have to give proactive assurance of the physical accessibility of their service and that they have arrangement for interpreting and translation in place. In addition the CCG requires providers to include in their report details of the profile of patients who are accessing services. By reviewing this year on year trends can be identified and key priorities reviewed. Commissioners require Provider Organisations to agree, understand and promote a strategic approach to using patient and public insight, experience and involvement to reduce health inequality and to drive improvement. Commissioners require Provider Organisations to use patient and public insight, experience and involvement to inform decisions, actions and evaluation throughout the Provider Organisation in order to reduce health inequality and to drive improvement. Commissioners require Provider Organisations to continually improve how they use patient and public insight, experience and involvement to reduce health inequality and to drive improvement. As a result the CCG can be confident that all patients including those from vulnerable groups are able to access services and should any issues arise, these will be identified so that they can be addressed.
Age Disability	Objective 1 Objective 2	Article 2 Article 3	**Patient Choice** supports patients to choose where they have their NHS treatment. The NHS is offering more and more options to enable patients to make choices that best suit their circumstances, giving greater control of their care and	Increased patient involvement and increased choice supports the CCG in delivering the best quality person

Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 5 Article 8 Article 14	hopefully better results. View what choices are currently available to NHS patients in the NHS Choice Framework on GOV.UK. Here information can also be found about when a patient can't choose, for example, if there is a need for emergency care or a member of the armed forces. https://wolverhamptonccg.nhs.uk/your-health-services/patient-choice	centred care
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**The Learning Disability Assessment and Treatment Service - Pond Lane** - is a hospital for adults with learning disabilities who are registered with a Wolverhampton GP and who need to go into hospital because of a mental health problem or a behaviour that is labelled as challenging. People are supported with their mental health problems by specially trained team of staff – including nurses, psychiatrists, occupational therapists and psychologists. People stay at Pond Lane for a short time, and go home as soon as they are well enough. Things need to change because the Pond Lane site is isolated from the Trust's and other services for people with learning disabilities. This raises environmental, clinical and staffing concerns which have an impact on the delivery of the service to this very vulnerable group. The CCG in partnership with Black Country Partnership Foundation Trust (BCPFT) feel that a clinically safer and more viable service could be provided at BCPFT's other Learning Disability Inpatient services in Dudley, Walsall and Sandwell. All of these services are less isolated and provide a full Assessment and Treatment Service. They are all accessible by public transport. https://wolverhamptonccg.nhs.uk/images/NHS_Arden_8pp_Document_web.pdf https://wolverhamptonccg.nhs.uk/images/easy_read_consultation_lo_res__v5a.pages.pdf **Pond Lane linked to 1.3**	Clinical safety will be improved through the provision of more robust clinical cover arrangements, particularly at night and at weekends and by nature of being on a larger site. Single-sex accommodation will be able to be delivered as Black Country Plans with the Trust seek to have inpatient provision concentrated on only three sites. Clinical effectiveness will be improved through delivering inpatient services over few sites, with more expertise focused onto three wards. Patient experience will be improved due to the delivery of a safer, more clinically effective model of care. Enhanced assurances around safeguarding. Enhanced compliance with: • Winterbourne Concordat 2010 • The National Plan - Building the Right Support 2015 • Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition Service model for commissioners of health and social care services 2015 • NICE Guideline: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges • NICE Learning disabilities: challenging behaviour Quality standard • NICE Guideline: Mental health problems in people with learning disabilities: prevention, assessment and management 2016 • Equality Act 2010
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Wolverhampton WCCG commissions (buys) **Musculoskeletal (MSK) services** on behalf of the population of Wolverhampton. MSK services diagnose, treat and care for conditions or injuries that affect muscles, tendons, ligaments, bones, joints and associated tissues for example arthritis, back pain, and osteoporosis. Such services can include treatment by a physiotherapist, rheumatologist or orthopaedic care. The service commenced in April 2017 and performance is good; waiting times are between 4-6 weeks and patient feedback has been positive. https://wolverhamptonccg.nhs.uk/images/docs/MSK_consultation_evaluation_report_FINAL.pdf	Provide a more streamlined, efficient, high quality service for patients, in a local community setting. Provide a value for money service. Patients managed within one integrated service with access to appropriate specialists/diagnostics and interventions Patients will receive education and advice on self-management where appropriate; • Services closer to home, in the community, reducing the need to travel • Reduced visits to secondary care • Quicker access to diagnostics and treatments • Holistic approach/MDT approach to care management/treatment plans

				• Streamlined patient journey with easy access back into the service once discharged • Need for GP referral into different specialties' reduced resulting in a speedier patient journey • Health economy – greater community provision and increased education/awareness • Future providers/staff – new opportunities, improved ways of working.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Communications and Engagement Strategy** for the CCG, sets out the strategic vision. It builds on the legacy of strong communications and engagement which already exists and outlines the ambitions for patients, members and other stakeholders to work in partnership with the CCG to deliver improved health outcomes for the population of the CCG. Wolverhampton CCG is a diverse city with many residents who face complex and challenging health needs. The CCG would like to ensure all residents have a voice in local health services. The CCG have already made excellent links to many patients and community groups across the city and are very much committed to seeking the views of those groups who may not have been heard in the past. Page 10 of the document clearly identifies equality as a key driver for engagement. Key examples can be found in the CCG's Communication and Engagement report:	The CCG has worked to ensure that it provides the opportunity to comment and shape services across the CCG's population base.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The **Interpreting Services** provide an interpreting service to be used by GP practices and Dentists within Wolverhampton CCG. **Linked to 2.1 and 2.2**	Procure a high quality service that meets the needs and requirements of Wolverhampton. Improved access and experience.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Children and young people with **SEND** are identified through the Education, Health and Care (EHC) Process and their health needs assessed and monitored via this process http://wolvesiass.org/wp-content/uploads/2016/02/Education-Care-Health-Plans-New-Editon.pdf The Designated Medical Officer (DMO) is a Medical Director, whom works at the acute trust and is therefore able to communicate well with providers. Part of the DMO role is to co-ordinate the health advice for the EHC plans from both the acute trust and the CAMHS trust and to ensure advice is returned in a timely manner. The EHC plans will also specify other health needs which are not related to a child or young person's Special Educational Need. The CCG has formal oversight of all EHC plans requiring health input and therefore is involved in the moderation and review of these. Any issues in relation to the effectiveness of services are raised with relevant managers of services. Regular attendance at the EHC funding panels where wider demands are recognised and addressed enables the CCG to see whether health needs are assessed and met in appropriate and effective ways particularly when taking the needs of the post 16 cohort into account. The EHCP process is continuously reviewed with the local authority in order to ensure timeliness and process issues are addressed. A specific focus group to review the Children's Continuing Care process will be developed.	Children and young people with SEND are assessed in a timely way to meet their needs.

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Mental Health -** The intermediate care team deliver the National Framework for NHS Continuing Health Care (CHC). This is an end to end service, including a single point of referral, assessments, reviews and commissioning of care to meet identified needs. We collect the equality data as part of the assessment process. Patients and, if they wish their families/carers, are fully involved in the process and are given choices as to how the care is delivered; including the option of a personal health budget to support their needs. We have a Care Home Framework within the city; which is a quality based NHS Contract that care homes could apply to join. Opportunities to join this will be provided on at least an annual basis via an AQP procurement exercise.	High quality services are delivered offering the best possible outcome for all patients including diverse and vulnerable groups. Outcomes include: • CCG Recognised by NHSE as an area of good practice. • Monthly completion of quality dashboards and monitoring. • Quarterly quality/contract review meetings.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 14	**Seamless care for patients – A new Strategy**, will explain how primary care will change and be delivered over the next few years. It will describe how more services will be delivered locally, meaning more opportunities for GPs and specialist nurses offering specialist care in the community; as well as increasing job satisfaction it will help to attract the necessary health care staff to Wolverhampton that will be needed to provide this service. It will also mean patients will gain more support in their own community and homes with less hospital visits. https://wolverhamptonccg.nhs.uk/news/blogs/221-seamless-care-for-patients-thanks-to-new-strategy	Patients can access care effectively and will not be required to travel long distances or spend time as inpatients unnecessarily.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 14	**Urgent and Emergency Care Services** - In summary, the plans describe how urgent and emergency care services will be brought together into a new purpose-built centre, based at New Cross Hospital which will be open all day, every day. This was successfully completed and opened in November 2015. The new Urgent and Emergency Care Centre building accommodates a number of services, including the new Emergency Department which was the first element of the urgent emergency care services. The second element of the plans was the development of an Urgent Care Centre. The Walk in Centre at Showell Park and the GP Out of Hours Service came together to form the Urgent Care Centre based in the new Urgent and Emergency Centre on the first floor above the Emergency Department in April 2016. This means that any patients who self-present to the Emergency Department will have the opportunity to speak to a nurse to determine if their care can be managed more appropriately in the Urgent Care Centre. https://wolverhamptonccg.nhs.uk/your-health-services/improving-urgent-care https://wolverhamptonccg.nhs.uk/news/193-improving-urgent-care	Enhanced urgent care services improve outcomes for patients, reducing waiting times and where care can be effectively provided elsewhere they can be triaged effectively.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 14	**Voice of the Child** 1. Statutory health assessments for all of our Children and Young People in Care (CYPiC) should gather their views and feelings. Each assessment is quality assured against a national screening tool that requires the voice of the child to be captured. 2. Joint CCG and local authority quality assurance visits to placements where an issue has been identified. This would involve audit of documentation and wherever possible direct liaison with the child. 3. LAC training delivered by the Named Nurse for CYPiC (RWT) includes the importance of obtaining the voice of the child. 4. The Children in Care Council (CiCC) is a group of Looked after Children and Young People who help to shape the care system. The group is made up of young people aged 11 to 18 years old who meet at least once a month.	The CCG gains assurance that this group of patient's needs are met. The key aim here is that the voice of the child is incorporated in all service planning.

			5. All reports that are presented to the Corporate Parenting Board are sent to the CiCC beforehand for their information and comments, ensuring they are aware of any issues that may impact or affect them in any way. Please see www.wolverhamptonlac.co.uk for further information.	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**A review of the Community SEND local offer** is currently in progress which will enable the CCG to be clearer around the provision for SEND 0-25 years and crucially including key transition points into adult services.	The revised service will be as effective as possible since SEND patients will have been extensively involved in the service development.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Mental Health –** The CCG work jointly with our local authority colleagues to ensure that if a person no longer meets eligibility for CHC the transfer of responsibility is undertaken in a structured way; following the correct processes. The CCG have also introduced a transition programme for young people with complex care needs who may be eligible once they reach 18 for adult CHC. We commissioned Changing Young Lives to co-produce improved pathways for young people moving into adult services. Linked to the Mental Health Strategy 1.1	Patients experience a structured transfer and are not left with a care gap or left waiting for information.

1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed

How does the CCG ensure patients and carers are well-informed when moving between services/care pathways? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The redesign of End of life care services across Wolverhampton of a person-centred, integrated, end to end End of Life care service, is in response to the delivery of the 6 core principles detailed within the Wolverhampton Integrated End of life care Strategy published in October 2016: · Early identification of the dying person to ensure patients are receiving appropriate care · Advance care planning to facilitate the persons needs and wishes · Coordinated care to ensure people don't fall through gaps · Optimum symptom control based on clinical need · Choice to support preferred place of care and death · Workforce fit for purpose We intend to ensure our workforce is fit for purpose and that they work with patients and carers to 'make every moment count'. Effective access to this service is reliant on effective **interpreting and translation** services being in place as per the provider's contract. Particular consideration given to ensure the service is fully accessible and appropriate for patients with a **learning disability and those with Dementia**. Providers are expected to comply with and implement the **Mental Capacity Act** for patients with conditions included in the legislation and ensure that where patients have particular communication needs these are fully and appropriately met. Services will be expected to ensure that they are able to facilitate all **religious requirements/beliefs/customs** up to and following the death of a loved one . The service must ensure due regard is given to **cultural** needs and differential expectations on end of life care from **different ethnic and cultural groups** inline with their preferences and wishes	Aim to improve the delivery of care for those approaching end of life and also those patients within the last 12 months of life Improved coordination of care Improved symptom control Improved experience of care Improved quality of life 1. Better health outcomes for all Better personalised care for all patients approaching end of life 2. Improved patient access and experience To improve the experience of health & social care services and to receive responsive, person centred care 3. Empowered, engaged and included staff To ensure a workforce fit for purpose, fully equipped to deliver quality services to this patient cohort 4. Inclusive leadership at all levels The proposed redesign will include input from all levels of leadership from providers and commissioners Access to a full range of palliative and end of life care

			Providers are expected to ensure that services are designed and delivered to include patients in **temporary accommodation and of no fixed abode**. Services will be provided in Community locations to enable ease of access for this patient group.	services. The service is specifically for adults age 18+.
			The establishment of the Black Country Strategic Information Partnership (STP) is key to enhancing cross system working between Commissioners, Providers and the Local Authority. It is led by the CCG. •Maternal and infant health – reduce current high levels of infant mortality to bring them in line with the national average, avoiding the death of 34 babies a year. •GP and community services – invest an extra £25m in GP services by 2021. •Hospital services – the new Midland Metropolitan Hospital will treat over 570,000 people when it opens in 2019 and will be one of a network of hospitals serving the Black Country and offering the right care in the right place at the right time. •NHS 111 – ringing one telephone number, the people of the Black Country will be able to book a doctor's appointment, in evenings and at weekends, get dental advice, order a repeat prescription, or get urgent advice. •Mental health services – changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks. •Tackling deprivation – co-operate across all STP partners to tackle deprivation and other wider determinants of health such as low educational achievement, inadequate housing and unemployment •Workforce – build a stronger, more resilient health and care workforce that is able to take advantage of expanded career opportunities across the STP footprint.	Establish a system wide approach to reduce barriers and ensure seamless transition between services.
			Where a SEND patient has been referred for a continuing care assessment but is not found eligible the CCG ensures that the patient is transferred back to Children's Social Care to ensure continuity of care. To ensure effective multi agency working, representatives from local authority social care are part of the CCG's panel. Where a young person is placed in a residential setting outside of the city the CCG ensures it is involved in a review of that placement.	Barriers for patients in accessing / continuing to access services are reduced / removed.

1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

How does the CCG ensure patient safety is a priority and ensures patients are free from mistakes/mistreatment/abuse? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Adult Safeguarding –** The CCG believes that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people, and to protect adults from abuse and risk of harm. The CCG aims to commission services that promotes and protects individual human rights and effectively safeguard against abuse, neglect, discrimination or poor treatment. The CCG recognises that safeguarding adults and children is a shared responsibility and ensures appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards. The CCG recognises and supports the need for robust and proportionate information sharing arrangements between health professionals and partner agencies to ensure the safety and wellbeing of children, young people and adults and in the interests of public safety.	By ensuring effective and robust safeguarding processes are in place the CCG ensures that relevant patients are protected and kept safe.

			The CCG is currently developing a joint children and adults commissioning policy. https://wolverhamptonccg.nhs.uk/your-health-services/safeguarding https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/562-adult-safeguarding-policy-1/file	
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Children's Safeguarding –** The CCG believes that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people and to protect adults from abuse and risk of harm. The CCG aims to commission services that promotes and protects individual human rights and effectively safeguard against abuse, neglect, discrimination or poor treatment. The CCG recognises that safeguarding adults and children is a shared responsibility and ensures appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards. The CCG recognises and supports the need for robust and proportionate information sharing arrangements between health professionals and partner agencies to ensure the safety and wellbeing of children, young people and adults and in the interests of public safety. https://wolverhamptonccg.nhs.uk/your-health-services/safeguarding https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/562-adult-safeguarding-policy-1/file	By ensuring effective and robust safeguarding processes are in place the CCG ensures that relevant patients are protected and kept safe.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Clinical Quality Review Meeting (CQRM) –** The CCG is the host commissioner of services delivered by various providers. As far as possible the CQRM will be used by commissioners for clinical quality discussions with provider representatives in an attempt to minimise replication and burden to the provider as there can be multiple commissioners. Representation will be required from both commissioning organisations and the contracted provider with a responsibility for reviewing the overall quality and performance of the commissioned service(s) to ensure patient care is delivered safely and focused on providing a positive experience for patients. Both Royal Wolverhampton Trust and Black Country Partnership Trust for whom the CCG is responsible Lead Commissioner report bi annually against their contract requirements on Equality Inclusion and Human Rights. This allows the CCG to ensure that patient's needs are being met and that any issues / lessons learned are applied. Patient Safety is also a key reporting theme within the CQRM annual timeline for each provider.	Quality of service assurance. Compliance with required standards, constitutions and legislation.
			Pond Lane linked to 1.2 & 1.3	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Healthwatch are a member of the Health **SEND** work streams and invited to all meetings. Quality Assurance visits are carried out. All providers are expected to clearly set out their Complaints management process and have Whistleblowing and Safeguarding procedures in place. All providers are expected to follow safe recruitment processes.	By including an independent representative an additional assurance check is provided to ensure the best possible outcomes for patients. Patient safety is key and the CCG utilises its inspection regime to complement other mandatory inspections to maximise patient safety.

1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

How does the CCG work in partnership to support health promotion in its local communities? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Not completed by CCGs as this is a Public Health function				

2. Improved patient access and experience				
The NHS should improve accessibility and information, delivering the right services that are targeted, useful and useable in order to improve patient experience				
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds				
How does the CCG ensure all people can access healthcare services where no one is discriminated against and denied access on unreasonable grounds? Please give examples				
Protected characteristics	**Equality objective**	**Human Rights**	**Evidence (What has actually been done/ achieved?)**	**Impact**
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The CCG relies upon those organisations who provide services on its behalf to deliver services in line with the agreed specification and the principles of equitable access. To ensure these services are delivered in such a way. The CCG places a number of contractual requirements on the providers to ensure it can check – these are included below: c) Demonstrate full compliance with Equality and Human Rights Legislation in line with the EIHR protocol. *(Detail set out in requirements 1, 2, 4 and 6 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).* v. Equality Act 2010 vi. Public Sector Equality Duty (PSED), including the duty to publish information in relation to the equality profiles of service users and the workforce. vii. Evidence of Equality Analysis and Due Regard processes. viii. Action plans and progress in addressing issues identified. *d)* Demonstrate compliance with NHS Contractual requirements *(requirements 3, 5, and 7 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).* iv. Equality Delivery System2 (EDS2) v. Workforce Race Equality Standard (WRES) vi. Workforce Disability Equality Standard (WDES) Action plans and an update on progress in addressing issues identified. These contractual requirements ensure that providers are required to evidence to the CCG how they are meeting their legal duty and are delivering the best possible outcomes for all patients. In particular the provider must satisfy the CCG that vulnerable group's needs are met and that access to services is equitable. These requires apply proportionately to all organisations who provide services on the CCG's behalf In addition the CCG will review provider's complaints reports, lessons learned and any complaints made by patients to the CCG. By doing so the CCG ensures that it is aware of any issues and that remedial action is taken. On occasion there will be an equality related issues within a reported Serious Incident or Never event, in such a case the remedial action agreed in response will have due regard to that issue.	By ensuring through robust monitoring and complaints analysis the CCG can be assured that patients are able to access services and that an individual's needs are taken into account.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The Quality Nurse Advisors role is to provide assurance to the CCG that the care delivered in **Care Homes** is safe, high quality, effective and responsive to the needs of the individual. The Quality Nurse Advisors assess care delivery by carrying out quality monitoring visits and analysing data received from care homes on the national safety thermometer and the monthly quality indicator submissions. The CCG developed best practice guidelines that were based on need for example; poor record keeping and pressure injuries. The CCG has won an award for a tool to risk assesses and audit pressure injury.	The CCG is assured that care home resident's needs are met and that services are effective and appropriate. Where issues do arise these are addressed robustly and lessons learned developed.

	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The **Interpreting Services linked to 1.2** High quality interpreting services are key to ensuring that patients can access services effectively. The CCG has put in place a contract that ensures that interpreters are available when required for GP and Dental appointments. The provider is required to ensure that such interpreters are fully qualified to the required standard and subject to DBS checks and other requirements. Where organisations provide services on behalf of the CCG they are also required under their contract to have interpreting and translation services in place to meet the needs of patients when required.	Access to such services ensures due regard to the accessible information standard and ensures that barriers in accessing NHS services are removed.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Accessible Information Standard (AIS)** The CCG has fully committed to following the principles of the NHS Accessible Information Standard. It also monitors the compliance of those organisations that provide services on its behalf. Through the Quality Schedule and through complaints / feedback the CCG proactively works to ensure access for all patients to services, working with GPs and providers. Within the schedule for each contract the CCG includes a range of requirements including around the AIS. These requirements ensure that services provided on the CCG's behalf are accessible and that each provider is meeting their legal duties and the requirements of holding an NHS contract.	The AIS is key to ensuring that all patients can access services especially those who have additional communication needs. The CCG's implementation of the AIS has ensured that communications it makes are accessible to all patients and through its contract monitoring process it is assured that both Primary Care and Commissioned services also have fully implemented the AIS. By starting with primary care services, the CCG ensures that when a patient is referred onto other services their communication needs are known and can be met. The contract requirements ensure that a diverse range of patients can access services. For example providers have to give proactive assurance of the physical accessibility of their service and that they have arrangement for interpreting and translation in place. In addition the CCG requires providers to include in their report details of the profile of patients who are accessing services. By reviewing this year on year trends can be identified and key priorities reviewed.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The **SEND** Local Offer provides information in a single place for children and young people with special educational needs (SEND) and their parents or carers http://www.wolverhampton.gov.uk/send/health Parents/carers are able to comment on the Local Offer in a 'You Said, We Did' format with the responses published to ensure that the site is continuously improving. Parents were proactively engaged in the initial designing of health pages for the Local Offer and ensuring that it is useful, useable and meets their needs. They continue to be involved when issues are raised via the Local Offer to comment on the responses to ensure that they are parent friendly. Routine Contract Review meetings to address any issues. Parents are actively involved in the Health Work-stream and as a result are able to discuss with commissioners and service leads any issues that have been reported to them regarding the services commissioned by the CCG. Parents and carers are a key stakeholder and their views will be sought in the review of the community health local offer.	Wolverhampton's work on the health component of the Local Offer has received national recognition in the Contact A Family good practice guide for parent participation. Families should be able to navigate the site so that all information in relation to SEND is accessible, up to date, comprehensive and transparent.

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Mental Health -** Discharge to Assess Programme has been developed to improve patient transfers when they no longer require acute care but are unable to return to their usual residence without support or require a period of care within a bed based provision (intermediate Care). This is a collaborative programme of work with the CCG, Local Authority and acute trust that will ensure a system wide approach to the changes required.	This minimises delayed transfers of care and individuals no longer requiring acute care will receive a period of assessment and support in the most appropriate setting to maximise their potential and minimise their long term care needs.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Digital Consultation service -** The Project will enable patients who would normally be unable to access the service to interact and receive a GP consultation via a video link. It may be useful for Care Homes where the GP may not be able to schedule a visit. May benefit patients with mobility problems who will now have access to appointments more quickly. May benefit reduced mobility patients with travel issues. Video Consultations will not be an option for some patients who are unable to use the required equipment either as a result of limited vision or a learning disability. Home visits will continue to be available for such patients and it is hoped that the increased capacity provided will have an impact on making such visits easier to provide. Due regard must be given to the need for Interpretation and Translation for patients during consultations. Low income families may not have access to electronic devices or internet access at home. Such patients will continue to be supported with home visits where appropriate.	Improving Quality and Safety. Reduce Health Inequalities System Effectiveness
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Digital Counselling service -** The CAMHS transformation plan 2015-16 identified that there was a gap in provision at the Emotional Mental Health and Wellbeing service level previously called 'tier 2 services' which was supposed to shift the focus of services from crisis intervention to one of early intervention and prevention. Future in Mind made a recommendation that there should be clear and safe access to high quality information and online support for children, young people and parents/carers; Children and young people should be able to access the help they need online. Provision of this online service will ensure that high quality information will be available for CYP as well as online counselling and support. The aims of the service is as follows: •Improve the emotional wellbeing and mental health of CYP by providing an early response to emotional wellbeing and/or emerging mental health needs via an online digital service. •Improve CYP access to services and support through the use of digital services built around the needs and views of CYP •Increase early detection of mental health problems so they can be addressed promptly, thus preventing problems from getting worse and requiring a more specialist response •Improve access to the provision of self-care tools and resources, some of which will be specific to Wolverhampton, which support CYP and their families to help themselves and build resilience •Reduce demand on specialist children's services, particularly CAMHS and social care •Improve partnership working across the whole Children and Young People mental health system by working in collaboration with local services and support, building on, complementing and enhancing existing service provision •Improve access to services for CYP who are vulnerable/disadvantaged and hard to reach by removing some of barriers to meet their needs. A suggestion has been made to undertake an assessment of the service with a cohort who have sight difficulties to establish if the service can be accessible for them.	This service specification is intended to increase the number of CYP accessing services through self-referrals and also to ensure that they are accessing services at an earlier opportunity than previously was available. CYP from aged 11 to 18 are intended to benefit from the development of this service specification. CYP are intended to benefit from the development of this service specification to ensure they can access high quality information about emotional mental health and wellbeing as well as online digital counselling support at an early intervention level.

			Evidence has suggested that there is a reluctance for members of some BME communities from accessing mental health services which includes emotional mental health and wellbeing and specialist CAMHS. However, provision of an online counselling service will remove the stigma of CYP being 'seen' attending a service as it can be accessed from arrange of locations and in private. Access to high quality information about emotional mental health and wellbeing as well as online digital counselling support at an early intervention level will be of great benefit to CYP considering gender reassignment /transgender and will enable them to receive early support to help with any decisions they need to make regarding their future and gender. This proposal will be explained on the CCG website and on the local offer as well as being publicised via HeadStart. Team W will be informed about the service available as well as a note going out to GPs via the e bulletin that they receive. As part of the mobilisation of the service, there is a request for a member of staff from the online counselling service to be made available to go into all secondary schools in Wolverhampton to advertise the service and explain what is available and what it will entail.	

2.2 People are informed and supported to be as involved as they wish to be in decisions about their care

How does the CCG ensure that people are at the centre of the decisions about their care? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**End of Life Care – "**Helping residents live well until they die, and die well where they choose" The aim of this strategy is to detail Wolverhampton's integrated approach to the design and delivery of a person centered, integrated, end to end, End of Life care service. The CCG believes this strategy will deliver a flexible, responsive, quality service to those approaching the end of their lives. It will provide reassurance that services will be wrapped around the patient at this difficult time and will facilitate person centered care encompassing the following elements: • Early identification of the dying person to ensure patients are receiving appropriate care • Advance care planning to facilitate the persons needs and wishes • Coordinated care to ensure people don't fall through gaps • Optimum symptom control based on clinical need • Choice to support preferred place of care and death • Workforce fit for purpose Future planning will see the beginnings of conversations with different ethnic groups. https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/1496-wolverhampton-integrated-end-of-life-care-strategy/file https://wolverhamptonccg.nhs.uk/news/288-health-and-social-care-set-to-work-together-to-deliver-improved-end-of-life-care-for-wolverhampton-patients https://wolverhamptonccg.nhs.uk/images/end_of_life_newsletter_patients_pub2.pdf Patients satisfaction survey - www.ncpes.co.uk	Integrated approach to a person centered, end to end and End of Life care service.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Cancer Strategy 5 Year Plan –** There are 6 priorities; 1. Prevention and Public Health 2. Earlier diagnosis 3. Patient experience 4. Living with and beyond cancer 5. Delivering a high quality service 6. Overall commissioning and provision and accountability	

Sex Sexual Orientation			https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/1496-wolverhampton-integrated-end-of-life-care-strategy/file	
			Patient and Public Partnership (PPG) – linked to 2.1	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**SEND** - A key feature of the Education & Health Care process is that families should be at the centre of decisions made about their child's care. The extent to which families wish to exercise choice and control around their child's health needs varies and the CCG is proactively developing a personal healthcare budget offer. Young people and their carers are co-producing the personal health budget offer for Wolverhampton. Ensuring that young people are involved in this key piece of work, which will ensure the offer is fit for purpose, sustainable and personalised. The Young People's Forum has been involved in working with other peers to engage with the market to ensure more personalised packages of care. Young people have also been involved in the interviewing of new members of staff as part of a children's Panel.	Families will feel part of the decisions regarding their children and empowered to voice their views. Families will take control of the services and support required. That professionals put the child/young person and their family at the centre of any decisions made. All agencies, including the CCG have a good insight into the feelings of children and their families.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Mental Health -** All individuals are encouraged whenever possible to be involved in the decision making as to where and how their care is delivered. This ensures that where a patient has capacity, they can be involved in their care choices. A key aspect of this is ensuring patients make informed decisions, to do this every effort is made to explain the position appropriately to the patient with due regard to their communication needs.	We provide a choice of provision when ever possible. We ensure that for individuals who have family living out of area that they can choose a care home within their area, once we have established it delivers safe care. We offer personal health budgets for all CHC eligible individuals living in the community and are currently working with Arden & Gem CSU to expand our PHB offer.
Age Disability Pregnancy & Maternity Race Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**Smoking Cessation Service -** A commitment has been made within the region to reduce smoking in pregnancy and the infant mortality rate. This project seeks to introduce an evidence based smoking cessation programme targeting pregnant women who have multiple social issues. The project intends to support and complement existing approaches that are delivered to women in Wolverhampton creating a holistic approach to the needs in order to improve reduce the current rate of smoking at time of delivery and address multiple social issues that are identified for women and their families. The project will be supported by a smoking cessation champion, who will be an integral part of Maternity Services. This champion will aim to bring together advice based on a medical model and a holistic approach to tackle the wider determinants of health, therefore supporting women to tackle wider issues that contribute towards smoking. This project will impact upon pregnant women/women of child bearing age including vulnerable young people who are teenage parents/ who may have safeguarding and welfare issues. The policy is designed to ensure groups are supported appropriately to stop smoking. Women who may have a disability/additional needs, a Learning Disability vulnerable women/safeguarding and women who may have substance misuses and mental health issues need to be supported and referred to support services A list of outcomes will be established. Women will be identified through maternity services. Personalised plans will be created for each woman and Progress of each woman monitored regular. The project will contribute towards improved health outcomes for this group of women and their families; Reduction in smoking; Reduction in respiratory conditions; Cancer prevention; Reduce risk of still birth; Reduce risk of low birth weight babies; Reduce the risk of infant death; public health and maternity data will provided evidence of impact.	1. Improving the quality and safety of the services we commission - The implementation of a dedicated maternity smoking cessation provision will improve both the quality of life for women and their babies who will both be at risk of poor health outcomes. 2. Reducing Health Inequalities in Wolverhampton - The Project should enable the CCG to improve the health outcomes for women across Wolverhampton who smoke during pregnancy. To improve access to preventative ill health measures self-help, peer support, improve access to community support within their local geography. The project aims to deliver care closer to home. 3. System effectiveness delivered within our financial envelope Enable the improvement in performance, women's outcomes and experience and deliver value for money

2.3 People report positive experiences of the NHS

How does the CCG engage and involve people to listen to their views of the NHS? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Commissioning Intentions – Engagement Report The CCG's engagement with patients received a range of feedback on services, in particular patients were highly satisfied with the Diabetes education programme and services at new Cross, which were felt to be high quality services. It was also noted that patients (in general) agreed that delivering services within the community was the best way forward The report does however highlight challenges in access to primary care and capacity – which is a national problem. Actions undertaken to address this can be seen within the report however as the CCG looks to enhance the extended access to GP practices, outside core hours. **Public and stakeholder involvement groups** We encourage people to get involved in shaping the services that we commission by giving them the opportunity to attend a range of involvement groups. These include: **Patient Partner Scheme** – Our Patient Partner Scheme is a free membership scheme that provides interested local people with information about new health initiatives and how they can share their views by taking part in events and consultations. The public can fill in an online or paper form to join up and can let us know which areas they are most interested in learning about. **Patient Participation Groups and Citizen's Forum** – Over the past year our PPG Chairs and Citizen's Forum groups have continued to meet bi-monthly to share our current local and national projects. The Citizen's Forum Group is made up of community leaders from faith, disease specific groups and local community groups. At these joint meetings we informed and updated them on WCCG workstreams and changes in Primary Care. We have taken time this year to enable understanding of the new models of Primary Care that have evolved during the year and they have started to meet together within their own new models of care. We feedback any of their issues to the Governing Body through our Lay Member. **Joint Engagement Assurance Group** – We continued to meet quarterly to share engagement opportunities across the city with our stakeholders and provide assurance to the engagement framework effectiveness as outlined in our Communications and Participation Strategy. Further details can be found on the CCG's Talk to Us page.	The CCG can evidence that it has given patients an opportunity to feed into its strategic direction and have their voices heard. Within the report specific reference is made to vulnerable groups for example patients with limited English. LPPGs provide an opportunity for patient feedback to shape service design. Effective engagement with patients is key to ensuring that services genuinely meet the needs of all patients. The CCG makes effective use of the PPG network to ensure patients have a voice on decisions.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	**The Friends and Family Test (FFT)** is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/ http://content.digital.nhs.uk/workforce	Patient feedback obtained and used for service improvements.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	The CCG has a mechanism for engagement with children and young people with **SEND** and their families via the SEND Partnership Board where there are parents and young people present to contribute to the shaping and designing of local SEND related policies, strategies and developments. The parents were actively engaged with health services to co-produce the services pages on the Local Offer and continue to be involved with the responses provided to any queries raised by parents regarding the health services and ensuring that any updates are parent friendly.	Numbers of compliments/complaints received.

			There are parents participating in the Health work-stream and actively involved in contributing specifically to the shaping of health services to meet the needs of the local population regarding SEND. A Young Persons SEND Board will also be developed to provide challenge where appropriate. There are good links with Parent Carers Forum and Changing Young Lives with regular attendance at meetings. Young people and their families have also been involved in developing transition plans for people with complex health needs and identified providers who were able to deliver services required jointly with the CCG.	
			The Young people's forum are producing a video around SEND for the CCCG's Governing Body in which case studies will be showcased. The CCG intends to continue working with the forum on market engagement events to stimulate the market in order that choice can be exercised by patients from this group with their PHBs in order to the best outcomes for them.	By providing a patient story to Governing Body the CCG's senior leaders are able to gain an enhanced understanding / empathy with this group. This will assist them in giving due regard in future decision making.
			The Children in Care Council (CiCC) – linked to 1.3	
			Communications and Engagement Strategy – Linked to 1.1	

2.4 People's complaints about services are handled respectfully and efficiently

How does the CCG handle and monitor complaints ensuring action is taken? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 9 Article 10 Article 14	The CCG has a **Complaints Policy**. This policy outlines the process by which complaints will be handled by the clinical commissioning group (CCG) when raised by a user of the service or their representative, or a member of the community who comes into contact with the service by other means or CCG employees. The CCG places high priority upon the handling of complaints and the organisation recognises that suggestions, constructive criticisms and complaints can be valuable aids to improving services and informing service redesign. Feedback from service users and their relatives is welcomed in line with our Public & Patient Engagement Strategy. The policy also has implications for providers of services to the CCG and they also have a duty to have a complaints policy structured in line with national policy. This policy applies to all complaints received by and made against the CCG. The CCG also has a Serious Incident policy. The purpose of this policy is to outline the CCG's governance arrangements for the performance management of serious incidents requiring investigation (SI's) and ensure that patient safety and other reportable incidents are appropriately managed within the CCG's commissioned services in order to address the concerns of patients and promote public confidence. The CCG will ensure incidents are investigated properly, that action is taken to improve clinical quality and that lessons are learnt in order to minimise the risk of similar incidents occurring in the future. https://wolverhamptonccg.nhs.uk/contact-us/how-to-complain As shown in the 2.3, as part of setting its strategic direction, the CCG has engaged with patients on its Commissioning intentions. The report highlights some key concerns, particularly around primary care, which the CCG will respond to.	Clear understanding of how to complain and who is accountable. Patient complaints are investigated thoroughly and the CCG ensures that it works with providers to ensure that any lessons learned are put into practice. Giving patients the opportunity to have this involvement is key to ensuring that services are as effective and accessible as possible.

3. A representative and supported workforce				
The NHS should support the diversity of its workforce (whether paid or non-paid) to improve the quality of their working lives, enabling them to better respond to the needs of patients and local communities				
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels				
What systems and processes are in place for fair recruitment at the CCG at all levels? Please give examples **How is the recruitment and selection process monitored and evaluated? Please give examples**				
Protected characteristics	**Equality objective**	**Human Rights**	**Evidence (What has actually been done/achieved?)**	**Impact**
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG is strongly committed to a fair and effective recruitment process that delivers a workforce as representative of the population it serves as possible. The advertisement of posts and recruitment process is managed primarily through the established NHS Jobs Portal which ensures that applicants have equitable access to jobs. Within the initial process a range of support processes exist which directly inform the recruiting manager of any adjustment or support need from a candidate. The approach is set out in the CCG's **Recruitment and Selection Policy**. Additional supporting policies include: • **Recruitment Policy** • **E&D Policy** • **Flexible working policy** • **Special leave policy** • **Sickness absence policy** • **Bullying and harassment policy** • **PDR policy** • **Training and development** The CCG has committed to have due regard to the Workforce Race Standard (WRES) and use it as a force for driving change, both as an employer and as a Commissioner of services. The CCG will review both the template submissions and the action plan of each provider for which it is lead commissioner to gain assurance that the health economy as a whole is taking action in this important area. See BSC's own performance against the WRES standard: The CCG's template can be found via the following link: https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018	By establishing and maintaining a robust effective recruitment process which takes account of the needs of applicants the CCG can be confident that the recruitment process is supporting its aims in this area. The CCG's annual survey provides a level of validation and a snapshot of the CCG's position on its journey towards having a fully representative workforce.

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations				
How does the CCG demonstrate its commitment to equal pay for equal work and how is this monitored and evaluated? Please give examples				
Protected characteristics	**Equality objective**	**Human Rights**	**Evidence (What has actually been done/achieved?)**	**Impact**
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 10 Article 14	The CCG is committed to being as representative as possible across relevant protected characteristics in relation to the population it serves. The CCG is committed to ensuring that equal pay for work of equal value is maintained through the effective use of the NHS Agenda for Change (AfC) pay scale and inclusive recruitment, retention and selection procedures. This is shown in the CCG's Commitment Statement on Equal Pay. All of the CCG's internal workforce policies have been developed, and continue to be updated, in line with current legislative requirements including the Equality Act 2010. These policies cover the recruitment, selection and appointment process as well as all aspects of working for the CCG. The CCG carries out regular reviews of the workforce demographics though in view of the CCG's size this data cannot be published without risking identifying an individual. All new or amended job descriptions are evaluated in accordance with Agenda for Change evaluation and job matching processes. This is provided by Arden & GEM CSU to ensure independent objectivity and consistency of application of process. Results of job matching and evaluation are available to staff and their representatives on request. http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay	The approach taken gives staff assurance that the CCG is committed and working to deliver this aim. Monitored systems and processes in place for fair recruitment.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	Demonstration of commitment to equal pay; • Equal Pay Audit • NHS Agenda for Change Terms and Conditions • Starting salary statement • CCG Annual Equality Report	CCG demonstrates its commitment to equal pay and that this is monitored and evaluated.

3.3 Training and development opportunities are taken up and positively evaluated by all staff

How does the CCG support the development and training needs of its staff? Please give examples
How does the CCG monitor the effectiveness of training through feedback from staff? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 14	The CCG is strongly committed to ensuring that such opportunities are taken up and that all staff feel their development is being supported. The results of the CCG's annual staff survey provide a measure of that success. By supporting its staff the CCG increases staff wellbeing and maintains confidence – helping staff retention. The CCG support the development and training needs of staff, and monitors the effectiveness of this using various processes; • Equality Analysis Training • Mandatory training on Equality and Diversity • Learning & Development Strategy • Team & Organisation development events • Leadership programmes	Fair and equitable access to training is provided. By supporting its staff the CCG increases staff wellbeing and maintains confidence – helping staff retention.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	Staff survey data is monitored and maintained by the CCG. Retrospective information on Statutory & Mandatory training is held by Arden & GEM CSU on ESR.	CCG gains assurance on the equitability of training takeup.

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

What systems and processes are in place to ensure that CCG staff are not exposed to abuse/harassment/bullying /violence at work? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	**The CCG has updated its Zero Tolerance Scheme,** which manages continuity of access to care for **Excluded Patients.** It is now called the **Special Access Service** and manages where patients who have been abusive to staff, can be managed and staff are protected. The service will be available to patients who have been removed from a General Practice list due to violent, aggressive or behavioural problems and are resident within the boundary of Wolverhampton CCG. The review included completion of an updated Equality Analysis of the scheme and the proposed change. The key focus of which was to ensure that vulnerable patient's needs were fully considered. The CCG would also look at whether lessons have been / can be learned around the circumstances that led to the need to a patients removal from a practice.	Staff are protected from harassment by patients and their families.

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG has a suite of policies to ensure staff are protected and supported; • Employee relations data • Harassment & Bullying policy • Staff Forums • Staff Surveys • Whistleblowing policy	By setting out the required standards the CCG ensures staff are aware of their rights and responsibilities and should anyone have a concern they have a clear route to raise it.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG has a Bullying and Harassment Policy which was updated in April 2016 and reviewed regularly. Relevant cases are monitored by the CCG's HR Business Partner along with any action taken as required.	Staff are clear on their rights and responsibilities and the relevant route to raise concerns.

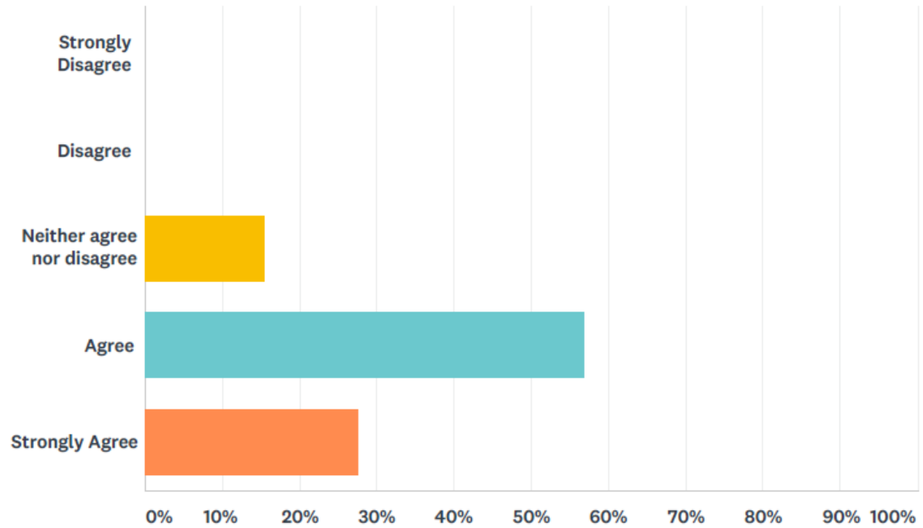
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

How does the CCG facilitate a work-life balance and ensure flexible working options are available for all staff? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	As part of its commitment to its staff and offering genuine work life balance the CCG has adopted the following policies: • **Flexible Working Policy** • Carers leave; maternity & paternity; adoption policies By supporting staff to be flexible the CCG ensures roles are open to those with caring responsibilities or disabilities and ensures that reasonable adjustments can be accommodated. The staff survey indicates that staff appreciate the opportunities and consider them key to effective working, though some feel further opportunities would be advantageous.	The approach taken helps the CCG in delivering a positive achieving culture.

3.6 Staff report positive experiences of their membership of the workforce

How does the CCG engage with its employees and use their feedback constructively and positively to improve morale and experience? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG engage with employees to gain their feedback by; • Staff survey • Exit interviews • Turnover data The CCG's staff survey was updated during 2018 to enhance the demographic detail gathered on respondents. This has allowed the CCG to look at the views and perceived experience of different groups within the workforce. This action was identified in the CCG's WRES action and has helped the CCG enhance its report with regard to the metrics of this standard. Once the survey is completed the results will be reviewed for any differences. It should be noted that the staff survey has shown a range of positive responses and places the CCG well against equivalent organisations.	CCG gains assurance that staff are feeling supported.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG conducts an annual staff survey, the outcome of the staff survey is presented to Staff Forum and an action plan is put together. The following chart taken from the survey shows that the vast majority of staff feel positive about the CCG and recommend it as a place to work. Q23 I would recommend my organisation as a place to work? Answered: 65 Skipped: 0  The survey includes a range of standard questions and opportunity for feedback on actions that could improve things further. A key recommendation from staff is around increased opportunity for flexible working.	CCG gains assurance that staff are feeling supported.

			Staff Forum is held bi-monthly where representatives from each department come together to discuss any topics related to staff. This forum is also used to approve any changes or new HR policies. Charity raising and health and wellbeing initiatives are also discussed at this forum. Any constructive feedback from departments is also discussed at staff forum. Anonymous comments box in CCG facilities for staff to share any concerns anonymously.	

4 Inclusive leadership

NHS organisations should ensure that equality is everyone's business with everyone taking an active role

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

How has the CCGs senior management and governing body promoted equality throughout the organisation and the local health economy? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	The CCG leadership are strongly committed to promoting Equality within the organisation and within the wider health economy. Taking an active role in the joint working across the black country the CCG's leadership works to ensure health inequalities are identified and addressed. Leadership of the CCG have committed to understand and promote their organisation's strategic approach to using patient and public insight, experience and involvement to reduce health inequality and to drive improvement. The CCG demonstrate evidence by; a) *Comprehensive Communications and Participation Strategy* details our approach in this area with the focus on how patient and public insight will drive quality. Future work will build on this to improve linkages to health inequalities Section1 Section 3 Section 4 Section 6 Section 7 b) The CCG's operational arrangements detail that there will be a report on patient and public involvement to each meeting of the Governing Body. In addition, all reports to Governing Body and Committees include details of Patient and Public Insight activity and patient representatives sit on the *Quality and Safety, Commissioning and Primary Care Commissioning committees*. Communications & Engagement representatives attend *Programme Boards* and *Senior Management Team* meetings to ensure patient and public insight is considered throughout the project cycle and at senior levels. Key messages from patient and public insight are disseminated to all staff via staff meetings. The Arden & GEM CSU *Communications and Engagement* lead is embedded in the Operations team and meets with the directorate management team weekly to provide updates on patient and public involvement. Regular operational meetings also take place with Governing Body Lay member, Associate Director of Operations, Chair and Communications &Engagement team. The CCG's Equality Inclusion and Human Rights page illustrates the CCG's own approach and activity. In updating its objectives in 2018 the CCG highlighted the important role of its leadership with the following objective: The CCG's leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country.	Leaders understand the strategic approach and therefore how and why the use of patient and public insight, experience and involvement reduces health inequality and drives improvement. Leaders are actively promoting the strategic approach and ensuring it is understood throughout the organisation. The organisation has a documented, strategic approach describing how patient and public insight, experience and involvement is used to reduce health inequality and to drive improvement.

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	Leaders ensure patient and public insight, experience and involvement informs decisions, actions and evaluation throughout the organisation in order to reduce health inequality and to drive improvement. a) Patient and Public insight has been used to develop the CCG's *Commissioning Intentions* for the year, the *Primary Care Strategy* as well as a number of procurement exercises (details attached) and is reported through our formal processes including the *Joint Assurance and Engagement Group*. The CCG are seeking to move to greater involvement for patients in its operational work through the development of a *Patient Reviewers programme* who will support the CCG's work monitoring quality. b) The CCG works closely with Public Health to develop an overall understanding of population needs and health inequalities via the *Joint Strategic Needs Analysis* (JSNA), including sharing details of its development with the Governing Body. This includes evaluation of Patient and public insight but not necessarily in a structured way. c) Specific work has taken place to understand access to Primary Care through a structured survey. This formed part of the wider engagement work on the Primary Care Strategy. Work on Commissioning Intentions was subject to a 'You Said - We Did' report at the conclusion of the exercise. https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did	Leaders ensure patient and public insight experience and involvement informs the development of possible solutions, decisions made and actions taken throughout the organisation in order to reduce health inequality and to drive improvement. Leaders ensure patient and public insight, experience and involvement is used to identify and fully understand all health inequalities and inequities. Leaders ensure patient and public insight, experience and involvement informs evaluation of decisions and actions including the impact of these decisions and actions on health inequality and improvement. Leaders ensure all learning gained through using patient and public insight, experience and involvement to reduce health inequality and drive improvement is shared throughout the organisation.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective3 Objective 4	Article 2 Article 3 Article 8 Article 14	The **Senior Management** and **Governing Body** demonstrate their commitment to promoting equality throughout the organisation and the local health economy by ensuring that the potential equality implications of issues under consideration are addressed throughout decision making processes. In particular, the Governing Body has demonstrated its commitment during the year by increasing its understanding of its legal duties to engage with the whole community when making decisions that lead to a procurement of services. A dedicated development session with legal advice was held where the importance of engaging with all sectors of the community was re-confirmed.	Equality issues/implications and potential equality implications of issues under consideration are addressed throughout decision making processes.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 4	Article 2 Article 3 Article 8 Article 14	The Chief Operating Officer of the CCG has taken on the leadership of the STP, expanding her impact across the system. As a member of the programme board of Transforming Care Partnership she has been an active advocate for patients with a learning disability. In addition the CCG leadership has taken a key role within the local integrated care programme driving forward an initiative to bring health and social care under the same roof. This saw health and social care services in Wolverhampton bring more than 60 front-line staff together into a single office as part of a bigger programme to develop community neighbourhood teams across the city. The new multi-disciplinary 'team' includes district nurses, community matrons and social workers. Housing, mental health and social prescribing staff will also work with them at their offices at Wolverhampton Science Park 'The immediate advantage of bringing health and social care professionals together will be the face-to-face conversations they can have around the patients and families they are supporting. It will enable us, as a CCG, to ensure our population receives the right interventions at the right time; and we've done it with existing funds,' said Steven Marshall Director of Strategy and Transformation at Wolverhampton CCG. 'Wolverhampton is an extremely diverse population and there are areas with high levels of deprivation. And in times of stretched resources we need to be even smarter about how we are working.' Joint weekly team meetings are already in place and staff will use these to begin harmonising working practices and procedures. This will mean, for example, GPs having a single point of contact if they are unsure whether a patient needs health or social care, or both.	The CCG leadership have enhanced due regard to vulnerable groups within the system in their role as system leaders.

			The CCG also received a rating of excellent through NHS England's Improvement Assessment Framework. This is a testament to the quality of services commissioned and the engagement of patients and CCG colleagues in the decision making including vulnerable groups.	

4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

What processes are in place to demonstrate that the CCGs decision making committees have considered equality relating impacts? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	The CCG's Constitution clearly states in discharging its functions the group will meet the Public Sector Equality Duty and how this will be achieved. (Page 6/7 – 5.1.2) https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf	The CCG demonstrates its commitment to Equality from the top down.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	The CCG has established a robust Equality Analysis process, embedded within the CCG's Programme Management Office processes to ensure analyses take place throughout the project lifecycle. Additionally, decisions to disinvest in services require further consideration of the equality implications of any decisions. All reports to committees and the Governing Body include a section requiring report writers to set out the equality implications of their reports and attach the analysis. The Equality Analysis form was updated during 2018 and has been enhanced measuring the impact of a decision on carers, as well as their patients and other vulnerable groups. Carers play a key role in supporting patients and while the 9 Protected characteristics of the Equality Act 2010 are key we must also consider other vulnerable groups such as the homeless if we are to ensure services meet the needs of all patients who need to use them. This has highlighted that a key challenge is the need for patients to register with a GP practice. This can be more difficult for those who are homeless or have no fixed address. With this in mind services which have this requirement are required to identify an alternative access route / support for such patients.	The CCG can be assured and is able to routinely demonstrate that every decision it makes is subject to robust equality analysis to which due regard is shown. The CCG has gained further assurance that vulnerable patients and those who may be exceptions are able to access services as effectively as the majority of patients.

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

How does the CCG ensure managers proactively engage with their staff to value diversity and so creating an inclusive working environment? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	In addition to the policies and procedures set out in section 3, the CCG has gained support from Arden & GEM CSU EIHR team to run training sessions for all staff. Fairness at work and good job performance goes hand in hand. Tackling discrimination helps to attract, motivate and retain staff and enhances an organisation's reputation as an employer. Eliminating discrimination helps everyone to have an equal opportunity to work in an environment of mutual respect and dignity.	By providing training and support the CCG gains assurance that managers and staff are supported to work in culturally competent ways, eliminating discrimination and ensuring patients and staff benefit.

Race Sex Sexual Orientation			Working together as a team is a fundamental element to any organisation; it is evident that staff at the CCG want to feel more comfortable and confident when they have something to say. The feedback also suggests the need to be listened to, especially those who would normally be quiet in discussion matters. The CCG will continue to engage with staff through the annual staff survey and review the responses to ensure that all can work in an inclusive working environment. By providing training and support the CCG gains assurance that managers and staff are supported to work in culturally competent ways, eliminating discrimination and ensuring patients and staff benefit. **Linked to 3.6**	

Equality Objectives 2018-2021

Wolverhampton CCG has developed the following objectives for launch on the 1st of April 2018 with a three year timeframe. These objectives will form part of the CCG's strategic direction around equality, supporting action plans are being developed and updates will be published during the timeframe of the objectives on the CCG's website.

1. **The CCG to work towards a comprehensive understanding of the barriers to accessing services experienced by patients. To work to reduce the barriers identified with partner organisations and stakeholders.**
2. **The organisation will ensure that due regard is given to the needs of the CCG's population during service change, including vulnerable groups, through effective engagement aligned with the profile of the population affected by particular changes.**
3. **The organisation will use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive, supportive values and competencies across the workforce.**
4. **The CCG's leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country.**

Objective 1: has been developed to support and identify the work the CCG undertakes to enhance access to services for all patients, particularly those from vulnerable groups. This objective requires joint working between the CCG, relevant provider organisations and GP practices. It also requires on-going engagement with patient groups to ensure barriers are identified and resolved. Success will be measured through evidence of service change / enhancements that have addressed health inequalities.

Objective 2: recognises that the NHS is currently in a period of substantial change and that the impact of such changes is felt particularly by vulnerable groups. The CCG will use the findings of completed equality analysis to inform service change and ensure that it works with partner organisations to improve outcomes for vulnerable groups.

Objective 3: This objective has been designed to build on the CCG's internal focused organisational development and will evidence success through the CCG's relevant action plans, achieved goals and annual EDS2 progress against goal 3 of EDS2.

Objective 4: This objective is linked to the CCG's actions as system leader, involvement in the STP for the black country and actions of the leadership. Evidence of success will include STP activity and evidence from goal 4 of EDS2.

Updates against these objectives can be found on the CCG's Equality page and in these annual equality reports.

These objectives have been reviewed by the CCG's Patient Participation Group Network, who provided feedback on them. They have been produced with due regard to the NHS Long Term Plan (LTP). This is key since the LTP has put a renewed focus on commissioners' responsibility for reducing health inequalities.

Key updates:

Objective 1:

As services are re-procured, access for patients is reviewed and where possible enhanced, in particular the continuation of the model of moving services from one hospital location to community hubs is intended to improve access across the localities, benefiting a number of groups – especially those for whom travel is more difficult such as older patients and those with mobility reducing conditions. An example of this is the current re-procurement of diabetes services.

Objective 2:

The CCG completes Equality Analysis for all projects and their findings are used to inform the decision making process, examples of changes that have been made in response to the findings include a requirement for providers to demonstrate additional support for patients with a learning disability and a requirement for providers to themselves complete equality reviews on new services when they launch.

Objective 3:

The CCG continues to review the HR policies and processes, staff feedback through annual surveys and staff focus groups reports to continue to improve and enhance the diverse working environment within the CCG.

Objective 4: As the host for the STP the CCG has enhanced the system approach on equality analysis across the STP to ensure robust considerations of impact around decisions made.

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NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 8th January 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Nicola Hough – PA to Chief Nurse and Director of Quality, WCCG (Minute Taker)
Mike Hastings – Director of Operations, WCCG
Ankush Mittal – Public Health Consultant, Wolverhampton Council
Sally Roberts – Chief Nurse and Director of Quality, WCCG

Lay Members:
Jim Oatridge – Lay Member (Deputy Chair)
Peter Price – Independent Member – Lay Member
Sue McKie – Patient/Public Involvement – Lay Member

In attendance (part):
Sarah Clarke – Quality and Safeguarding, WCCG
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Maxine Danks - Head of Individual Care, WCCG
Peter McKenzie - Corporate Operations Manager, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG

APOLOGIES:
Yvonne Higgins – Deputy Chief Nurse, WCCG
Kelly Huckvale - Compliance Officer (Information Governance), CSU
Marlene Lambeth – Patient Representative
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG

QSC/19/001 Apologies and Introductions

Apologies were received and noted as above and introductions took place.

QSC/19/002 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/19/003 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/003.1 Minutes from the meeting held on 11th December 2018 (Item 3.1)

The minutes from the meeting which was held on 11th December 2018 were read and agreed as a true record.

QSC/19/003.2 Action Log from meeting held on 11th December 2018 (Item 3.2)

QSC/18/071.2 - Primary Care Report: Complaint – One issue being referred to PEIG; to chase it up and copy Mrs Roberts into the e-mail.

Update provided in report under item 5.2 (January 19).

It was agreed that this action could be **closed** and **removed** from the action log.

QSC/18/071.1 - Quality Report – To share the presentation that was used at the meeting with Cancer Alliance and NHSE as they were assured of the actions being taken by RWT and CCG.

Mrs Hough advised that she had sent this around this morning.

Mr Hastings apologised for the lateness of the presentation.

It was agreed that this action could be **closed** and **removed** from the action log.

QSC/18/69.2 & QSC/18/045.1 - Quality Report including Primary Care and Care Home Report: Black Country Partnership (Penrose Unit) – To raise the national issue around Mental Health beds at QSG and ask others about their experiences.

Mrs Roberts advised that the Quality Team are actively working with Penrose and they will do another unannounced visit soon.

It was agreed that this action could be **closed** and **removed** from the action log.

QSC/18/69.2 & QSC/18/045.1 - Quality Report including Primary Care and Care Home Report: Black Country Partnership (Penrose Unit) – Ms Higgins to find out about mental health step down beds and let Dr Rajcholan know.

Mrs Roberts commented that she didn't think there were any.

It was agreed that this action could be **closed** and **removed** from the action log.

QSC/18/031 - Apologies and Introductions – To speak with Dr Hibbs regarding the appointment of another Secondary Care Consultant.

Mrs Roberts advised that recruitment will be shortly underway for another Secondary Care Consultant.

It was agreed that this action could be **closed** and **removed** from the action log.

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 they had agreed some terms and had met with a company in December 2018. She is in the process of getting some people for each directorate to lead on Health and Safety and added that she would provide a further update in February 2019.

ACTION: Mrs Roberts

QSC/19/004 Matters Arising

There were no matters arising.

QSC/19/005 Performance and Assurance Reports

QSC/19/005.1 Quality Report (Item 5.1)

The above report was previously circulated and noted by the Committee.

Mrs Roberts advised that she believed the CQC report for BCFT was being released today and added that there were no major concerns identified within the final report. She added that the report was going to both Trusts and advised that the merge is to go through.

Cancer – With regards to the 104/62 day breaches; RWT still continues to be under performance; they are on national escalation and have had a visit from Dr Cathy McClean; there is a comprehensive plan, there was a walkround and they advised who they wanted to meet. Dr Hibbs went on behalf of the CCG; positive feedback was received and they noted that patient experience was poor for MRI, given where the MRI scanner was housed. IST had already stated that capacity and demand work was an issue. Awaiting formal report but we do expect additional IST support to be offered to the trust with ref to clinical pathways.

Harm Reviews – This was up to date as of December 2018; plan going forward with help from Dr Rajcholan and Mrs Lesley Thorpe. Key themes and trends arising from reviews are fed back into cancer team for improvement.

Tertiary Referrals – These continue and there are less than five per week, but are still significant; with regards patient's pathways mainly from Dudley and Walsall and one from HEFT.

Weekly Calls – These still continue; evidence that the trust are working hard through their backlog activity; with Christmas and New Year holidays we expected a dip, but this was more significant than was expected. Trust improvement plan identifies backlog is due to be reduced around April time.

Radiology – Additional financial support from NHSI and CCG has supported additional capacity for diagnostics. IST has indicated RWT are one MRI scanner down and David Loughton is working on this STP wide.

Mr Hastings commented on tertiary referrals being received; there are referrals being made to RWT that should be going elsewhere.

Dr Rajcholan enquired if RWT was having another urology surgeon to undertake robotics.

Mrs Roberts replied that yes they are training a few more surgeons. The focus is on STP and they have recognised wider participation.

Mr Price enquired as to whether there was recognition that everyone is pulling in the right direction.

Mr Hastings commented that NHSE/NHSI have noted that Cancer in Wolverhampton is the biggest concern and although they are not hitting the target they are seeing that the CCG are doing everything that needs to be done.

Mrs Roberts added that we are at the right level of referral; they have got their eye on it. NHSE/NHSI will continue to scrutinise.

Dr Mittal stated that on the reverse NHSE and breast cancer screening and other cancers; Wolverhampton is ahead of some others with getting people to attend their screening. Work is being done around prevention and screening.

Mrs Roberts advised that she and Dr Mittal are going to do some work around this for the next meeting.

ACTION: Mrs Roberts/Dr Mittal

Mr Hastings stated that we are ahead of the game; there are more appointments available; open access point, get more referrals in, work being done around this. One in 15 go forward for treatment, in October 2019 the timings are increasing for patients to be seen.

Mortality – The Bereavement Suite has now opened. The Medical Examiners also start this week. SJRs (Level 1) they are getting through them, Trust undertaking a SJR for each patient. Level 2 is more structured and Dr Rajcholan will be sitting on SJR Level 2.

This will then determine next steps and whether it goes for SI or RCA etc. There were 55 cases in hospital deaths for SJR 2; more meaningful learning comes from them. We will start to see the outcome of the SJRs. External investigation report expected in mid-January 2019. With regards to Quality of Care; Stan Silverman has not determined whether there was a lack of care or not. Working with Public Health the wider system work will focus around frailty and end of life etc. Wider community services, getting infrastructures correct. Not expecting to see a real dip in performance we will need to give them a 6-12 month to see a difference. Continue to actively work together.

Sepsis – Quarter 2 there is work that needed to be done. Ms Higgins has been doing some work with front door staff and the team should commence February 2019. The Chief Nurse at RWT is focussed on this work.

Mr Oatridge wondered if there was some sepsis work reflecting into the mortality work.

Mrs Roberts replied that yes it does. With regards to Vital Pac and NEWS2 they are slightly behind compared to other local trusts.

Mr Hastings commented that Simon Stevens had recently discussed the A&E Targets; Heart Attack, Stroke and Sepsis within 4 hours. To be implemented in October this year.

Maternity – There is some good work around capacity; they have now moved over to Badgernet which has gone really well and they are now getting reports from Badgernet. Royal College of Obstetricians and Gynaecology went into the unit October time and we are still awaiting for the report to be shared with us.

Ms McKie commented that Badgernet should help with CDOP work.

Mrs Roberts advised that emergency c-sections remains elevated and she is speaking with the Clinical Director for obstetrics and gynaecology.

Mr Oatridge asked if it was elevated, how important was it.

Mrs Roberts replied that this is the argument the Head of Midwifery would put in; we do know our population will require more C Sections so we should be asking how we are monitoring and helping them.

Dr Mittal asked how RWT compares to other areas.

Mrs Roberts replied that they are slightly higher than other Black Country neighbours.

Dr Mittal asked what potential difference can be made antenatally.

Mrs Roberts stated that it is this very much around the model of care and what is being done antenatally. The infant mortality rate is still poor. Continuity of Care national agenda is really positive and RWT are actively engaging in this work to ensure vulnerable women are cohorted appropriately.

Mrs Corrigan joined the meeting.

Mrs Roberts advised that the capping is still in place and they had taken 4/6 ladies with specific clinical reasons from Shropshire; she added that the CCG continue to support the cap.

BCPFT – With regards to an adult and MH breach they are still awaiting the RCA report. There was two to one support for a patient in ED and then to AMU; learning from RCA is to come back here. Awaiting CQC report.

Nursing Home – Work continues with Probert Court; it was quite volatile. With regards to the Discharge to Access provision there were issues around the home and the Trust. The CCGs Quality Nurse Advisors went in every day for two weeks to see what was happening; there was an issue with clinical oversight and leadership. There are now

clear actions from the Chief Nurse (RWT); the home can use RWT bank staff from April, and also offer teaching packages, it has been well received from the home. Mrs Henriques-Dillon chaired a meeting with the home and trust staff, they will strengthen the care home provision, still monitoring closely.

HCAI – There is a new amber alert; there has been an increase in C *Diff* and MRSA rates. This has been flagged with the contracts team and will strengthen work with Public Health too. CCG needs to do some system wide work with regards to gram negative bacteraemia.

Mr Price stated that it was a comprehensive report and added that it would be good to milestones when it is expected to move from red to amber etc.

Mr McKenzie joined the meeting.

Mr Oatridge agreed with Mr Price and commented that updating the column has really improved but are not getting to end. The Risk Register has clear timelines and shows when it will be completed and if they don't get there what will happen.

Mrs Roberts replied that she will take it away and review it.

ACTION: Mrs Roberts

Ms McKie commented on the Serous Incidents on page 9 of the report and asked for clarity of difference with numbers for chart 1 and 2. She also commented on the Survey for Care homes (section 6.4) and asked how many Homes we have.

Mrs Roberts replied that there are about 16 on contract, but there are about 22 homes and added that we should be reporting as percentages.

Mr Oatridge stated that some graphs have no November data in them and as we are in January asked if there was an issue.

Mrs Roberts replied that it was probably reporting due to Christmas and hopefully they will catch up next month.

QSC/19/005.2 Primary Care Report (Item 5.2)

The above report was previously circulated and noted by the Committee.

IP Audits – Mrs Corrigan has met with IP lead in November and understands it more now. She has discussed it with contracting; the issues are mainly damage to walls/décor etc. they are looking into this. The IP&C team is doing a session around Safer Sharps and Sepsis.

Flu Vaccines – Everybody now has got access to over 65 injections; there had been a slight shortage. The uptake is increasing but not as good as last year. There have been issues with the computer; some practices are not being reported in a timely manner.

Quality Matters – This is now up to date.

Practice Issues – There has been some issues with a particular practice and Mrs Corrigan was meeting with them next week. There has been an issue with labels and Mrs Corrigan was hoping for an update next week. With regards to the issue with DocMan there have been no reports of any harm.

Complaints – All complaints are now closed. There was one being dealt with by the practice.

PEIG – There was one issue but there are no further actions for us.

FFT – This is the best ever uptake; they have been increasing on monthly data. Texting id the higher responses and then screens and some paper. Some practices are still not reporting; they are going to be asked to provide an action plan as well as those who don't provide enough responses. However, some practices have done really well.

Management Group – There has been a spike in patients unlikely to recommend; unsure if it is an anomaly; the figures on the report were October's figures and could be connected to the lack of flu vaccines available.

CQC – There has been no new activity.

Collaborative Contracting Visits – These are now all up to date. They visited Woden Road before Christmas and had planned to visit Parkfields in two weeks; the issues being found are easily remedied. Going to use new form from January.

Workforce Activity – This has been agreed and now rolled out; there are workstreams; coaching and mentoring and portfolio update. Paul Aldridge is looking at replicating the same for Practice Nurses across the Black Country.

Mr Oatridge commented on the workforce numbers and stated that it was difficult to understand whether it was a basic spread and whether it was at optimal level and other areas shift into salary fees.

Mrs Corrigan replied that she can do a comparison across the CCG.

Mrs Roberts advised that benchmark work has already been done which could be shared.

Mrs Corrigan stated that compared to other CCGs we were quite good and advised that she would share work next month.

ACTION: Mrs Corrigan

Mrs Roberts commented on the attractiveness around Primary Care and advised that Mrs Corrigan is leading on this across the STP. There is a GP that is sitting on group with Mrs Corrigan.

Mrs Corrigan commented on the figures over 55 and advised that they are not necessarily looking at retiring.

Practice Nurse Strategy – Also looks at other professionals. They are looking at increasing student nurse placements also Return to Practice and sponsored training.

Spirometry Training across Wolverhampton – Looking at funding for his as well as diabetes training. Working with Dudley CCG for programme for Practice Nurses to use fundamentals to help with getting people in their post etc. There is also a lot going on with non-clinical staff and the Practice Managers diploma.

Training Hub – This is procured by Health Education England, there has been a delay in process, they are looking at a solution and it has been put on the Risk Register as an amber risk.

Dr Rajcholan enquired about the Practice Manager Diploma for Wolverhampton and whether they will fund one place per CCG.

Mrs Corrigan replied that it is per CCG and added that the CCG has funded another one.

Dr Rajcholan asked if there was somebody interested who they should contact.

Mrs Corrigan replied that they should contact Jo Reynolds.

Dr Rajcholan commented on the case studies and action 1 of 10 point plan.

Mrs Corrigan advised that this was to do with work experience for students in year 12 in secondary schools and added that it was a joint venture CCG, Public Health, Pharmacy etc. Practice Nurse fast track for practice nurses who are new in post; to give them the training to help to get them up and running.

Mrs Corrigan left the meeting.

QSC/19/005.3 Information Governance Report (Item 5.3)

The above report was previously circulated and noted by the Committee.

Update on Information Governance – This has got to be completed by the end of March and we are on track to work on Information Governance.

Updated NHS Digital requirements – This is on the CCG intranet. Updated information asset register; Ms Huckvale is following up on this now.

Staff Training – Update for Information Governance at beginning of the year; need to get 95% by end of year.

Information Governance incidents – Ongoing work; there was none in this quarter.

Subject Access Requests – There were a couple in the last quarter; don't get a vast number of these.

GDPR Programme – Need to update policy, should come to next meeting for approval.

Consent Forms – Need to review the consent forms, CHC are working on this with Ms Huckvale.

Mr Hastings commented that there were intermittent problems with ESR which would affect mandatory training and wondered whether it was worth contacting someone to ask if there is a fall back.

Mr McKenzie replied that they are working on this and there was a fall back. Ms Huckvale had mentioned that there were some elements in the toolkit and she has had to clarify what we asked for, but it is all on track.

Mr Strickland joined the meeting.

Mrs Roberts commented that we are learning from Information Governance incidents and asked if there was any learning and whether it was being shared.

Mr McKenzie replied that yes they have used a variety of mixed communications to share the learning e.g. newsletters, screen savers and GDPR updates.

QSC/19/005.4 GDPR Workplan Update (Item 5.4)

The above report was previously circulated and noted by the Committee.

QSC/19/005.5 FOI Report (Item 5.5)

The above report was previously circulated and noted by the Committee.

Mrs Roberts left the meeting.

Mr McKenzie advised that there was a slower volume of FOI requests and had missed a statutory deadline due to staff illness; staff not around to ask. Unable to reply within 20 days for two FOIs.

Mrs Roberts rejoined the meeting.

The requests come from a wide variety of people; media is the main one, the recent one was whether the CCG was going to pay for any settle status (Brexit) it is usually what is on the news but there was nothing noteworthy.

Mr McKenzie and Mr Price left the meeting.

QSC/19/005.6 Quarterly CQUIN Update (Item 5.7)

The above report was previously circulated and noted by the Committee.

Mr Hastings presented the report and advised that it was self-explanatory and that the report was showing quarter 2 data and gave total monies achieved for the quarter and to date. The Royal Wolverhampton NHS Trust was showing the total value of £687,568 out of a possible £815,759 and Black Country Partnership Foundation Trust was showing total value £85,513 out of a possible £122,965 and Nuffield Health was showing a total of £14,118 out of a possible £14,118. He added that Mrs Moon monitors this with Mr Parvez.

Mrs Roberts commented on the sepsis Indicator for RWT and advised that Ms Higgins has been going into the Trust to help with this; so hopefully they will achieve the indicators in quarter 4.

Mr Price rejoined the meeting.

Dr Mittal commented on the Smoking indicators and queried as to whether discussions had taken place with regards to this and the national CQUIN.

Mr Hastings replied that discussions had taken place with Dr John Denley.

Mrs Roberts commented on Tobacco control indicators for BCPFT and advised that she was unsure what was happening with this and added that she would ask for an update next time.

ACTION: Mrs Roberts

Dr Mittal stated that all trusts ask patients if they smoke, drink etc. but he was not sure where the detail is stored. He added that he would discuss smoking with the team.

Mrs Roberts advised that there was some work being done around vaping and added that smoking CQUINS are not part of the NHS Long Term Plan.

Dr Mittal commented that a lot of good work was being done around alcohol and withdrawal etc.

Dr Rajcholan stated that there was no longer funding for smoking cessation but practices will continue to help patients with stopping smoking.

Discussions took place around smoking and smoking around pregnancy and prevention and young people.

QSC/19/005.7 Quality Assurance in CHC Report (Item 5.6)

The above report was previously circulated and noted by the Committee.

Fast Tracks – the amount of these have come down; this could be due to changing the process; fast tracks are managed in house; the team has provided lots of training and is still ongoing. The team is recording all referrals on a spreadsheet so that they can audit it; patients can access appropriate treatment and movements to homes and Compton Hospice etc.

Appeals – There is currently eight appeals in the system; five are ready to go to local panel and there are a few awaiting dates for panels; one appeal has been overturned as they have been given new information and all the others were upheld.

New National Framework (2018) – This is now in place and documentation has been amended to support it.

CHC Personal Health Budget – The team continue to try and improve the possible 70 adult CHC personal health budgets, for children there are currently nine in place.

Step Down – The number of patients in step down on average is between 30-35 per week; the person who normally deals with these has been off sick but they are now back.

Quality premium for NHSE – This requires 80% of full CHC assessments to be completed within 28 day timescale and less that 15% of CHC full assessments to be completed in an acute setting, the team are currently assessing them within 29 days.

Workloads – It is still high, but is getting better now. They are trying to stop people doing the checklist in the hospital but to do them in the Community instead. As well as putting on some face-to-face learning.

Vacancies – The team has recently appointed to the band 2 and band 5 vacancies.

Budget wise – They are currently breaking even. Since 2014/2015 the budget has gone up £35,000 in 5 years.

Care Home Framework – An evaluation of this will be undertaken shortly.

STP Footprint – The team is working across the STP footprint to identify how best to commission the care for highly complex/specialist mental and physical health placements. They are not assured at the moment that patients get the same standard of care across the STP.

Mrs Roberts advised that a paper is going to JCC on Thursday regarding this.

Ms Danks added that everybody is on board and it was a positive for patients.

Mr Oatridge commented on the quality of care and safety of patients in care and the availability and enquired where that goes with personal health budgets.

Ms Danks replied that for patients at home the local authority broker some care for us and if we are concerned about something we can contact Public Health. They get three quotes from different providers and it is discussed with the patient and they also get feedback from patients already using the services. She added that they haven't got anybody in Wolverhampton who has got their own budget. With regards to complex care needs the company is employed to do work for us; they are on call 24/7 from the company and support from complex care nurses in the team.

Mr Oatridge queried that as this rolls out more how do we get assurance of quality of care budgets.

Mrs Roberts advised that some patient stories come here; for multi complex patients there are a lot of challenges; there are multiple patients that have issues which are managed through the CHC team and added that we don't always recognise the work being done.

Mr Oatridge enquired how we understand quality and value of money.

Mrs Roberts replied that the team deal with this on a daily basis.

Ms Danks added that with regards to quality of care, the team will link with Public Health when they do the next procurement so to help with understanding Personal Health Budgets.

Mr Oatridge stated that the team have a grip on that and added that it is the unknown issues.

Ms Danks replied that they get NHSE to get some evidence to share PHBs.

Mrs Roberts stated that national issues don't support our local demographics.

Ms Danks commented that she could bring some patient stories to the Committee if required.

Dr Rajcholan commented on the care home framework and that they have 405 beds in nursing homes that are quality assured.

Ms Danks replied that they are hoping that the number will increase; they are looking at 600 by the beginning of the next financial year. She added that patients are all placed in framework homes now. Patients have face-to-face three monthly meetings to discuss their issues.

Ms Danks left the meeting.

QSC/19/006 Risk Review

QSC/19/006.1 Quality and Safety Risk Register (Item 6.1)

The above report was previously circulated and noted by the Committee.

Mr Strickland advised that there no new risks added to the register this month and added that Corporate risks are due to be reviewed this month

QS09: Potential issue with supply of adjuvented trivalent influenza vaccine (aTIV) for 2018/19 influenza season: There has been a change in score for this.

QS01: Out of Hours Provider - inaccurate reporting of performance data/quality assurance - Mr Strickland advised that he was still awaiting feedback regarding Vocare CQC Visit and added that he would pick this up with Ms Higgins.

QS05: Maternity Capacity & Demand – Mr Strickland queried whether this was to be kept on the risk register as it was ongoing.

Mrs Roberts replied that due to issues at Stafford and Shropshire it was felt it should be kept on the register due to the vulnerability of the service.

SEND – Mr Strickland commented that at the last meeting SEND was mentioned as they was awaiting information and wondered if this needed to go on the Risk Register.

Mrs Roberts advised that she would check this with Ms McCormick.

ACTION: Mrs Roberts

Mr Strickland asked if there were any new risks to be added.

Mrs Roberts replied that there was some work to be done around screening, which might need to be added to the Risk Register, there was also some work to be done around HCAI.

Mr Strickland left the meeting.

QSC/19/007 Feedback from Associated Forums

QSC/19/007.1 Area Prescribing Committee (Item 7.1)

The Area Prescribing Committee minutes were received for information/assurance.

QSC/19/007.2 Commissioning Committee (Item 7.2)

The Commissioning Committee minutes were received for information/assurance.

QSC/19/007.3 NICE Group (Item 7.3)

The NICE Group Minutes were received for information/assurance.

QSC/19/007.4 Primary Care Operational Management Group (Item 7.4)

The Primary Care Operational Management Group minutes were received for information/assurance.

QSC/19/008 Items for Escalation/Feedback to CCG Governing Body

- Nothing

QSC/19/009 Any Other Business

Flu Vaccines – Dr Mittal advised that there had been an increase in the uptake of children's vaccine and that it was positive as an increase is better.

Mrs Roberts advised that RWT had done some work with the ED around flu and they are starting to see the impact now. Russells Hall Hospital had been on a level 4, RWT was on a level 3 on ITU but it was managed and contained.

Dr Mittal added that there was one case he was aware in a Care Home.

Mrs Roberts stated that RWT will be asked for off-loads of ambulances.

Mr Hastings commented on the children's book that had been designed by PH and asked if there had been any uptake.

Dr Mittal replied that the book had been done as parents might not understand the letter; they will take it to NHSE for the West Midlands; NHSE are setting up a group for screening etc.

Mrs Roberts advised that the long term plan has been released and added that people will need to digest and understand it and they are awaiting guidance around it too.

QSC/19/010 Date of Next Meeting: Tuesday 12th February 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.40pm

Signed: …… **Date**: ……
Chair

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 29th January 2019
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.334 There were no declarations of interest.

3. Minutes of the last meetings held on 27th November 2019

FP.335 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.336 Item 139 (FP.328) – The conversion rates at RWT A&E from arrival to decision to admit or treatment to be checked – item deferred

Item 140 (FP.328) – Quality Premium summary for 2017/18 to circulated – report included on agenda – action closed.

Item 141 (FP.339) – Risk Assessment for E-referral issues to be carried out as to whether this needs to be added to the Committee Risk Register – a meeting was due to be held with RWT and the level of risk would be

determined after this meeting and would validate if a risk assessment is required. An update to be given at the next meeting.

5. Matters Arising from the minutes of the meeting held on 29th January 2019

FP.337 There were no matters arising to discuss from the last meeting.

6. Risk Report

FP.338 The Risk Report was considered as follows;

Corporate – Organisational Risks:

- CR18 Failure to Deliver Long Term Financial Strategy – the Long Term Financial Plan for the period 2019-20 to 2024-25 was due to go to the Governing Body for consideration by March 2019, however, as this now had to be consistent with the STP Plan, which is due to be finalised in the summer, the deadline would be reviewed in line with the meeting schedule for the Governing Body.

  Clarification was given that the plan for 2019-20 would be agreed locally by the Governing Body and the rest of the Long Term Financial Planning would be in line with the STP.

  Mr Hastings reported that he was the CCG's SRO for Brexit. A list of preparations as directed by NHSE had been put in place. A report was to be taken to the February Governing Body meeting indicating that the risks are mitigated against. All GP practices had been contacted to return their mitigations; which is difficult to do as there are a lot of unknowns at present.

Committee Level Risks

- FP06 Over Performance of Prescribing Budget – a query was raised regarding the impact of a 'no deal' Brexit and a hike in prices and whether this should be reflected in the financial risk. It was discussed that this was already reflected due to increased prices for no cheaper stock available drugs and was covered in this financial year and would be considered going forward.

- FP05 Over-Performance of Acute Contract – consideration to be given to including over performance at other acute providers

other than RWT. Mr Middlemiss to liaise with the CCG's Governance & Risk Coordinator

- FP14 Transforming Care Partnership – Financial impact - The CCG is able to mitigate the non-recurrent financial risk through the application of reserves.

- FP08 NHS Property Services Charges 2017/18 &2018/19 – Mr Gallagher and Mr Hastings are currently reviewing this risk and will update accordingly

Resolved: The Committee noted the updates

7. Contract and Procurement Report

FP.339 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

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Commissioner Queries – there were a number of on-going queries to which the Trust had not responded. At the last Contract Review meeting it was emphasised that timely responses are required for the process to be effective.

Dermatology – the CCG had formally issued notice on part of this acute service. Work was on-going by the CCG's Business Insight Team and RWT to gain a shared understanding of the activity data/patient cohorts that may be shifted into the community versus that which will remain at RWT.

It was noted that this is a challenging speciality and there had been difficulties in recruitment. The CCG had supported RWT who had engaged with Concordia and South Staff provider to revise care pathways.

The CCG is assessing commissioning an external Dermatology Consultant to provide a clinical view on the services which are proposed to remain with the Trust versus those to transfer.

E-referrals – the issue of agreeing local exclusions remain unsolved. A meeting was to be held early February to discuss.

2019/20 Planning Round – National planning guidance had been received. This was being interpreted to assess how this feeds into the planning round to develop an initial offer. There were no escalation issues at present.
Mr Gallagher explained that the guidance had been received later than expected and that the tariff had not been agreed. He highlighted that there

was a considerable amount of work to be done to interpret the guidance and understand all of the associate requirements. This will then progress to the CCG working up initial offers prior to the deadline of 21st March 2019 to sign off contracts.

A detailed plan was to be worked up by 5th February and would be brought to the next meeting.

Black Country Partnership Foundation Trust (BCPFT)

Improving Access to Psychological Therapies (IAPT) target – The CCG had committed to investing into IAPT services at BCPFT. The CCG had requested further information as to where the Provider is with its plan and the current position; however, it is difficult to get this information.

Additional staff had been recruited and training sourced. BCPFT is now referring patients to the third sector organisation Serenity for low intensity treatment. Since the report had been written the Trust was no long sub-contracting to the independent provider IESO, however, it is in discussion with another 3rd sector organisation, Big White Wall. SLA's are in place for these services. This is a high priority focus area for NHS England (NHSE).

Additional investment had been given to gain greater assurance that the increased target will be achieved next year. Information of how this would be achieved had been requested, however, this had yet to be provided by the Trust. Mr Gallagher queried if a deadline for the response had been included in the request for information. Mr Middlemiss agreed to review the email sent to check this.

Other Contractual Issues

Planning round 2019/20 – Two Finance and Commissioning sub-group meetings had been held to date and an offer was being worked up. Mr Middlemiss reported that discussions had taken place with Mr Marshall regarding the importance of the sub categories of the offer and what these are targeted against and the expectations are delivered.

Nuffield

Contractual issues – there were no specific issues to report at this time.

Urgent Care/Ambulance/Patient Transport

WMAS – Non-Emergency Patient Transport Services (NEPTS) – a meeting had taken place following the Contract Extension Proposal from WMAS which requested a 55% increase in funding. The Provider had requested £2.5m increase to cover an unsustainable cost pressure. It was confirmed that the annual contract value is £4.5m; the CCG is responsible for 40% of this. Wolverhampton CCG holds the contract and Dudley is the main co-commissioner.

A combination of factors had impacted the costs of the service. WMAS had invested in additional staffing and vehicles which was at risk as it was not agreed with the CCG. However, the Provider had been informed by CQC that it needs to invest more for a safer service.

WMAS had agreed to review their proposal to ascertain what the minimum funding level is to maintain safe and effective service delivery. This had led to a request for minimum funding of £2.1m.

Other contracts

Midlands Partnership NHS Trust (formally SSOTP) – Mrs Sawrey highlighted a cost pressure arising from the over performance of this contract. Mr Middlemiss stated that there is a need to understand why District Nurses are not going over the border. This issue had been raised with the Trust and will be discussed further during the contact negotiation process. It was anecdotally noted that this was also an issue in other areas.

Resolved: The Committee;

- Noted the contents of the report and the actions being undertaken

8. Monthly Performance Report

FP.340 Mrs Moon presented the key points of the report as follows;

Referral to Treatment (RTT) – validated performance for November was at 90.8%. The dip in performance in November was reflected nationally. The Month 8 in-year trajectory (as agreed with NHSI) was not achieved. The Trust is focussing on the National requirement to sustain or reduce RTT waiting list size against the March 2018 deadline and is currently on track to achieve this.

The CCG's performance for patients registered with a Wolverhampton GP waiting start treatment at any Trust is 91.38%. This was mainly affected by performance at RWT and Nuffield.

Nuffield performance is at 87% although previously reporting achieving target. Data is being checked and verified. This will be reviewed at the Contract Review meeting. It had also been raised with other CCG's Performance Teams.

National validated data had confirmed an increase in the percentage of patients waiting less than 6 weeks from referral to Diagnostic Test (97.29% against the 99% target). The Trust is reporting full recovery by February.

Urgent Care – there was a dip in performance in November achieving 89.15%. The Black Country STP achieved 85.7% and England 87.6% Performance recovered to 92% in December. No push back on this had been received from NHSE as the Trust is one of the higher performers nationally.

Cancer Recovery Action Plan update – The Trust did not meet the recovery trajectory in November. The Trust is reporting that it is on target to achieve this in December. An improvement had been seen in 62 day waits; however, activity was down in December with patients choosing to defer treatment until after Christmas and New Year period. This will impact on 2 week waits in January. An increase in referrals was seen in January.

An increase in breast cancer referrals had been seen since October which was breast cancer awareness month. It was considered whether this impacted on the number of referrals each year.

Work is ongoing with STP and Cancer Alliance colleagues to improve performance in these areas.

Mr Gallagher queried whether it would be possible to share the Remedial Action Plan and information relating to late retiary referrals with Walsall following a query from the Walsall CCG's Governing Body. It was agreed that this information would be shared

Resolved: The Committee

- noted the contents of the report
- Mrs Moon to share STP Performance Action Plan with Mr Gallagher.

9. Finance Report

FP.341 Mrs Sawrey introduced the report relating to Month 10 January 2019

- All financial metrics are being meet
- Month 9 Forecast Outturn is breakeven
- Risks and mitigations are balanced, all known risks are fully mitigated

It was noted that previously RWT performance had been monitored on a PBR arrangement; however, going forward the aligned incentive contract will be implemented.
Elective activity is showing underperformance which is giving concern for the achievement of RTT at RWT.

The CCG is reporting achieving the QIPP target of £13.984m; however, reserves have been deployed as planned in order to meet the QIPP target.

Continuing Health Care Adult is recording an underspend overall. This is mainly due to a reduction in numbers. A key risk to the financial position is the potential increase in the number of high cost patients.

Mr Gallagher noted that since the report had been written an approach had been agreed with Black Country councils and funding agreements of allocations had been finalised for this year. The risk associated to this can be managed.

Prescribing – the Year to Date Prescribing budget is currently reporting an overspend, of which, £1.6m is due to No Cheaper Stock Obtainable (NCSO) and Category M.

It was highlighted that there is a significant work still to be completed prior to the signing of contracts and it would be challenging to do this by the 21st March deadline.

Mr Gallagher gave an update regarding the £4.8m outstanding RWT invoice. NHSE and NHSI are pressuring both organisations to resolve this issue. A payment of £2.4m had been accepted in principle, in exchange for the CCG's principles to move towards an Integrated Care Alliance. This needs to be considered by the Governing Body and a paper would be taken to the February meeting.

Mr Trigg queried whether the QIPP shortfall being covered by reserves would have an ongoing impact into the next financial year. Mr Gallagher explained that it had been planned at the start of the year to delivery QIPP target with the use of reserves. Although it is not a national requirement the reserves will be reinstated for the new financial year to enable a similar approach to be adopted in 2019-20

Resolved: The Committee

- noted the contents of the report

10. Additions/updates to Risk Register

FP. 342 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. Quality Premium

FP.343 Mrs Moon presented an updated on the current positon of the CCG achievement of the Quality Premium for 2017/18 and 2018/19.

Confirmation of achievement for 2017/18 was expected in Quarter 3 of 2018/19, however, the CCG had not yet received formal verification. The

CCG is currently predicting no achievement of Quality Premium in 2017/18. However, if there is partial achievement plans will be required to spend the money which must be in line with the Scheme.

The CCG is currently predicting partial achievement in 2018/19. Further information would be shared with the Committee when received.

Resolved: The Committee noted;

- The update and current predictions for achievement in the final years 2017/18 and 2018/19

12. **Any other Business**

FP.344 There were no items to discuss under any other business.

13. Date and time of next meeting

FP.345 Tuesday 26th February 2019 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 26th February 2019
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
Dr M Asghar	Governing Body GP
Mr S Marshall	Director of Strategy and Transformation (part)

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr V Middlemiss	Head of Contracting and Performance (part)

In attendance

Mr P McKenzie	Corporate Operations Manager (part)
Mrs H Pidoux	Business Operations Support Manager

1. Apologies

Apologies were submitted by Mr Hastings

2. Declarations of Interest

FP.346 There were no declarations of interest.

3. Minutes of the last meetings held on 29th January 2019

FP.347 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.348 Item 139 (FP.328) – The conversion rates at RWT A&E from arrival to decision to admit or treatment to be checked – the activity data was shared at the meeting and it was agreed that this would be circulated by email after the meeting – action closed.

Item 141 (FP.339) – Risk Assessment for E-referral issues to be carried out as to whether this needs to be added to the Committee Risk Register

– a productive meeting had been held with the Trust and the exclusion criteria had been agreed. The Committee was advised that this did not need to be a Committee risk and would be managed via the contracting process – action closed.

5. Matters Arising from the minutes of the meeting held on 29th January 2019

FP.349 There were no matters arising to discuss from the last meeting.

6. Finance Report

FP.350 Mrs Sawrey introduced the report relating to Month 11 February 2019

- All financial metrics are being meet
- Month 10 Forecast Outturn is breakeven
- Underlying recurrent surplus metric of 2% is being maintained
- Currently reporting a nil net risk

The key points to note were;

- Planning for 19/20 is affected by an increase in the level of activity going through RWT. Forecast outturn reporting £1m underspend against the Aligned Incentive Contract this had dropped to breakeven due to activity levels in M9.The volatility is in out patients and elective care. The Risk/Gain Share Agreement encompasses non-electives. The CCG is closely reviewing data and is having constructive dialogue with the Trust.

Clarification was given that the figures reported in the Finance Report pertain to Month 10, whilst the figures in the contracting report relate to M9. This was due to a difference in reporting timeframes.

- CHC position had moved by £200k due to a high cost client being identified that was not on the QA database. Steps are being taken to address this happening in the future.

- Prescribing – volatile area due to NCSO and Category M drugs. These are national issues and the CCG is seeking clarity from NHSE regarding whether these pressures are recurrent.

- Primary Care Delegated Budget – In 2017/18 the CCG assumed responsibility for this budget. This was reliant on the historic performance data from NHSE and it was reported that this would breakeven and provision was made to ensure that resources were available to do so. As QOF, DES and locum claims have not been made as anticipated reporting is for £1.4m underspend. A review is to be undertaken, including Steven Marshall and Sarah Southall, to review the budgets received from NHSE to identify the level of funding which could be assigned to a discrete development fund

within the delegated primary care budget. The CCG Executive's had considered future planned developments to assess if these could be brought forward, however, this had not been possible.

A quarterly report containing the granular level of detail is taken to the Primary Care Commissioning Committee. It was agreed that in future this would be shared with this Committee.

Resolved: The Committee;

- Noted the contents of the report and the actions being undertaken

7. Contract and Procurement Report

FP.351 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

- Community Phlebotomy – following a query from this service RWT had advised that a proportion of Rheumatology patients who were originally seen in New Cross Hospital had now been referred to the RWT community. This had caused an increase because it has revealed that the activity wasn't previously recorded. This will be picked up via the Planning Round process to ensure the activity is appropriately planned for in 2019/20.

- Referral To Treatment – the CCG had offered non-recurrent funding for the outsourcing of General Surgery and Ophthalmology. This offer had not been taken up due to the complexity of the patients involved which was felt by the CCG to be a legitimate explanation. Additional clinics are being held in some areas of the Trust to reduce waiting lists.

- Dermatology – The CCG had shared its initial analysis, at patient group level, with the Trust relating to activity to be moved to the community versus activity to remain at the Trust. The Trust is required to carry out patient level analysis to validate the assumptions. An external Dermatology Consultant has provided a clinical view on the service assumptions.

  The Trust had been asked to confirm that they were definitely not going to be bidding or intending to be part of a bid. They had responded by stating that they are in discussion with another provider of dermatology services both in terms of interim capacity and support to longer term provider partnership (with RWT as a named sub-contractor) arrangements.

- E-referrals – a productive meeting had been held with the Trust and a list of local exemptions to supplement the national criteria had been agreed. The monitoring of these will be challenging and further work is to be completed to ensure the reconciliation process is not onerous.

Planning round – The Forecast outturn had been completed using 2019/20 tariff prices and will refreshed using Month 10 data once available. The CCG is awaiting a response from the Trust on specialised service changes and QIPP.

The risk/gain share agreement had been discussed and it was felt that the framework agreed for 2018/19 could be carried forward, with a caveat that non-electives are considered and potentially revised (with respect to the introduction of blended payments for emergency activity as part of the tariff changes). The three South Staffordshire CCGs (which currently have their own risk gain share agreement with RWT) had expressed a desire to be aligned with Wolverhampton CCG, as a working principle.

Black Country Partnership Foundation Trust (BCPFT)

Planning Round 2019/20 – The CCG's offer to the Trust included inpatient beds moving to cost and volume and away for the previous block arrangements. The Trust has business cases, yet to be seen by the CCG, for increased investment.

Discussions are on-going in regards to investment into IAPT to help reach the 22% access rate and moving to recovery targets for 2019/20. The Trust has been asked to confirm what can be provided with the current investment.

An internal meeting was to be held and a further meeting with the Trust the following week. The negotiations are at a critical stage and there may be some potential escalation issues.

The cost of Psychiatric Intensive Care Unit beds were discussed including the use of the private sector.

Nuffield

Discussions are on-going as the CCG intends to take out a percentage of MSK activity to align with the commissioned pathway. It was noted this can be done and remain in the envelope of the Long Term Finance Model. This is being considered by the Provider.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

This is a challenging area and had been discussed at the CCG's private Governing Body meeting. A meeting had also taken place between WMAS, Wolverhampton and Dudley CCGs. A letter had been sent to WMAS setting out the CCGs position.

The increase in the funding requested by WMAS is not affordable and the Provider cannot demonstrate that the level of investment it had made is required and had been asked to negotiate to a level that can be evidenced.

A meeting is to be held on 7th March and a response had been requested from the Provider prior to this to frame discussion. The CCGs will seek to either achieve a mutually agreeable contract level to allow extension or, if the CCG is unable to reach agreement, explore the option of re-procurement.

It was noted that other contracting issues are being raised and discussed at the Commissioning Committee.

Concerns regarding the Dermatology Service provided by Concordia were raised and it was confirmed that this had been raised with Mrs Roberts, the CCG's Chief Nurse and Director of Quality. Clarification was given that the current contract ends in November 2019 and that the procurement process was in line with this.

Resolved: The Committee;

- Noted the contents of the report and the actions being undertaken

8. Monthly Performance Report

FP.352 Mr Gallagher presented the key points of the report on behalf of Mr Hastings as follows;

Royal Wolverhampton NHS Trust

- Referral to Treatment Time (RTT) – the Trust is failing to meet the national standard. The Trust had been achieving the national requirement to sustain or reduce RTT waiting list size against the March 2018 baseline; however, for the first time in 2018/19, the list size in December 2018 exceeded this position.

It was noted that there was a significant increase in December and whilst it was acknowledged that this had been affected by patients choosing to wait until post-Christmas to commence treatment, it was queried if this was true year on year. Mr Gallagher agreed to raise this with Mr Hastings to clarify and if this year was significantly different to other years, why this was and what the Trust was going to do to address

this. A Remedial Action Plan to be considered to meet the waiting list size target.

The wording of the first bullet point in this section was considered; 'The Trust's verified performance for December was 90.7% with an average (median) waiting time of 6.8 weeks and 92% patients waiting 19 weeks to start treatment'. It was felt that this needed to be clarified as it was unclear.

- Zero 52 week waiters had been reported by the Trust. The patient waiting over 52 weeks at the Royal Orthopaedic Hospital NHS Foundation Trust (T&O) had been removed from the waiting list.

- A&E – with performance at 92.4% the Trust was not meeting the national standard of 95%, however, it is meeting the monthly PSF trajectory target of 90.2%. It was noted that nationally only 11 acute trusts out of 136 achieved the national standard with RWT ranked at 28th.

- The Statistical Process Charts for 4 hour wait performance was considered as the control limits had a target of 90% and the national target is 95%. Mr Gallagher agreed to raise this with Mr Hastings.

- Cancer – the Trust had achieved the locally agreed recovery trajectory for December. Scrutiny in this area is high. The Trust was originally reporting a recovery trajectory as June 2019, however, is now planning to submit a later date. Discussions are ongoing with the Trust.

- Delayed Transfers of Care – the Trust was performing very well in this area; targets had been achieved for both NHS delays and all delays.

<u>Black Country Partnership Foundation Trust (BCPFT)</u>

- IAPT Performance – the Provider was not meeting target. The CCG is exploring the use of other providers to support access targets. Third party providers had supplied files for upload to the Mental Health Minimum Data Set to support STP performance, however, initial uploads had been declined by the national system due to file errors. This was being investigated to resolve.

<u>Nuffield</u>

- Referral to Treatment – the performance levels of 100% compliance previously reported by the Provider had been challenged by the CCG. December performance had now been confirmed as below target at 87.95% (with the Wolverhampton element at 87.47%).

Resolved: The Committee

- noted the contents of the report

- Mr Gallagher to raise with Mr Hastings the following;
    - Decrease in RTT performance in December
    - Statistical Process Chart control limits

9. Risk Register

FP. 353 Mr McKenzie asked the Committee, as part of the continued advancement of the CCG's risk management process to conduct a review of the committee risk profile with an emphasis on whether each committee risk should either continue to be Treated or the residual level of risk be Tolerated. The aim of this was to identify whether there are any gaps in the controls applied and to ensure the Committee was satisfied that those risks within the profile were appropriately managed or tolerated. The Committee was also asked to consider if any of the risks had been mitigated enough to bring about closure or whether they can de-escalated to be managed as business as usual.

The Committee level risks were considered as follows;

- FP11 – System Pressures – A&E Performance – risk should remain high – risk is continued to be treated

- FP15 – IAPT Access Rate Target (BCPFT) – risk should remain at high - risk is continued to be treated

- FP14 – Transforming Care Partnership – Financial Impact – risk to remain as moderate as going forward allocations are not known – risk is continued to be treated.

- FP05 – Over-Performance of Acute Contract – further review following contract sign off – had been treated by the Risk/Gain Share agreement – risk tolerated.

- FP06 – Over-Performance of Prescribing Budget – EU exit impact and volatility in prescribing to be reflected. , exceeding QIPP target – the Committee was broadly of the view that this risk can be tolerated, however, further detail to support the narrative was required.

- FP04 – Increased Activity at RWT – narrative to be updated, monitoring actions in place to treat – risk tolerated.

- FP02 – Loss of Key Staff and Business Continuity – that had been treated within the Finance Team due to the recruitment of new staff and redistribution of responsibilities – risk tolerated

  (Noted: that this risk is wider than the Finance Team going forward).

- FP07 – CHC Budget – update required from Maxine Danks, Head of Individual Care – risk tolerated

- FP08 – NHS Property Services Charges 2017/18 & 2018/19 – handler to be changed from Maria Tongue to Allan Kay – treated - risk are the same going forward – risk tolerated

It was noted that the NEPTS contract issues are being overseen by the Commissioning Committee. The BCPFT contract negotiations will be logged as a risk if this becomes necessary.

Resolved: The Committee noted;

- The current position of the Committee level risks.

Mr Marshall, Mr Middlemiss and Mr McKenzie left the meeting

10. Budget Paper

FP.354 Mrs Sawrey presented the Committee with the draft financial plan for 2019/20 which adhered to the planning rules and noted that the report highlighted the risks contained within the financial position.

- As required the CCG submitted a 1 year plan, 2019/20, to NHSE in mid-February.
- In January 2019 the CCGs received their allocations for 5 years from 2019/20. It was noted that within the notified allocation for 2019/20 there is a targeted allocation for Ambulance services of £366k. As a consequence the percentage growth remaining for non-targeted services is around 5%.
- The minimum cumulative historic underspend to be 1%
- Mental Health Investment Standard to be delivered (6.7% growth) including the additional 0.7% growth.
- Drawdown only with permission of NHSE
- Removal of the requirement of any portion of the allocation to spend non-recurrently (previously 1% reserve) although NHSE had advised the CCG should maintain 1% underlying surplus and it was felt prudent to do so.
- Technical adjustments to the tariffs set out in the new tariff guidance absorb growth.
- In order to submit a balanced, assured plan for 2019/20 the CCG had included a QIPP programme of £13.5, 3.2% of its allocation. This is an extremely challenging target.
- There are no national uplifts for activity this year

Budgets are currently based on the Month 9 forecast outturn and are being signed off by budget holders. However, it was acknowledged that there may be some movement between Month 9 and Month 12. Any material changes will be reflected and signed off prior to the budgets being uploaded to the ledger.

The CCG had identified risks included within the 2019/20 budgets which total £3.05m. The key risks were as follows:

- £750k relates to potential level of overspend in the Acute Sector, a somewhat lower figure than 18/19 in anticipation of the agreement of an Aligned Incentives contract.
- £500k in relation to the volatility of Mental Health services particularly individual cases and NCAs.
- £500k associated with Prescribing and the volatility within this budget particularly around NCSO and QIPP
- £200k in relation to the uncertainty around Other Programme Services such as NHS Property Services.
- £1.1m potential slippage in QIPP schemes

The CCG had identified mitigations for risks as detailed below

- £1.95m - as in 2018/19 the CCG will utilise all of the Contingency reserve to offset overspends if they arise.
- £1.1m of further efficiency extensions.

It was concluded that the financial plan for 2019/20 met all the planning requirements and can withstand the mitigation of a certain level of risk and that it had been passed by NHSE. However, there are still a number of variables that, without resolution, place undue additional risk on the position that may make it undeliverable. In summary these were;

- Risk associated with continued NSCO costs
- Impact of any EU withdrawal consequences
- Future funding of Transforming Care Partnership (TCP) and the potential impact on the Local Authority
- Changes to the responsible commissioner for Specialised Commissioning portfolio

Mr Gallagher asked the Committee to support the paper, with a view to recommending to the Governing Body to sign off the budgets.

Resolved: The Committee;

- Noted the contents of the report
- Noted the level of financial risk associated with the proposed 2019/20 budgets
- Recommends to the Governing Body that it signs off the budget, noting the inherent risk and supporting the CCG's Executive Team to pursue avenues to close the QIPP gap and therefore reduce financial risk.

11. **Any other Business**

FP.355 There were no items to discuss under any other business.

12. Date and time of next meeting

FP.356 Tuesday 26th March 2019 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

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 ~~had~~ 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
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 5 February 2019 at 2.00pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

Name	Position	Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP (non-voting)	Yes
Dr Manjit Kainth	Locality Chair / GP (non-voting)	No
Dr Salma Reehana	Clinical Chair of the Governing Body (non-voting)	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	Yes (part meeting)
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
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Lesley Sawrey	Deputy Chief Finance Officer	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Jon Denley	Director of Public Heath	Yes
Diane North	PMO Administrator (WCCG – minutes)	Yes

Welcome and Introductions

WPCC443 Ms McKie welcomed attendees to the meeting and introductions took place.

Apologies

WPCC444 Apologies were submitted on behalf of Mr T Gallagher, Mrs L Corrigan and Drs H Hibbs, M Kainth and B Mehta (LMC).

Declarations of Interest

WPCC445 Drs Bush and Reehana declared that as a GP they had a standing interest in all the items relating to primary care.

Dr Bush declared an interest in Item 8a, Minor Surgery as his practice provided this service, however as the item under discussion was to note a virtual decision this did not constitute a conflict of interest.

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.

Mrs Gaytten declared that, as her employment with the University of Wolverhampton involved interaction with GP practices, she had a standing interest in all items relating 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 4 December 2018

WPCC446 The minutes from the meeting held on 4 December 2018 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC447 There were no matters arising from the minutes.

RESOLVED: That the update was noted.

Committee Action Points

WPCC448 **Minute Number WPCC436 – Healthwatch Wolverhampton: GP Communication Report (Action 24).** Discussions on the recommendations continued. An update to be provided at the next meeting.

Minute Number WPCC439 – Enhanced Services (Action 25). The revised service specification was circulated to committee members on 09/01/19. **Action closed.**

Minute Number WPCC439 – Enhanced Services (Action 26). Operational Management Group to provide a process for urgent approvals.

Minute Number WPCC440 – Unprocessed Files associated with Docman (Action 27). Investigations had been undertaken into potential alternatives to Docman however it was noted that none offered equivalent functionality, particularly as Royal Wolverhampton Trust (RWT) had invested in a Docman solution. It was noted that further assurance that the ongoing Docman 10 rollout would resolve the unprocessed files was required.

Minute Number WPCC440 – Unprocessed Files associated with Docman (Action 28). It was confirmed that claims totalling c. £29,000 had been received from practices with the majority of claims now resolved. **Action closed.**

Finance Position – Month 9 Update

WPCC449 Ms Sawrey presented the report on behalf of Mr Gallagher, which gave the committee its regular quarterly update on Primary Care finances. She highlighted that, in response to previous feedback from the committee, the report not only gave details of financial performance in relation to the budgets delegated from NHS England, but also funding from the CCG's own financial allocation used to fund Primary Care services.

Ms Sawrey advised that at Month 9 the delegated budget position was forecasted to breakeven and to meet the required financial metrics set by NHS England, including achieving a 1% level of contingency. She advised that the budget position included an additional uplift of £304,000 to provide for changes in the global sum based on Quarter 3 list sizes across the CCG. She also highlighted the funds available through the Primary Medical Services (PMS) premium. These were planned for investment in additional services in primary care, including in reach into care homes and social prescribing.

Details were also given of funds committed across Primary Care and the impact of additional cost pressures on the prescribing budget, including as a result of no cheaper stock being available. In response to a question, Ms Sawrey advised that a number of factors impacted on this element of the prescribing budget, including the UK's impeding exit from the European Union. It was noted that the table in the report on the prescribing budget had been updated and would be circulated to committee members after the meeting.

Dr Bush referred to the recently announced GP contract for 2019/20 and asked whether the impact of the provisions within it had been modelled. Ms Sawrey advised that, it had not yet been modelled and that the CCG's draft financial plan submitted to NHS England assumed that any additional funding required for Primary Care as a result of the new contractual arrangements would be met from delegated rather than CCG budgets.

RESOLVED:

- **That the revised prescribing information be circulated to Committee members.**
- **That the update on the Month 9 finance position be noted.**

Ms Sawrey left the meeting

Primary Care Operational Management Group Update

WPCC450 Mr Hastings presented the Primary Care Operational Management Group Update, highlighting that matters discussed at the most recent meeting had included: -

- Work to plan for the mobilisation of the Alternative Primary Medical Service (APMS) awarded at the last meeting was now underway. Both the incoming and outgoing providers had engaged with the process and were actively participating.
- The clinical IT system work associated with the APMS mobilisation (which included both a merge and migration) was planned in to ensure resources were committed.
- Discussions had taken place with NHS England around the support provided via the Primary Care Hub. Mr Dhami confirmed that the hub would continue to provide equivalent support to that currently available.
- Work continued to develop options to deliver improvements in Primary Care estates, including in the Bilston and Oxley areas. In response to a question, Mr Hastings confirmed that in line with both ongoing work and the implications of the new GP contract, it was recognised that investment in estates would be required to support hub working across Primary Care networks.
- In response to work undertaken by the Primary Care team to develop a 12 month programme of work, the group would assess the operational requirements to support the implementation of the CCG's Primary Care priorities.

RESOLVED: That the update is noted.

Primary Care Contracting Update

WPCC451 Ms Shelley provided an update on primary care contracting to the committee

The report highlighted that the Quality Outcomes Framework (QOF) Post Payment verification (PPV) process reported to the last meeting of the committee would take place in February. In addition, a PPV would take place in relation to enhanced services, done via tabletop exercise to identify practices that were outliers in relation to the level of claims.

RESOLVED: That the update was noted.

Sally Roberts joined the meeting

Primary Care Strategy Quarterly Assurance Update

WPCC452 Ms Southall presented the report on behalf of Ms Reynolds, giving an update on the implementation of the CCG's Primary Care strategy and GP Forward View (GPFV) programmes of work.

The report included highlights of the work of each of the individual workstreams associated with both the Strategy and GPFV, which Ms Southall advised would be combined into a single Primary Care work programme aligned with STP priorities for 2019/20 onwards. The majority of actions in relation to both programmes of work were either completed or on track. Where a number of actions relating to the GPFV were not on track, the milestone review board had agreed a remedial action plan. This included a number of IT based projects such as online consultations where, although technical solutions had been implemented, work was still required to ensure uptake of the programme was sufficient to demonstrate the benefits in terms of patient access. She also highlighted the following key points:-

- The referral rates for both Social prescribing and the Primary Care Counselling service had been discussed in detail. A number of actions had been agreed with the providers of these services to continue to improve usage rates.
- As reported in the previous update report, a programme of training for administration and reception staff in GP practices on key areas of work had now commenced.
- The Home Visiting pilot service was now underway, with initial feedback on the value of the service very positive.
- Work was underway to consider enhancements to the Quality Outcomes Framework Plus (QOF+) scheme for 2019/20 following successful sign up across practices for 2018/19.
- The service specification for the CCG's clinical peer review scheme was being reviewed to ensure it remained fit for purpose and delivered improvements in outcomes for patients.

An update was also given on initiatives being delivered by practices working at scale across the Primary Care groupings. This included NHS health checks and Mr Denley highlighted the significant improvements achieved in this area with Wolverhampton moving from the bottom 8% in terms of uptake to the top quartile. He paid tribute to the partnership working across public health, primary care and the CCG that had helped to achieve this significant improvement in performance.

In response to a question about the social prescribing service, it was noted that whilst the service did have capacity to manage additional referrals, work would need to be targeted to ensure that they were drawn from appropriate sources. In particular it was noted that referral rates across individual practices remained variable and that, whilst there would be a benefit from increasing referrals from social care, this would need to be carefully managed.

Mr Marshall advised that, in line with the work to align work programmes, a refresh of the Primary Care Strategy itself would be undertaken and brought to

the committee for consideration in April 2019.

RESOLVED:

1) **That the update on the implementation of the Primary Care Strategy be noted.**
2) **That an update to the Primary Care Strategy be considered at the April 2019 committee meetings.**

Primary Care Quality Report

WPCC453 Ms Roberts introduced the report on behalf of Liz Corrigan. The report gave an update on quality improvement across Primary Care, highlighting performance in areas including Infection Prevention, Serious Incidents, Friends and Family uptakes and Care Quality Commission inspections of GP practices.

In response to a question relating to following up patients with flu jabs, raised as a result of patient feedback to Healthwatch, it was confirmed that lessons learned associated with the experience with flu vaccine would be incorporated into planning for 2019/20.

RESOLVED: That the update be noted.

Minor Surgery Enhanced Service

WPCC454 Ms Southall introduced the report on behalf of Lucy Sherlock. The report set out a revised service specification for an enhanced service for minor surgery which had previously been commissioned by NHS England as a Directed Enhanced Service (DES). Due to a change in commissioning arrangements, it was proposed that the service be commissioned as a Local Enhanced Service (LES) by the CCG. The service specification for the LES adopted the same payment arrangements and quality requirements as the DES but also allowed the flexibility for practices to offer this as a service across the primary care groupings as a service at scale.

The Committee noted that, due to urgency, the decision relating to this report had been taken virtually and the service specification had been agreed.

RESOLVED: That the urgent decision to commission a Minor Surgery Local Enhanced Service in line with the outlined service specification be noted.

Pharmacy First Scheme

WPCC455 Ms Southall introduced the report, which set out a proposal to continue commissioning a pharmacy first scheme for minor ailments. The report set out that, following a decision by NHS England to cease commissioning the pharmacy first scheme in 2018 the CCG had commissioned an equivalent service. The report set out the outcomes of a review of the service which gave details of utilisation, demonstrating that access to the scheme was supporting more appropriate use of GP appointments.

It was noted that, in commissioning a local scheme, the CCG had aligned its

arrangements with other CCGs in the Black Country which varied slightly from the service originally commissioned by NHS England.

A query was raised about the financial details given in the report and it was noted that the figures relating to GP consultations were illustrative of the cost that would be better utilised by continuing with the scheme rather than savings that would be realised. This meant that, financially the service was a cost to the CCG with its benefits realised in quality terms as a result of improved access for patients. It was noted that the outlined costs had been accounted for in the Primary Care budget and that any additional work to expand the scheme would incur additional costs.

RESOLVED: That the pharmacy first scheme be re-commissioned for 2019/20

Date of Next Meeting

WPCC456 Tuesday 5 March 2019 at 2.00pm in PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 28th February 2019 commencing at 1.00 pm in the CCG Meeting Room 1, 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	Yes
Sarah Smith	Head of Commissioning - WCC	Yes

In Attendance ~

Alison Lake	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes (Part)
Sarah Fellows	Mental Health Commissioning Manager	Yes (Part)
Susan Eagle	Local Council Commissioner	Yes (Part)
Sharon Nisbet	Deputy Head of Medicines Optimisation	Yes (Part)
Claire Morrissey	Solution and Development Manager	Yes (Part)
Philip Strickland	Governance & Risk Coordinator	Yes (Part)

Apologies for absence

None

Declarations of Interest

CCM775 None.

Minutes

CCM776 The minutes of the last Committee meeting, which took place on 31st January 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM777 None

Committee Action Points

CCM778 None to review.

Contracting Update

CCM779 The Committee was presented with a report update for the period February 2019.

Royal Wolverhampton NHS Trust

Contract Performance (activity and Performance)

The current acute performance shows that the Trust continues to perform below the required contract standards and continues to be an ongoing challenge.

Commissioner Queries

Community Phlebotomy – This service continues to over perform, the provider has been challenged but has not be able to deliver a rational. Rheumatology patients referred into RWT Community and may be contributing to the rise in demand. The planning and contracting round will ensure activity is appropriately planned for 19/20.

Performance Targets

Diagnostics - the Trust has not achieved the target since September 2018 but has shown significant improvement in December 2018. An increase in urgent Gastroscopy and Neurophysiology referrals have impacted on this service and led to an adverse effect on routine waiting times.

Referral to Treatment - There has been a significant decline in December 2018 for this service due to patient referrals being deferred to the New Year.

Cancer - Breast referrals have been steadily increasing by a growth of nearly 20% per week Analysis is being undertaken to identify the reasons behind this high

demand to determine if this is a spike or the 'new norm'

Other Contractual Issues

Dermatology
Work continues project to re-procure the Community Dermatology services. The planned February meeting with the Trust has been deferred to the beginning of March 2019. An external Dermatology consultant is being employed to provide a clinical view on the remainder of the service verses transfer

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

The CCG is investing additional funding in the IAPT service to ensure delivery of the Access and Recovery targets. The Trust is currently in the process of recruiting additional staff and sourcing training.

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. Contact has been made with Birmingham commissioners to compare pricing across the patch. A specific paper will be taken to the private Governing Body meeting in February to provide an update and outline the CCG's options.

Other contracts

AQP Audiology

The contact for this service is due to expire at the end of June 2019 however due to service specification changes being agreed, an extension of 3 months was requested to allow for re-procurement process. The service will continue to be procured collaboratively.

DIEP Flap Breast Reconstruction

UHB Trust has served notice on this service and an alternative provider is currently being sought, a recent benchmarking being undertaken revealed that the price paid for this service is well in excess of the national tariff).

RESOLVED: That the above is noted and approval given for the 3 month extension requested for AQP.

Dementia Strategy

CCM780 The committee was presented with a report on a joint Dementia strategy for Wolverhampton. The collaboration with the Local Authority, Public health and Wolverhampton CCG aims to ensure support to dementia diagnosis, to prevent dementia risk factors and promote community asset-based services. Extensive consultation has taken place with all areas of support to assess patient needs in the development of the strategy.

RESOLVED: The Committee noted the above and approval was given.

Social Prescribing Report

CCM781 The committee was presented with an evaluation report of the pilot scheme launched in 2017. While the non-financial benefits of the service are clear, a request was made that additional research take place to quantify the financial consequences, in particular a reduction in GP demand loads.

RESOLVED: The Committee noted the above, assurance was given and an update due in October 2019

Medicines Optimisation QIPP 2019/20 – Prescribing Incentive Scheme

CCM782 The Committee was presented with a report to approve amendments of the current scheme for continued support to GP practices.
The amendments include the potential of payment based on population within the GP practices catchment area and only on achievement of the scheme.

RESOLVED: The Committee noted the above and approval was given

Health Ageing Co-Ordinator

CCM783 The committee was presented with a report to agree a scheme for patients with frailty. The coordinator will assess the level of the patients by undertaking a health ageing check using an assessment tool and identify the best support to improve their independent living standards and improvement for patient outcomes.

RESOLVED: The Committee noted the above, assurance and approval was given with a request of 6 monthly review to be brought to the committee in October 2019.

Review of Risks

CCM784 The committee was updated on the current risks –

Corporate level risks – are currently undergoing review.

Committee level risks:
Two new risks have been added to the register as agreed by the committee -

CC16 – WMAS contract extension proposal

CC15 – AQP Audiology re procurement

CC11 – BCF a meeting will be held in February outcome to be update at the next meeting.
CC14 – Acute Dermatology provision RWT have confirmed community service will be continued until 30 November 2019.

A new risk process will be introduced on a quarterly basis under the task headings of Tolerate or Treat each risk.

RESOLVED: That the above is noted and agree the new process

Any Other Business

CCM785 The Chair gave thanks on behalf of the committee Sarah Smith of the local Council for her input and expertise throughout her commissioning committee participation and wished her well in her new job.
Andrew Wolverson will be attending the meeting from this date forward.

Date, Time and Venue of Next Meeting

Thursday 28th March 2019 at 1pm in the CCG Meeting Room 1

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NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 13 November 2018 commencing at 4.14pm
In Stephenson 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:

Mr T Gallagher	Chief Finance Officer, WCCG and Walsall CCG
Mr J McLarnon	Manager, External Audit, Grant Thornton
Ms T Putwa	Counter Fraud Manager, PwC
Mr M Stocks	External Audit Partner, Grant Thornton
Ms J Watson	Senior Internal Audit Manager, PwC

Apologies for attendance:

AGC/18/93 Apologies were received from Dr H Hibbs, Dr S Reehana, Ms M Tonge, Mr Mohan, Mr Grayson

Declarations of Interest

AGC/18/94 There were no declarations of interest.

Counter Fraud Progress Report

AGC/18/95 Ms Putwa presented the Counter Fraud Progress Report for information.

The Executive summary gave progress to date and the Committee were advised that a Fraud Risk Group meeting had taken place since the last Audit and Governance Committee Meeting. The Anti-Fraud standard action plan had been discussed at the group.

Mr Cullis asked about the fraud referral received in February 2018 and asked if it was a significant referral. Ms Putwa said that she couldn't say if it was at this stage as they were still waiting to have a conversation with the relevant manager at the Trust. Mr Gallagher advised that he would

need to meet with the Head of Medicines Optimisation to see if this needed to be progressed.

RESOLUTION: The Committee:

- Noted and accepted the report.
- Mr Gallagher to speak with the Head of Medicines Optimisation about the fraud referral received in February 2018.

Minutes of the last meeting held on 31 July 2018

AGC/18/95 The minutes of the last meeting were agreed as a true record.

Matters arising (not on resolution log)

AGC/18/96 There were no matters arising.

Resolution Log

AGC/18/97 The resolution log was discussed as follows;

- Item 126 (AGC/18/80a) – Internal Audit Report – 2017/2018 Primary Care Commissioning – Mr McKenzie to ensure that audit finding reports were taken back to the relevant committees – This had been picked up at the respective meetings. Closed.
- Item 127 – (AGC/18/80b) – Internal Audit Report – 2017/2018 Primary Care Commissioning – Mr McKenzie to ensure that conflicts was highlighted as a top priority at the PCCC – This had been picked up and highlighted and committee members were adhering to the guidance around Declarations of Interest.
- Item 128 – (AGC/18/81) – Internal Audit Charter – Revisions – the Head of Internal Audit opinion was added to the Internal Audit Charter - This had been completed. Closed.
- Item 129 – (AGC/18/83) - Annual Audit Letter – Mr McLarnon to check if there was an internal quality report for Grant Thornton which could be shared with the Committee - Document circulated for information on 25.10.18. Closed.
- Item 130 – (AGC/18/85) - Risk Register Reporting/Board Assurance Framework – Mr McKenzie to report at next Audit and Governance Committee on end dates for risks where appropriate – Mr Oatridge had met with Mr P Maubach and Mr A McIntyre and constructed a template for risk reporting. This would be used if any joint commissioning took place and that this would discussed at the Joint Commissioning Committee. Mr Maubach had asked Mr Oatridge to raise how other CCGs would feel about having a common audit meeting. The group discussed this and felt that at present there was not a need for this.
- Item 131 – (AGC/18/85) - Review of Performance against Whistleblowing Policy - 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 – On agenda.

- Item 132 – (AGC/18/86) - Feedback to and From the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum – Mr Oatridge and Mr McKenzie to liaise and arrange another date for the BCJGF – On agenda.
- Item 133 – (AGC/18/88) - Suspension, Waiver and Breaches of SO/PFPS – Mr Gallagher to bring year on year trend report to next Audit and Governance Committee – On agenda.

Mr Price asked that it was noted that under AGC/18/79 – Internal Audit Report 2017/2018 Governance Arrangements Relating To The Better Care Fund that the report that had been presented at the Health and Wellbeing Board had now been shared with Governing Body Members.

Internal Audit Progress Report

AGC/18/98 Ms Watson presented the Internal Audit Progress Report to the Committee. Ms Watson asked the committee to approve the recommendation to merge Ref 4 - GP Five Year Forward View into Ref 1 - Corporate Governance Primary Care Strategy recommendation. This was accepted by the Committee.

In addition updates were given for:

- Risk Management
- Finance
- Safeguarding
- Quality and Safety
- Information Governance
- Audit Follow Up
- Delegated Commissioning

The Committee were asked to approve the recommendation that PwC use the freed up days from the Information Governance review to complete Delegated Commissioning work. The Committee agreed to this recommendation.

Progress on actions allowed the Committee to see the status of a number of actions. Ms Watson highlighted two actions around Contract Management where further extensions had been requested. Mr Price queried why an extension had been requested again. Mr Gallagher advised that he would speak to the Head of Contracting and Procurement about this. Mr Oatridge and Mr Trigg voiced concerns about leaving unresolved actions.

There were seven overdue actions and not update had been received as at 6 November 2018 on the Wolverhampton CCG Connect site. Mr Price asked Mr Gallagher if he could remind managers to update the action log.

RESOLUTION: The Committee:

- Noted and accepted the report.
- Accepted the recommendation for Ref 4 - GP Five Year Forward View to be merged into Ref 1 - Corporate Governance Primary Care Strategy.
- The Committee approved the recommendation that PwC use the freed up days from the Information Governance review to complete the Delegated Commissioning work.
- Mr Gallagher to speak with the Head of Contracting and Procurement regarding the request for extensions on the actions identified by Internal Audit.
- Mr Gallagher to remind managers to update action log.

Internal Audit Charter

AGC/18/99 Ms Watson presented the Internal Audit Charter to the Committee in response to the action from the last meeting that the Head of Internal Audit opinion was added to the document.

RESOLUTION: The Committee:

- Noted and accepted the report.

Internal Audit of Finance

AGC/18/100 The Internal Audit of Finance document was presented to the Committee. Ms Watson advised that positive comments had been received.

RESOLUTION: The Committee:

- Noted and accepted the report.

Internal Audit of Quality and Safety

AGC/18/101 Ms Watson presented the Internal Audit of Quality and Safety which was received as being positive. There was one low risk and one advisory reported.

Mr Cullis queried if there was a 60 day reporting period for Serious Incidents and if the CCG was within this time frame. Ms Watson said that she would check this. The report would be taken to the Quality and Safety Committee next month.

RESOLUTION: The Committee:

- Noted and accepted the report.
- Ms Watson to check if the CCG were adhering to the 60 day reporting period for Serious Incidents.

Primary Care Internal Audit Framework including Draft Reporting Template

AGC/18/102 The section under item 23 on page of the document highlighted the key areas which were:

- Commissioning and procurement of Primary Medical Services
- Contract Oversight and Management Functions
- Primary Care Finance
- Governance

Mr McKenzie stated that the CCG Governance statement would need to be updated with the information from the Governance section.

RESOLUTION: The Committee:

- Noted the report.

External Audit Progress Report

AGC/18/103 Mr McLarnon presented the External Audit Progress Report to the Committee. Page number 4 headlined the progress to date. It was expected that an audit plan summarising the external audit approach to key risks would be produced in February 2019.

Annual Accounts Workshop dates had been emailed out to staff.

RESOLUTION: The Committee:

- Noted the report.

Governance Statement

AGC/18/104 Mr McKenzie 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 the impact of the role of the STP under the leadership of the Accountable Officer.

Mr Oatridge offered some comments under Governance Arrangements, Risk Management and Management to Excess Treatment Costs.

RESOLUTION: The Committee:

- Noted the report.

Risk Register Reporting/Board Assurance Framework including GBAF and Risk Register

AGC/18/105 Mr McKenzie presented the report on the Risk Register Reporting/Board Assurance Framework.

The Risk Register and Board Assurance Framework in the pack were the latest versions. They had been discussed at the Senior Management Team last month. Risks are being updated and discussed at committees. A table top review had been undertaken by the CCG Governance team.

The risk level for BAF3a had been reduced and details were given of changes in the overall corporate risk profile. It was highlighted that the risk around Governing Body leadership (CR06) remained open as the Governing Body Secondary Care Consultant had recently resigned.

Mr Price said that the culture around risk was changing and that it was being discussed more at Committees.

RESOLUTION: The Committee:

- Noted the report.

Risk Management Progress including Deep Dives

AGC/18/106 This had been discussed with the Senior Management Team and the template which would be used was attached to papers.

Risks had been scored appropriately and one new risk had been identified. There had been discussions around staff capacity challenges.

Mr Gallagher felt that it was a positive step that this had been taken through SMT.

Mr Price asked Internal Audit if they had seen any examples of Executive Directors attending Audit & Governance Committees to discuss risk rather than just at Executive meetings. Ms Watson and Mr Stocks said that it was individual preference.

Mr Oatridge asked if further assurance could be received around staff and especially around staff retention. Mr McKenzie was asked to bring a further update around this.

RESOLUTION: The Committee:

- Noted the report and its recommendations.
- Mr McKenzie to bring back a further update around staff retention.

Whistleblowing Update

AGC/18/107 There had been no issues raised under the Whistleblowing policy.

There had been a previous discussion about disclosures being made by non CCG staff and not having protection. Mr McKenzie gave a brief overview of whistleblowing polices at The Royal Wolverhampton Hospitals Trust and the Black Country Partnership Foundation Trust and also about arrangements in Primary Care. NHS England had introduced a learning package for staff around national developments, assurance aspects and next steps.

Mr Cullis asked if a summarisation of the programme of communications

would be helpful.

Mr Cullis asked if there was a whistleblowing hotline. Mr McKenzie advised that he was the Speak up Guardian and that the policy had all the relevant numbers in there.

The Committee continued to voice their concerns that there were no whistleblowing cases being raised, Mr Gallagher said that the statistics were also similar in Walsall CCG and if they could be reassured that the policy was effective.

RESOLUTION: The Committee:

- Noted the report and accepted the next steps.
- Mr McKenzie to pick up comments given by the Committee.

Mr Trigg left the meeting.

Feedback to and From the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

AGC/18/108 Mr Price highlighted the Governing Body had discussed Cancer Targets and Mortality.

The Black Country Joint Governance Forum had been discussed previously.

RESOLUTION: The Committee:

- Approved the report.

Compliance with Constitution and Principles of Good Governance

AGC/18/109 This item was not discussed.

Losses and Compensation Payments – Quarter 2 2018/2019

AGC/18/110 There were no losses or payments to report.

RESOLUTION: The Committee:

- Noted the above.

Suspension, Waiver and Breaches of SO/PFPS

AGC/18/111 Mr Gallagher noted the below in quarter 2 of 2018/19:

- During quarter 2 of 2017/18 there were 14 invoices in breach of PFPs (5.30% of all invoices paid);
- 17 waivers were raised during quarter 2;
- 32 non-healthcare invoices were paid without a purchase order being raised during quarters 2.
- Assured the Committee that the Finance department liaised with

individuals where invoices were paid without a Purchase Order.

The report requested to show trends against performance last year with regards to non-purchase order was presented to the committee.

Mills and Reeves continued to be retained as the legal provider for the CCG following a look at other potential providers as they provided better value for money.

RESOLUTION: The Committee:

- Noted the above.
- An extra column to be added to the spreadsheet showing value for money where evidence is available.
- Mr Gallagher to look into where people were asking for legal advice and if it is value for money.

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

AGC/18/112 The Committee noted that as at 30 September 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.

Mr Gallagher also highlighted that there were issues around STP recharging as there was not a formal process in place. The CFOs of each CCG were in discussion about this.

The £4.8million from RWT had still not been paid. Mr Stocks said that he would like this to be resolved by 2018/2019.

RESOLUTION: The Committee:

- Noted the above.

Local Security Management Update

AGC/18/113 Mr McKenzie presented the progress report on behalf of Mr Grayson.

RESOLUTION: The Committee:

- Accepted the report.

Any Other Business

AGC/18/114 There were no items to be discussed under this agenda item.

Date and time of next meeting

AGC/18/115 Tuesday 19 February at 11am at Wolverhampton Science Park

Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 8th November 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton 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
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG
Alastair McIntyre – Portfolio Director, Black Country and West Birmingham STP

In Attendance:
Andrew Hood – CSU
Charlotte Harris – Note Taker, NHS England
David Frith – CSU
Jonathan Fellows – Black Country STP Independent Chair
Laura Broster – Director of Communications and Public Insight
Lucy Heath – RightCare, NHS England
Pavinder Bhangu – NHS Leadership Academy, Dudley CCG
Simon McBride – Black Country STP Clinical Lead for Stroke
Wendy Macmillan – Black Country STP Programme Manager, Planning

Apologies:
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. None were declared.

1.4 The minutes of the meeting held on the 11th October were agreed as an accurate record with the exception of a missing action for item 2.5 stating "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." Matthew Hartland confirmed that issues have been identified and this will be updated on at the next meeting.

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 action 102, three dates have been set for the interviews of the chair of the Clinical Leadership Group (CLG). Dr David Hegarty will be attending as part of the panel at two of these. One interview has been completed. The others should be completed by the end of the week commencing 12th November. The CLG was cancelled for November.

2. MATTERS OF COMMON INTEREST

2.1 Place Based Commissioning Update – Dudley MCP Discussion

2.1.1 Paul Maubach presented on the Dudley MCP progression to date. There are significant challenges around disease, changing conditions and increased demand. The place based solution for Dudley was a Multi-speciality Community Provider (MCP). The key issues and agendas were managing demand of long term conditions and the coordination of complex needs, supporting Primary Care, population health management, and the MCP providing a mechanism for addressing ensuring the right services are together. This will involve working as a partnership with a single leadership and organisation being brought together. The Multi-Disciplinary Teams (MDTs) were part of the increased collaboration. Dudley wanted the sole purpose of the organisation to be the integration agenda. For the hospital and MCP there will be 50/50 funding.

2.1.2 The care model for the MCP and its evolution was discussed. The MDTs will move into an Integrated Care Team (ICT) with two per locality or Primary Care Network. This will enable a Dudley wide clinical communications centre to focus on out of hours, handovers and business intelligence. There are a couple of practices that are large enough to have their own ICT. This could be the vehicle to access hospital based services. This is still developing in terms of funding and organisation decision. However, there are some areas in place such as central medicine management. The outcomes framework for GPs that replaces QAF and the outcomes framework for the MCP were outlined.

2.1.3 The MDT impact was reviewed and it was noted there is increased productivity. The links to the voluntary sector is important and should be utilised as there are more complex needs that are not just to do with the person's health. The personalised care planning looks at long term conditions and setting own goals to increase resilience and activation of the patient. There has been a single focus on hypertension where diagnosis has increased and mortality decreased. There has been an impact on the individual patient level with the risk of admission reducing.

2.1.4 Paul Maubach outlined the progress so far around extensive Primary Care access, improved long term conditions management, care coordination, and improved staff and patient engagement. However, there are still 40% of patients being taken to A&E and them being admitted. There is a need to review the workforce model and Primary Care at scale. The Healthy Life Expectancy (HLE) trajectories are progressing in the wrong direction. In regards to recruitment retention, there has been a 16% reduction in GP capacity. This is having an impact on A&E attendance, non-elective admissions, cost, and outpatient departments. This has led to a net increase of 12% in demand.

2.1.5 There is a need to build resilience in Primary Care to reduce the impact on A&E. It was noted, there has been a reduction in practices. The existing practices have absorbed the demand. This could lead to the system collapsing. The solution is to have Primary Care at scale to increase resilience. HLE is declining. There were discussions on an improved Dudley health and wellbeing through advanced population health and wellbeing

management. Projections of this reverse HLE by 5 years. This ambition only comes with Primary Care being at scale. An ambition of Dudley is to have fully integrated care. This will bring together the people working on the same issues with the same population. They can set same outcome objectives and introduce shared population responsibility. There will be incentives and services at scale.

2.1.6 It was noted the commissioning approach is a whole population budget. It is a ten plus five year contract with an outcomes framework. 10% of the contract value will be linked to outcome delivery. The contract obliges the MCP to deliver a national mandated care model. There have been two judicial reviews on the contract, with one still in appeal. The single organisation and single contract will be held account. The CCG will be transferring resources to the MCP and scaling back its nature. There will be risk and gain share with providers.

2.1.7 The services in scope includes; all of general practice, some outpatients at the hospital mainly long term conditions, prescribing budget, public health services commissioned by the council, community services for adults and children, costs in the hospital associated with ambulatory care sensitive conditions, continuing healthcare, mental health and learning disabilities, and adult social care is included in the procurement but the council are going to phase this in. The planned contractual arrangement is the CCG or Council will contract to the MCP. There will be subcontracts to providers from the MCP and an integration agreement with the GP practices. The timetable of the MCP was discussed from the MDTs being developed in August 2014 to the MCP beginning from April 2020. The ISAP checkpoint two and transactional review with NHSI was discussed.

2.1.8 Paul Maubach outlined the other organisational forms that were considered instead of the MCP. The MCP/PACs being a division of Dudley Group FT was declined as the GPs did not support the proposal and it would invalidate the procurement process. The MCP as a joint venture as a Community Interest Company was declined as it would lead to a £3 million VAT liability. The MCP forming from a “vacant” provider was rejected by NHSI due to the time it would mean the organisation being a shell company. Other than repurposing an existing trust, creating the MCP by splitting an existing foundation trust was the only allowable route. One criticism of this is the STP will see the MCP as an additional provider within the Black Country.

2.1.9 The financial arrangements of the MCP were discussed with the MCP receiving £240 million and Primary Care receiving £42 million through an integration agreement. £131 million will be funded to Dudley Group FT. There are discussions around how a risk/gain share agreement between MCP and Dudley Group FT will work. It was noted the MCP fits with the STP strategy as it sets out place based provision. The MCP builds up from practice population with no cross border financial flows. It does not include acute services which might form part of the Black Country acute network. Mental Health and Learning Disability services are in scope but it allows services that will form part of joint Mental Health arrangements to be subcontracted from Mental Health providers.

2.1.10 Andy Williams raised questions around the challenge of managing risk once the MCP is established, the residual providers carrying risk with the gap of demand and resource, and ensuring the MCP success does not negatively impact the trust. Paul Maubach noted the initial set up of restructuring the system reviewed having enough capacity and ability to deliver without destabilising the providers. The balance of direct and subcontracted finances will protect existing providers. There is a need for sophisticated oversight. The current pressures in the system were discussed and the balance of investment in the system needing to stabilise the whole system. Providers collaborating can make a difference with them sharing the risk between them rather than being at the CCG level. Matthew Hartland outlined the new contracting budget for Dudley Group FT and the contracting mechanism in

place. There were discussions on how a shared control total for the acute hospitals could make them stronger as they will come together to resolve issues.

2.1.11 Dr David Hegarty noted that it was not sustainable to continue as is and the risk of having no change. There is a reduction in clinical sessions and availability of workforce. The workforce is also ageing. Individual GPs spending time in MDTs saw benefits as they were caring for patients in a better way and reducing patients continually attending. The ambition is to have the workforce working a bit longer in the system. There were questions raised as to why it required a new organisation to improve GP recruitment and retention. It was noted that GPs were against the MCP/PACs being a division of Dudley Group FT and the GPs did not want to be taken over by the hospital. There is greater resilience in larger practices. There is now one IT system. This can allow appointment sharing and enable people to work a bit longer with different roles being available when needed or wanted. This has increased engagement into Primary Care. Paul Maubach noted the lifespan of a CCG is limited. There needs to be a greater understanding of Primary Care. It is imperative to create an organisation that will have a Primary Care voice as this is not currently adequately represented at scale. Primary Care needs a long term voice in the system. The culture and risk model needs to empower the individual.

2.1.12 Mike Abel questions whether the work on HLE went far enough and whether there needed to be more involvement from wider public services to reduce a boundary around the health system. Prof Nick Harding noted the timescale has meant that other organisations will be able to catch up on progress without facing as much challenges. This could result in a national programme without the need to split up foundation trusts. Jim Oatridge noted the length of time and energy put in to establish the MCP. The timetable for legislative change is shorter than proving the MCP works. There were questions raised whether future legislation can be influenced to facilitate more rapid capability. Paul Maubach informed this will be presented to the Health Select Committee and MPs. The report is currently being finalised.

Action: Paul Maubach to share the report for the Health Select Committee regarding the benefits of legislative change.

2.1.13 Paul Maubach noted it would be beneficial to have endorsement that the MCP is consistent with the wider strategy and there be support as arguments develop around legislative change.

Andrew Hood, David Frith and Simon McBride entered the meeting.

2.2 **Stroke Data Presentation – CSU**

2.2.1 Andrew Hood informed as part of the strategy and programme board, there is a need to improve the services of stroke. There has been a focus on acute and modelling. They have estimated likely changes in demand and reviewed current STP plans. The planned changes are around Thrombectomy centres, Acute Stroke Units and Hyper Acute Stroke Units. For the Black Country, they have planned for the consolidation of Sandwell into the Midland Metropolitan Hospital. They reviewed the baseline, demographics, prevention and efficiency savings to result in final activity, demand and flows. The modelling factors were presented and the impacts of prevention on stroke incidence. The projected changes by the STP were moderate. There were alternative scenarios shown for acute configuration which were modelled as either Midland Metropolitan or Dudley Group. There was a comparison of modelled activity for the scenarios. Alastair McIntyre informed there had been a conversation at the CLG regarding the steer. Kiran Patel has been drafting an email regarding this work.

2.2.2 Prof Nick Harding questioned whether the inputs were correct with the modelling and whether there had been CCG input. There is a need to model the types of stroke going into

hospitals as these have different rehabilitation needs. Due to the demographic area, the information modelled may not be a true reflection. There were questions raised over the drive time percentage to get the first unit to be dealt with and the review of the quality impact. There is data required on the cost and staff driver before a decision can be made. Andrew Hood noted there is parallel work around workforce occurring. This is being led by a Public Health representative. This will include potential impacts but there may be a need for a greater focus. The demographics include population growth not ethic group. Simon McBride noted for the Hyper Acute Stroke Units and rehabilitation has been in imbedded in. Workforce and sustainability in the future is important. There needs to be the right resource and the right time. Technology has progressed and there is a need for stroke consultant expertise.

2.2.3 Dr Salma Reehana noted there is a lot of the prevention aspect being reviewed in the CLG. There is a need to review the community rehabilitation pathway. Andy Williams suggested the need to model the impact of the new configurations on the ambulance services and the relationship between services such as Specialised Commissioning needs to be understood. Dr Helen Hibbs suggested the need to join up with the provider vulnerability and sustainability review. There needs to be clear reasons for a case for change. Dr David Hegarty informed Prof Nick Harding chaired the stoke review for Birmingham and Black Country. The suggestion did not progress due to the capacity issues at University Hospital of Birmingham.

2.2.4 Simon McBride will take these views back to the Stroke Board. The recommendations back to Kiran Patel will be to explore another perspective.

Andrew Hood, David Frith and Simon McBride left the meeting.

2.3 **RightCare Programme**

2.3.1 Lucy Heath presented 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.

2.3.2 Lucy Heath gave an update on the work that the CCGs and STP has done with support from RightCare over the last two years. Lucy Heath has been supporting the CLG and Clinical Strategy. There are working groups for respiratory, cardiovascular disease (CVD) prevention, frailty, MSK, children and young people, and cancer. There has been a suggestion that potential work could be carried out in diabetes. This could come under CVD prevention. Within the Clinical Strategy, there can be chapters added regarding cross cutting pathway components such as IAPT for long tern conditions, personalisation and physical activity. They are looking at tools to gain a wider understanding. This could result in training and business case templates.

2.3.3 Paul Maubach discussed at scale business solutions such as the MCP and whether there is something similar for the acute hospitals. There is a need for at scale intelligence as some services are not delivering to the pathways. There is also a need for live tracking of problems as there is a disservice to patients if they are unaware that problems are arising.

3. FORMAL DELEGATION

3.1 **Transforming Care Partnership (TCP)**

3.1.1 Dr Helen Hibbs gave an update on the TCP work. There has been a lot of work within this area. Numbers are still providing a challenge. There has been acceptance that the number at the end of the programme will not meet the trajectories set; there will be 20 for CCGs not 16 and 35 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. The Black Country has the highest rate of discharges but admissions are still occurring. The Black Country is leading the quality outcomes dashboard. The patients need to have good experiences of care and be better in the community setting. It was noted the judicial review in Walsall should not affect the timeframes.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 There were no comments made.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 It was agreed the December meeting would be used as a Chairs and Accountable Officers development session. Due to board commitments, it was agreed the future meetings would be extended by half an hour, to commence at 09:30 moving forward.

6. DATE OF NEXT MEETING

Thursday 10th January, Boardroom, 2R, Kingston House, 438-450 High Street, West Bromwich, B70 9LD

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.
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
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	
128	8th Nov 2018	Paul Maubach to share the report for the Health Select Committee regarding the benefits of legislative change.	Paul Maubach	

Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 14th February 2019

Members:
Dr Salma Reehana – Chair, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Dr Anand Rischie – Chair, Walsall 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
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG
Alastair McIntyre – Portfolio Director, Black Country and West Birmingham STP

In Attendance:
Charlotte Harris – Note Taker, Black Country and West Birmingham STP

Apologies:
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr David Hegarty – Chair, Dudley CCG
Laura Broster – Director of Communications and Public Insight
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 Salma Reehana asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. It was noted that there would be some conflict of interests for the Accountable Officers due to the papers that were being discussed.

1.4 Matthew Hartland offered some comments on the minutes of the meeting held on the 10th January from Paul Maubach. It was noted that for 2.1.4, there was a difference in the papers going to the Governing Bodies because Andy Williams made a suggested change to the paper after the deadline for papers for Walsall and Dudley CCGs had past. There needed to be additional action added to the action log regarding James Green and Matthew Hartland to review the overall financial flows in and out of the STP; and the potential changes in flows that might arise from significant new services such as MMH; to assess any overall risks that might arise within the STP or for the STP as a whole. It was also noted that for item 3.1, it needed to include the recommendations that were made and the (different) conclusions that were reached and agreed upon the meeting. It was agreed that Dr Helen Hibbs would review this item and amend to reflect this. It was also noted that in item 6, Dr Anand Rischie served

his term for 12 months and Dr Salma Reehana will now be chairing the JCC for the next 12 months.

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 action 091, it was agreed this would be picked up with the Clinical Leadership Group (CLG).

1.7 In regards to action 102, this will be discussed at the CLG but there is not enough information to approve this at the moment. This will be raised at a later date.

1.8 In regards to action 128, the legislative change proposals are now listed in the Long Term Plan.

1.9 In regards to action 130, they are reviewing next year's contract agreements. There will a paper to the March meeting.

1.10 In regards to action 131, Alastair McIntyre and Dr Helen Hibbs have a meeting with the leaders of the Black Country Authorities. It is important to keep dialogue open.

1.11 In regards to action 132, Sarah Shingler has offered to lead a review on a specific piece of work on TCP for children.

1.12 In regards to action 133, James Green distributed a paper on *Black Country Infrastructure Cost 2019/20*. This included additional spend items and the funding going forward including the share between the organisations in the STP. There have been discussions from the Providers as to whether some of the items should be a CCG cost only. Additional costs were highlighted and included; Administration assistant B4, Programme Manager x4 (B 8a/b) and Transformation support Managers x3 (B 8a/b). It would result in £114,867 per organisation of the STP. It was suggested to approach the Providers regarding contribution. It was noted that there may be need for immediate support regarding TCP and Personalisation due to the contracts of staff ceasing in March. It was agreed the Finance Directors will review the detail and this will be presented to the Health Partnership Board on Monday 18 February. It was confirmed this would be cash contributions. It was suggested to add the average cost needed for areas to be driven to greater understand the work being put into the workstreams. There was also a suggestion to review the method of equal shares, or whether capitated or budget based contributions would be more appropriate.

1.13 There was a discussion regarding the length and detail required within the minutes. It was noted that for a formal meeting, evidence behind decision making would need to be include. There was a discussion on how to present the JCC minutes to the Governing Bodies.

Actions:
Alastair McIntyre to discuss with Paul Maubach the comments received regarding the length of the minutes and the level of detail of the discussion required.
Dr Salma Reehana and Alastair McIntyre to discuss whether the full minutes of the meeting or a summary paper should be provided to each Governing Body.

2. CCG TRANSITION BOARD

2.1 The first meeting of the CCG Transition Board is occurring after the JCC meeting. Each Governing Body has received the draft Terms of Reference (TOR) and are supportive of the group. There were some concerns raised regarding the need to bring forward and deliver the option appraisal. It was noted that there is a need to be clear on what the end state will be

and what they are transitioning to, with clear milestones. There were discussions regarding the need for independency such as with the Chair of the group, the Transition Director and getting advice from other economies. There is a need to ensure staff and morale are maintained. There were questions raised regarding the authority of the Transition Board and accountability.

2.2 There were questions raised regarding the consultation of Sandwell & West Birmingham CCG and the impact this may have. In regards to the boundary for Sandwell & West Birmingham, there is an agreed process and it is being reviewed in the context of commissioning as a STP. There will be close engagement with partners. The option appraisal will be viewed in the April Governing Body, with a formal consultation period and a proposition put to vote by the June/July Governing Body. There was a discussion on Primary Care Networks (PCN) being geographically based and the boundary issue it could result in for some practices depending on the decision. It was noted, the Black Country will need to work with the Birmingham and Solihull STP to ensure that Midland Metropolitan Hospital remains sustainable during any changes.

3. CLINICAL LEADERSHIP GROUP UPDATE

3.1 At the CLG meeting on 07 February, there was a discussion on the implications of combining RightCare and Get It Right First Time (GIRFT), a presentation from Anna Lock on the End of Life Working Group, and a review of the Vulnerable Services paper. The output of this will be combined with the previous work completed by Richard Beeken. The schedule of the meetings will change from March to the third Thursday of the month, but will remain at 16:00-18:30. It was agreed the minutes of the meeting could be circulated at the JCC.

4. FORMALLY DELEGATED AREAS

4.1 Transforming Care Partnership

4.1.1 The programme is in red escalation. The National team are noted to be exercised with the performance. At the end of November, the target was to have 20 CCG patients discharged, and 11 Specialised Commissioning patients. However, there are 17 delayed CCG patients with 9 being post programme, and 9 delayed Specialised Commissioning patients with 4 being post programme. There are measures in place including weekly Case Management meetings and reports to the Directors of Nursing. There are weekly calls with NHS England (NHSE) and week by week discharge plans. This programme will continue in the next financial year with standards at CCG level as well as TCP. For Sandwell & West Birmingham, the target will be 7 CCG patients discharged and 7 Specialised Commissioning patients discharged. For the other CCGs, the targets are 4 and 4 respectively. There are 5 Children and Young patients that will be separated out. There is a need to discharge those patients that can be. This programme is important and is the right for the patients.

Action: Dr Helen Hibbs to highlight the individual problematic areas for each CCG to the Accountable Officers for additional support to the Transforming Care Partnership programme.

4.2 Mental Health

4.2.1 This item was deferred until March.

5. RISK REGISTER

5.1 The risk register has had no changes made since January. It was suggested there be a review of the risk rating of TCP in light of the update from Dr Helen Hibbs.

6. MATTERS OF COMMON INTEREST

6.1 Place Based Update – Walsall Together

6.1.1 Matthew Hartland presented on Walsall Together. KPMG has been working on the Business Case for Walsall Together with the draft being sent through the Governing Body. There were some challenges on the clinical model. They are currently going through the NHSE Service Change process. They are not going through an ISAP process. Year one will be implementation, with a hard launch in 2021. Lessons learnt will be shared with Sandwell & West Birmingham.

6.2 Performance and Assurance Return

6.2.1 Alastair McIntyre presented a narrative report alongside the output report from Aristotle. In future, key issues and trends will be highlighted. There are no new issues to report. There are some new requirements on the transformation requirements from NHSE which will be presented at the next meeting.

6.3 West Midlands Quality Review Service

6.3.1 Tim Cooper presented a paper on *West Midlands Quality Review Service Proposal to Black Country and West Birmingham STP 2019/20 Work Programme*. There are different arrangements on how the West Midlands Quality Review Service (WMQRS) is contracted across the Black Country. The WMQRS complete clinical quality assurance and clinical peer reviews. They are improvement focused. The Black Country are the biggest users of clinical peer reviews. They offer an opportunity to learn from each other and improve. A different arrangement was proposed whereby the resources across the STP is pooled through the CLG and there would be 12 credits available for use across the patch.

6.3.2 It was agreed that if this was to be agreed, it would need to be across the STP. It was also noted that this cost was not included in the paper provided in item 1.12. Dr Anand Rischie suggested a two tier approach with there being local credits for local issues and the STP having separate credits.

Action: The Accountable Officers to research the benefits of the West Midlands Quality Review Service proposal and to speak to their clinical nurses to understand the current use of the service.

6.4 SCC Planning Commissioner Update

6.4.1 This item was deferred until March.

7. FEEDBACK FROM GOVERNING BODIES

7.1 This was discussed under item 2.

8. UPDATE FROM STP

8.1 The STP is currently in the Planning round. This will need to be aligned across the STP. The Activity and Finance plans have been submitted. The aggregation of these plans needs to be completed by 19 February. Matthew Hartland noted there needs to be clarity from Sandwell & West Birmingham on repatriation as there is a risk for the provider and the STP control total. Wendy Macmillan is pulling together the submission from individual CCGs.

Action: James Green to share the Activity and Finance plans that have been submitted by the Black Country.

8.2 At the STP Leaders event, there were discussions regarding the misalignment between NHSE and NHS Improvement (NHSI). The senior management team should be confirmed by the end of March. The "agenda for change" staff will be in an interim situation. From April, there should be more alignment between NHSE and NHSI. There were also discussions on the Long Term Plan and the PCNs having a Clinical Accountable Officer around the STP table. There will be a different model of commissioning with strategic commissioning. There will be a maturity matrix for becoming an ICS. It is unclear on the procedure should a STP not meet the criteria of an ICS. There will be monitoring of the transformation programmes and there will be a focus on digital work across the West Midlands. There is a big drive for system working.

9. ITEMS FOR INFORMATION

9.1 Alastair McIntyre discussed the letter from Prof Keith Willett on the EU Exit. There is a workshop in Leicester on 15 February. Feedback will be given post the session. It was confirmed this item is on the agenda at all Governing Bodies. The risk of capacity for the UK was discussed regarding medical treatments increasing from UK citizens living, working or studying abroad.

10. ANY OTHER BUSINESS

10.1 Alastair McIntyre noted a SharePoint form requiring completion for access to the system.

11. DATE OF NEXT MEETING

Thursday 14 March, Boardroom, Walsall CCG, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL

JCC Action Log

No.	Date	Action	Lead	Deadline	Status Update
130	10th Jan 2019	Analysis of differences between each place based arrangements in regards to financial flows with reasoning and any risks this could result in for the STP.	James Green Matthew Hartland		
131	10th Jan 2019	Collaboration work to be completed on the future relationships with Local Authority if there is a move to a single CCG as per the Long Term Plan.	Andy Williams Dr Helen Hibbs Paul Maubach		
133	10th Jan 2019	A presentation of overall financial commitments for the JCC and STP to be delivered.	James Green		
134	10th Jan 2019	James Green and Matthew Hartland to review the overall financial flows in and out of the STP; and the potential changes in flows that might arise from significant new services such as MMH; to assess any overall risks that might arise within the STP or for the STP as a whole.	James Green Matthew Hartland		
138	14th Feb 2019	The Accountable Officers to research the benefits of the West Midlands Quality Review Service proposal and to speak to their clinical nurses to understand the current use of the service.	Andy Williams Dr Helen Hibbs Paul Maubach		
139	14th Feb 2019	James Green to share the Activity and Finance plans that have been submitted by the Black Country.	James Green		
135	14th Feb 2019	Alastair McIntyre to discuss with Paul Maubach the comments received regarding the length of the minutes and the level of detail of the discussion required.	Alastair McIntyre		**Completed**
136	14th Feb 2019	Dr Salma Reehana and Alastair McIntyre to discuss whether the full minutes of the meeting or a summary paper should be provided to each Governing Body.	Dr Salma Reehana Alastair McIntyre		**Completed**
137	14th Feb 2019	Dr Helen Hibbs to highlight the individual problematic areas for each CCG to the Accountable Officers for additional support to the Transforming Care Partnership programme.	Dr Helen Hibbs		**Completed**

Health and Wellbeing Together
Minutes - 23 January 2019

Attendance

Members of the Health and Wellbeing Together

Councillor Roger Lawrence (Chair)	Leader of the Council
Emma Bennett	Director of Children's Services
Brendan Clifford	Service Director - City Health
Tracy Cresswell	Healthwatch Wolverhampton
John Denley	Director of Public Health
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Councillor Hazel Malcolm	Cabinet Member for Public Health and Wellbeing
Steven Marshall	Director of Strategy & Information, Wolverhampton CCG
Linda Sanders	Independent Chair of Adults and Children's Safeguarding Board
Meredith Teasdale	Director of Education
Councillor Wendy Thompson	Conservative Party Leader
David Watts	Director of Adult Services

In Attendance

James Annakin	Principal Public Health Specialist
Lucy Armstrong	Wolverhampton BID
Jennifer Brake	Service Director Strategy and Change
Jo Cadman	Black Country Partnership Foundation Trust
Madeleine Freewood	Development Manager – City Health
Sheila Gill	Healthwatch Wolverhampton
Shelley Humphries	Democratic Services Officer
Tanya Johnson	P3
Lina Martino	Consultant in Public Health
Cheryl Rock	Anti-Social Behaviour Team Leader
Anthony Walker	Homelessness Strategy and External Relationships Manager

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Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**

Apologies for absence were received from Dr Alex Hopkins, Chief Superintendent Andy Beard, Sarah Smith, Tim Johnson, Councillor Paul Sweet, Councillor Jasbir Jaspal, Councillor Sandra Samuels OBE, Dr Helen Hibbs, Lesley Writtle and Jeremy Vanes.

2 **Notification of substitute members**

Jo Cadman attended on behalf of Lesley Writtle.

3 **Declarations of interest**

There were no declarations of interest made.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 17 October 2018 be approved as a correct record and signed by the Chair.

5 **Matters arising**

There were no matters arising from the minutes of the meeting held on 17 October 2018.

6 **Health and Wellbeing Together Forward Plan 2018 - 2019**

Resolved:

That the Forward Plan be noted.

7 **Working Together to End Rough Sleeping**

Madeleine Freewood, Development Manager – City Health, presented the Working Together to End Rough Sleeping report. The report outlined that a multi-agency Task Team, chaired by the Leader, had been established to tackle the issue of individuals sleeping rough in the City and had operated from July 2017. Health and Wellbeing Together had been asked to commit to collaborating with the work undertaken by the Task Team and to have oversight of the Homelessness Prevention Strategy 2018 – 2022.

Anthony Walker, Homelessness Strategy and External Relationships Manager delivered a presentation which provided an update on the aims and achievements of the Task Team and included plans for the next steps and sustainability of the programme.

Focus was drawn to the ‘Day of Action’ event of 8 June 2018 which had involved volunteers and Task Team members providing immediate support to rough sleepers and offering advice to access other available support. This event included an exercise to record the number of individuals sleeping rough in the City.

Tanya Johnson, Service Co-ordinator P3 and Cheryl Rock, Antisocial Behaviour (ASB) Team Leader delivered a summary of the involvement and extensive work of the P3 Charity which included providing emergency accommodation and working with rough sleepers to support them in gaining access to services. Partners were invited to attend further Day of Action exercises and contribute to the work being undertaken.

Lucy Armstrong, Wolverhampton BID provided an introduction to the Alternative Giving Campaign, a charity which assisted in funding services such as P3, emergency accommodation and other support for rough sleepers. It was noted that local businesses had been encouraged to participate and donation boxes had been placed in 19 locations, including the Civic Centre and large stores such as Boots and Sainsbury’s.

It was highlighted that £14,858 had been raised to date and that ways to encourage more businesses to participate were being explored. It was reported that some of the businesses approached, including Jaguar Land Rover, Tarmac and the transport network had shown an interest already.

City Ambassadors had become involved in raising awareness of the Alternative Giving Campaign and its activity in the City Centre. It was noted that there had been instances of individuals bedded down in shop doorways becoming aggressive towards staff opening up in the early morning. It was noted that awareness of who to report to in this situation may help alleviate the problem. It was noted that there were already several trustees for the charity in place who were to meet in early February.

It was reported that a monthly count took place to allow for a better understanding of figures, however accuracy was an issue as the number of people identified as rough sleepers fluctuated throughout the day. This was also affected by the fact that there were several transient individuals as well as entrenched rough sleepers.

The ongoing work was commended as excellent and it was noted that, due to the complexity of the needs of these vulnerable individuals, there was no simple solution to the issue and further commitment from the Authority and partner organisations was needed to tackle it.

Attention was drawn to a number of rough sleepers bedded down in a subway near Bentley Bridge. The advice to partners from P3 was to call the helpline to advise when they were there and an outreach team would be sent to the location to assist.

It was confirmed that case information about individual clients was used by services to enable a person-centred approach to support rough sleepers. This was facilitated by the Public Health-led monthly group.

In relation to safeguarding, the work was commended as a practical and proactive partnership undertaking. It was highlighted that John Denley, Director of Public Health had agreed to contribute to national work on safeguarding and prevention of homelessness. Anthony Walker, Homelessness Strategy and External Relationships Manager was invited to join a Safeguarding Work Committee to share ideas.

A concern was raised regarding individuals discharging themselves from hospital over the weekend where services and medication had potentially limited availability. It was noted that P3 had a hospital discharge team to provide support. It was added that there was a Council link within New Cross Hospital to assist with these issues.

The work was again praised by Councillors and it was agreed that the final Homelessness Prevention Strategy 2018 – 2022 report would be provided at a future Health and Wellbeing Together meeting.

Resolved:

1. That the progress and achievements of the Leader's Tackling Rough Sleeping multi-agency Task Team be noted.
2. That the recommendations for the Leader's Tackling Rough Sleeping multi-agency Task Team's 'next steps' be agreed.
3. That a commitment to collectively tackling rough sleeping through a partnership model be agreed.

4. That the final Homelessness Prevention Strategy 2018 – 2022 report would be provided at a future Health and Wellbeing Together meeting.

8 **Healthwatch Deaf and Hard of Hearing Report**

Tracy Cresswell, Wolverhampton Healthwatch presented the Healthwatch Deaf and Hard of Hearing report. The report outlined that a consultation had been conducted to ensure that the deaf and hard of hearing community could share their experiences of health and social care services and provide feedback on improving access.

It was outlined that the attached appendix, Access to Health and Social Care Services for Deaf and Hard of Hearing People in Wolverhampton, had been compiled in conjunction with the University of Wolverhampton and went into detail about the experiences of British Sign Language users (BSL) both deaf and hard of hearing, from which a set of responses was published. Comprehensive case studies had been included to inform decisions for improvements.

The report had been shared with the deaf and hard of hearing community through the Deaf-led charity Zebra Access in September 2018 and had been met with a positive response. It was noted that the community had welcomed the fact that their feelings and suggestions had been taken into consideration.
Health and Wellbeing Together were asked to support the following:

- To encourage the Clinical Commissioning Group (CCG), City of Wolverhampton Council (CWC) and Royal Wolverhampton Trust (RWT) to deliver deaf awareness training to their staff.
- To continue to include deaf and hard of hearing users in commissioning BSL interpreters.
- To only use one provider of BSL interpreters as the current use of three different providers had caused confusion.

David Watts, Director of Adult Services stated that the opportunity to be involved was welcomed, although it was suggested that earlier involvement of the Council may have been beneficial. This was not to diminish the content of the report, which was particularly good, however a joint strategic approach was usually favourable.

It was also noted that, following the consultation, communication cards had been introduced to offer to individuals accessing health and care services. The cards identified the service user as deaf or hard of hearing and included a list of preferred forms of communication to be used by healthcare professionals. The cards had been funded by the Authority and were reported as working well.

Resolved:

1. That the responses to the consultation be supported by Health and Wellbeing Together.
2. That the Clinical Commissioning Group, City of Wolverhampton Council and Royal Wolverhampton Trust be encouraged to have deaf awareness training delivered to their staff.
3. That deaf and hard of hearing users would continue to be included in the commissioning of interpreters.
4. That only one provider of interpreters be commissioned across CCG, CWC and RWT.

9 **Consultation Feedback and Joint Health and Wellbeing Strategy 2018-2023**

James Annakin, Principal Public Health Specialist delivered the presentation on the Consultation Feedback for the Joint Health and Wellbeing Strategy. The presentation covered the seven priorities as outlined in the Joint Health and Wellbeing Strategy 2018 – 2023, the outcomes under each priority identified in the consultation and the proposed 'Future Focus' commitments asked of Health and Wellbeing Together.

The results of the consultation had shown that the majority of participants had supported the approach presented in the strategy.

The survey conducted as part of the consultation had also asked participants what would help them lead happier, healthier lives. 1,230 people had taken part and their responses identified the key themes as:

1. Feeling Safe
2. Green Spaces, Clean Air and Good Housing
3. Rewarding Work, Good Mental Health and Less Stress
4. Eat Well, Exercise More and Social Life
5. Easy Access to Health Services

The outcomes from the public consultation were weighed against the outcomes from the Health and Wellbeing Together self-assessment undertaken at the meeting of 17 October 2018 and provided insight into what other issues could be addressed. The Future Focus of Health and Wellbeing Together statements for each priority had been based on the issues raised in the public consultation responses.

Resolved:

1. That the Joint Health and Wellbeing Strategy 2018 – 2023 be approved.
2. That the findings of the public consultation be noted.

10 **Joint Public Mental Health and Wellbeing Strategy for Wolverhampton**

Lina Martino, Consultant in Public Health presented the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton. The report outlined the aims and scope of the Strategy which had been developed in close collaboration by City of Wolverhampton Council and Wolverhampton Clinical Commissioning Group (CCG) led by Sarah Fellows. The report stressed the importance of mental health as being equal to physical mental health and that each had a fundamental effect on the other.

It was noted that the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton had been approved by Cabinet on 12 December 2018 and had been brought to Health and Wellbeing Together for approval and for the Full Board to consider its role in the implementation of the Strategy.
It was added that the Strategy had been submitted to the Wolverhampton CCG governing body and fully endorsed.

The collaboration was commended by Councillor Hazel Malcolm as excellent and it was anticipated that the implementation of the Strategy would greatly improve quality of life.

Resolved:

That the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton be approved.

11 **Autism Strategy Progress Report**

Robert Hart, Head of Inclusion Support presented the Autism Strategy Progress Report. The Board was advised that the Autism Strategy was halfway through its life and had needed refreshing. The report outlined progress in all areas achieved during the delivery of the strategy to date. It proposed a new focus on three key themes; promoting awareness and understanding; developing service pathways; and promoting independence. It also included proposals for new governance arrangements for the oversight of the Autism Strategy.

It was noted that the strategy had been developed jointly with Wolverhampton Clinical Commissioning Group (CCG) and City of Wolverhampton Council, involving input from people with autism, their families, carers and other stakeholders.

Three organisations had been highlighted to work with the National Autistic Society towards achieving Autism Friendly Organisation status:

- City of Wolverhampton Council
- Royal Wolverhampton Hospital Trust
- University of Wolverhampton

This would include offering co-ordinated awareness training for employees and developing a network of 'Autism Champions' to promote awareness and understanding throughout the City. It was noted that renewed focus was on the City of Wolverhampton achieving Autism Friendly City status.

The review and improvement of post-diagnostic support was also highlighted as a priority and work was being undertaken to ensure that people with autism could be supported to live an independent life. This would include ensuring a smooth and effective transition to adulthood and support in seeking employment.

It was explained that an Autism Partnership Board had been established which was to meet on a quarterly basis to provide oversight of the strategy. David Watts, Director of Adult Services had been identified as Chair. Three strategy implementation groups had been also been developed to focus on each of the three key themes, which were to feed back into the Autism Partnership Board.

Another key aim of the strategy was identified as providing effective support. It was to be explored how many people with autism were receiving support and how many more could be helped. A support group had been established for parents of autistic children and, as part of the Talent Match scheme, a young person had successfully secured funding to establish their own support programme in April 2019.

It was also noted that the strategy was due to be subject to a Scrutiny review in March 2019.

Resolved:

1. That the proposals for the refresh of the Autism Strategy be approved.
2. That the proposed governance arrangements for the Autism Strategy be approved.

12 **City of Wolverhampton Council Plan 2019 - 2024 Consultation**

Jennifer Brake, Service Director Strategy and Change delivered a presentation on the City of Wolverhampton Council Plan 2019 – 2024 Consultation. It was stated that the plan set out the priorities and framework for the next five years and was intended

to supersede the existing Corporate Plan 2016 - 2019. It was highlighted that the focus was on delivering improved outcomes for the City whilst continuing to deliver the expected savings.

It was reported that engagement had taken place over the last six months including face to face sessions and online surveys, during which over 3,000 people had supplied their views. There had been organisational development with Council employees and the it was reported that Tim Johnson, Managing Director had participated in ward walks.

The six key priorities of the Plan were outlined as:

1. Children and Young People Get the Best Possible Start in Life
2. More good Jobs and Investment in Our City
3. Well Skilled People Working in an Inclusive Economy
4. Better Homes for All
5. Strong, Resilient and Healthy Communities
6. A Vibrant, Green City that We Can Be Proud Of

It was highlighted that it was important to recognise the City's diverse culture and cohesion whilst improving the City's reputation. It was noted that maintaining a realistic approach considering the financial position, managing expectations and honesty about what the Council aimed to do were also of key importance.

It was highlighted that collaboration was key and it was requested that the delivery of the outcomes be aligned with the work of the Board and that members support the aims of the Strategy. It was agreed that a copy of the draft City of Wolverhampton Council Plan was to be circulated to all members following the 25 January 2019 meeting and any feedback could be provided outside of the meeting.

The Council Plan 2019 – 2024 was to be reviewed at C3 Scrutiny Board on 6 February 2019, followed by approval by Cabinet in March 2019 and Council in April 2019.

Resolved:

1. That the City of Wolverhampton Council Plan 2019 – 2024 Consultation be noted.
2. That Health and Wellbeing Together members provide feedback on the draft City of Wolverhampton Council Plan.

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