NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 10 September 2019 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

A G E N D A

		1	Apologies for absence		
		2	Declarations of Interest		
		3	Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body held on 9 July 2019		1 - 10
		4	Matters arising from the minutes		
		5	Committee Action Points ~ there are no actions		
		6	Chief Officer Report	Dr H Hibbs	11 - 16
			I***tems for Decision***		
		7	Governing Body Vacancy	Mr P McKenzie	17 - 22
		8	Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration - Outline Case for Change	Ms S Liggins/ Ms L Broster	23 - 34
		9	Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration - Communications and Engagement Plan	Ms L Broster/Ms S Liggins	35 - 62
		10	Community Model for Learning Disabilities in the Black Country	Ms S Roberts	63 - 194
		11	Integrated Care Alliance (ICA) Progress	Ms A Smith/Ms K Evans	195 - 226
			Items for Assurance		
		12	Better Care Fund Quarterly report	Ms A Smith	227 - 236

		13	Sustainability Transformation Plan (STP) Planning	Dr H Hibbs	237 - 264
		14	Board Assurance Framework and Risk Register	Mr P McKenzie	265 - 278
			Committee Reports		
		15	Commissioning Committee	Dr M Kainth	279 - 286
		16	Quality and Safety Committee	Ms S Roberts	287 - 312
		17	Finance and Performance Committee	Mr T Gallagher	313 - 356
		18	Audit and Governance Committee	Mr P Price	357 - 362
		19	Remuneration Committee	Mr P Price	363 - 366
		20	Primary Care Commissioning Committee	Ms S McKie	367 - 374
		21	Communication and Engagement update	Ms S McKie	375 - 382
			Items for Information		
		22	Workforce Race Equality Standard (WRES)		383 - 400
		23	Minutes of the Quality and Safety Committee		401 - 432
		24	Minutes of the Finance and Performance Committee		433 - 444
		25	Minutes of the Primary Care Commissioning Committee		445 - 450
		26	Minutes of the Commissioning Committee		451 - 458
		27	Minutes of the Audit and Governance Committee		459 - 466
		28	Black Country and West Birmingham Joint Commissioning Committee minutes		467 - 486
		29	Any Other Business		
		30	Members of the Public/Press to address any questions to the Governing Body		

			Date and time of next meeting ~ Tuesday 12 November 2019		

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 9 July 2019
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~	
Ms S McKie	Chair
Clinical	
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 J Green	Joint Chief Finance Officer for Sandwell/Wolverhampton CCG
Mr M Hastings	Director of Operations
Dr H Hibbs	Chief Officer
Mr S Marshall	Director of Strategy and Transformation
Lay Members/Consultant	
Mr J Oatridge	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member

In Attendance	
Ms K Garbutt	Business Operations Officer
Ms Y Higgins	Deputy Chief Nurse (Part)
Ms K Kaur-Wilson	Black Country Partnership Foundation Trust (Observer)
Mr P McKenzie	Corporate Operations Manager

Apologies for absence

Apologies were received from Ms S Roberts, Dr D Bush, Mr D Watts, Mr J Denley, Mr P Price and Ms S Gill.

Ms S McKie introduced Ms Kuli Kaur-Wilson to the meeting as an observer.

Declarations of Interest

WCCG.2406 There were no declarations of interest declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body

WCCG.2407 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group (WCCG) Governing Body meetings held on the 14 and 21 May 2019 be approved as correct records.

Matters arising from the Minutes

WCCG.2408 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2409 There were no Committee Actions

RESOLVED: That the above is noted.

Chief Officer Report

WCCG.2410 Dr H Hibbs presented the report. She pointed out that the Black Country and West Birmingham Sustainability and Transformation Plan (STP) and the Birmingham and Solihull STP held a Board to Board meeting to look at areas of common interest and the potential to collaborate in the future.

The Clinical Commissioning Group (CCG) has six Primary Care Networks set up as per national guidance and timescales. Clinical directors have been appointed.

Dr Hibbs stated that the Integrated Care Alliance (ICA) Development is continuing to progress well on plans on delivery around Frailty, Palliative and End of Life Care.

Cancer performance nationally remains an issue with headline news reporting on the situation across the UK. The recovery actions that we have been implementing at the Royal Wolverhampton Trust (RWT) have made inroads into improving performance. A request has gone to

providers across the Black Country to allow RWT and Wolverhampton CCG to implement a targeted referral diversion to improve waiting times for patients. This involves giving patients information on waiting times so that they can make an informed choice. Good collaborative work is taking place between Wolverhampton, Walsall and Dudley Trusts and the CCGs.

On the 11 June 2019 we formally launched our STP wide specialist Perinatal Mental Health service. The service actually started last year with transformation money won in April 2018 and is recurrently funded through the CCG baselines this year. This service is valued by mothers and families.

RESOLVED: That the above is noted.

Commissioning Committee

WCCG.2411 Dr Kainth presented the May report. He pointed out the Committee was presented with a report for assurance regarding continuation of the Elective Care Transformation Programme 2019/20. It is a collaborative programme across the STP footprint. Approval was given at the Committee.

The Committee was presented with the Glaucoma Referral Refinement service specification following the approval of the business case in January 2019. Approval was given at the Committee.

Dr Kainth referred to the June report and pointed out the performance targets. The Referral to Treatment (RTT) for April 2019 was missed. RWT have moved to an electronic referral system, due to technical issues RWT has put in place a manual system to ensure information for each patient is entered onto the system on a daily basis. Improvement is required regarding achievement of the cancer target particularly Breast Cancer referrals. Although demand has been increasing, the recent audit has demonstrated that this is in line with national profiles.

Mr J Oatridge referred to the Non-Emergency Patient Transport Service (NEPTS) procurement process. Compliant tenders were due by the 28 June 2019 and asked if these had been received. Mr S Marshall confirmed tenders had been received for this procurement.

Dr Hibbs pointed out that Acorn Children's Hospice is not closed, however if they do not receive additional resource they will need to. This is very important and pressing issue and discussions are ongoing across the Black Country regarding providing different funding and a different way of working on this.

Ms McKie mentioned that she was helping with surveys on peoples' experience of health services in Bilston recently. She had a few queries from patients how they obtain patient transport. Dr J Parkes stated that patients book this themselves through the telephone number provided.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2412

Dr R Rajcholan presented the report. She pointed out performance of all cancer targets at RWT remains significantly challenged with further deterioration of all cancer targets except 31 day sub-treatment surgery and anti-cancer drug. RWT is supporting the 28 day faster diagnosis pathway, all breast referrals now go through the "one stop clinic appointment" whereby patients are seen by a consultant and have diagnostic testing performed on the same day.

RWT is currently reporting one of the highest Standardised Hospital Mortality Index (SHMI) in the country. The SHMI for January 2018 to December 2018 is 1.2083, which is a very slight decrease on the previous 1.21. The SHMI is rated red and the banding still remains higher than expected.

Dr Hibbs referred to the harm reviews which continue for patients treated at 104 plus days on a cancer pathway and asked if there had been any patient harm. Ms Y Higgins reported there has been one gynecology patient which has been reported as a serious incident. Dr Hibbs also asked about sepsis and emphasised that it is a big national concern and requires further assurance and asked if there has been any improvement.

Dr R Gulati pointed out a declaration of interest as her husband is employed by RWT and left the meeting.

Ms Higgins reported 100% of patients receive antibiotics within one hour and this is focused on A&E. Sepsis is currently not flagging as a mortality outlier but progress is still going well.

Dr M Kainth referred to the mortality rates over the last 5 years and asked if the outcomes are worse. Dr Hibbs stated that there is no excess mortality according to the evidence we have.

Dr J Parkes referred to a Never event which had been downgraded to a serious incident. Ms Higgins reported this was for a dental extraction and the local was given on the incorrect side. This did not meet the never event report therefore it will be treated as a serious incident in order for a full investigation can take place.

Dr Rajcholan pointed out the 2 additional documents enclosed with the report regarding Black Country Child Death Overview Panel and Safeguarding Children and Young People in Wolverhampton.

Ms Higgins left
Dr Gulati returned to the meeting

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2413 Mr T Gallagher presented the report. He referred to the table on page 78 of the report detailing the year to date position against key financial performance indicators. This position takes account of an additional £3.15m of additional surplus as required by NHS England/Improvement. Across the Black Country this is disproportionate and the CCG is working with the other CCGs across the Black Country to ensure Wolverhampton is not significantly disadvantaged.via a Black Country Risk share arrangement.

Mr Gallagher referred to the Quality, Innovation Productivity and Prevention (QIPP) Programme Delivery Board information on page 79 of the report. The CCG is reporting achieving its QIPP target. The key points to note are the submitted finance plan prior to the request to increase the in year surplus required a QIPP of £13.536m or 3.5% of allocation.

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 1% recurrent surplus as shown in the table on page 80 of the report.

Mr Gallagher referred to Risk and Mitigation on page 93. The CCG was required to resubmit a plan which demonstrates £6.3m risk which currently is fully mitigated based on the assumption that the Black Country Risk share agreement will be enacted. He added that we are on target to meet the key financial metrics. There is some over performance with RWT especially around elective work, however this should be manageable.

Mr Gallagher pointed out the table on page 87. The CCG is currently reviewing the way in which performance is reported to the Finance and Performance Committee in the short term interim period the performance report will focus on the CCG's performance against the NHS Constitutional Standards as detailed in the table. All the reds are around cancer,

previously mentioned. In addition Referral to Treatment (RTT) standards are also proving challenging at the current time.

Dr Hibbs expressed her concern regarding RTT and pointed out the cancer problem and ophthalmology. Currently a piece of work is being undertaken around ophthalmology. Dr Gulati pointed out there is also a considerable wait around gynecology referrals.

Mr Oatridge referred to the revisions to the Scheme of Delegation and asked if we need a formal resolution to this. The Board agreed to this.

RESOLVED: That the Scheme of Delegation was agreed.

Audit and Governance Committee

WCCG.2414 Mr L Trigg gave a brief overview of the report. He referred to the Internal Audit Annual report 2018/19. The internal audit team confirmed that following the completion of audit work the opinion Audit Option given to the CCG was "satisfactory", the highest rating of assurance provided. The rating of satisfactory was rarely given and the CCG was commended on this.

The Head of Financial Resources presented the final accounts with the changes that had been made. The changes were approved and the Chair recommended the signing off of the accounts at the Governing Body meeting.

RESOLVED: That the above is noted

Remuneration Committee

WCCG.2415 Mr McKenzie stated the report gives details of the issues discussed and decisions made at the meeting of the Remuneration Committee on the 18 June 2019. Mr Oatridge pointed out that a Remuneration meeting has taken place across the Black County and a helpful discussion took place.

RESOLVED: That the above is noted.

Primary Care Commissioning Committee

WCCG.2416 Ms McKie presented the report. She pointed out the spirometry Service. Currently the service is purchased from RWT. The Committee approved to the service to be taken forward at Primary Care networks level subject to a revised business case being presented at the July 2019 meeting following a review of the costing model.

Currently the Primary Care Commissioning Committee meets monthly. Discussions are taking place for these meeting to be bi-monthly, no meeting will take place in August and this will be reviewed.

Dr Hibbs pointed out the proposed closure of Tettenhall GP practice in Wood Road. The proposed closure would potentially affect 4,000 people registered at the branch. A signed petition is being submitted to the House of Commons by Wolverhampton MP Eleanor Smith. A public meeting is scheduled to take place on the 11 July 2019 Dr Hibbs and Mr Marshall will be attending. This will be reported at the next Governing Body meeting in September. A discussion took place.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2417

Ms McKie referred to the report. She highlighted section 4 Patient and Public views. Residents in Wolverhampton are being asked "What Matters to You?" when it comes to local healthcare services. Ms McKie stated that were not too many negative comments received when she was in Bilston, however patients highlighted their struggles to obtain appointments with their practices. Ms H Ryan stated a lot of feedback has been received within her practice. She added that it would be valuable to consider marketing the different clinical roles within practices in order for patients to be more aware.

A Perinatal Mental Health workshop took place on the 24 June 2019. The event gathered views from local mums and their families to understand and improve user experience for women experiencing any kind of mental, psychological or emotional ill health during or after pregnancy. Mr Hastings added that the contents of this are being reviewed.

Dr Hibbs stated that the Long Term Plan and Implementation framework have been received and our Sustainability Transformation Plan (STP) response needs to be submitted by November. A report will be brought to the Governing Body in September. Dudley Healthwatch are leading a piece of work on public response to the Long Term Plan and will be presenting at the STP Board meeting in July.

Dr Hibbs pointed out the Annual General Meeting is scheduled to take place on Wednesday 18 September 2019 at the Molineux, Wolverhampton.

RESOLVED: That the above is noted.

Dementia Strategy Implementation Plan

WCCG.2418 RESOLVED: That the report is noted.

Minutes of the Quality and Safety Committee

WCCG.2419 RESOLVED: That the above minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2420 RESOLVED: That the above minutes are noted

Minutes of the Primary Care Commissioning Committee

WCCG.2421 RESOLVED: That the above minutes are noted

Minutes of the Commissioning Committee

WCCG.2422 RESOLVED: That the above minutes are noted

Minutes of the Audit and Governance Committee

WCCG.2423 RESOLVED: That the above minutes are noted

Black Country and West Birmingham Joint Commissioning Committee Minutes

WCCG.2424 RESOLVED: That the above minutes are noted

Minutes of the Health and Wellbeing Board

WCCG.2425 RESOLVED: That the above minutes are noted

Any Other Business

WCCG.2426 RESOLVED: That the above is noted.

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

WCCG.2427 There were no public or press present at the meeting.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2428 The Board noted that the next meeting was due to be held on **Tuesday 10 September 2019** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.10 pm

Chair..……..

Date ……

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
10 September 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 Sustainability and Transformation Plan (STP) Planning

2.1.1 The Black Country & West Birmingham STP is working to deliver both the 'Strategic Planning Tool' (combined finance, activity and workforce plan for STP) and the STP 5-year plan (the STP's response to the NHS Long Term Plan). The draft narrative is currently under development with each organisation contributing to and collaborating on the plan. Each CCG will be seeking the views of patients and the public during September, along with working with local authority partners to present to Health and Wellbeing Boards in September/October. This should ensure that while the plan is being developed at an STP level it is being locally owned. The final draft of the plan will go to Governing Bodies during November 2019, with a launch and publication date by the end of November 2019.

2.2 STP Assurance

2.2.1 The STP Stocktake meeting took place on Friday 30 August 2019. Discussions were held regarding performance, finances and the development programme of the STP as it moves to become an Integrated Care System.

2.3 Collaborative Commissioning

2.3.1 The Joint Commissioning Committee of the CCGs continues to meet and has an overview of the Transforming Care Programme and the Mental Health programme of work with a particular focus on new resource that has been attracted into the Black Country and West Birmingham to enhance mental health services.

2.4 Single Accountable Officer Recruitment

2.4.1 In July 2019 each of the Black Country and West Birmingham CCG's Governing Bodies (Sandwell and West Birmingham CCG, Dudley CCG, Wolverhampton CCG, Walsall CCG) received a paper seeking to progress the appointment of a single Accountable Officer in preparation for the possible progression to a single commissioning voice from April 2021. This role is currently being advertised via NHS jobs and additionally via HSJ jobs. The closing date for the advert is the 9th September 2019. The interviews have been scheduled for the 25th September 2019 at the Science Park in Wolverhampton. A full assessment day has been arranged. The planned assessment day includes inviting stakeholders, staff representative and patient representatives from across the Black Country and West Birmingham to take part in the recruitment process.

Once the successful candidate is appointed they will be invited to meet with the staff from across the Black County and West Birmingham to introduce themselves and discuss the plans for the integration of staff into one management structure for the region.

2.5 **CQC RWT**

2.5.1 Following the use of resources CQC review, the Care Quality Commission (CQC) is currently conducting an inspection of The Royal Wolverhampton NHS Trust. During the inspection various clinical areas have been visited over the past three weeks, including Critical Care, Out Patient Departments, Paediatrics and Maternity, Medicine and ED. Focus groups, with staff on a variety of sites, have also been undertaken. Following the inspection initial feedback will be provided to the Trust, prior to the formal feedback which will be checked for factual accuracy. The CCG are not aware that any immediate issues have been highlighted to the Trust. A well led review is also planned for mid- end of September with the trust.

2.6 **Annual General Meeting**

2.6.1 The Wolverhampton CCG Annual General Meeting is due to take place on Wednesday 18 September 2019 at 12.30pm at the Molineux in Wolverhampton.

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:	**28 August 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**	**21/06/19**

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NHS
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WOLVERHAMPTON CCG

GOVERNING BODY
10 SEPTEMBER 2019

Agenda item 7

TITLE OF REPORT:	Governing Body Vacancy
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	A vacancy has arisen due to Dr Parkes resignation from the Governing Body and the Governing Body is responsible for determining whether to fill it via a by-election.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:3	• Dr Julian Parkes has resigned from his position on the Governing Body following his retirement as a GP. • This creates a vacancy in the elected GP positions on the Governing Body, for Vertically Integrated Practices • The Governing Body is responsible for determining whether to fill the vacancy.
RECOMMENDATION:	That the vacant position on the Governing Body is filled by a by-election for a GP from the Vertically integrated practices.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Continuing to meet our statutory duties and Responsibilities</u> The CCG is required to have a Governing Body constituted in line with statutory requirements and the CCG's constitution

1. BACKGROUND AND CURRENT SITUATION

1.1. The membership of the CCG's Governing Body includes six positions for GPs from member practices, drawn from the clinical groups operating across the CCG. The places were allocated based on the size of the groups at the time of the last election.

1.2. Dr Julian Parkes, who was elected by the vertical integration group, resigned from the Governing Body in July following his retirement as a GP. The Governing Body is responsible for deciding whether to fill the vacancy via a by-election.

2. BY-ELECTION

2.1. The structure of the elected membership of the Governing Body is intended to ensure that the different working arrangements in Primary Care are reflected in the clinical membership. In line with the CCG's constitution, any vacancy that arises and subsequently filled by a by-election is filled until the end of the usual term of office, which would be until October 2020.

2.2. Whilst the context of primary care groupings has changed since the structure was developed it is not considered viable to review the overall allocation of places to individual groups. This means that if a by-election is held, it should be to elect a new GP member from a vertically integrated practice to ensure continuity of inclusion. Failing to fill the vacancy would also mean the overall number of GPs on the Governing Body was reduced, impacting on both clinical input and quoracy requirements. On this basis, the Governing Body are recommended to hold a by-election.

2.3. Any by-election to fill the vacancy would be open to all GPs working within the Vertically integrated practices to stand and vote in. If the Governing Body agrees to proceed with the by-election this will be undertaken by the Corporate Operations Manager and overseen by the Local Medical Committee in line with the CCGs constitution.

2.4. The outline timetable for the election would be as follows:-

- **Declaration of Election** – 11 September
- **Nominations Close** – 18 September
- **Polls open (if required)** – 23 September
- **Polls Close** – 4 October

2.5. It is suggested that, given there are already difficulties managing the conflicts of interest associated with GPs from vertically integrated practices being employees of Royal Wolverhampton Trust, any GPs with leadership roles within the Vertically

Integrated Primary Care Network should be excluded from standing on the grounds that this additional conflict will be too significant to manage effectively.

3. CLINICAL VIEW

3.1. The Local Medical Committee have been approached to support the by-election process.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

5.1. If the Governing Body is not fully constituted there is a risk that there will not be sufficient clinical input. There is also an increased risk that meetings will not be quorate. Holding a by-election mitigates these risks.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. There are no financial implications associated with this report. The by-election will be conducted within existing resources and the Governing Body place is funded.

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. The by-election will be conducted in line with the provisions of the CCG's Constitution.

Other Implications

6.5. There are no other implications arising from this report.

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

RELEVANT BACKGROUND PAPERS

CCG Constitution

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	Dr Mehta – LMC Chair	14/08/19
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	Report Author	
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 McKenzie**	

NHS
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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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Black Country and West Birmingham Governing Bodies
10 September 2019

Agenda item 8

TITLE OF REPORT:	**Outline Case for Change** Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration.
AUTHOR(s) OF REPORT:	Sharon Liggins
SENIOR RESPONSIBLE OFFICER:	Accountable Officers
PROGRAMME MANAGER:	Deborah Rossi
PURPOSE OF REPORT:	As part of the journey towards a strategic commissioner, the Black Country and West Birmingham CCGs need to formally consider the options for continued collaborative work or merging. This paper sets out the options considered by the Black Country and West Birmingham Joint Commissioning Committee and the Transition Board.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance** ☐ **Information**
KEY POINTS:	• The NHS Long Term Plan indicates NHS England's preference to have one commissioner for each Integrated Care System (ICS). • This paper outlines an initial case for change in order to seek Governing Body support for stakeholder engagement and the development of a full case for change which will be required for any formal application to merger the CCGs.
RECOMMENDATION:	Governing Bodies are asked to: 1. Note the contents of the report and support the BCWB JCC and the Transition Boards recommendation to formally explore the option to merge Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG CCGs. 2. Give approval to seek views of stakeholders. 3. Note the timeline outlined in section 4.4 is high level and a detailed programme plan will be developed. 4. Mandate the CCG Transitional Board to provide oversight of the consultation, development of the full case for change and the development of the merger application.

KEY IMPLICATIONS:	• Risk – a number of high level risks have been identified, • Finance – there is opportunities to achieve greater commissioner efficiency • Quality – there is greater opportunity to achieve system level improvements • Patient and Public Involvement – engagement activities are outlined • Equality and Inclusion – a full impact assessment is required • Legal - to be confirmed • HR & Organisational Development
CONFLICTS OF INTEREST MANAGEMENT:	All Governing Body members are directly conflicted.
LINK TO TRIPLE AIM OPPORTUNITIES WITHIN THE BLACK COUNTRYSTP CLINICAL STRATEGY	
1. Better Health	Consistent system level commissioning leadership, and local level integrated care. – resulting in effective population health priorities and local delivery/management.
2. Better Care	Consistent system level commissioning leadership, planning and approach to quality. Focussed on local delivery/management via local integrated care models.
3. Better Value	System and local control totals. Greater efficiency of running costs, increase in frontline care and improved quality.

Outline Case for Change
8th August 2019

Black Country and West Birmingham Clinical Commissioning Groups
Merger or Continued Collaboration

1 Introduction

1.1 The current Sustainability and Transformation Partnerships (STPs) will evolve into Integrated Care Systems (ICSs) by April 2021. By such time, NHS organisations will be expected not only to provide high-quality care and financial stewardship for their individual organisation, but also to take on responsibility for wider system objectives in relation to the use of NHS resources and population health.

1.2 The NHS Long Term Plan sets out how system level collaboration will benefit patients whilst also helping to address the challenges facing NHS, these include:

- More joined-up and coordinated care by breaking down traditional barriers between care institutions, teams and funding streams, so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care.

- Being more proactive in the services it provides, supplemented by a move to 'population health management', using predictive prevention (linked to new opportunities for tailored screening, case finding and early diagnosis) to better support people to stay healthy and avoid illness complications.

- Being more able to differentiate the support offered to individuals, to make further progress on prevention and on inequalities reduction. Being more responsive to population diversity. Providing the right support, to people of all ages who can and want to take more control of how they manage their physical and mental wellbeing.

1.3 ICSs are seen as the vehicle for bringing together system leadership and organisations in order to redesign care and improve population health. Together ICS leaders will create shared leadership and action to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Whilst delivering rigorous and disciplined financial management across all NHS organisations.

1.4 Clinical Commissioning Groups will continue to play a prominent role within the future ICSs. The NHS Long Term Plan confirms the direction of travel for CCG configurations:

"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically

involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation".

1.5 STPs are increasingly the conduit by which NHS England communicates, seek assurance and release new funding into health care systems. Significantly, individual CCGs are no longer required to produce individual planning submissions (where there are multiple CCGs in the same STP), instead STPs are collating and submitting system plans currently in the form of the Long Term Plan

1.6 As members of the Black Country and West Birmingham STP; Dudley CCG, Walsall CCG, Wolverhampton CCG, and Sandwell and West Birmingham CCG have been working closely together through the Black Country and West Birmingham Joint Commissioning Committee (BCWB JCC) and specific system level work programmes, such as, the development of the STP primary care strategy, the delivery of the local maternity system plan, the development of the joint clinical strategy, the mental health and the transforming care programmes.

1.7 As the CCGs plan for the implementation phase of the Long Term Plan the need to work collaboratively becomes even more apparent.

1.8 As a natural progression the CCGs have recently agreed the appointment of a single Accountable Officer and where it will add value, the development of committees "in common".

1.9 As part of the journey towards a strategic commissioning voice for the Black Country and West Birmingham, the CCGs need to formally consider the options, benefits and dis-benefits associated with either continuing to work collaboratively or formally merging.

2 Options

2.1 The Black Country and West Birmingham Joint Commissioning Committee (BCWB JCC) and the CCG Transition Board have considered a range of options for how the four CCGs can work together in the future. The options are outlined in table 1 below;

Table 1 **Developing a Single Commissioner Voice.**

Option	Description	Points Considered
1	No change to current status: Individual CCGs retaining Governing Bodies with separate management and governance structures. BCWB JCC formed with no	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • Sustaining four CCGs, requires sustaining four administrative processes - Governing Bodies, Committee Structures and Directorate Structures etc. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees "in common".

	delegated authority and no joint commissioning decisions	• The new Accountable Officer will need to design an operational structure that will enable them to deliver their duties in the most effective and efficient way, this may include a review of the executive team structure. • The BCWB JCC currently has limited delegation for mental health and learning disabilities, but it oversees the commissioner involvement and the required commissioner actions to support the STP work streams. • The majority of decisions for shared programmes continue to be made by the individual CCG governing bodies; this requires shared papers to be presented to four governing bodies. There remains a risk that one or more CCGs may disagree with at BCWB JCC recommendation, resulting in a protracted decision making and delays in implementation. • The CCGs are duplicating clinical and managerial leadership for a range of work streams. • Increasingly the CCGs are working together but pace has been slow and there are differences in individual CCG approach. • The BCWB JCC would continue to support the development of local models taking into account local partnership and aspirations.
2	Black Country and West Birmingham Joint Commissioning Committee with delegated responsibilities and decisions making at a system level. CCGs retain their individual management teams and structure.	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”. • The new Accountable Officer will need to design an operational structure that will enable them to deliver their duties in the most effective and efficient way, this may include a review of the executive team structure. • The BCWB JCC could have delegated duties for the CCGs statutory commissioning duties but some areas cannot be double delegated i.e. primary care. • The CCGs would need to continue to resource the membership and functioning of the 4 Governing Bodies and associated subcommittees. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM. • The BCWB JCC would continue to support the development of local models taking into account local partnership and aspirations.
3	Form a shared Executive Management Team but Not a Joint Committee i.e. each CCG maintains separate governance structures	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”. • This option would involve dissolving the current BCWB JCC. Without the BCWB JCC the CCGs would find it difficult to co-ordinate shared decision making and agree shared system communication.
4	Joint Committee with delegated responsibilities from all CCGs with a shared Senior Management Team.	• The NHS Long Term Plan clearly articulates the aspiration to have one commissioner for the STP/ICS. • The CCGs have agreed the appointment of a single Accountable Officer and are actively exploring the formation of committees “in common”.

	Each CCG would retain their individual governance and sub-committees	• The BCWB JCC could have delegated duties for the CCGs statutory commissioning duties but some areas cannot be double delegated i.e. primary care. • The CCGs would need to continue to resource the membership and functioning of the 4 Governing Bodies and associated subcommittees. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM.
5	Form a Federation – continue with separate CCG's but establish shared management team, governance and decision making.	• Forming a Federation may or not be legally possible • This option would provide some system efficiencies but each CCG would be required to resource the membership and functioning of the 4 Governing Bodies. • The CCGs would continue to consume the resources required to manage the accounts of the organisation, including holding an annual AGM.
6	Full Merger of all CCGs and Creation of Single Black Country and West Birmingham CCG able to maintain 'Place/Localities' •	• One CCG would deliver the aspiration of the NHS Long Term Plan to ideally have one CCG per ICS. • One CCG would reduce running costs – infrastructure, workforce, leadership, administration, procurement etc. • One CCG would have the authority to deploy resources in the most efficient way to achieve the required equality, quality and performance. • The new CCG would need to sustain and deliver the local commitment to developing the four locality integrated care models and the partnerships with the five local authorities. • One CCG would be able to effectively and efficiently deploy resources across local and strategic (at scale) commissioning portfolios. • Reducing running costs in this way will allow maximum resource to be spent on front line patient care • The cost of resourcing the development of the case for change and the management of the transition will be offset by the longer term efficiencies.
7	Merger of Dudley CCG & Walsall CCG - variation of Option 6- merge the two CCG's who currently share AO and CFO	• The CCGs have agreed a single AO for the four CCGs.

3 Financial Consideration

3.1 CCGs are facing a requirement to reduce their running costs by 20% from 2020/21 which for the Black Country is a consolidated reduction of £3.5m compared to the historic level of expenditure incurred. It will not be possible to discharge the commissioning duties in the same manner with 20% less resource.

3.2 Governing Bodies have already taken a decision to appoint a single Accountable Officer, who will at some point consider a consolidation of the four senior executive teams. This would contribute some financial benefit towards the running cost reduction. However as there would remain four individual organisations, each requiring a separate Governing Body and most likely

separate teams to discharge commissioning duties, the majority of the benefit would be derived from consolidating the executive structure only. A broad estimate would be 60% of the existing cost of the four separate executive teams (this is dependent upon the actual structure developed).

3.3 A merger into a single CCG would offer additional cost saving opportunities:-

- A single executive team – similar estimate of 60%
- A single Governing Body – estimated 60% of existing governing body costs, allowing for increased volume of lay representation and clinical input (compared to existing individual CCG governing body roles)
- Merged operational teams – An estimated 15% cost saving compared to existing structures as the opportunity to carry out functions once for the whole Black Country would be greater than it would be if four individual organisations remain
- Support service contracts – There will be opportunities to reduce the costs associated with some support functions (i.e. CSU services).
- Premises costs – Whilst it is likely that each 'Place' will require a local presence, a merged CCG would likely consolidate into a single headquarters and operate smaller satellite offices in each place; the size of which would most likely be substantially smaller

3.4 Whilst a detailed plan to value the actual cost savings that would accrue from a merged CCG will need to be developed, the above opportunities are likely to deliver significant cost and operational efficiencies in order to address the required 20% reduction to running costs.

4 Exploring the opportunity

4.1 Over the last few months the executive teams of all four CCGs (at BCWB JCC Development Days and the CCG Transition Board meetings) have reached a consensus that option 6 would provide the CCGs with the best opportunity to improve commissioning efficiency and deliver the single commissioner voice for the future Black Country and West Birmingham ICS.

4.2 Having reached a consensus, it is important that this view is tested with a wide range of stakeholders before the CCGs considers formally consulting and compiling a full case for change submission to NHS England.

4.3 In addition to the clinical commissioning benefits identified above, there are a number of benefits that will be felt either directly or indirectly by patients, local people, GPs, other clinicians, health and care partners, such as alignment of harmonisation of treatment policies, equality of clinical pathways across providers, improved access for patients, better shared capacity and a locality up approach to strategic planning in the future ICS.

4.4 It is believed that a merger into a single statutory commissioning organisation that values the five distinct local communities (West Birmingham, Dudley, Sandwell, Walsall and Wolverhampton) each with their own unique histories,

strengths, challenges and approach to integration will provide the following benefits;

a. **Better healthcare and health outcomes**: The current CCGs are all rated good or outstanding, combined in one organisation the expertise will be used to ensure the new CCG continues to be managed efficiently and effectively – delivering demonstrable improvements in quality and performance, with a focus on local integration and a strategic focus on improving health outcomes and addressing health inequalities.

b. **Better use of human resource:** Merging the four CCGs into one will provide the CCG clinical and managerial leadership the opportunity to deploy human resources in an efficient and effective way, reducing duplication , thereby providing the opportunity to direct expertise towards tackling both local and strategic priorities.

c. **Greater support for transformation and local innovation:** Merging the CCGs provides the environment for scaling-up the most successful local clinical innovations to rapidly share best practice across a wider area. It provides additional buying power and resources.

d. **Provides additional investment for frontline care:** Having a single organisation would eliminate the duplication of running costs and enable the CCG to better invest in healthcare and addressing inequalities.

e. **A consistent commissioner voice:** Merging the CCGs will provide a stronger, single and more consistent commissioning vision, leadership, voice and approach within the Black Country and West Birmingham ICS. Clinical commissioning leadership will have a greater impact, with consistent decision-making and more clinical efficiency at a system-level, as well as within the locality Primary Care Networks (PCNs) and locality ICPs.

f. **Wider benefits:** Merging the CCGs will deliver additional benefits;
- Greater level of clinical leadership and a better opportunity to balance the demands of frontline care, IPC and PCN development.
- Greater buying power with the ability to deliver better value for money.
- Better opportunity to attract, afford and retain staff with the right talent and skills.
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care.
- Making it easier for health and care partners in the ICS to engage and work with clinical commissioners.
- Improved affordable therefore making it more likely to be sustainable in the longer-term.
- It would enable system level standardisation where clinically indicated.
- It would improve system decision making.

4.5 The new CCG would continue to focus dedicated support towards the development of PCNs and ICPs in each of the localities. Over time, the remit of the CCG will change, giving PCNs and ICPs in each place the opportunity to

lead local service development and transformation in partnership with local authorities. The locality PCNs and ICPs will have partnership relationships with key stakeholders; voluntary sector, local authorities.

4.6 As a member of the ICS, the CCG will be able to implement a single, cohesive strategy, accompanied by speedier decision-making, thereby enhancing the pace at which transformation can be achieved.

4.7 The new CCG would continue to be an active member of local Health and Wellbeing Boards and support the aspiration to improve outcomes for local people. The locality CCG teams will work closely with local authorities to deliver shared programmes and meet statutory duties to work in partnership. Local authorities will also continue to have a lead partnership role within the ICS.

4.8 The CCG would continue to meet its statutory duties to effectively engage, consult and co-produce with patients and the public via an engagement model that supported both strategic and locality level engagement. At some point in the future, it is envisaged that the ICPs will lead the majority of local engagement and co-design.

4.9 The CCGs need to engage with patients, their carers, their communities, members of the public, CCG General Practice members and wider stakeholders regarding the potential merger of the CCGs. The outputs and insights gained from the engagement will be included in a full case for change which will be submitted to Governing Bodies in due course. Should the CCGs decide to submit an application to merger with NHS England, the full case for change and the outputs of the engagement will be required.

5 NHS England Requirements

5.1 When applying to merge CCGs are required to provide the following evidence to NHS England:

- Signatures of the existing CCG Accountable Officer(s) and a declaration that the decision to apply for merger is made in accordance with each of the existing CCGs' governance arrangements.
- The proposed new CCG name (to comply with the CCG Regulations 2012 (3) to (6).
- Map(s) and population details; reference to current health outcomes and health inequalities.
- Reference to the PSED (Public Sector Equality Duty) impact assessment for the proposed new CCG.
- The reasons for the application (to comply with the CCG Regulations 2012 10 (4)) and an outline description of benefits of merger, including the impact on the registered and resident population of the new CCG, the impact on STP/ICS partners and any other significant partner organisations.
- Summary of joint working to date, including joint appointments, committees in common, lead commissioner arrangements, etc.

- Confirmation of Governing Body support for the merger from each of the existing CCGs.
- Reference to the merger communications and engagement plan, including confirmation of engagement of the relevant local authorities, the membership of the existing CCGs and local Healthwatch and consideration of their feedback
- Financial position (current and high-level forecast)
- Reference to current status regarding delegated authority for primary medical care services
- Desirable – as an appendix: joint letter of support from STP leaders for the merger.
- A high level HR/OD strategy for the new CCG
- Procurement plan for key support services.
- Clinical commissioning strategy/population health management plan.
- The new CCG Engagement Strategy/Plan

5.2 To deliver the above requirements, a significant amount of work will need to be undertaken and the CCGs will need to ensure the sufficient resource is available.

5.3 The CCG Transitional Board would be ideally placed to oversee the development of the full case for change and the associated transition plan (as outlined in section 5.1).

5.4 The following milestones would need to be achieved in order to meet the NHS England merger application deadline for an April 2021 launch.

September	Governing Bodies, support the recommendation to pursue a formal merger of Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG. Give approval to seek views of stakeholders (separate paper). Mandate the CCG Transitional Board to continue to oversee the delivery of the engagement plan and the requirements outlined in 5.1.
September	Engagement Teams commence pre engagement period, 4 public events, a survey to stakeholders and 4 members events, presentations to Healthwatch, Scrutiny Committees and Governing Bodies including sharing the full engagement plan. Transition Director commences EQIA and Quality Impact Assessment process.
November	Governing bodies receive progress paper, outlining the result of the pre-engagement exercise and the proposed formal consultation documents.
December	Formal consultation for 6 weeks period.

February	Governing Bodies receive the analysis of consultation and impact assessments and full chase for change. Commence GP Member ballot (based on individual CCG constitution).
March	Report to Governing Bodies.
March/May	Collation of the evidence for formal merger application.
May	Governing Bodies sign off the formal application. Application submitted to NHSE.

6 Risk and Mitigation

6.1 The capture and management of risks will be a fundamental component of the full business case development and the subsequent transition planning process. Risks will be reported and managed in accordance with CCG policy. The following table identifies high level risks;

Table 2 **Risks and Mitigation**

Risk	Mitigation
NHS West Midlands may not agree with the new CCG footprint	Ensure the full case for change clearly articulates the patient flows within the Black Country and West Birmingham STP/ICS, identifying the benefits to wider regeneration and economic stability of the health and care system.
Partners may not support the argument for the merger of the four CCGs	Clearly articulate the continued role and leadership of localities. Clearly set out the case for change, complete a pre-engagement phase to ascertain the views of partners/stakeholders and the potential questions that will need answering. Design the consultation phase to address the concerns and questions of partners and wider stakeholders.
Higher than expected attrition of staff due to uncertainty and/or the potential reduction in workforce due to efficiencies and organisational restructure	A robust and transparent engagement and communication plan. An organisational development plan to support staff during transition phase. A plan to sustain corporate memory.

7 Recommendation

Governing Bodies are asked to:

1. Note the contents of the report and support the BCWB JCC and the Transition Boards recommendation to formally explore the option to merge Dudley CCG, Walsall CCG, Wolverhampton CCG, Sandwell and West Birmingham CCG CCGs.

2. Give approval to seek initial views of stakeholders prior to full consultation.

3. Note the timeline outlined in section 4.4 is high level and a detailed programme plan will be developed.

4. Mandate the CCG Transitional Board to provide oversight of the consultation, development of the full case for change and the development of the merger application.

Black Country and West Birmingham Governing Bodies
10 September 2019

Agenda item 9

TITLE OF REPORT:	**Communications & Engagement Plan** Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration.
AUTHOR(s) OF REPORT:	Laura Broster
SENIOR RESPONSIBLE OFFICER:	Accountable Officers
PROGRAMME MANAGER:	Deborah Rossi
PURPOSE OF REPORT:	As part of the journey towards a strategic commissioner, the Black Country and West Birmingham CCGs have agreed to seek the views of stakeholders on the options for continued collaborative work or merging. This paper sets out the communications and engagement plan for this, along with the key messages proposed for the listening period in October.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance** ☐ **Information**
KEY POINTS:	• The plan details the steps we will take to ensure stakeholders have opportunity to influence our proposals for a strategic commissioner • There are draft key messages which we hope to use in a listening exercise during October to further inform this plan • The question we are hoping to explore with stakeholders is, **'if we move to a single CCG what would good look like?'** • The Governing Bodies of the 4 CCGs want to hear stakeholder views to inform a formal consultation process • The feedback given during the listening period will go to CCG Governing Bodies in November • A decision will then be taken as to whether to proceed to formal consultation on any proposal to merge the 4 CCGs
RECOMMENDATION:	Governing Bodies are asked to: 1. Endorse the Communications and Engagement plan 2. Give approval to seek views of stakeholders using the key messages in appendix 4 of the plan
KEY IMPLICATIONS:	• Risk – a number of high level risks have been identified, • Finance – there is opportunities to achieve greater commissioner efficiency • Quality – there is greater opportunity to achieve system level

	improvements • Patient and Public Involvement – engagement activities are outlined • Equality and Inclusion – a full impact assessment is required • Legal - to be confirmed • HR & Organisational Development
CONFLICTS OF INTEREST MANAGEMENT:	All Governing Body members are directly conflicted.
LINK TO TRIPLE AIM OPPORTUNITIES WITHIN THE BLACK COUNTRYSTP CLINICAL STRATEGY	
1. Better Health	Consistent system level commissioning leadership, and local level integrated care. – resulting in effective population health priorities and local delivery/management.
2. Better Care	Consistent system level commissioning leadership, planning and approach to quality. Focussed on local delivery/management via local integrated care models.
3. Better Value	System and local control totals. Greater efficiency of running costs, increase in frontline care and improved quality.

Communications & Engagement Plan

The Future of NHS Commissioning in Black Country and West Birmingham

1. Introduction

This document sets out the process of communication and engagement (including consultation) to support the work of the Black Country and West Birmingham Transition Board.

2. Background

There are four Clinical Commissioning Groups (CCGs) in The Black Country and West Birmingham:

- NHS Dudley CCG
- NHS Sandwell and West Birmingham CCG
- NHS Walsall CCG
- NHS Wolverhampton CCG

The four CCGs have been working increasingly closer together over the last few years, and there are now arrangements in place to appoint a shared Accountable Officer.

There is an increased need for aligned working across the Black Country and West Birmingham to enable effective decision making, eliminate duplication and deliver 20% savings on running costs (not affecting clinical services) by April 2020.

The recently published NHS Long Term Plan clearly sets out the vision of consolidated commissioning arrangements by having a single commissioning voice per STP/ ICS footprint, supporting the development of a fully operational Integrated Care System within the next 2 years.

Several options have so far been considered by a Transition Board, made up of representatives from each CCG Governing Body. They were as follows:

- Option 1
  No change to current status – Individual SMT and Governing Bodies with separate management and governance structures maintained, JCC formed with no delegated authority and no joint commissioning decisions
- Option 2
  Joint Committee with Delegated responsibilities and decisions taken at a Black Country/West Birmingham level with individual management teams remaining in place i.e. each Governing Body delegate's decision making to the Joint Committee
- Option 3
  Form a shared Executive Management Team but Not a Joint Committee i.e. each CCG maintains separate governance structures
- Option 4
  Joint Committee with delegated responsibilities from all CCGs with a shared Executive Management Team, individual governance and sub-committees
- Option 5
  Form a Federation – continue with separate CCG's but establish shared management team, governance and decision making.
- Option 6

Full Merger of all CCGs and Creation of Single Black Country CCG able to maintain 'Place/Localities'

- Option 7
  Merger of Dudley CCG & Walsall CCG - variation of Option 6- merge the two CCG's who currently share AO and CFO

There has been an options appraisal by the Transition Board. There is consensus from those discussions that the option 6 for a single CCG by April 2021 was the preferred option at this stage with a phased approach of option 5 by April 2020.

This preferred option would build on existing and planned aligned working while also minimising the period of change and provide needed clarity for staff, partners and other stakeholders. It would enable a two-step change with more aligned ways of working, becoming a single team from April 2020 and a single CCG by April 2021.

The next steps are to further explore the views of staff, GP members and wider stakeholders as part of a listening exercise. Then, further to agreement from the Governing Bodies, a formal consultation would commence in the new year (Jan 2020) along with a GP Member Ballot in the New Year. To support this process, an equalities analysis will be conducted in order to identify any potential disproportionately affected protected groups.

3. Regulatory and Legal Context

The *NHS Long Term Plan*[1] describes how the commissioning environment will continue to evolve and it is in this context that CCGs will operate in future.

The NHS Long Term Plan sets out an intention for Integrated Care Systems (ICSs) to cover the whole country by April 2021. It states that: *'Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level… CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.'*

It goes on to say that by 2020/21, individual CCG running cost allowances will be 20% lower in real terms than in 2017/18 and CCGs may therefore wish to explore the efficiency opportunities of merging with neighbouring CCGs.

The latest NHS England Guidance[2] states that the existing CCGs must demonstrate how the merger would be in the best interests of the population which the new CCG would cover. The guidance details the steps which CCGs would need to take if they were considering a formal merger of CCGs. These include evidence of the following for any application process:

- the extent to which the CCG has sought the views of the following, what those views are, and how the CCG has taken them into account:
  - any unitary local authority and/or upper tier county council whose area covers the whole or any part of the CCG's area;
  - any other CCG which would be affected; and

[1] NHS Long Term Plan, NHS England, January 2019

[2] Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution, NHS England, April 2019

    - any other person or body which in the CCG's view might be affected by the variation requested
- the extent to which the CCG has sought the views of patients and the public; what those views are; and how the CCG has taken them into account;
- the existing CCGs must demonstrate in their application that they have effectively consulted with the relevant local authority(ies) regarding the proposed merger, record what the local authority(ies)' views are, and what the CCGs' observations on those views are.
- Evidence is required that each of the existing CCGs have engaged with, and seriously considered the views of, their GP member practices, and local Healthwatch, in relation to the merger.

Each CCG Constitution sets out the arrangements for seeking the views of GP Members in any decision of this nature including whether a vote is required.

It is also clear that there are many other stakeholders who would have an interest in any CCG constitutional change of this nature. These are mapped in appendix 1.

Section 14Z2 of the Health and Social Care Act 2012, places a requirement on CCGs to ensure stakeholder involvement in commissioning processes and decisions.

Additionally, as ultimately this decision is for NHSE, under section 13Q of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has a statutory duty to 'make arrangements' to involve the public in commissioning services for NHS patients.

It is important to bear in mind that this is not a significant service change and so it could be argued that there is no need to formally consult. However, it is clear that in terms of the evidence required by NHSE in any application process that a more formalised arrangement for seeking views is required. It is also important to note that as other areas considering similar changes have set a precedent and arguably a legitimate expectation with formal consultations, the benefits of doing so outweigh the reasons for not doing so. It is therefore proposed that CCGs undertake pre engagement, a period of formal consultation and a GP Member Ballot.

This plan sets out arrangements for that.

4. Objectives

Based on the situation outlined above, and communications and engagement best practices, the key communication and engagement priorities are:

- To communicate the case for any change across the Black Country and West Birmingham
- To seek views of stakeholders on any proposal before decisions are made to ensure all factors have been considered
- To understand what the barriers / unforeseen consequences may be that would need to be considered
- Engaging local stakeholders to build a vision for the future, ensuring that they are involved in decision making; and
- Adherence to legal duties and to follow the Gunning Principles:
    1. To seek views when proposals are still at a formative stage
    2. To give sufficient reasons for proposals to permit 'intelligent consideration'
    3. To allow adequate time for consideration and response
    4. Views expressed must be conscientiously taken into account

5. Key messages and narrative

The guiding principle of our messaging will be straightforward dialogue, that isn't too simplistic, patronising or defensive; promoting respect and recognition to our audiences.

Knowledge and insight gained from pre-consultation engagement (listening exercise) with our identified audiences must be used to shape key messages in the consultation materials that will follow.

The key messages and narrative in the pre-consultation engagement phase are set out in Appendix 5.

Several materials will be produced as part of the public consultation (should the Board agree to proceed). These will include a full consultation document, as well as supporting materials, which will raise awareness of the consultation and encourage people to take part. Full and final messaging will be determined following the pre consultation phase.

6. Staff Engagement

Ensuring our staff have an equal opportunity to contribute the listening exercise and the formal consultation is key. This will be achieved through the collective efforts of HR/OD and Communication colleagues. The principle of no surprises for staff will be followed wherever possible. If there is a risk that news if decisions is leaked in one place or via media every effort will be made to ensure staff get a message in advance of any media.

We will maximise the use of exiting channels to reach staff in a way that is familiar to them.

We have also agreed the following to support the delivery of this plan:

- HR will work closely with comms to ensure staff side are briefed and staff engaged
- an email account will be established and monitored by HR to ensure staff have single point of contact for queries
- a message will go out after each TB to inform staff of decisions
- a formal staff consultation will be managed by HR if applicable
- face to face team briefs will happen at least monthly in each place to allow staff time to ask questions directly of their leadership team

It is also important that senior leaders refrain from speculating or giving their opinions on a matter until a decision has been reached by all and all CCGs are agreed on key messages.

7. Member Practice Engagement

In the pre-consultation engagement phase we will ensure that GP members have the opportunity to refine the options available and highlight any potential concerns and risks, in partnership with the Transition Board and CCGs Governing Bodies. This stage will address any questions from GP members regarding the proposed option(s), prior to formal consultation. Member practices are the highest authority regarding constitutional changes to the make-up of the CCGS. Therefore, this step is imperative to ensure members are fully engaged and sighted on the proposal before going out to formal consultation.

Following the formal consultation process we will then facilitate a vote with GP members using an agreed formula to ensure equity across the 4 CCGs. The voting will be run and overseen by an external organisation, to ensure independent oversight and scrutiny. The result of the vote built on

the feedback from the consultation with staff, and stakeholders will determine the future form of commissioning arrangements to enable a single set of commissioning decisions at a system level to be signed-off by CCGs Governing Body. Final approval will also be to subject to NHS England agreement.

To ensure that our GP members are fully informed and engaged we will maximise the use of existing channels and relationships that are familiar to them.

This will include:

Ensuring that colleagues supporting Primary Care are briefed on a regular basis, to ensure consistency and timeliness of message and opportunity. This includes briefing local place-based primary care teams, and Clinical Directors.

Engaging effectively with member practices. This might take the form of:

- Face-to-face discussions
- Articles in Members News or equivalent publications
- Members briefings
- Members meetings
- Surveys/questionnaires
- A forum for Q&A's linked to members areas on CCG websites
- Member Ballot Event (s)

We will ensure that the engagement and consultation process reinforces the importance of member practices understanding their constitutional responsibilities and which enables them to share their views via the channels outlined above.

8. Resource Requirements

Every effort will be made to ensure value-for-money is achieved during this process. However, this desire will need to be balanced with the reality of time constraints, the breadth and depth of the communications and engagement activities required as well as the specialist skills needed to deliver them.

To ensure a consistent, timely and coordinated response to the Consultation the Transition Board have supported the need to commission some additional, specialist support from a Commissioning Support Unit (CSU).

Local Communications and Engagement Specialists will orchestrate the development and delivery of this plan. The CSU would seek validation of the plan and advice from the Consultation Institute, assist in the development and design of the consultation materials, host the survey for formal consultation, and produce a consultation report.

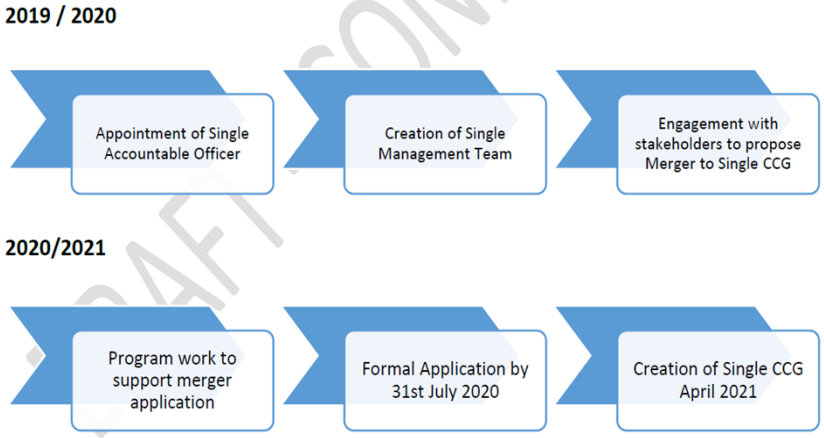
The cost for the CSU work should be funded jointly by the 4 CCGs.

In addition to the communications and engagement support there needs to be HR/ OD support for the staff engagement and formal staff consultation. There also will need to be identified GP member liaison resource in each CCG to ensure that this group of key stakeholders are given the information they need to make an informed choice at the ballot stage.

There will also need to be an Equality Impact Assessment undertaken to understand whether there is a potential impact on our protected communities.

9. Key Milestones

The overarching timeline for this piece of work (should a merger be the agreed way forward) is set out in the image below.



The communications and engagement key milestones to support this process are summarised below:

- **July-** Governing Bodies give approval to seek views of stakeholders.
- **August –** production of final Engagement Plan and pre Eng materials for sign off at Transition Board
- **September-** CCG Governing Bodies to consider the full plan and materials as part of a wider 'case for change' paper
- **October -** A period of pre engagement to inform the consultation documents (5 public events, a letter and survey to stakeholders, 5 staff events and 5 members events)
- **Nov-** analysis of the pre engagement events and production of consultation docs- for Nov Transition Board
- **Nov-** Governing Bodies to consider consultation and give delegation to TB for final sign off of associated documents
- **Dec-** sign off consultation docs
- **Jan –** formal consultation for 6 weeks starting on the 6th Jan.
- **Dec- Feb-** GP Membership team to commence formal Member Engagement (visits to practices)
- **Feb-** GP Ballot
- **March -** Analysis of consultation
- **End of Feb –** 1st Member ballot
- **End of March – 2nd** Member ballot (if required)
- **April –** Final Engagement report and outcome of ballot to Transition Board
- **May -** Papers to Governing Bodies for decision on whether to put in application to NHSE

A full plan is included in appendix 3

10. Risks

The following communication and engagement risks and mitigating actions have been identified:

Risk	Mitigating action
Timescale for pre-consultation engagement and formal consultation are tight. This could lead to challenge by Health Overview and Scrutiny Committees or other partners on whether the consultation process has been appropriately informed by pre-consultation or whether an appropriate number of views will be sought.	Health Overview and Scrutiny Committees will be engaged by senior leaders at the earliest opportunity to help them understand the CCG plans and to seek their endorsement for the overall process. The communications and engagement plan demonstrates how the CCGs will gather an appropriate response from the population within the timescales that are set out.
Timescale for analysing and production of report is extremely tight. This could impact on overall quality of final report.	Response analysis, trending and theming and report writing resource has been sourced externally to assist with the production of this as no single CCG team has capacity to do this work.
As membership organisations it is imperative that there is an effective approach to clinical engagement as part of the programme and that members feel informed and able to shape the proposals.	CCGs identify senior clinical leads / and an overall GP engagement lead to engage with GP members at locality and practice level to provide assurances around proposals and to understand any underlying concerns.
Staff do not feel able to support of convey positive messages about the proposal.	There are mechanisms to inform staff and provide them with mechanisms to give early influence. HR/OD plan will run in parallel to this and lead into formal consultation stages if required.
Single Accountable Officer may not accept this as the direction of travel or the pace of change	The listening exercise and consultation are post AO interviews. It is recommended that the listening exercise is Chair led.
There is a risk that stakeholders feel a single option consultation with predetermined policy direction leaves no room for influence. (Gunning Principle 1)	Clearly articulate the options appraisal and clarity on case for change. Allow opportunity for people to shape what that looks like through the listening exercise. Governing bodies only move to consult after consideration of the listening exercise.
There will be the perception from GP members, the public and key partners (including Local Authorities) that focus on 'place' will be weakened by forming a larger strategic commissioning organisation	Important that these issues are understood during listening exercise and that key messages make clear that the CCGs understand the key issues around place and that the changes will allow for greater focus and resource on the developing primary care networks as part of an Integrated Care System
That NHSE move us to a single CCG and local Members and stakeholders disagree with this.	Be clear on the policy position as a key message, clearly explain that this is the decision of NHSE not CCGs, and leave opportunity to influence on the how this will work.

11. Evaluation

Measurement of communications and engagement outcomes will take place throughout the process; to ensure that we remain aligned to the delivery to our goals. Evaluation allows us to: improves the effectiveness of our activities; adapt our approach as situations change; and allocate our resources appropriately.

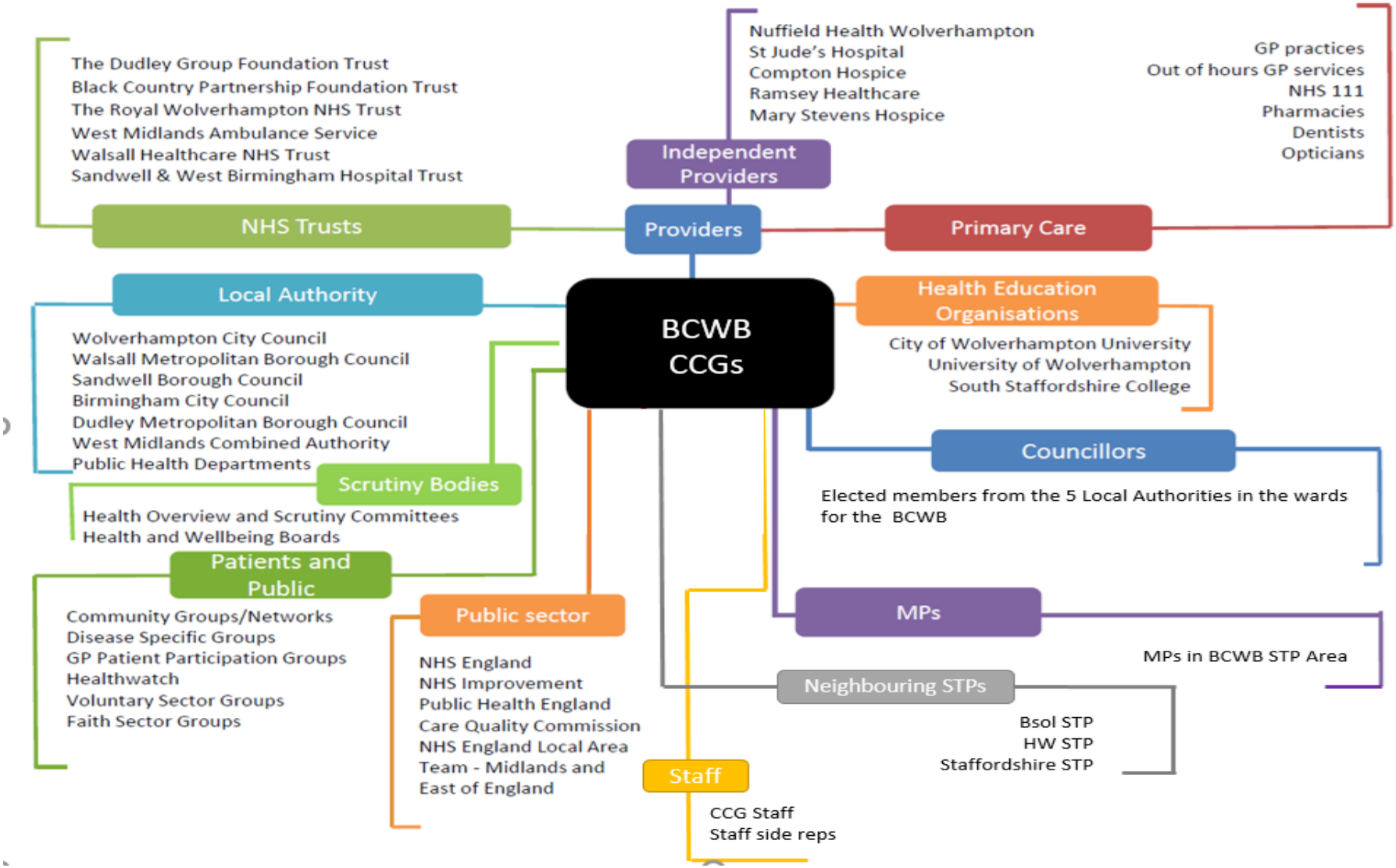
Effectiveness of the communications and engagement activities will be measured by:

1. The number of stakeholders who engage in the events/ submit views
2. The overall number and range of responses;
3. The number of survey response aligned to the demographic profile of the Black Country and West Birmingham
4. For digital communications and social media; user statistics, number of posts, number of retweets, comments, likes and shares
5. How feedback given by all stakeholders has meaningfully influenced the proposals; this will be demonstrated via regular 'you said, we did' communications to ensure that we are maintaining interest.

Appendix

1. Stakeholder map
2. Outline plan
3. Key channels
4. Key messages for listening exercise

Appendix 1- Stakeholder Map



Appendix 2- Plan

Date	Activity	By who	Outcome
July	CCG Governing Bodies accept move to exploring options for single commissioning voice… including move to Engage	AOs	Support of GB members that we are exploring options Confirmation that Single AO and Single team will be in place
July	Staff message from TB to confirm current decisions re single AO and move to explore options for Single Commissioning Voice… including possibility of merger engagement	Comms	Staff up to date and aware of potential for external messaging about option of merger
8th August 2019	Transition Board to receive full comms/ eng plan setting out steps to involve people in decision around whether we move to single CCG	Comms	-Clear plan -Support for resource -Prioritisation of activity required to deliver
12th Sept 2019	Dudley CCG GB	AO/ Transition Director	Sign off on pre eng materials and overall plan
	Walsall CG GB		
	SWB CCG Governing Body		
	Wolverhampton CCG GB		
TBC after each GB	Notify NHSE of intention to start listening exercise	Comms	To establish if there is anything missing from the plan
Sept	Set up staff email account as single point of contact	IT/ HR	To ensure staff have an opportunity to give feedback and ask questions and these can be collated centrally
October	EQIA	Equality leads	
October 2019	4 x CCG Staff Events	HR/OD	
	5 x public events	Comms	
	5 x members events	Primary Care	
Nov	Analysis of listening exercise feedback and writing full consult documents	Comms	To ensure full consultation

			documents reflect the qs people want answering
Nov 14th	Transition Board	Comms	To provide TB with feedback from Listening Exercise
14th Nov 2019 12th Nov 2019 19th Nov 2019 6th Nov 2019	Dudley CCG GB Wolves CCG GB Walsall CCG GB SWB CCG GB	AO/ Transition Director	Decision on whether to go to consult Delegate to TB to sign off final materials Agree to start formal member engagement
after GBs	Finalise consultation plan and materials	Comms	
December	Start Member Engagement/ practice visits	Primary Care	
12th December 2019	Transition Board	Comms	Sign off consultation materials
Dec after TB	Key stakeholder briefings (MPs, elected members etc)	Comms/ Transition Director/ AO	
Dec after TB	Letter to HASC Chairs	Comms	To establish whether they want to receive a plan at next meetings
6th Jan 2020	Formal public consultation starts	Comms	
6th Jan 2020	Press activity launches (print and social media)	Comms	
6th Jan 2020	Online survey launches	Comms	
6th Jan 2020	Formal briefings with stakeholders and partners	Comms/ Transition Director/ AO	
Tbc	Public consultation meetings	Comms	
Tbc	GP membership meetings	Primary Care	
Tbc	CCG staff meetings	HR/OD	
24th Feb 2020	Formal Consult ends	Comms	
w/c 24th Feb	GP ballot	Governance leads	
March	Analysis of consultation feedback	CSU	
April	TB to receive final report on Consultation	Comms	
May	GB to receive final report on Consultation	Transition Director	Decision on whether to submit to NHSE

Appendix 3

Category	Why	Aim	Groups
Patients, carers and public	Apart from legal and statutory duties to engage with the public and patients, it is clear that better and more realistic options are developed when they are influenced by this important group	Involve local people in the programme, making sure all options are tested and feedback is shown to have influenced their development and choice of potential solution	• Patients • Public • Carers • Healthwatch • Patient Groups • PPGs
GP membership	They must be involved in developing the options for change co-creating new ones. They are also hugely influential with patients and the public. CCGs are also membership organisations	To gain their support for and understanding of the potential changes taking place. Ensure member practices also support changes from a commissioning perspective.	• CCG member practices • LMC
Opinion formers	Politicians, both national and local, have a duty to protect the interests of their constituents and so need to be kept informed and updated regularly. The media also need to be kept informed of progress.	To keep opinion formers aware of the proposed changes, attempt to mitigate any politically sensitive issues, and to provide them with a narrative they can support, e.g. in conversations with constituents	• MPs • Councillors (leaders, chairs) • Council Chief Execs • Health and Wellbeing Boards • Public Health leads • Health Scrutiny • Print and online media
Staff and unions	Changes to the way health and care services are delivered could affect roles and ways of working. Lay members should be involved in potential changes	Informing and updating staff on developments and giving them the opportunity to be involved from the start of the programme	• CCG workforce (wider workforce, managers, executives, lay members) • Trade Unions
Wider health and care economy	Health systems are linked, and changes in one part of the health system could have a dramatic impact on others	Updating senior stakeholders at organisations in the local and surrounding area that might be affected by potential new organisational structure	• BCWB STP • Neighbouring STPs • NHSE / NHSI • Providers • Vol sector Councils • MLCSU • AGCSU

The future for CCGs in the Black Country and West Birmingham

Listening Exercise

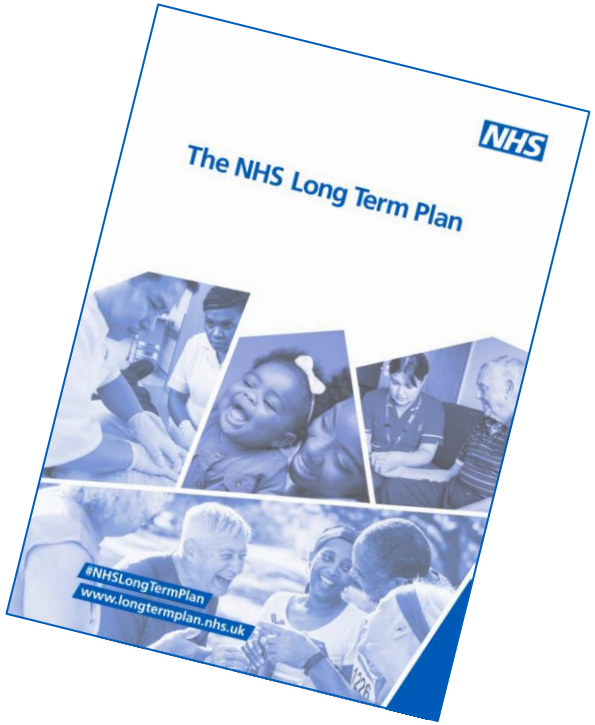
Laura Broster
Director of Communications &
Public Insight

Current position

- We currently have 4 CCGs in the Black Country and West Birmingham serving 1.2 million people
  - NHS Dudley Clinical Commissioning Group (320,000 population)
  - NHS Sandwell and West Birmingham Clinical Commissioning Group (xxx population)
  - NHS Walsall Clinical Commissioning Group (xxx population)
  - NHS Wolverhampton Clinical Commissioning Group (xxx population)
- A collective budget of over £2 billion
- The 4 CCGs manage contracts with our main hospital, community, mental Health and Primary Care providers
- There are 5 Local Authorities
  - Dudley Metropolitan Borough Council
  - Walsall Metropolitan Borough Council
  - Sandwell Borough Council
  - Wolverhampton City Council
  - Birmingham City Council
- We have 1 Sustainability and Transformation Partnership with 18 partner organisations

Background and context

- NHS **Long Term Plan** published January 2019
- Real focus on **collaboration**, moving away from market, competition and transacting
- *'…CCGs will become more **strategic, leaner organisations**…'*
- *'… There will be **one CCG** per STP/ICS area by March 2021…'*
- **Integrated Care Systems** are the policy focus



Changes to commissioning

- Greater focus on **strategic commissioning**, less on detail of pathway design
- **Population health management** principles
- Bigger geographical footprint and larger population
- Promote **partnership working** with local Government, NHS providers and other partners
- Support **Primary Care Networks** to develop
- Refocus some of the **clinical leadership and input**
- Develop **place based models of care** to focus on improving health outcomes for people in each of the 5 places

Place Based Care

Our health and care needs are changing, with more people living longer often with multiple long term conditions. Partnerships are being formed in each of the 5 places, between the NHS, local government and the third sector to integrate care and better meet health and care needs now and in the future.

Wolverhampton and Walsall

<u>Wolverhampton</u>
Integrated Care Alliance Wolverhampton

What is the vision?
The development of a health care alliance across Wolverhampton with a focus on a place based model

Who is involved?
City of Wolverhampton Council, Black Country Partnership Foundation Trust, Wolverhampton CCG, The Royal Wolverhampton NHS Trust and local GP practices. Also, Healthwatch and Local Medical Committee representatives

How will it work?
The system-wide alliance will be clinically led and will focus on shifting resources out of hospital to support more patients at home and in their communities and health promotion and disease prevention

Population size
Approx. 256,000 people

<u>Walsall</u>
Walsall Together

What is the vision?
To develop an integrated health and care alliance for the delivery for place-based services

Who is involved?
Walsall GP practices, Walsall Borough Council, Walsall Healthcare NHS Trust, One Walsall, Healthwatch, Dudley & Walsall Mental Health NHS Trust and Walsall CCG

How will it work?
An alliance model with shared governance and integrated management will provide place-based services. Currently, a host provider model is the preferred option for the alliance which will be phased in over three years.

Population size
Approx. 272.000 people

Dudley
Dudley Multispecialty Community Provider (MCP)

What is the vision?
To integrate primary and community care within a single organisation and to improve access, continuity and coordination of care

Who is involved?
Dudley CCG and Dudley Metropolitan Borough Council are leading the procurement of Dudley MCP in dialogue with partnership of four local NHS trust and local GPs

How will it work?
The model is based on an ethics of "community where possible, hospital where necessary" by creating a network of GP-led health and care teams. network will focus on co-ordination of care across the system

Population size
Approx. 316,000 people

Sandwell
What is the vision?
Healthcare without boundaries

How will it work?
By giving patients and the wider population the opportunity to benefit from healthier lifestyle and designing services to meet the needs of the local population.

Who is involved?
Sandwell council, Sandwell GP practices, Sandwell and west Birmingham Hospital, Black Country foundation NHS partnership Trust, Healthwatch, SCVO

Population size
Approx. 575.000 people (all together)

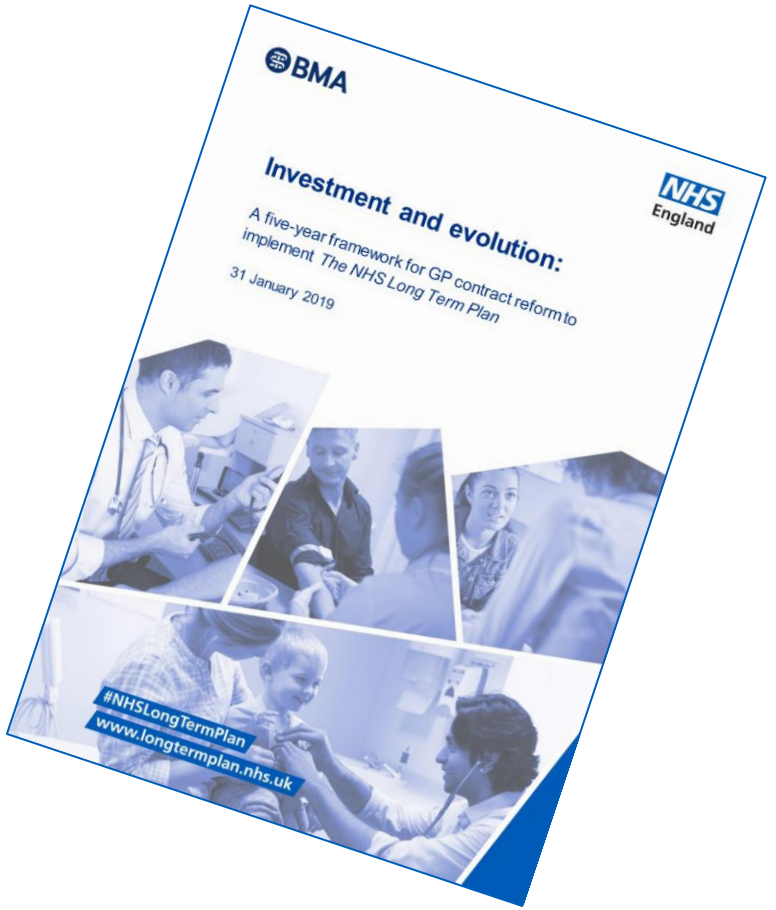
West Birmingham
What is the vision?
Providing greater integration between all providers including primary, community, mental health and independent providers to shift care closer to home, improve patients experience to provide seamless and timely services and take lessons learned from the vanguard

How will it work?
Focus on keeping local people well and tackling underlying causes of ill health, inequality and vulnerability.

Who is involved?
Birmingham and Solihull mental health partnership trust, BVSC, Healthwatch, West Birmingham GP practices, Birmingham Council

Primary Care Networks

- Also published in January, **£4.5 billion extra** (nationally) for primary care over 5 years to fund 20,000 additional staff.
- Two main aims –
    - **bringing GP Practices together** in networks so they can support each other and increase resilience
    - **Create an infrastructure** for the alignment of community health resources
- In the Black Country and West Birmingham **we have 34 Neighbourhood Teams** serving communities ranging from **xxx** pop to **xxx** pop



Key Question for CCGs…

- The 4 CCGs will have a single Accountable Officer and a single Management Team
- The question that we are now exploring is, **'if we move to a single CCG what would good look like?'**
- The Governing Bodies of the 4 CCGs want to hear your views to inform a formal consultation process
- The feedback you give us during this listening period will go to CCG Governing Bodies in November

What do we think the main benefits might be of moving to a single CCG?

Patients:

- Single commissioning policies so reduced **'postcode lottery'**
- **Less fragmentation** of NHS organisations
- Reduced variation in quality of care
- Ability to drive **improved care** from providers

Staff:

- Larger organisation **more resilience** and **reducing duplication**
- Builds on work already in place, **removes uncertainty** for staff

CCG Organisations:

- Increased **financial resilience** through risk sharing
- 20% **reduction in management costs** spend, reduced duplication

Partners:

- **Strategic focus for commissioning**, easier to engage at Black Country and West Birmingham Level
- Maintain the opportunity to engage at **Neighbourhood** (PCN) & **Place** (ICS)
- Supporting the move to an **Integrated Care System**

What do we think the main issues might be of moving to a single CCG?

- How would we ensure any change doesn't negatively impact on 'business as usual' performance?
- How would we retain local knowledge and insight to best serve local population need?
- How would we work with partners in each of the 5 places?
- How would we support our GP Membership in each place?
- How would we support staff through any changes?
- How would we ensure public accountability, openness and influence of decisions taken?

Options and Processes

- There is **predefined national policy**
- Decision to merge CCGs is for **NHS England**
- Preferred option of the four CCGs is to proceed with a formal consultation to seek views on the proposal to **merge in April 2021**
- Your views now will **inform** that **consultation**
- **This is your opportunity to tell us:**
  - What do you value from the current CCGs?
  - What would good look like to you in terms of future CCG arrangements?
  - How would you feel if the CCGs merged?
  - What would be your concerns?
  - How might these concerns be resolved?
  - What questions would you want answered before you could decide if it was something you supported, Or not?
- **Help us to respond to your questions/ concerns/ issues**

Questions

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Governing Body Report
10 September 2019

Agenda item 10

TITLE OF REPORT:	Black Country TCP Community Model
AUTHOR(s) OF REPORT:	Helen Hibbs
SENIOR RESPONSIBLE OFFICER:	Helen Hibbs
PURPOSE OF REPORT:	To review the new community model for intensive support and forensic support for patients with Learning Disability and or Autism. To consider the engagement report as part of the consideration of the location of assessment and treatment beds in the Black Country To make a recommendation to the governing bodies on the future of assessment and treatment beds and the associated community services
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance** ☐ **Information**
KEY POINTS:	• The Black Country Transforming Care Partnership Programme Board has commissioned a community intensive support team and forensic model for patients with Learning Disability in line with the national service specification • This new model is now starting to embed as business as usual and is starting to become effective • As a result of changing the model of care to one much more focused on community provision and less on bed based services the number of assessment and treatment beds required in the Black Country has reduced. • Consideration needs to be given to the location of the ongoing assessment and treatment beds ,the number required and closure of those no longer required
RECOMMENDATION:	• The impact of the new model of care is noted • The engagement report on the location of assessment and treatment beds is reviewed and any mitigations are discussed and agreed • A recommendation goes to all Black Country CCG Governing bodies on the future bed base for assessment and treatment beds with any beds no

	longer required being closed.
KEY IMPLICATIONS/RISKS:	There remains a key risk for the Black Country Transforming Care Programme Board that we will not be able to meet the NHS Midlands agreed trajectory for reducing the number of patients in beds.
CONFLICTS OF INTEREST MANAGEMENT:	None known at time of writing the report
LINK TO TRIPLE AIM OPPORTUNITIES WITHIN THE BLACK COUNTRYSTP CLINICAL STRATEGY	These proposals meet the triple aims with improvements to health, quality and also to financial sustainability in the longer term.

Background

Following the Panorama programme exposing the terrible abuse of residents at Winterbourne View in 2011 a full investigation of the circumstances leading to the situation was instituted. It became evident that the NHS was too reliant on using long stay inpatient facilities for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

As a result in February 2015, NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community. This was outlined in the document Building the Right Support.

A national ambition to reduce the specialist hospital beds for adult patients with a Learning Disability was set at 55%.

All areas across England were formed into Transforming Care Partnerships (TCPs) which include commissioners, local authorities and providers. These TCPs have been set challenging trajectories to reduce the number of patients in inpatient beds. For clarity, our TCP covers the four CCGs and their registered patients) within the Black Country (BC), West Birmingham is within the Birmingham TCP.

NHS England commissions High, Medium and Low secure services for patients with the most complex and challenging needs who pose a risk either to themselves, to others, or both. Almost all of these patients will have been in contact with the criminal justice system and will have been charged and convicted of a criminal offence. These individuals will be detained under the Mental Health Act 1983 and

the decision to admit to these beds will have been based on a comprehensive risk assessment and detailed consideration of how the identified risks can be managed.

The CCGs commission locked rehabilitation inpatient services which provide secure but less restricted environments for those individuals who still pose a risk to themselves and or others and who are usually also sectioned under the Mental Health Act. These services are usually considered appropriate for people who are still receiving treatment, but where they no longer require the procedural, relational or physical security of a secure service.

In addition CCGs commission assessment and treatment inpatient services. These services are for adults with learning disabilities who need to go to hospital because of either a mental health problem or behaviour that is labelled as challenging. Patients should stay in these beds for a short period of time whilst they receive assessment and / or treatment to enable them to return home or occasionally to be transferred to another more appropriate hospital setting. With the changing model of care fewer assessment and treatment beds will be required and it is these beds and the new complimentary community services which are discussed further in this report.

In the Black Country taking into account adults and children we have reduced in patient bed usage by 24% whilst nationally the reduction is closer to 13%. This reduction took place during the reporting period 31/12/2015 – 31/03/2019. In Wolverhampton the IST has been embedded for three years and this area has seen an overall reduction in in-patient beds of 41% suggesting that the IST and forensic teams become more effective over time.

1. Our Response to the Transforming Care Challenge/Our Model

1.1. The Black Country has an adult population of around 1.147,000 of which 2-3% of people are predicted to have some level of learning disability. Of these, approximately 20% are predicted to have a moderate to severe learning disability and to be in receipt of services.

1.2. Within this cohort, at any one time, there are a number of people living with learning disability and or autism who have a mental health problem or who display behaviours that are labelled as challenging. Our response to how we support these people is central to the delivery of our programme.

1.3. A national service model has been developed and adopted within the Black Country. This describes a philosophy of care that delivers the following objectives.
Citizens with Learning Disabilities and or Autism:

- Are supported to live great lives in their own homes as much as possible
- Access mainstream services in the same way that people without learning disabilities do
- Have access to specialist care services only when needed
- Don’t live in hospital
- Are cared for with the least restrictive option

1.4. At the start of the programme, the Black Country had some differences in the delivery model in the different places and retained a large number of inpatient beds including assessment and treatment beds in Sandwell (Penrose), Dudley (Ridge Hill), Walsall (Daisy Bank), Wolverhampton decommissioned its inpatient beds early in this journey replacing them with enhanced community services.

1.5. During the programme the Black Country TCP has worked together to implement a Black Country wide Forensic and Intensive Support Community Team in line with the national service specifications.

1.6. The four CCGs continue to commission place based community learning disability services in the four localities of the Black Country close to people's homes. These community learning disability teams are made up of nurses, psychologists, Occupational Therapists, Psychiatrists, Physiotherapists, and Speech and Language Practitioners. The community facing learning disability services provided by BCPFT have not changed and vary across the four areas dependent on historical investment and historical service configuration. In some cases some of the services are provided for our citizens from alternative providers**.** For example in Wolverhampton physiotherapy is provided by the mainstream community services and not by the Learning Disabilities service provider.

1.7. The new community model works with a tiered approach requiring a small number of assessment and treatment beds for those patients who cannot be safely supported at home. The length of stay in these beds is now kept to the minimum required. The next smallest cohort of patients are able to access community intensive support team and forensic community team to support them at home in a crisis situation. The third cohort receiving secondary care services are those using the local learning disability services including the community LD nurse team, psychology, psychiatry, behaviour support, dysphagia, SALT, physiotherapy, outpatients etc. The final cohort and the majority of people living with learning disabilities are able to be supported in mainstream primary care and mainstream services.

2. Process We Went Through

2.1. Considerable work was undertaken by the commissioners and the service provider to transform our local services. This involved the development of a business case and service specifications. During this development phase, a model of coproduction was used both with service users and with the provider.

2.2. The provider has worked with its staff in a management of change to enable the new services to be mobilised. Mobilisation of the Intensive Support Team and Forensic Community Team started in September 2018.

2.3. A Quality Impact Assessment (appendix 1) and Equalities Impact Assessment (appendix 2) have both been undertaken to ensure that the new

model being proposed did not negatively impact on quality nor increase inequalities.

3. Engagement

4.1 Dudley Voices for Choices (DVC) are a self- advocacy organisation supporting people who have a learning disability or autism and are a member of the TCP programme board. Their membership is to ensure that people with learning disabilities are represented at programme level. In appendix 3 you can see a report which summarises the involvement of key stakeholders in the development of the community model. This includes work with service users and their families.

4.2 The following common themes have emerged across the different engagement processes:

- Service users had a negative experience of hospital care and were much happier in their community placements where they generally felt safe and experienced improved health
- Service users have a variety of aspirations and ambitions and should be helped to pursue them to promote independence and self-confidence
- Increased focus on early intervention is vital to avoid hospital admissions
- Service users and their families should be seen as partners in planning their care
- Service users require consistent and ongoing support from a multi-specialist team to avoid/alleviate crisis situations and prevent future hospital admissions

4.3 During the summer of 2018 the TCP Programme went to each Local Authority Health Scrutiny Committee to share the development of the model, the engagement process and the proposals to reduce the number of Assessment and Treatment Beds. Further contact was made to each of the Health Scrutiny Committee Chairs and to NHS England in February 2019 by the programme manager to detail the formal engagement process and confirm that consultation was not required.

4.4 The formal engagement exercise was undertaken by the CCGs from Thursday 21 March 2019 to Thursday 23 May 2019 and the full report can be found in appendix 4a and 4b.

4.5 The purpose of the engagement process undertaken was to seek the views of stakeholders, service users, carers and family members on the following:

- The introduction of a new community model for people with learning disabilities that provides enhanced support in the community.
- The permanent closure of specialist inpatient beds at Ridge Hill Hospital, Dudley and Orchard Hills/Daisy Bank, Walsall. (These are beds that are reserved for assessing and treating people with learning disabilities and are not connected to general hospital services).

4.6 Engagement process

- The CCGs managed all stakeholder engagement across the Black Country and West Birmingham.
- The CCGs commissioned NHS Arden and GEM CSU to produce an engagement document to promote understanding of the TCP programme and the proposed new model and questionnaire to allow feedback; to advise on the format of the stakeholder events; to capture all feedback at those events.
- As Dudley Voices for Choices support people with learning disabilities and autism to speak up for themselves, they were also commissioned to undertake outreach engagement in the community and produce an easy read version of the engagement document and questionnaire.
- Arden and GEM were also commissioned to analyse all feedback from the engagement process and to produce the engagement report.
- Several thousand stakeholders were contacted by the CCGs and invited to get involved by attending one of the four stakeholder events and/or completing the online questionnaire.
- Four stakeholder events (one in each of the Black Country and West Birmingham CCG areas) took place to explain the TCP programme and hear views on the proposed service model. All feedback from the stakeholder events has been collated in this report.
- Outreach engagement with service users, their carers and families was undertaken by DVC; 174 conversations took place. DVC undertook interviews across Sandwell, Wolverhampton, Walsall and Dudley.
- A press release and social media also informed people how to get involved by attending one of the four stakeholder events and/or completing the questionnaire.
- Information was published on the CCG websites.

4.7 Key themes from the stakeholder events included:

- Positivity for the community focus offered by the new model.
- The importance of relationship building and maintaining good relationships between, patients, family members, carers and professionals.
- Transport and access to the Penrose site for visitors.
- Consideration for those with autism.
- Consideration for those in transition (aged 16-18 years old).
- The response to crisis.
- The number of treatment and assessment beds (10) in the new model.

4.8 Key themes from the outreach engagement included:

- Transport and access to the assessment and treatment centres.
- Cost implications of travelling around the areas.
- Enough beds to meet the needs of all areas.

4.9 Questionnaire analysis (50 surveys completed)

- Most respondents (62%) felt it would have a positive impact if care and support was delivered in the community rather than in a hospital, compared to 10% of respondents who said it would have a negative impact.
- Nearly half of respondents (46%) felt it would have a positive impact if care and support was delivered in the community for a person with a learning disability and/or autism displaying challenging behaviours, compared to just over a quarter (28%) who believed this would have a negative impact.
- Many more family members and carers (44%) felt it would have a positive impact if care and support was delivered in the community, than felt it would have a negative impact (14%).
- When asked: 'If the assessment and treatment centre was based at Penrose House what would the impact be for you?', 28% of respondents felt it would have a negative impact; 22% believed this would have a positive impact. Other responses (36%) included: 14 respondents were not sure; three believed the distance to be an issue; one preferred not to answer this question.
- When families and carers were asked about the impact of having the assessment and treatment centre based at Penrose House, 20.41% felt this would have a negative impact; 18.37% believed the impact would be positive. The largest number of respondents (51.02%) were unsure; 10.20% believe this would have no impact.
- People were asked how important help/support and information and advice was across a range of circumstances. This included: personal support; environments; family carer support; information and advice, for all areas most people selected 'very important' as their answer.
- People answered questions on prevention of crisis admission to hospital, categories included: support with daily activities; communication; understanding situations that may lead to challenging behaviour and avoidance; personal support; environment; family/care support and information and advice. For all answers most people said it was 'very important' to have support across all categories to prevent crisis.
- People were asked questions on support needed for discharge to prevent readmission. A range of categories were considered: support with daily life; communication; behaviour; personal support; environment; family/carer support and information and advice. Most respondents felt that support for all categories was very important.

4.10 When asked what respondents felt stopped or delayed a person getting the right support in the community areas included:

- Lack of family support and affordable care homes
- Lack of funding for services
- Lack of communication between the different services and professionals

- The need for accurate and up to date information about services to be available
- The need for more qualified staff

4.11 People were asked to consider their experience of things going wrong with being supported / supporting someone in the community, responses included:

- Lack of information for patients being discharged from hospital
- Lack of support when carers are sick
- The right support may not be offered
- Lack of communication and not planning for end of life care which can result in unnecessary hospital admissions
- Not having appropriate funding in place to support patients

4.12 Key themes and considerations

The majority of people asked believe strongly in the value of community rather than hospital based services. The key themes and considerations required by the Programme Board are below.

4.13 Positivity about the community focus offered by the new model

Most people were positive about the community focus of the new model. However, when asked about the location of the assessment and treatment centre, more people (28% of respondents) felt it would have a negative impact if the centre was based at the Penrose site; (22% believed this would have a positive impact). When carers and families were asked about Penrose as the preferred site 20.41% felt this location would have negative impact; 18.37% believed the impact would be positive. The negative response to these questions will need to be mitigated if the final decision made is to have the treatment and assessment centre based at Penrose. It is recommended that the provider communicates the outcomes of this engagement process and continues to involve service users in the future developments of the community service model, for example in the design of any new buildings/facilities.

4.14 Relationship building

The importance of relationship building and maintaining a good relationship between, patients, family members, carers and professionals.

4.15 Transport and access to the Penrose site for visitors

Many people were concerned about travel to the Penrose site. It is recommended that the equality impact assessment is revisited, and travel and access for all reviewed. Learning from the previous relocation of the Wolverhampton Assessment and Treatment service to the Sandwell site (Penrose) has been positive, with commissioners supporting the provider to offer transport costs to families, and additional, personalised support, as and when required.

4.16 Consideration for those with autism.

It is recommended that a plan is developed to take into consideration the needs of adults with LD and autism.

4.17 Consideration for those in transition (age 16 to 18yrs).

It is recommended that a plan is developed to take into consideration the needs of those in transition.

4.18 The response to crisis

It is recommended that consideration is given to the response to crisis.

4.19 The number of beds (8) in the new model

Ongoing communication with patients and the public is recommended to mitigate concerns that ten beds will be enough for service delivery going forward.

4.20 Concerns about not having enough staff

Ongoing communication with patients and the public is recommended to mitigate concerns about not having enough staff.

5. Mitigations

5.1 We have already taken mitigating action for many of the points above. We are developing services for people with autism, a pathway for children and young people which will include a focus on transitioning to adult care and Black Country Foundation Trust has made provision to provide transport for families and carers of service users when required subject to them meeting the appropriate criteria.

6. Outcomes – Is it working?

6.1 Since the introduction of the new community model, in September 2018, 20 admissions to hospital have been prevented by the new intensive support teams.

6.2 The current caseload of the forensic team is 66 and for IST it is 19. There are a further 6 people who are known to IST and being monitored closely through the place-based community MDT, but who are not requiring active direct interventions from IST.

6.3 Whilst the numbers for IST appear small, the stepped care model supports many more individuals who are in crisis. This can be through community nursing and the behavioural support team in addition to the IST and Forensic teams. The IST often works jointly with the community teams but step the individual up and down in relation to their presenting risk threshold as and when required. IST monitor all individuals on the learning disability risk registers for the 4 locality areas and deploy their support as and when required for any individuals that are not able to be managed via the community teams who are amber or red rated for their risk. This approach

supports and empowers community teams to deliver holistic care and support to people who are known to them, with a stepped model of advice and guidance, and then direct interventions as and when required.

6.4 BCPFT IST are part of a regional piece of research/collaboration with other Trusts that are benchmarking what caseloads IST Teams have. They are also examining quality standards for these teams. BCPFT are hosting the next meeting in the Black Country. It is anticipated that the research initial benchmarking data is likely to be available towards the end of this year.

6.5 For those patients who are inpatients in assessment and treatment beds, the length of stay from January 2018 – November 2018 averaged 298 days. From December 2018 to July 2019 (including current inpatients) average stay is 112 days.

6.6 Patient and Carer feedback on the new model of care has been positive. And a patient story is given below to highlight the work of the IST

6.7 An individual was discharged to a community setting following a long period in an assessment and treatment unit. The individual has a long history of multiple foster placements and has spent most of her adult life in institutional care. Several community placements had broken down in the past with recurrent hospital admissions. In her current community placement her behaviour started to deteriorate with an increase in self harm and staff unable to cope resulting in staff burnout and compassion fatigue. In order to manage the situation the IST provided assessment of the community placement advise to the care and support provider, training for the staff to implement a trauma model of care considering psychological defences and regular visits. Three months into the placement the new provider is managing the individual well with new systems implemented for early identification and management of risk and hospital admission was recently avoided when the individual went into crisis. There is clear and consistent support for the provider with an identified care co-ordinator, weekly reviews with the IST. Longer term monitoring is now in the process of being stepped down to the community learning disability team for intervention in line with presenting risk thresholds and least restrictive option. In the event of escalation a CTR will be held and the IST can again become involved.

7. Quality

7.1 From April 2019 the CQRM reporting requirements for Black Country Partnership Foundation Trust (BCPFT) as the provider of the new service and the Assessment and Treatment service has been strengthened within the 19/20 contract.

7.2 The four CCGs have worked collaboratively with BCPFT to revise the format of quality reporting to ensure there is an increased focus on outcomes,

actions taken and risk mitigation in place. Benchmarking data will also be included to enable comparison with model hospital data and national comparison. The reporting now includes an increased focus on theme and trend analysis and inclusion of month on month run chart data, with trend lines. Trajectories for improvement are then identified based on data analysis and identification of priorities.

7.3 The terms of reference for the CQRM have been reviewed and revised and this meeting is now chaired by Wolverhampton CCG Chief Nurse to highlight the significance of the meeting and provide strategic leadership and challenge. Previously the BCPFT CQRM focused on a service per month (Learning Disability, CAHMS and Mental Health) however from September 2019 the format of the meeting will change to ensure that a strengthened report is received from each service on a monthly basis. This will enable timely information to be provided with an increased focus on each service and overall organisation performance.

7.4 A visit schedule for the year has been established and collaborative visits have been undertaken to Learning Disability inpatient areas and inpatient mental health beds. This allows earlier identification of any quality issues arising and provides an opportunity to discuss actions planned to gain assurance.

7.5 This revised schedule and arrangements will also include the arrangements for TCP. In particular there has been significant and co-ordinated work related to the Penrose assessment and treatment unit – Wolverhampton CCG have led two co-ordinated visits to the unit and all 4 CCGs were represented. At the second visit positive improvements were identified with multidisciplinary working within the area, with Speech and Language Therapy, Occupational Therapy and psychology services based within the unit and strengthened leadership from a newly appointed Matron. Areas for improvement included increased support for staff when managing violence and aggression incidents and the provision of more autism training. BCPFT have agreed with the findings of the report and have produced an action plan to ensure progress. The visit reports are discussed at CQRM with action plans to drive improvement also monitored via the contractual route.

7.6 The TCP governance arrangements are being reviewed and will strengthen the assurance element of TCP delivery and future reporting at CQRM will include all TCP pathways.

6. Finance

8.1 The new service model will effectively represent a reduction in the expenditure associated with commissioning in-patient beds and an increase in investment in community services of circa £3m. The tables below show how the overall expenditure is to remain in line with overall costs of the old model at c.£14.7m

(at 18/19 prices) and there will be the relevant inflationary uplifts applied each year in line with tariff.

Previous Service Model	Total Expenditure (£000)
Acute Inpatient Assessment & Treatment Beds	5,609
Community Nursing (including BST)	4,178
Community AHP and Psychology	2,101
Outpatients	1,140
PAMHS	704
CQUIN	323
Ridge Hill Premium	693
TOTAL	**14,748**

New Service Model	Total Expenditure (£000)
Acute Inpatient Assessment & Treatment Beds	2,197
Observations	330
CLDT	8,123
Forensic, ISS and Management	3,405
Ridge Hill Premium	693
TOTAL	**14,748**

8.2 All CCGs within the TCP are committed to this level of investment to support a model that will enable patients to be discharged from an acute in-patient setting at the earliest opportunity. The reinvestment in areas such as the intensive support service allows us to enhance the community services in order to achieve this.

8.3 In addition, as a key part of our strategy, we are likely to attract £7.5m of capital expenditure in relation to the replacement Penrose facility planned for 2023/24 financial year (subject to NHS England / Improvement sign-off).

9. Recommendations

9.1 The Board are asked to

9.2 Consider all feedback from the engagement process recorded in this report and appendices before making a recommendation to the CCG Governing Bodies on the future of Assessment and Treatment Beds.

9.3 Discusses the mitigations required in order to recommend the closure of inpatient beds at Daisy Bank in Walsall and Ridge Hill in Dudley as these beds are no longer required with the new focus on maintaining patients in the community where possible.

9.4 Note the implementation of the new Black Country IST and forensic service across the Black Country in line with Building the Right Support and the national service specification.

10. Equality Implications

10.1 The equality impact assessment is included as appendix 2 and does not evidence any negative impact on equality

Name: Helen Hibbs
Job Title: Accountable Officer NHS Wolverhampton CCG and Black Country and West Birmingham STP SRO
Date: 2 August 2019

ATTACHED:

Appendix 1 – Quality Impact Assessment
Appendix 2 – Equality Impact Assessment
Appendix 3 – Stakeholder Event Summary
Appendix 4a – Engagement
Appendix 4b – Final Engagement Report

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Quality Impact Assessment (QIA) 2019/20

Project Ownership (Section A)	
Project Name	Transforming Care Programme, Community Model and bed reduction.
Project UI Number	
Quality Of Care Statement	
Project Board	Transforming Care Partnership Board
Project Lead	Kulbinder Thandi
Exec Lead	Helen Hibbs
Quality Lead	Tom Richards, Sandwell & West Birmingham CCG
Clinical Lead	NA

Project Overview (Section B)

The Transforming Care Programme (TCP) aims to improve the lives of children, young people and adults with a learning disability and/or autism that display behaviours that challenge including those with a mental health condition. the mandate to reduce hospital beds followed the Winterbourne Review. The TCP programme has 3 key aims: a) To improve **quality of care** for people with a learning disability and/or autism. b) To improve **quality of life** for people with a learning disability and/or autism. c) To enhance community capacity, thereby **reducing inappropriate hospital admissions and length of stay.**
Transforming Care is all about improving health and care services so that more people can live in the community, with the right support, closer to home.

Quality Indicators

National reduction of people requiring assessment and treatment beds:
CCG level: 10-15 per million population **NHSE:** 20-25 per million population
Black Country TCP 2018/19: CCG level: 16, NHSE level: 27 (including children and young people) **Black Country TCP**
2019/20: CCG level adults 19, NHSE level adults: 19, children and young people: 5

PLANNING ASSESSMENT (Section C)

	Quality Improvements of the Project:	Possible Concerns of the Project:
For Patients (safety and experience)	Improved outcomes for people with learning disabilities and/or autism. People will be 'closer to home' and remain well within their own home. There will be a reduction in the need for Assessment and Treatment beds as per NHSE Transforming Care Mandate as the loccal clinical community teams evolve to provide support within the community and minimise the need for crisis admissions.	Potential lack of assessment and treratment beds and service provision should admission be required. Increasing complex patients managed within community settings
For the CCG	The proposed new clinical service model will consist of a community learning disability team within each locality, a new Community Forensic service and new a Community Intensive Support Service which will cover the whole of the Black Country TCP/STP footprint . The services will be in addition to the existing services across the Black Country and provide consistency and flexiblity but also meet the needs of the local population in each area.	Potential lack of assessment and treratment beds and service provision should admission be required. If not implemented lack of alignment with national TCP model
For Effectiveness of Care	The purpose of the new model is to prevent people from entering crisis and receive appropriate care at the right time to minmize the potential risk of hospital admission. Patients will receive care within a familiar environment in own setting. This will provide increased patient experience and satisfaction and potentially minimize anxiety.	Lack of resouces to provide intervention in a timely manner which impact on effectiveness of care.
For Service Quality	There will be an equitable service across the Black Country TCP footprint, this includes standardisation of quality measures allowing a more joined up colloborative approach to monitoring quality by the Black Country Learning Disability Commissioners.	Risk of higher acuity patients not being able to access quality care in an appropriate setting.

RISK GRADING (Section D)

Risk Grading
Risk of Possible Concerns Occurring

	Likelihood Score	Consequence Score	Overall Risk Score: Likelihood x Consequence (L x C) = R (Risk score)	Overall Risk Grade
Patient Safety	*1*	*2*	*2*	1 to 3: Low Risk
Patient Experience	*1*	*1*	*1*	1 to 3: Low Risk
Clinical Effectiveness	*1*	*2*	*2*	1 to 3: Low Risk

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

	Likelihood				
Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Clinical Review (Section E)	
GP / Clinical Name	NA
Date	
Comments	

APPROVAL (Section F)

Project Lead	Kulbinder Thandi
Date	01/07/2019
Comments	Quality is the key to success of this programme. The intention has been to deliver high quality, responsive services for people with learning disabilities and/or autism. The new services: Community Forensic Team and the Intensive Support team have been co-produced in collaboration across the 4 CCGs and BCPFT, and partners including the 4 local authorities. The new services have been commissioned on the TCP/STP footprint as mandated by NHSE and 'Building the Right Support'. In order to ensure quality is continually being monitored and reviewed, the commissioners, BCPFT, and quality leads from each CCG have worked together to agree the (SQPR) service quality performance review indicators. We all acknowledge that the service is evolving and maturing as it responds to the needs of the patients and that the quality issues will change. In agreement with BCPFT, we are continually monitoring on a monthly basis and will review as part of the service reviews. The SQPR is reported to the 'one commissioner' learning disability contract review meetings and the Clinical Quality Review meetings (CQRM). As the new community model has developed there has been a natural significant reduction in the usage of beds, people are being admitted only when clinically appropriate and more people are being supported and treated at home. The engagement carried out on the development of the community model has brought positive feedback from people with learning disabilities and their families, in that they would prefer not to be admitted to assessment and treatment beds when they are not well.
Has Sections A, B, C, D, E Been completed?	The original business case was done using the Sandwell & West Birmingham CCG process and templates. This document supports those papers.

Quality Lead	Tom Richards/Yvonne Higgins/ Sukhi Parvez
Date	01/07/2019
Comments	The Quality Team has engaged with CCG partners in developing a comprehsive suite of LQRs to support the ongoing delivery of this project, and attendance/engagement and ongoing review/monitoring at Clinical Quality Review Meetings. The iniative will enable improved patient outcomes and experience by providing care closer to home.
Has Sections A, B, C, D, E Been completed?	The original business case was done using the Sandwell & West Birmingham CCG process and templates. This document supports those papers.

completed?	The original business case was done using the Benefits at Trust Birmingham SOC process and template. This document supports those papers.

Approval Agreed	Yes

Review Board	
Date	
Comments	
QIA Supported	YES/NO

Approval Board	
Date	
Comments	
Approval Agreed	YES/NO

CLOSURE ASSESSMENT		
	Quality Outputs Achieved	Outcomes of the Change (positive)
For Patients (safety and experience)	<To Be Filled In>	<To Be Filled In>
For the STP Footprint	<To Be Filled In>	<To Be Filled In>
For Effectiveness of Care	<To Be Filled In>	<To Be Filled In>
For Service Quality	<To Be Filled in>	

Is there any Negative Impacts of the change:	
For Patients (safety and experience)	<To Be Filled In>
For the STP Footprint	<To Be Filled In>
For Effectiveness of Care	<To Be Filled In>
For Service Quality	<To Be Filled In>

Quality Lead		Closure Review Date:	

1 Rare	1 Negligible	1 to 3: Low Risk
2 Unlikely	2 Minor	4 to 6: Moderate Risk
3 Possible	3 Moderate	8 to 12: High Risk
4 Likely	4 Major	15 to 25: Extreme Risk
5 Almost Certain	5 Catastrophic	

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Sandwell and West Birmingham Clinical Commissioning Group

Equality & Diversity Impact Assessment – Commissioner Version

DOCUMENT CONTROL

Reference Number	Version	Status	Sponsor(s)/Author(s)
	V2		Saba Rai
{lead in specific policy area to provide once policy ratified)	V1.1	Final	Kathy Lyons, Partnership Development Manager Saba Rai, Senior Commissioning Manager (Lead) Terence Read, Partnership Development Manager

Amendments	Date	By whom
Purpose changed on Page 22 - option D now "To inform a commissioning decision".	18/7/2017	Terence Read
Refinement of commissioning guidance.	18/08/17	Saba Rai

Intended Recipients:	Group/Persons Consulted:
An equality impact assessment (EQIA) is a process of systematic analysis where we consider how our policies, strategies, services or functions are likely to impact upon the protected characteristics of our population	E&D Sub Committee Strategic Commissioning and Review Committee Chief Officers PMO Senior & Commissioning Managers

Monitoring Arrangements and Indicators:

Implementation of the EQIA process is monitored at the E&D Sub Committee. Outcomes and indicators are linked to those found in the EDS2 process.

Training/Resource Implications:

Training workshops to be provided for all Senior & Commissioning Managers as part of

commissioning process	
CCG Value:	This policy supports the delivery of all the CCG's assurance frameworks and outcomes.
Approving Body: Quality and Safety Committee (as part of Commissioning Process	**Date Approved:**
Date of Issue	
Review Date	6 months/post commissioning intention
Contact for Review	Terence Read - Partnership Development Manager
Policy Location:	Intranet, SWB CCG Website and Strategic Commissioning and Review Team.
Summary An equality impact assessment (EQIA) is a process of systematic analysis where we consider how our policies, strategies, services or functions are likely to impact upon the protected characteristics of our population	

Contents

Purpose

This document is in two sections:

1) EQIA Guidance
   a) This should be read before completing an assessment, to ensure the author of the EQIA assessment is familiar with the process.
2) EQIA Assessment templates
   a) To be completed as per the process, by the Commissioner.

1. EQIA Guidance

This Guidance sets out

a) The purpose of an equality impact assessment
b) When to undertake an EQIA
c) Where responsibility for conducting an EQIa lies.
d) The EQIA process
e) Where you can get support and assistance.

Guidance Notes to Complete an Equality Impact Assessment Screening and Assessment

a) Purpose of an Equality Impact Assessment?

An equality impact assessment (EQIA) is a process of **systematic analysis** where we start to consider and document how our commissioning options, intentions or decisions are likely to affect different groups or communities.

The process helps to ensure that commissioning decisions take account of the diversity of local population groups and do not create or exacerbate existing inequalities or variations in outcomes. An Eqia can assist the commissioner to identify **practical steps** that can be taken from the outset to ensure that the services commissioned, reviewed or evaluated will deliver the desired outcomes for all groups.

The EQIA process is also about **documenting** the thinking and rationale that underpins the commissioning of a service The completed EQIA paperwork will demonstrate that the commissioner have taken a considered, evidence-based approach when commissioning a new or evaluating an existing service. EQIAs are one of the tools available to commissioners to try to **tackle the inequalities people can experience in access to and experience of healthcare and health services**. Inequalities can occur due to a range of factors, including a person's age, sex , gender identity race (culture/language/ethnicity), sexual orientation, religion, disability, relationships, socio-economic

status, homelessness, political beliefs, or if someone is a carer, is pregnant, a sex worker or a drug user.

These inequalities can mean some people do not have the same access to services or opportunities (at work and in broader life), have poorer experiences of services or employment, and have poorer outcomes.

EQIAs can help the commissioner to **improve the quality and effectiveness** of the services that are being developed or reviewed. The analysis that is undertaken will help you to understand:

1. The diversity of the population groups within SWB CCG and the sub groups that will be impacted by the services that are being developed or reviewed i.e. *population of SWB CCG with type 2 diabetes*
2. Whether there are any *unintended consequences* for some groups from the different service options / intentions ;
3. Whether there are unintended consequences resulting from changes that may be happening in the way services are commissioned / delivered across partner organisations.
4. Whether taking into account all the above evidence your plans will be *fully effective* for all your intended audiences; and
5. How you can alter or adapt the service to minimise unintended consequences and be more effective for all groups.

EQIAs also help us **comply with legislation**. The *Equality Act 2010* provides protection from discrimination, harassment & victimisation to people with 'protected characteristics'. These are:

- Age
- Disability including carers of a person with a disability
- Gender reassignment
- Pregnancy/maternity
- Marriage/civil partnership
- Religion/belief
- Race
- Sex
- Sexual orientation.
- Vulnerable Groups – although this group is not a protected group. It should be treated in the same way.

Discrimination can be direct or indirect. We also need to **avoid indirect discrimination**, which may occur where an apparently neutral provision, criterion or practice puts people with a 'protected characteristic' at a disadvantage. We need to systematically check that our projects or plans do not unwittingly discriminate, even though they appear to apply to everyone equally.

The Human Rights Act 1998 introduces an explicit **human rights** dimension into Public Sector decision making and actions. The introduction of this Act has meant that every action taken by the CCG must be compatible with the rights stated in the Human Rights Convention. The potential implications of these human rights for healthcare are listed in the appendices.

1) Responsibility for conducting an EQIA:

It is important to determine where responsibility for conducting the EQIA lies. The table below provides an outline of the different ways services are commissioned and the stages of the commissioning cycle when an EQIA may be required to support decision making.

	Purpose of Equality Impact Assessment (EQIA)		
Commissioning Approach	**EQIA to inform the development of new service**	**EQIA to inform review or evaluation of existing service**	**EQIA to inform decisions to disinvest or substantially change an existing service.**
CCG directly commission the Service	CCG officers	CCG officers	CCG officers
CCG has delegated authority to commission a service	CCG officers	CCG officers	CCG officers
CCG is a partner in a jointly commissioned service **but not** the lead commissioner	Lead Commissioner of joint Service	Lead commissioner of joint service	CCG officers (impact of disinvestment / change proposed by the CCG)
CCG is a partner in a jointly commissioned service and lead commissioner	CCG officers	CCG officers	CCG officers

For example, the table above indicates that where the CCG has delegated authority to commission a service, its officers are responsible for conducting an EQIA, regardless of the purpose of the EQIA. However, if the CCG is a partner but not the lead commissioner, CCG officers are responsible for only

conducting an EQIA on the component that will inform **its** decision to either disinvest in or substantially change the service.

It is important for good governance that commissioners clearly articulate where responsibility for undertaking the EQIA lies, and have a robust audit trail of this agreement. Not conducting an EQIA, conducting a limited / light touch EQIA or retrospectively conducting an EQIA can result in a legal challenge to decisions that are reached.

Where the CCG has been identified as the lead commissioner, has delegated authority to commission or directly commissions a service - The CCG's EQIA process should be followed.

For jointly commissioned / funded projects for example with a local authority, or another CCG(s) or provider(s); the service steering or programme group will be required to confirm with the CCG lead officer who the responsible lead organisation for conducting the EQIA will be and therefore which governance process to follow.

The lead officer responsible for the service area is responsible for ensuring that an EQIA is carried out. It is important that the person conducting the EQIA has an in-depth knowledge of the proposed service, procedures or functions so they can understand its potential impacts. The EQIA should be a collaborative process involving relevant steering groups, colleagues and teams i.e. public health.

Within the CCG, the Governing Body is ultimately accountable for ensuring that EQIAs are completed. When a service evaluation or a project initiation document is submitted, the Governing Body and/or committee papers should include results of the EQIA.

2) When do I need to complete an EQIA?

For a new service:

The EQIA process must be carried out at the start or as part of the development of the service and not in retrospect. The EQIA should inform the project/service initiation documentation and be integral to the business case for the new service. The EQIa should be proportionate to the potential level of investment in and political sensitivity of the service. A clinical lead or service steering group should have oversight of the EQIA process.

For existing services:

Where the CCG is reviewing the effectiveness of an existing service/pathway or model an EQIA is required to understand the impact of the service on all groups that should benefit from it. The time spent on the EQIA should be proportionate to the level of investment and political sensitivity of the service. The EQIA process includes a requirement to ascertain from providers the impact of the service on service users.

Where the CCG is considering disinvesting in or substantially changing the way a service is delivered an EQIA is required to understand the impact of the disinvestment or change. The EQIA should be proportionate and consider the impact on service users (existing and future), the impact on the viability of the remaining service, the impact on staff employed by the service, the impact on partners where a service is jointly commissioned and any political impact of disinvestment or change.

3) How do I complete an EQIA?

EQIA Principles

Your EQIA should be:

1. **Proportionate**: '*You need only pursue the EQIA process as far as the activity in question warrants*'[1].
    - The more politically *sensitive* the service, the greater *its potential impact* and therefore the more robust your EQIA should be.
    - The greater the investment or proposed investment in the service and the

2. **Timely**
3. **Evidence-based:** State in your EQIA what you know to be true, what you think/assume (perhaps based on a hunch or what you've heard anecdotally), and what you don't know.

[1] Professor Peter Latchford, Chief Executive, Black Radley Ltd: 'Equality Impact Assessment: The Curse and the Cure'.

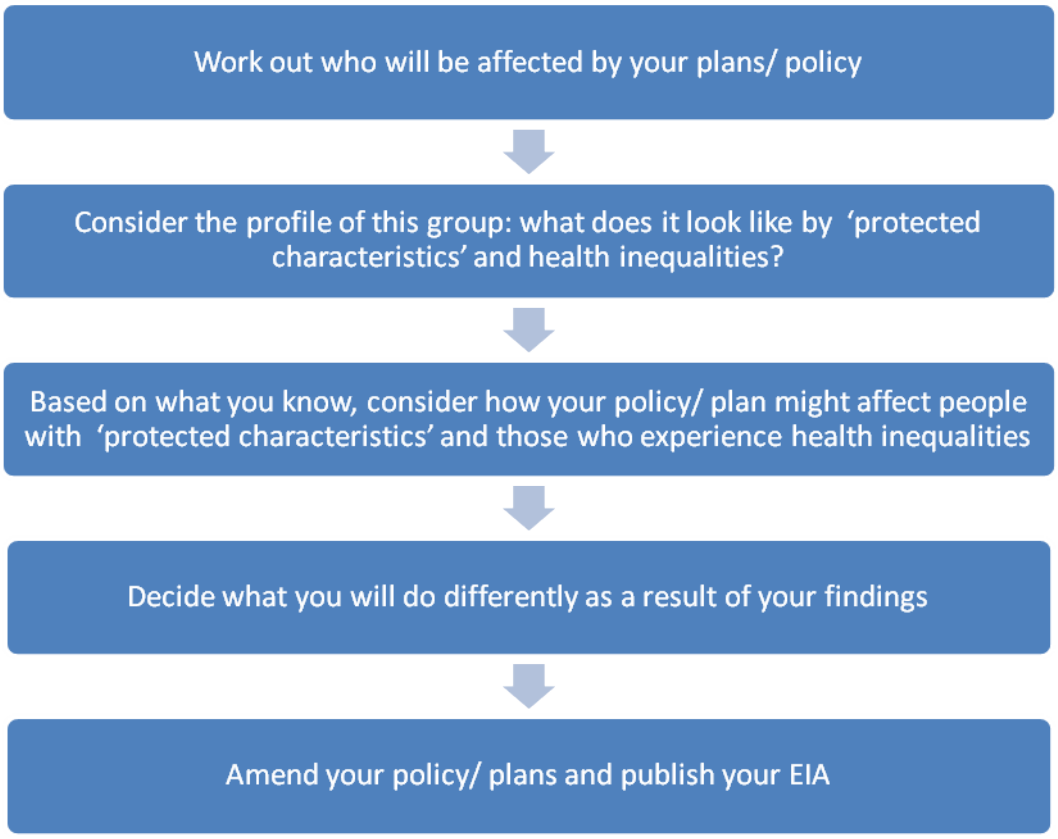
4. **Integrated**: Build equality considerations into your decision-making process from the start, and into your final project. This means explicitly including equality considerations in the project itself.

b) Where to get support and assistance;

- Support Senior Commissioning Manager (SCM)/Commissioning Manager (CM) to complete the initial EQIA screening process to identify if any groups are affected by service changes and any impacts.
- Review full EQIA findings, conclusions and recommendations.
- Provide support for SCM/CM to take service proposals to the next step in the commissioning cycle.
- Report on a quarterly basis to the Equality & Diversity Committee the EQIA's we have reviewed and the proposed service changes

Process

This flow chart sets out the process for completing an EQIA:



The detail below sets out how to complete each of the sections in the form.

Section 1: Screening

This stage involves an initial analysis of any adverse impacts or potential adverse impacts for protected groups. The author should draw on their knowledge and experience of the service/ plan / policy/ project/ decision and the people that are affected. It is therefore beneficial to seek the views of a range of people at this early stage. E.g. you may wish to involve the E&D Manager or relevant working group. You should consider the following when undertaking screening:

- Is there a higher prevalence of any group(s) in relation to the prevalent conditions?
- Are there any concerns about the participation of any group(s) in the service or any aspect of the service?
- Are there any known barriers or potential barriers to access for any group?

You will need to record your explanation of any adverse impacts or no impacts. If adverse impacts or potential adverse impacts are identified you will need to complete the rest of the impact assessment. Defining the scope of your Equality Analysis (EA) will help to establish the specific aspects of the service/ plan / policy/ project/ decision that require further examination.

People affected by the project

To begin your analysis, you need to know who is affected, how they are affected, and to what extent. This information should also be included in the relevant project documents describing its scope and/ or target audience.

The form then requires you to consider the profile of both service users and staff affected by 'protected characteristics'. This will help you identify any particular groups you need to pay greater attention to when you are analysing potential equality impacts.

In some cases, the profile will be our local population or the CCG staff as a whole, in which case you can use the demographic data found in the JSNA and in discussion with public health or from electronic staff records data via HR.

In other cases, your target audience will be a subsection of our local population or staff, e.g. older people, women[2], clinical staff, or managers. If you do not have a profile of your audience already, the public health team may be able to help you pull this together.

You may need to include other potentially vulnerable groups that your project may affect such as carers; people who are homeless, live in poverty, who are long term unemployed, in stigmatised occupations (sex workers both women and men), who misuse drugs, with limited family or social networks or who are geographically isolated.

It is likely that some of the information will not be available at a local level (e.g. on sexual orientation, religion/ belief, transgender). In this case, you can refer to regional or national figures. Public health may be able to help you locate this information.

Section 2: Summary of findings

This section will be completed once the EQIA has been completed. It asks you to provide a summary of your findings. This should include an overview of the positive and negative impacts which may arise as a result of the project and any resulting actions identified.

[2] Please note: some services and functions target specific groups, e.g. older people, or people from BME communities. This is usually to tackle disadvantages that these groups experience in mainstream services, so is not likely to be discriminatory.

Section 3: Consultation and Involvement

Involvement should be an on-going process throughout the Equality Impact Assessment. This should include keeping records of any draft documents e.g. new or revised policies, any changes that have resulted from involvement and consultation process.

Where you have identified potential issues you will need to consider:

- Which diverse groups you will need to consult with or involve in the EQIA.
- The scope / duration of the involvement and consultation should be in proportion to the issue identified.
- What is your consultation plan?
- Have other organisations held similar formal consultations;
- What have previous involvement or consultations shown;
- What experts will you be seeking advice from
- What are the outcomes of your involvement /consultation and how will this inform the development of proposed actions.

Please note that where Disabled groups will benefit from the work you are undertaking, there is a legal requirement to INVOLVE disabled groups.

Section 4: Evidence base

This section allows you to record the evidence you have used to base your equality analysis on. The form asks for details of any desk research you have done (can be both quantitative and qualitative data) – check for local and/or national evidence and engagement or consultation have conducted. Has any other engagement taken place with relevant patient groups locally or nationally? The engagement manager should be able to guide you on this.

Remember! The amount of evidence you gather and analyse should be proportionate to the scale of change and sensitivity of your project. You should discuss this with your line manager before you start this section. You may be able to rely on data you already have. Alternatively – for large scale and/or highly sensitive policies and plans – you may need to conduct meetings, surveys or engagement events with people who will be affected, including those in 'protected groups'.

For example, if you are designing a new diabetes service, you will want to involve service users and carers, and especially those from Black Caribbean and South Asian communities (who experience substantially higher rates of diabetes). If you are designing a policy and procedure to tackle bullying and harassment in the organisation, you may want to involve HR staff, wider staff groups e.g. staff with disabilities and BME staff.

If you want to arrange conversations with specific local communities to discuss your project, contact the engagement manager for information and advice.

Section 5: Analysis of impacts

When you consider how your project will affect different groups, you should think about:

- **Access**: Will all groups of service users/staff be equally able to access or take advantage of the service/procedure? Consider their ability to understand it, to access buildings where it will be held, to use any technology involved, to access it in the hours it is available.
- **Experiences**: Are there any groups who might have better/poorer experiences as a result of their 'protected characteristics'? Some groups might be more likely be to scared or confused, some may be anxious about potential prejudice and harassment they might face from healthcare professionals, other service users or colleagues; some may feel they are not able to be themselves at work, or to reveal information that will affect the healthcare and work opportunities they receive (e.g. about sexual orientation, disabilities, or being transgender).
- **Outcomes**: are there any groups who might have better/ worse outcomes due to their 'protected characteristics'? Consider patients' health outcomes, and staff members' ability to do their job to the best of their abilities. Poorer outcomes are often due to poorer access or experiences. However, some groups have greater pre-disposition to poor outcomes due to physiology or lifestyle (e.g. people in the South Asian community are up to 5 times more likely to have diabetes; the prevalence of stroke among African Caribbean and South Asian men is 70 per cent higher than the average).

Some of the things you might need to consider for each of the 'protected characteristics' is included in the appendices.

Your EQIA should record whether the impact is negative, positive or neutral.

A **negative or adverse impact** is an impact that could disadvantage one or more equality groups or communities.

A **positive impact** is an impact that could have a positive effect on one or more equality groups, or improve equal opportunities and/or relationships between communities.

Impacts may be differential, where the effect on one particular group is likely to be greater than on another. However, it is NOT necessary to automatically assume that a positive impact for one group will result in a negative impact elsewhere – certain policies or strategies are often designed for one particular equality community e.g. older peoples' services. However, it IS appropriate to consider whether there are differing needs within that particular group e.g. access rates of older people from a black or other minority ethnic background.

The form then asks you to list any human rights implications your project might have. Suggestions of possible implications for human rights in healthcare are included in the appendices.

Section 6: Conclusions and recommendations

This section allows you to record how your project will help us meet the Public Sector Equality Duties described on page 3 and what you will do as a result of your analysis.

Your final task is to include equality considerations explicitly in your project documentation so that those implementing can act on them.

Section 7: Monitoring and review

This section requires you to set out how the actions you have identified will be monitored and reviewed. This could be through project working groups; team meetings as part of service specifications and contract/quality monitoring.

The actions identified to be considered as part of the CCG's equality audit framework in discussion with the CCG's equality lead.

Section 8: Approval and publication

When complete the EQIA should follow the CCG's approval process outlined in Appendix 3. Following approval it will be published on the CCG's website.

Appendix 1: Possible human rights implications

Rights:	Issues:
A2: RIGHT TO LIFE	Abortion; availability of life-saving treatments; euthanasia; deaths in custody;
A3: PROHIBITION OF TORTURE & INHUMAN & DEGRADING TREATMENT:	Corporal punishment; "pin down"; respecting the dignity of vulnerable people e.g. the elderly mentally ill; female circumcision
A4: PROHIBITION OF SLAVERY	Effectively abolished in 1774, but note recent cases of servants held in slave-like conditions.
A5:RIGHT TO LIBERTY	Powers of arrest; detention of the mentally ill; periods of detention; detention without trial
A6:RIGHT TO A FAIR TRIAL	Court delays; disclosure of evidence; right to silence; search and seizure orders; legal representation
A7: NO PUNISHMENT WITHOUT LAWFUL AUTHORITY	Criminal law must be certain and an offence at the time it was committed e.g. marital rape. Penalties cannot be introduced afterwards.
A8: RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE	Access to records; public surveillance; telephone tapping; care orders; closure of residential homes; fertility treatment;
A9: FREEDOM OF THOUGHT, CONSCIENCE AND RELIGION	Blasphemy; employment practices; religious denomination schools; religious "cults"; charitable funding.
A10: FREEDOM OF EXPRESSION	Restrictions on the media re privacy; defamatory statements; reporting of court proceedings; "whistle-blowers";
A11: FREEDOM OF ASSEMBLY AND ASSOCIATION	Right to belong to trade unions; policing of demonstrations; music festivals; membership of "cults"
A12: RIGHT TO MARRY	Rights of transsexuals; same sex marriages; arranged marriages;
A14: PROHIBITION OF DISCRIMINATION	Prohibits "discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status".

Appendix 2: Examples of equality considerations by 'protected characteristic' and Vulnerable Groups

Protected characteristic	Legal definition	Some considerations
Age	All age groups are covered: children, young people. Teenagers, older people and/or the elderly.	Our older population and our children and young people have particular needs. Beware of assumptions about the age range, capability and generational viewpoints, teenage parents, children as carers. Confidence with technology and mobility may decrease with age.
Disability	The Equality Act provides protection to anyone who has a 'physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities.' This covers sensory impairments such as those affecting sight or hearing, severe disfigurements, mental health, and learning disabilities. The Act also covers those who are perceived to have a disability and those who are associated with a disabled person (e.g. carers).	NB 'disability' covers a massive range of conditions, abilities and needs. Even individuals with the same condition may have very different abilities and needs. Potential disadvantages include poorer health, barriers to accessing services or work opportunities, barriers in engaging with the way the NHS provides its services Consider what positive steps you can take to ensure disabled people can access services and access & progress in employment. Consider carers' needs: opening hours, work hours, timing of meetings. Consider accessibility: Communication formats (for example, Braille, audiotape, induction loop, Easy Read). Physical and sensory access, including transport and built environment. Giving enough time for understanding

Protected characteristic	Legal definition	Some considerations
Gender reassignment	Covers people who are proposing to undergo, are undergoing, or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex. A person does not have to undergo medical procedures to be protected by the law.	Transgendered people can face prejudice in all walks of life, including healthcare and employment. This is often down to lack of understanding. Healthcare issues are not just about gender reassignment services (and some transgendered people choose not to undergo surgery or treatment). Beware offering inappropriate healthcare, or failing to offer appropriate healthcare (breast and prostate screening; cervical smears, etc). Dignity and privacy are particularly important, especially in intimate care. Transgendered people should be treated according to their acquired gender (and they should not routinely be asked for their Gender Recognition Document as proof of their legal gender). This includes in admission to wards. It can be hard to ensure proper representation from the transgendered community on groups.
Marriage/ civil partnership	In employment, people who are married or in a civil partnership are protected from discrimination on the basis of their marriage/civil partnership. There is no legal protection from discrimination on this basis in the provision of services (unless a civil partner is treated less favourably than a married person – could be discrimination on the basis of sexual orientation).	The Act offers limited protection on this basis in employment. You can include provisions which favour married people/ those in civil partnerships, but not provisions which disadvantage them.

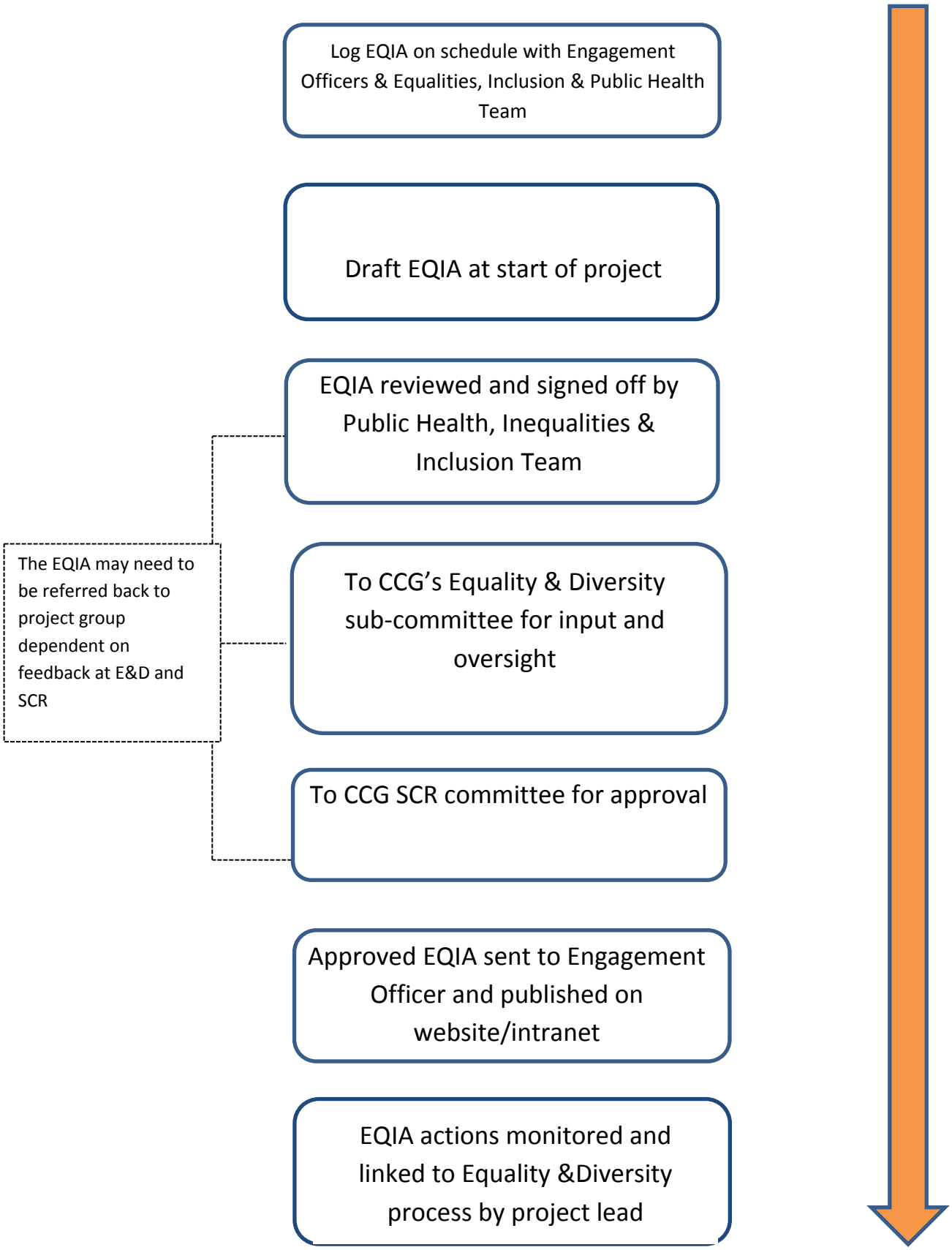
Protected characteristic	Legal definition	Some considerations
Pregnancy/ maternity	The law protects women from being treated unfavourably due to being pregnant, having given birth within the last 6 months, or breastfeeding an infant 6 months old or younger. Sex discrimination laws may apply where a woman is breastfeeding a child older than 6 months. This applies to receiving services and to employment.	In providing services, we cannot treat a service user unfavourably because of her pregnancy or maternity. Service providers must not discriminate against, harass or victimise a woman because she is breastfeeding. In employment, we cannot demote or dismiss a woman due to her pregnancy (or pregnancy related limitations or sickness) or maternity leave, or deny her access to training or promotion opportunities. Beware assuming a woman returning from maternity leave will want less responsibility or hours. There is no statutory right for workers to take time off to breastfeed, but employers are expected to try to accommodate women who wish to do so. Employers have a duty to provide a space in the workplace for female workers who are breastfeeding.
Race	Race includes all colour, nationality and ethnic or national origins. This means white people and Black & minority ethnic communities are covered. Also includes Gypsies & Travellers, migrant workers, and 'newly arrived' communities	Some racial and ethnic groups are at higher risk than others of developing certain diseases, are less likely than others to engage with health services and experience inequality in health outcomes. Consider communication formats and language needs, cultural considerations, lifestyle, isolation, work patterns, understanding of how our healthcare system works In the workplace, we need to consider dress code, language requirements (e.g. standard of English required), and diverse modes of communication.

Protected characteristic	Legal definition	Some considerations
Religion & Belief	Religion or belief includes any religion and any religious or philosophical belief. It also covers lack of religion or belief.	Affects health, use of health services, expectations of health providers and how people would like to be treated by healthcare staff. In respecting and reflecting diverse cultures, lifestyles, customs and values consider: Work hours and appointment times Provision of quiet rooms where possible Dietary requirements for meetings and on wards Dress codes Possibilities of time off for religious observances
Sex	Refers to males or females of any age: women, men, girls, and boys.	Women are more often the main carer of children Consider physical access (pushchairs/toddlers), single parents, caring costs/facilities, restrictions on times for meetings, safety issues regarding time and place of meetings/clinics. There are biological differences between females and males which lead to some diseases affecting one gender more than the other. There are differences between the sexes in how they access, use and experience health services. Women dominate some professional groups in the NHS, though men are more likely to hold more senior positions.

Protected characteristic	Legal definition	Some considerations
Sexual Orientation	Covers gay men, lesbians, heterosexual/ straight people and bisexuals. It relates to how people feel as well as their actions. The law includes discrimination connected with manifestations of sexual orientation, including appearance, where people spend time and who they spend time with.	Gay, lesbian and bisexual people face discrimination in many aspects of their lives including their relationship with health services, and in employment. Healthcare challenges for lesbians, gay men and bisexuals are not just about sexual health! Sexual orientation can have an impact on physical and mental health. Fears of discrimination and homophobia may mean people do not disclose their sexual orientation to healthcare professionals, and may therefore not receive relevant advice. May ignore preventative health messages as they feel they are not targeted at them. Healthcare professionals and colleagues may make assumptions about partners and family life/types. Can lead to awkward conversations, and potential breaches of dignity and privacy. NB needs particular attention around discussions of next of kin, power of attorney, living wills, etc. Remember that gay men, lesbians, and bisexuals can also be parents and have caring responsibilities.

Protected characteristic	Legal definition	Some considerations
Vulnerable Groups	There is no exhaustive list but vulnerable groups may include the following: • Homeless / rough sleepers • Travellers / Gypsies • Older BME • Migrant communities • Single parents • Low income families • Teenage parents • Children in / transitioning out of Care settings • Unaccompanied minors • Refugee and asylum seekers	Potential disadvantages include poorer health, barriers to accessing services or work opportunities, barriers in engaging with the way the NHS provides its services Consider what positive steps you can take to ensure vulnerable people can access services and access & progress in employment. Consider accessibility: Communication formats (for example, translation services, induction loop, Easy Read). Giving enough time for understanding

Appendix 3 - EQIA Approval Process



Equality Impact Assessment

Please read and refer to the above *equality impact assessment guidance* before you complete this analysis.

Title (Service, Plan, Project, Policy)	Transforming Care Programme, Learning Disabilities		
Summary of Service, Plan, Project/ Policy	Transforming care is about improving health and care services so that more people can live in the community, with the right support, and close to home.		
Aims of Service, Plan, Project/Policy	• To improve quality of care for people with a learning disability and/or autism • To improve quality of life for people with a learning disability and/or autism • To enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay		
Project Lead	Kulbinder Thandi Senior Commissioning Manager	**Executive Lead**	Helen Hibbs (Accountable Officer)
EQIA author	Simon Somers & Kulbinder Thandi		
Telephone number	07834 172072/0121 612 1617		
Email	Simon.somers1@nhs.net K.thandi@nhs.net		
Date of EQIA	31/01/2018 revised 02/08/19		
Full Business Case Attached	**YES**	**NO**	x

SECTION 1 - SCREENING

PURPOSE:			
A To inform a proposal for new service , model, pathway or project	B To inform the development of a new strategy or Policy (or similar) etc	C To inform the review of an existing policy, service, model, pathway or project etc.	D To inform a commissioning decision
		X	x

SCREENING FOR ADVERSE IMPACTS (X PLEASE CHECK):							
Age		**Religion or Belief**		**Marriage and Civil Partnership**		**Disability**	x
Sexual Orientation		**Carers** (inc. young carer's)	x	**Sex** (men & women)		**Gender Reassignment/ Transgender**	

Race/ Ethnicity		**Pregnancy, Maternity, Perinatal**		**Multiple Social Deprivation**		**Human Rights** (FREDA) fairness, respect, equality, dignity & autonomy	

2. SUMMARY OF FINDINGS

Describe any potential or known adverse impacts or barriers for protected/ vulnerable groups: (if there are no known adverse impacts, please state who has been involved in the screening and explain how you have reached this conclusion, then move to Stage 6 sign off)
We know that people with learning disabilities have poorer health outcomes than the wider population. There are potential/known impacts on protected characteristics for people with learning disabilities and autism who access services and who form the cohort of patients within this programme. There may also be an impact on carers eg. Transport to visit at a one site hospital assessment and treatment unit which is not in the locality of where the family/carers live. Being unable to have contact with carers/family may have a negative or positive affect on the person admitted to a single site Assessment and Treatment Unit.

If adverse impacts or barriers ARE NOT identified you DO NOT need to complete the rest of the template.

3. CONSULTATION AND INVOLVEMENT

1. **Who – if anyone – have you spoken with/ involved in assessing the impacts of your project on equality?**
Black Country CCGs x 4, commissioners, patients, carers, providers, public consultation, Black Country LA x 4, adult social care patients, carers, providers, public consultation Dudley Voices for Choices – learning disability advocacy group with expert by experience (please refer to engagement report appendix 1)

4. EVIDENCE BASE

What evidence have you used in your analysis of the impacts?	
Evidence source	**Brief details (including links and publication date)**
Demographic data	National and local data has been obtained to support this programme of work https://www.england.nhs.uk/learning-disabilities/care/atd/
Research/ studies	Winterbourne View https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
Surveys (e.g. staff surveys, patient surveys, GP surveys)	Surveys have been to all patients/clients involved in TCP as part of the Black County TCP engagement plan.
Monitoring data (e.g. on access, experiences, outcomes)	https://www.england.nhs.uk/learning-disabilities/care/atd/ As part of contract monitoring BCPFT record experiences, case managers also record experiences of people with learning disabilities and their carers as part of their Care Treatment Review plan (CTR). All patients who are admitted receive these.
Results of engagement exercises	**Key themes** (please refer to engagement report appendix 1 page 36) **Positivity about the community focus offered by the new model**. Most people were positive about the community focus of the new model. However, when asked about the location of the assessment and treatment centre, more people (28% of respondents) felt it would have a negative impact if the centre was based at the Penrose site; (22% believed this would have a positive impact). When carers and families were asked about Penrose as the preferred site 20.41% felt this location would have negative impact; 18.37% believed the impact would be positive. The negative response to these questions will need to be mitigated if the final decision made is to have the treatment and assessment centre based at Penrose. It is recommended that the provider communicates the outcomes of this engagement process and continues to involve service users in the future developments of the community service model, for example in the design of any new buildings/facilities. **Relationship building** The importance of relationship building and maintaining a good relationship between, patients, family members, carers and professionals. **Transport and access to the Penrose site for visitors** Many people were concerned about travel to the Penrose site. It is recommended that the equality impact assessment is revisited, and travel and access for all reviewed. **Consideration for those with autism**.

	It is recommended that a plan is developed to take into consideration the needs of adults with LD and autism **Consideration for those in transition (age 16 to 18yrs).** It is recommended that a plan is developed to take into consideration the needs of those in transition. **The response to crisis** It is recommended that consideration is given to the response to crisis. **The number of beds (10) in the new model** Ongoing communication with patients and the public is recommended to mitigate concerns that ten beds will be enough for service delivery going forward. **Concerns about not having enough staff** Ongoing communication with patients and the public is recommended to mitigate concerns about not having enough staff. To consider all feedback from the engagement process recorded in this report and appendices.
Anecdotal evidence (e.g. conversations and meetings)	Winterbourne View – see link above, this is an NHS mandated programme of work Please refer to appendix 1 (engagement report) for Black Country STP footprint.
Complaints and public enquires information	Winterbourne View – see link above, this is an NHS mandated programme of work Please refer to appendix 1 (engagement report) for Black Country STP footprint.
Analysis of audit reports and reviews	Winterbourne View – see link above, this is an NHS mandated programme of work Please refer to appendix 1 (engagement report) for Black Country STP footprint.
Similar functions / policies elsewhere	Winterbourne View – see link above, this is an NHS mandated programme of work
Other:	NA

5. ANALYSIS OF IMPACTS

Based on the evidence, what impact (negative, positive or neutral[3]) could your project have on people[4] with particular 'protected characteristics'? Please explain the reason(s) for your decisions[5].

Group	Impact				Reason
	Negative	Positive	Neutral	Unsure	
Age	☐	x ☐	☒	☐	The TCP applies to people of all ages
Disability	☐	☒	☐	☐	Transforming care (Department of Health, 2012) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf Building the right support (ADASS, 2015) https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf Winterbourne View Review Concordat (2012) https://www.rcpsych.ac.uk/pdf/Concordat.pdf Valuing People Now (2010) Engagement through public consultation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215893/dh_122386.pdf
Gender Reassignment	☐	☐	☒	☐	The TCP programme applies to individuals of any gender.
Marriage & Civil Partnership[6]	☐	☐	☒	☐	NA
Pregnancy & maternity	☐	☐	☒	☐	NA
Religion/ Belief	☐	☐	☒	☐	The transforming care programme is based on supporting underpinning principles of choice, inclusion and independence for people with learning disabilities, including supporting them with needs or preferences relating to religion or religious practice.
Race	☐	☐	☒	☐	The transforming care programme is based on supporting underpinning principles of choice, inclusion and independence for people with learning disabilities, including supporting them with self-identified needs or preferences relating to culture or ethnicity. Transforming Care is about addressing health inequalities thereby there are no race related negative impacts. Research has shown that person-centred care along with nuanced cultural understanding is vital to ensuring that people in some Black and minority ethnic (BME) groups are equally satisfied with adult social care services: http://socialwelfare.bl.uk/subject-areas/servicesactivity/social-work-care-services/natcen/satisfaction14.aspx
Sex (gender)	☐	☐	☒	☐	The TCP applies to services for people with a learning disability and/or autism, any gender.

[3] Please see glossary of terms in guidance notes for an explanation of negative and positive impact.
[4] Including service users, staff and others affected.
[5] Consider their ability to access your services, activities, how they will experience them, and potential outcomes.
[6] Only applies to internal policies and procedures, not to service provision.

Sexual Orientation	☐	☐	☒	☐	Valuing People Now (2010) (section on relationships) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215891/dh_122387.pdf
Vulnerable Groups	☐	☐	☒	☐	People with learning disabilities or autism are classed as a vulnerable group
Other:	☐	☐	☒	☐	In section 4 results of engagement: people raised transport to the Sandwell locality Assessment and Treatment Unit as an issue. This is being addressed by BCPFT as part of their equality impact assessment response. They are developing a policy regarding travel expenses for families/carers. To date no one has requested funding for transport to Penrose in Sandwell.

What – if any – human rights implications do you consider your project to have[7]?
In relation to human rights, it is possible without appropriate support and care and systems working effectively together the human rights of individuals directly involved will need consideration. The following evidence base has been used to ensure any human rights issues are taken into consideration. **A Life Like Any Other? Human Rights of Adults with Learning Disabilities (2008)** https://publications.parliament.uk/pa/jt200708/jtselect/jtrights/40/40i.pdf British Institute of Learning Disabilities Factsheet – Human Rights Act https://www.thh.nhs.uk/documents/_patients/PatientLeaflets/general/HumanRights-BILD.pdf All TCP patients are considered for Deprivation of Liberty (DOLs) as part of standard practice.

You MUST Complete the below if the purpose of the EQIA is (as indicated in Step 1) option C or D. Otherwise, please continue onto next stage.

Must be completed to support Review / Disinvestment / Decommissioning decisions:	
Do you have evidence that some groups did not benefit as intended above?	**YES** NO Please provide evidence / attach hyperlinks if available: Transforming Care Winterbourne View https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf Winterbourne View evidenced that people with learning disabilities did not benefit. In response, the Transforming Care Programme is addressing this by developing and delivering the new care model.
Do you have evidence that the outcomes expected for these groups have not been	**YES** NO Please provide evidence / attach hyperlinks: Transforming Care Winterbourne View

[7] See guidance for a list of potential Human Rights implications in healthcare.

delivered?	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf Winterbourne View evidenced that people with learning disabilities did not benefit. In response, the Transforming Care Programme is addressing this by developing and delivering the new care model.
Do you have evidence of concerns regarding clinical quality or safety of this service?	YES **NO** Please provide evidence / attach hyperlinks:
Will changes to, or disinvestments in this service have an impact on other services?	**YES** NO Assessment & Treatment beds – to be reduced potentially to one site Community learning disability teams – change to role Inpatient provision will shift to community based provision impacting on community learning disability services delivered through BCPFT. New community services will be developed – community intensive support service, community forensic service
Are there plans for the service to be re-designed or re-procured?	**Yes** No Redesigned, time scale is 01/18 to 03/19
Please reference any documents that that will support your equality analysis.	***Name of document and document references*** As referenced within document Appendix : 1 engagement report
Does it contribute to the Equality Delivery System Goals? (specify goals and related outcomes)*	Better health outcomes

*Equality Delivery System goals are fully explained in the Equality Analysis Guidance notes.

6. CONCLUSIONS AND RECOMMENDATIONS

How will your project help us do the following to meet our Public Sector Equality Duties under the Equality Act?	
Remove or minimise disadvantages suffered by people due to their protected characteristics	People with learning disabilities will be supported to live 'regular lives' within the community unlike Winterbourne where people lived in institutions, there will be less reliance on hospital beds, the focus will be to keep people well at

	home so that they do not have a hospital admission. Improving access to health care screening Ensure reasonable adjustments are made for accessing primary care Contractual changes to new models of care to include a number of equality outcomes, building them into all new and current service specifications. Providers will complete EQIA with involvement of service users, carers, staff and community providers.
Take steps to **meet the needs** of people from protected groups where these are different from the needs of other people	Integration of care and services, so that they are commissioned around the needs of the patient and community rather than the needs of the professional or the service Contractual changes to new models of care to include a number of equality outcomes, building them into all new and current service specifications. This includes learning disability health checks and access to health screening. Commissioners are working in their localities to increase access to services via reasonable adjustments and education via the PAMHS teams.
Encourage people from protected groups to **participate in public life** or in other activities where their participation is disproportionately low	All patients/clients to have designated (CPA) support plan which includes leisure and lifestyle elements.
Tackle prejudice and promote understanding between people from different groups, even where this means treating some people more favourably than others.	Promotion of Learning Disability Health Checks and reasonable adjustments to access in primary care. Work with Mencap to promote the rights and needs of people with learning disabilities or autism.

7. MONITORING AND REVIEW

How will the actions identified above be monitored and reviewed? As a minimum all actions should be considered for inclusion in the relevant Equality & Diversity monitoring template.

Actions are monitored and reviewed in line with normal contract management review (CRM) meetings and contract quality review meetings (CQRM). Transforming care is a standing agenda item on both learning disability and mental health contract meetings.

8. APPROVAL AND PUBLICATION

Approval (You should arrange for an appropriate Chief Officer to sign off this EQIA)			
ROLE	**NAME**	**SIGNATURE**	**DATE**

When complete the EQIA should follow the CCG's approval process outlined in Appendix 3 of the guidance. Once approved it should be published on the CCG's website.

Appendix C All feedback from the stakeholder events

Stakeholder event - Yemeni Community Association, West Bromwich, B70 9SJ.
Monday 8 April 2019, 1.30-3.30pm

24 stakeholders attended the event from a range of organisations including: Options for Life, SAFS (Sandwell Asian Family Support Service), Sandwell MBC, West Minster School, El Marsh Care, Midway Care, Charnat Care, Careview Services, Sandwell & West Birmingham CCG (additional staff not delivering event). In addition there were 3 members of the public, and a student of Wolverhampton University.

Workshop discussion

Discussion point 1 - What are the positive impacts of the proposed community model?

- Accessibility
- Out of hours support
- Locality for Sandwell will be easier
- Family benefits
- Less admissions/less time spent/my community
- Working together
- CTR's are key to positive outcomes
- Carefully thought through
- Great that public participation is taking place
- Intensive support site – great to have additional support in the community that you can access quickly
- Valuable to have clear pathway
- Consistency across all areas

Discussion point 2 – Are there any negative impacts you would like to discuss?

- Timeframes – changing delivery model takes time
- Journey time/locality for other areas
- Support for families to visit
- TCP for children – joint working with TCP for adults
- One attendee had a bad experience of treatment and assessment model
- May need an increase in social care hours
- There may be a negative impact on the carer if loved one gets better care. It is difficult for carers to let people move on

Discussion point 3 - Is there anything else you would like to be taken into consideration?

- Do families know what services are out there? Providers could communicate this with carers
- It's more than just a health issue – improved working together between health and social care
- Making sure people have knowledge of how TCPs will work together
- Information on stakeholder events
- Access needs to be prompt and responsive to crisis
- Approval for support service when in crisis
- More information, clearer about 10 beds
- Clear information on the offer of teams that is updated
- Involvement – working together families/users
- Learning and evolution… no time limits

Stakeholder event Wolverhampton
Wolverhampton, WV1 4QR. Tuesday 9 April 2019, 10am-12pm
Tuesday 9th April 2019

Nine stakeholders attended the event from a range of organisations including the University of Wolverhampton, Dudley Voices for Choices, Beacon Vision and Mencap.

Following the presentation, the workshop followed.

Discussion point 1 - What are the positive impacts of the proposed community model?

- Quality of care
- Community integration
- Good move towards social model instead of medical model
- Bespoke for individual
- Improved efficiency
- No funding cuts/funds reallocated to community services
- Flexible staff movement
- Everyone has same level of care

Discussion point 2 – Are there any negative impacts you would like to discuss?

- Transport/travel to ATU in Sandwell
- Isolation due to ATU venue
- Support for families does not materialise

Discussion point 3 - Is there anything else you would like to be taken into consideration?

- Joint commissioning
- Strong user voice including family

As people were asked to consider positive and any negative impacts of the new model, questions formed, and the workshop went into a question and answer session:

Questions/statements

Statement: Transport - getting to Sandwell. If a carer doesn't drive. It's a long way to travel.
Answer: Provider impact assessment flagged this up - at the outset of introducing the new model. Also, not having as many visitors and the impact that might have on inpatients. Therefore, within BCPFT we have a small funding provision to support people to get across to visit their families. Local provision means to the Black Country areas, but to family and friends it's a real pressure if you have to cross the Black Country. We have considered that and made allowances for families.

Question: How will families be made aware of this support for travel?
Answer: At the point where there is a likelihood their family member will be admitted; the multi- disciplinary team will make the family aware of all the options available to support them.
Question: Are Daisy Bank and Ridge Hill temporarily closed?
Answer: Yes - no patients there now and closed to admissions. Some people are concerned about whether there will be enough beds but when we had all the units open they were not fully occupied. Sometimes only a couple of patients in one unit or three and four in another. Therefore, collectively, we have worked out how many beds we would need BCPFT to provide which worked out at 10 beds. Wolverhampton haven't had any admissions to Penrose this year, it is unusual to need to support someone to the point of admission.
Question: What is the fall-back provision if all 10 beds are full?
Answer: There are other beds available within the area and within the Black Country, we have beds for forensic patients (need to be appropriate) – i.e. as well as assessment and treatment need. They are a bit scattered.

We have supported people to use our mainstream Mental Health services e.g. have gone to Penn hospital. Not a foregone conclusion that everyone goes to Penrose. It is about their needs and what they need as support to get them home quickly. Not had anyone go to Penn either.

By working with Mental Health Services and Children's Services colleagues so that if we know someone coming through or back to area who might be at risk our community teams can link in at the earliest point to ensure planning is done and they get access to the right services.

Q: Can appreciate the argument for reducing beds and need to go into hospital facility but how will you offset this trend by improving non-hospital services within the community. If you are going to do less in hospital residential environment, same work needs to be done in non-hospital site.

Q: More people spending time at home, what are your ambitions to give families the support they need as they will be carrying a higher proportion of the burden than in the past.

Answer: Good point; important point - this is about looking to support people in a least restrictive environment. We are looking at the service differently, more about recovery, community participation as part of their treatment, working with behaviour support. Our Intensive and community support teams working with providers and families to make sure adults access the support. Day time activities, liaison with other services. What that person will do to live an active healthy life full of community participation.

Using Guernsey community participation tool - supporting people positively to be back in the community. A new approach to treatment.

Provider Alliance - workforce and training too, need everyone to be trained in positive behaviour support and autism, these are priority training areas whether in health or social care. All working to same training and competency framework to support consistency.

Question: What will happen when parents can no longer look after my son or daughter?
Answer: This is a small cohort of Learning Disability (LD) patients who need tier four level of support (high risk). But we need to ensure closer alignment with social care providers. If people aren't supported in the right way through budgets and activities, they will hit crisis point.

There is a cohort who don't engage with services for example the homeless, autism without LD. They can become isolated and if not managed properly can present to us in crisis. Therefore, while focusing on an intense section of the population, it's important that we consider all these other things. There is a lot of work being done with local authority colleagues to look at how we manage health and care together e.g. local risk registers to support the management of crises.

Question: If someone with complex needs where would they fit into this. Where would they go? Funding might come from Mental Health or Learning Disabilities, but do they come together to make that assessment so that each dept is taking responsibility?
Answer: As above.

Stakeholder Event in Walsall, WS1 4SA
Thursday 11th April; 4pm to 6pm
14 stakeholders attended the event from a variety of organisations such as Healthwatch; Dudley Metropolitan Council; Walsall Council; Dignus Health Care; Care First Ltd and Dudley Voices for Choices.
Key Discussion points and questions
Positive Impacts:

- Better integrated working, it was felt that the new model would offer this opportunity but needed time and investment to make it work.

- Patients not having to go out of area was positive.
- Reducing beds was seen overall as positive. It was felt that having less beds would drive the community model and would be an impetus for more people to be supported in the community.
- Being supported in the community was felt to be more positive than having to be admitted to hospital unnecessarily for prolonged periods of time.
- Stakeholders saw the location of the proposed community model as positive due to the proximity of more facilities such as shops and community activities.
- Stakeholders felt that Penrose would become a hub of services and this was seen as positive.
- IST already based at Penrose, so will aid smooth transition.

Attendees did not express negative impacts but asked questions:

Questions

Question: What about travel, public transport is not ideal?
Answer: It was explained that travel had been taken into consideration during the quality impact assessment and funding via an application process would be allocated for those who were finding travel difficult.

Question: Is the building fit for purpose, for example, are there male and female areas, has it been taken into consideration that people with learning difficulties will have different needs, for example those with autism.
Answer: The layout of the building was described, and reassurance given. It was also explained that as further development at the site was planned, stakeholders, patients and the public would be invited to feedback on the process.

Question: Why have 10 beds been allocated to the new service model?
Answer: A study of bed usage was undertaken to calculate how many beds would be needed to fulfil the requirements of the new service model.

Question: What about people who need a step-down from being in hospital for a long time to going back into the community?
Answer: It was explained that there would be purpose- built accommodation and support to fulfil this type of need.

Question: What about children?
Answer: A children's pathway is being developed as part of the Transforming Community Services Programme.

Question: What about people with autism?
Answer: This is also part of ongoing work.

Stakeholders also made the following points:

- The importance of working with partners such as the police service, the emergency services, and social care services, particularly to manage crisis situations. The importance of all personnel receiving training so that approach to crisis situations was consistent.

- Closer working together between health and social care across the area to meet patient needs was recommended.
- The importance of training and development for all staff working in the new model. The discussion point was made that if staff are working in both IST and AT4 legal boundaries need to be understood.
- The importance of patient centred services and the specialist support needed.
- Low need patients should be in mainstream services not specialist.
- There should be joint pathways with the mental health team.
- Currently, there are LD specialist nurses in Walsall for dementia and transition, it is important that these posts are maintained in the new model.
- It is important to consider how safeguarding responsibilities will be maintained in the new model e.g. Are the Safeguarding team at Sandwell ready for the impact of the new model?
- The importance of making and maintaining links to local community services. This will enable links to meaningful day opportunities. Community services available in the local area need to be scoped and relationships maintained.
- The importance of reablement skills development for service users.

Stakeholder Event in Dudley DY 1 Community building, Dudley, DY1 1RT. Thursday 2 May 2019, 5.30-7.30pm

13 stakeholders attended the event from a range of organisations including: Dudley Heathwatch, PPGs, Dudley Voices for Choices, Camphill Village Trust, Riverside House. A student nurse also attended and members of the public.

Key Discussion points and questions

Positive Impacts:

- Individuals are being considered
- Penrose is well placed
- Transport is on a simple route
- Provides more opportunities to be independent
- Good discharge plans
- Winterbourne must never happen again. This model is the right direction.
- Right treatment, right place, shorter stay.

Attendees did not express negative impacts but asked questions:

Questions

Question: Friends and parents need to be welcome, in the new model you talk about the new café for patients to use where they can meet and socialise with their families and friends. How will we achieve this, in my experience up and down the county it doesn’t happen?

Answer: We have funds to make the site more interactive so that it becomes a community hub and achieve a very different model. The new model will allow people to feel they remain in the heart of the community ready for rehabilitation.

Question: How many beds are there in the new model?
Answer: There are ten beds in the new model for patients within the Black Country.

Question: I am sceptical, my experience has led me to feel this. Are the ideas to be supported by the new model really achievable?
Answer: Yes, we are relocating, but the principles are already in place. Money is being invested to enhance the model.

Question: What is the current take up of beds, how do you know ten beds will be enough?
Answer: We did a complete bed analysis. Early indications are showing the calculations are correct. The introduction of the new teams is already having an impact. So far 15 admissions have been avoided.

Question: Has autism been considered as part of the new model of care?
Answer: We are currently looking at what an autism service could look like. We are working jointly with mental health. From the commissioner's point of view this piece of work it the initial stage. We are now working on how to meet existing gaps.

Attendees also made the following points:

- Autism should not be under mental health, it is neurological not mental health.
- Between the ages of 16yrs and 18yrs there is no support available. At 18 I can access adult services, but all young people should be supported with a transition plan (education and health plan), if you are not considered severe you don't get one. There is no access to mental health. There is a big gap in health services for 16 to 18year olds. The is needed before people get to crisis. Early intervention is needed. People need activity, purpose, opportunity, a lot has been cut and taken away and this leads to challenging behaviour due to frustration. There are not enough staff to provide the help needed, nurses have far too many patients.
- It is very important to understand that LD people can be very vulnerable in the community. People need to know how to look after themselves for example Safe Place schemes. There also needs more education to promote understanding amongst the community.
- Transport needs to be considered. It is important that access is easy so that relatives can visit.
- It is important that the length of stay in hospital is appropriate. Assessment and treatment centres should be no different than any other episode when you are treated for any other illness. The discharge date should be identified on day of admission.
- The environment and approach are so important. Well trained staff recognise triggers and crisis is prevented.
- The new model may need to families having more responsibility and it is important not to overburden them. There is a need for relationship building between professionals and the family for some previous experience has made

families reluctant to trust professionals. People need to understand what policies and processes are in place to ensure the patient's best interests are at the centre of decision making. Carers and parents really know the patients.
- People are viewed in the community more as an individual and not as 'a patient'.
- A de-escalation suite should be considered as part of the new model
- It is important to have access to other services.

Across all engagement events the new model was received with positivity, any concerns were shared and discussed, and questions answered. Key themes emerged, such as:

Key themes

- The community focus offered by the new model.
- The importance of relationship building and maintaining a good relationship between, patients, family members, carers and professionals.
- Transport and access to the Penrose site for visitors,
- Consideration for those with autism.
- Consideration for those in transition (age 16 to 18yrs).
- The response to crisis.
- The number of beds (10) in the new model

It is recommended that all notes from the events are read in full to ensure all points

Black Country Transforming Care Programme

Improving services for adults with learning disabilities

Engaging with you

Thursday 21st March to Thursday 23rd May 2019 (midnight) 2019.

Black Country Transforming Care Programme

Improving services for adults with learning disabilities

Engaging with You

Thursday 21 March to Thursday 23 May 2019 (midnight).

Contents

Foreword

Foreword

Welcome to our engagement on transforming care for people with learning disabilities in the Black Country.

Following the investigation into abuse at Winterbourne View in 2015 and other similar hospitals, there has been a cross-government commitment to move all people with learning disabilities who were inappropriately placed in such institutions into community care.

The local NHS clinical commissioning groups, the organisations that plan and pay for many of our health services, in partnership with the local authorities, have been working to make improvements in care and support following the Winterbourne investigation.

The Transforming Care Programme was established to build on that work and accelerate progress to transform care and support for people with learning disabilities and/or autism. It is a nationally mandated programme that is being rolled out across the country.

In the Black Country our work in this area aims to:

- Improve quality of care for people with learning disabilities
- Improve quality of life for people with learning disabilities
- Enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay

Our work so far has focused on areas such as:

- Early intervention to minimise the development of challenging behaviours
- Crisis prevention to provide the right kind of support to prevent and reduce instances of crisis
- Addressing crises by responding effectively to stabilise an individual's situation
- Ensuring effective discharge to avoid repeat hospital admissions.

All of this means developing more community-based teams with specially trained social workers, nurses, psychologists, psychiatrists and other staff working more closely together around the needs of the child, young person or adult and their family. With fewer hospital admissions, we are intending to free up resources from existing assessment and treatment units which can be invested in the community model.

This public engagement exercise is seeking people's views on the community-based services that have been put in place in the Black Country and the impact on specialist inpatient assessment and treatment beds for adults with learning disabilities.

It follows the service-user engagement that was carried out between April 2016 and July 2018 to develop and test the community services. It will ensure people living in the Black Country, regardless of which area they live in, have had the same opportunity to share their thoughts and views on the services and support we are putting in place for adults with learning disabilities.

The Black Country Transforming Care Programme is also developing services around autism and for children and young people and will engage separately on these pathways.

I would encourage anyone with an interest to take the time to read through this document and contribute to local plans to transform care by completing the short survey on page 17.

Alternatively, you can complete the survey and view this engagement document online at: Survey – Black Country Transforming Care Programme 2019.

If you would like to meet us to discuss anything outlined in the proposals before you complete the survey, please attend one of the public meetings highlighted on page 16.

- West Bromwich – Monday 8 April 2019, 1.30-3.30pm
- Wolverhampton – Tuesday 9 April 2019, 10am-12pm
- Walsall – Thursday 11 April 2019, 4-6pm
- Dudley – Thursday 2 May 2019, 5.30-7.30pm

Hafsha Ali
Programme Director
Black Country Transforming Care Programme

Introduction

This document describes the current Black Country position of the national Transforming Care Programme (TCP) for adults with learning disabilities, who display behaviour that challenges, including those with a mental health condition. It also sets out aims and proposals for the future.

Behaviour that challenges means people harming themselves or other people, or damaging property and things. It sometimes leads to people with learning disabilities getting into difficulties with the police and criminal justice system.

TCP is only concerned with low and medium secure hospital services, not high secure services.

The Transforming Care Programme is about making sure more people are supported to receive health assessment and treatment in the community and close to home wherever this is possible. Assessment and treatment will be provided by community teams with specially trained social workers, nurses, psychologists, psychiatrists and other staff. Service users will only go to hospital because their health needs cannot be met safely in the community at that time. That hospital care will be high quality specialist care and stays will be for the shortest time possible.

The Black Country TCP has been working with people with learning disabilities and their families and carers to develop and deliver a new community model of care that maintains their rights, respect and dignity. People who require assessment and treatment in an inpatient setting will still have access to beds in the Black Country.

However, because we are investing in a community model, we need fewer assessment and treatment beds. Clinicians and other experts have analysed the existing assessment and treatment units and believe the unit that best meets the requirements for a safe and effective service is Penrose House in Sandwell.

The purpose of this engagement is to seek your views on the following:

- The introduction of a new community model for people with learning disabilities that provides enhanced support in the community
- The permanent closure of specialist inpatient beds at Ridge Hill Hospital, Dudley and Orchard Hills/Daisy Bank, Walsall. (These are beds that are reserved for assessing and treating people with learning disabilities and are not connected to general hospital services.)
- The preferred clinical option to locate a single assessment and treatment centre at West Bromwich, Sandwell
- The impact (positive and negative) of proposed changes on service users, family members and carers and what support you feel needs to be in place to make the new model successful.

At the end of this document we ask you what you think of these plans and what we should consider when making changes, by filling in a short survey. We will use this feedback to ensure we understand the impact of our community model and are able to take any mitigating action – should it be necessary.

Who is involved in the Black Country TCP?

The Black Country TCP covers Dudley, Sandwell, Walsall and Wolverhampton. Partners include:

Clinical Commissioning Groups

- Dudley CCG
- Sandwell and West Birmingham CCG
- Walsall CCG
- Wolverhampton CCG

Local Authorities

- City of Wolverhampton Council
- Dudley Council
- Sandwell Metropolitan Borough Council
- Walsall Council

Provider(s)

- Black Country Partnership Foundation Trust (BCPFT)
- Wider social care market

Also participating in the programme are current service users, their families and the organisations that provide services for them.

The current situation in the Black Country

The Black Country is home to approximately 17,000 adults, over the age of 18 years who have a learning disability including 1,000 people with a severe learning disability and 300 who display behaviour that challenges[1].

We have already started to deliver a strengthened community model for people with learning disabilities that is designed to support people to stay in the community near their family and friends by ensuring services work together across health and social care, secure settings and other services in the Black Country.

The community model includes: an intensive support service to help avoid unnecessary hospital stays; a forensic support service for people involved in the criminal justice system, or likely to become so. See page 9 for more detail.

However, there will still be a need for short-term inpatient assessment and treatment beds for some people with learning disabilities to help them through a specific health need that cannot be managed in the community. Within the Black Country, we are reducing the number of specialist beds from 28 to 10. This is based on the national recommendation to provide 10-15 beds per 1m population.

In the Black Country we currently have one active assessment and treatment unit at Penrose House, Small Heath Lane Hospital in West Bromwich which has 10 beds and can treat men and women in separate facilities. In addition, community-based teams from Black Country Partnership NHS Foundation Trust support adults with learning disabilities.

Smaller assessment and treatment units at Ridge Hill Hospital (Dudley) and Orchard Hills/Daisy Bank (Walsall) are currently not in use following a clinical assessment of these provisions in January 2017. The assessment raised environmental, clinical and staffing concerns about the assessment and treatment services at these sites. Patients who were using these beds have been discharged and are being treated in the community. In 2016 three learning disability assessment and treatment in-patient beds at Pond Lane Hospital, Wolverhampton were closed, following a public consultation.

[1] Projecting Adult Needs and Service Information, Institute of Public Care, Oxford Brookes University

How the community model works

The Black Country Transforming Care Programme (TCP) has been working with people with learning disabilities, their families and carers to agree and deliver a community model of care based on the following principles

- Involving people with learning disabilities in their own care
- Better identification of people at risk who may need intensive support
- Support for families and carers to keep people in their own home environment

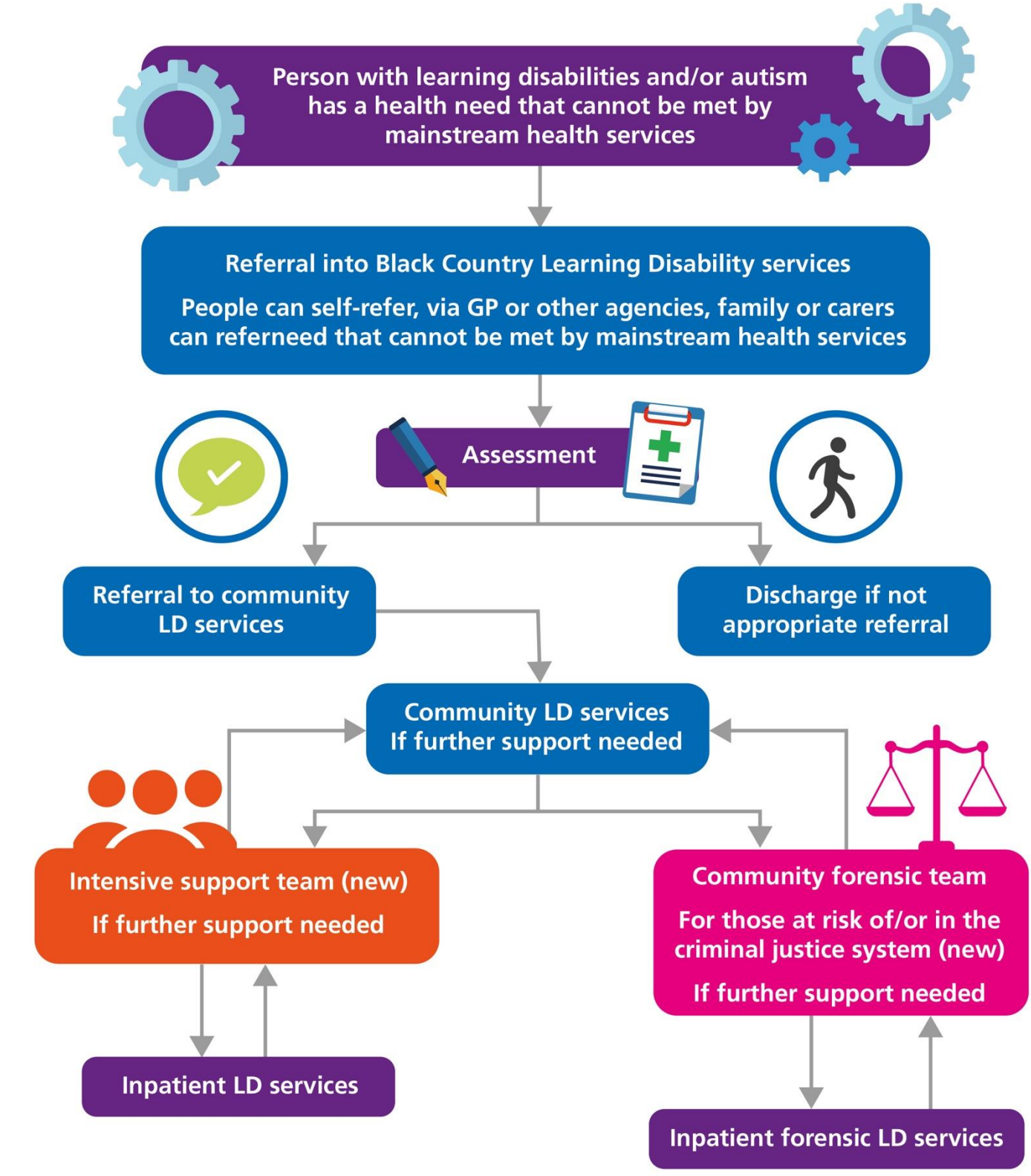
Through this work, we are ensuring services are available for people with learning disabilities in the right place, at the right time and delivered in the right way

We believe the best way to deliver services for people with learning disabilities is in the community, through the following services and the pathway can be seen on page 10.

- Community learning disability service
- Assessment and treatment beds
- Intensive support service
- Forensic support service

Black Country Transforming Care Programme – new patient pathway

TCP Black Country LD services patient pathway



Community Learning Disability Service

There are four community learning disability teams, one in each of the four Black Country and West Birmingham localities, Dudley, Sandwell, Walsall and Wolverhampton. The teams aim to provide a flexible, proactive, co-ordinated and integrated service for people over 18-years-old who have a diagnosed learning disability, are unable to access mainstream services and/or require access to a specialist health team.

The service enables service users to:

- Be as independent as possible, in the least restrictive way
- Avoid unnecessary hospitalisation
- Be discharged in a timely manner from hospital inpatient care
- Be supported to access their physical and mental health care in a way that meets their individual needs as far as possible
- To live as independently as possible in the community
- Be involved in decision making about their care
- Receive timely and accessible interventions when experiencing psychiatric, psycho-social, behavioural and/or pharmacological problems.

In addition, the service supports families and carers by improving communications methods and mechanisms and helping them to navigate the assessment process and meet the demands of caring.

It also supports staff and professionals who deliver the service by providing specialist training to enable them to support the needs of service users effectively.

Assessment and treatment beds

This is a 24-hour inpatient acute assessment and treatment service for people with learning disabilities and complex health needs.

The aim of acute learning disability inpatient services is to provide the following three core functions of support:

- The holistic assessment of and treatment for mental illness or disorder in an individual with a learning disability and associated emotional and behavioural distress, where it cannot be safely or appropriately managed in the community
- A safe place where people feel they are able to take steps towards their recovery
- Reintegration of the individual back into the community after hospital treatment including provision of support/guidance to families and carers in conjunction with Community Learning Disability and Intensive Support Teams.

Intensive support service

The Community Intensive Support Team provides a flexible, proactive, co-ordinated and integrated service, for people over 18 years-old, who have a diagnosed learning disability, are unable to access main stream services and/or require a specialist intervention team.

As with the Community Learning Disability Service, this service aims to prevent unnecessary hospitalisation, ensure timely discharge from inpatient care and support service users to live as independently as possible. In addition, the service enables:

- Early detection and timely early interventions at referral, working with community teams
- Intensive response to crisis
- Working alongside multi-disciplinary teams to assess and develop plans to support service users in managing challenging behaviours
- Planning of strategies to prevent future crisis, working with community teams
- Assessment of family carers' needs to support them with the demands of caring during periods of crisis
- Timely and accessible intervention for patients experiencing psychiatric, psycho-social, behavioural and/or pharmacological problems.

Forensic support service

The Community Forensic Team provides a flexible, proactive, co-ordinated and integrated service for people over 18 years-old with a diagnosed learning disability who are either subject to the criminal justice system or at significant risk of becoming so, are unable to access mainstream services and/or require a specialist forensic team.

In summary the service:

- Provides timely and accessible intervention to clients with active and ongoing forensic and psychiatric, psycho-social, behavioural or pharmacological needs, and consultation to the people who support them
- Promotes the qualities and values of the national Good Lives Model of offender rehabilitation
- Enables the highest level of independence possible, in the least restrictive way
- Prevents and avoid unnecessary hospitalisation.
- Facilitates timely discharge from hospital inpatient forensic care.
- Signposts and supports families and carers in accessing extra help with the demands of caring and involvement with the criminal justice system.

Identifying the best location for assessment and treatment beds

We recognise there will be times when some people with learning disabilities who may have autism need to go into a hospital bed. We know that when this happens, people want to be as close to home as possible, therefore retaining some assessment and treatment beds in the Black Country is a priority.

Our aim is to develop a single state of the art assessment and treatment centre that can provide the high level of care service users need with the focus on getting them back into the community, near their family and friends, as soon as possible.

As part of this process, senior clinicians and other relevant professionals The Black Country Partnership NHS Foundation Trust reviewed the three available units at Penrose House (Sandwell), Daisy Bank Unit (Walsall) and Ridge Hill Unit (Dudley) to determine which could best deliver the national TCP approach.

The clinicians concluded that both the Dudley and Walsall sites were inappropriate to deliver the new model of care for people with learning disabilities because:

- Both sites are in isolated community locations
- Neither affords a safe level of clinical support including emergency response to clinical incidents
- The physical environment at each of the two sites is inappropriate for managing the transformation of care.

The review also showed that Penrose House does allow for an emergency response from the MacArthur unit and Gerry Simon Clinic along with the surrounding support infrastructure. The review has therefore concluded that Penrose House is the clinically safest and most appropriate site for TCP assessment and treatment beds.

Have your say

We believe the Transforming Care Programme model of care we have outlined is the right one. We want to be sure we have captured all your thoughts and concerns before we ask our clinical commissioners to agree to the permanent closure of assessment and treatment beds in Dudley and Walsall. This will enable us to take any supportive action needed to ensure our community model delivers the best possible care for people in the Black Country with learning disabilities.

Throughout this eight-week engagement period, we will be talking to local councillors, MPs, GPs, NHS staff, specialist schools and advocacy services to seek their views too.

Now that we have described the national programme, the local situation and our plans for the future in the Black Country, we would like to know what you think about it. Your views are very important and will be used to understand any action needed as a result of inpatient bed closures, and to further shape community support.

This public engagement exercise runs from **Thursday 21 March to Thursday 23 May**.

You can get involved through a variety of different methods:

- **Attending one of our engagement events**
  - Yemeni Community Association in Sandwell Limited, Greets Green Access Centre, Tildasley Street, West Bromwich, B70 9SJ. Monday 8 April 2019, 1.30-3.30pm
  - Molineux stadium, Waterloo Road, Wolverhampton, WV1 4QR. Tuesday 9 April 2019, 10am-12pm
  - Bescot Stadium, Bescot Crescent, Walsall, WS1 4SA. Thursday 11 April 2019, 4-6pm
  - DY 1 Community building, Stafford Street, Dudley, DY1 1RT. Thursday 2 May 2019, 5.30-7.30pm

- Completing the questionnaire at the end of this document (Page 15) and posting it to **Freepost NHS QUESTIONNAIRE RESPONSES**

- Visiting: https://www.surveymonkey.co.uk/r/careprogramme and **completing the survey online.** If viewing this document online you can access the survey by clicking the following link Survey – Black Country Transforming Care Programme 2019

- **Inviting a representative from the engagement team to your meetings**, if you belong to a group or organisation. If you would like somebody to attend to speak to your members, colleagues, friends or staff please call 0121 611 0611.

Your views will feed into a full report which will be considered by the Transforming Care Programme Board as soon as possible once the engagement has been completed. The Programme Board will then make a recommendation to each Clinical Commissioning Group to inform decision making on the future of learning disability services in the Black Country.

Please take a few minutes to complete the questionnaire below:

Patient and public survey

Improving services in the Black Country for people with learning disabilities

Black Country Transforming Care Programme 2019 Survey

Q1. What impact do you feel it will have if care and support is being delivered in your community as outlined in the introduction to this survey, rather than in hospital?

- ☐ Positive Impact
- ☐ No Impact
- ☐ Negative Impact
- ☐ Prefer not to answer

Q2. What impact do you feel it will have if care and support is being delivered in the community rather than in hospital for a person with a learning disability displaying challenging behaviours?

- ☐ Positive Impact
- ☐ No Impact
- ☐ Negative Impact
- ☐ Prefer not to answer

Please tell us the reason for your answer:

Q3. What impact do you feel it will have if care and support is being delivered in the community rather than in hospital for a service user's family members or carer?

- ☐ Positive Impact
- ☐ No Impact
- ☐ Negative Impact
- ☐ Prefer not to answer

Please tell us the reason for your answer:

By treating more people with learning disabilities in the community we are reducing the need for inpatient beds but we will need some. Clinicians believe the unit that can best provide a safe and effective service is Penrose House, Small Heath Lane Hospital in West Bromwich, Sandwell. This site can treat men and women in separate facilities and has access to emergency services 24/7. Locating the unit here will mean the accommodation at Ridge Hill in Dudley and Orchard Hills/Daisy Bank in Walsall will remain closed

Q4. If the assessment and treatment centre was based at Penrose House what would the impact be for you?

- ☐ Positive
- ☐ Negative
- ☐ No impact

Please explain the reason for your answer:

Q5. If the assessment and treatment centre was based at Penrose House what would the impact be for family/carers?

☐ Positive

☐ Negative

☐ No impact

Please explain the reason for your answer:

Questions about the community model

The following three questions – Q6, Q7 and Q8 – ask about the importance of specific support for people with learning disabilities in different circumstances:

- To reduce the likelihood and severity of challenging behaviour
- In times of crisis
- When moving between hospital and community/home

We will use this information to inform further development of our community model.

Q6. How important are the following services in giving early help to reduce the likelihood of challenging behaviour being displayed, and the frequency and severity of challenging behaviour?

Please specify how important each type of support is by ticking the appropriate box.

Support Services	**Very Important**	**Important**	**Not important**	**Not important at all**
Support with daily life activities – help with day to day living e.g. washing, dressing, cooking, shopping				

Communication – help communicating with people				
Behaviour – help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse				
Personal support / being active in the community – help with making relationships and playing a part in family and community life				
Environment / home life - help with getting a good quality of life e.g. participating in wider activities, the opportunity to follow interests, trying new things				
Help to have the best physical environment. E.g. housing				
Help to deal with changing environments e.g. moving home, moving out of hospital, the right kind of housing				
Family carer support/ additional support - giving breaks to those being cared for, and their carers				
Information and advice – good information and advice to help make good decisions and to know what support is available				

Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference:

Q7. When a crisis happens, how important are the following services to prevent hospital admission?

Please specify how important each type of support is by ticking the appropriate box.

Support Services	Very Important	Important	Not important	Not important at all
Support with daily life activities - help with day to day living e.g. washing, dressing, cooking, shopping				
Communication - help communicating with people				
Behaviour - help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse				
Personal support/being active in the Community - help with making relationships and playing a part in family and community life				
Environment/ home life – help with getting a good quality of life e.g. participating in wider activities, the opportunity to follow interests, trying new things				
Help to have the best physical environment – e.g. housing				
Help to deal with changing environment: moving home, moving out of hospital, the				

right kind of housing				
Family carer support / additional support - giving breaks to those being cared for, and their carers; Support with helping a child progress to adulthood				
Information and advice - good information and advice to help make good decisions and to know what support is available				

Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference:

Q8. When someone is discharged from hospital, how important are the following services to prevent them going back in?

Please specify how important each type of support is by ticking the appropriate box.

Support Services	**Very Important**	**Important**	**Not important**	**Not important at all**
Support with daily life activities – help with day to day living e.g. washing, dressing, cooking, shopping				
Communication – help				

communicating with people				
Behaviour – help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse				
Personal support / being active in the community - Help with making relationships and playing a part in family and community life				
Environment / home life – help with getting a good quality of life e.g. Participating in wider activities, opportunities to follow interests, trying new things				
Help to deal with changing environments e.g. moving home, moving out of hospital the right kind of housing				
Help to have the best physical environment e.g. housing				
Family carer support / additional support – giving breaks to those being cared for, and their carers				
Information and advice – good information and advice to help make good decisions and to know what support is available				

Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference for people when they moving out of hospital and into the community:

Q9. In your experience what stops or delays a person getting the right support in the community? (For example, not enough funding for community services being available or in place).

Q10. From your experience please tell us what can go wrong with being supported/ supporting someone in the community? (For example, not having the support in place for the person early on).

Q11. Are you answering this survey as a:

- ☐ Service user
- ☐ Carer of a service user
- ☐ Family member of a service user
- ☐ Clinician working with service users
- ☐ Member of the public
- ☐ Other – please state …….

Q12. How satisfied are you with the way this public engagement exercise is being run?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither satisfied or dissatisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied
- ☐ Prefer not to answer

If you wish to expand on your answer please use the space below.

Q13. How did you find out about this public engagement exercise?

- ☐ Poster
- ☐ In a voluntary/community organisation
- ☐ At a learning disability day service
- ☐ Newspaper
- ☐ Social media (Facebook/Twitter)
- ☐ Drop-in event
- ☐ Someone stopped you in the street (NHS Outreach Engagement Team)
- ☐ Radio
- ☐ NHS or Council website
- ☐ A friend or family member told me
- ☐ Other

If other, please tell us how you heard:

Equalities monitoring

We recognise and actively promote the benefits of diversity and we are committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

Q14a. Which area/district do you live in?

My area/district is:

- ☐ Dudley
- ☐ Sandwell
- ☐ Walsall
- ☐ Wolverhampton
- ☐ Other

If you have selected 'other' please specify the area/district below:

……

Q14b. Please tick your postcode from the list below

Dudley Postcodes

B62 2 ☐ 8 ☐ 9 ☐	**B63** 1 ☐ 2 ☐ 3 ☐ 4 ☐	**B64** 5 ☐ 6 ☐ 7 ☐	**B65** 0 ☐ 8 ☐ 9 ☐	**DY1** 1 ☐ 2 ☐ 3 ☐ 4 ☐	**DY1** 9 ☐ 0 ☐
DY2 0 ☐ 7 ☐ 8 ☐ 9 ☐	**DY3** 1 ☐ 2 ☐ 3 ☐ 4 ☐	**DY4** 7 ☐ 8 ☐ 9 ☐	**DY5** 1 ☐ 2 ☐ 3 ☐ 4 ☐	**DY5** 9 ☐	**DY6** 0 ☐ 6 ☐ 7 ☐ 8 ☐
DY6 9 ☐	**DY7** 5 ☐ 6 ☐	**DY8** 1 ☐ 2 ☐ 3 ☐ 4 ☐	**DY8** 5 ☐ 9 ☐	**DY9** 0 ☐ 7 ☐ 8 ☐ 9 ☐	**WV1** 1 ☐ 4 ☐ **WV4** 6 ☐

If you live in Dudley and your post code is not listed, please write it here below:

……

Walsall Postcodes					
WS1 ☐	WS5 ☐	WS9 ☐	WS13 ☐	WV12 ☐	B43 ☐
WS2 ☐	WS6 ☐	WS10 ☐	WS14 ☐		
WS3 ☐	WS7 ☐	WS11 ☐	WS15 ☐	WV13 ☐	B74 ☐
WS4 ☐	WS8 ☐	WS12 ☐			

If you live in Walsall and your post code is not listed, please write it below:

……

Wolverhampton Postcodes					
WV1 ☐	WV4 ☐	☐	WS11 ☐	WV14 ☐	WV16 ☐
WV2 ☐	WV5 ☐	WV8	WS12 ☐	WV15 ☐	
WV3 ☐	WV6 ☐	WV9 ☐	WS13 ☐		
		WV10 ☐			

If you live in Wolverhampton and your post code is not listed, please write it below:

……

Sandwell Postcodes					
B16 ☐	B21 ☐	B63 ☐	B67 ☐	B71 ☐	WS1 4NH ☐
B17 ☐	B42 ☐	B64 ☐	B68 ☐	DY4 ☐	WS5 ☐
B18 ☐	B43 ☐	B65 ☐	B69 ☐	WS10 ☐	WV14 ☐
	B62 ☐	B66 ☐	B70		

If you live in Sandwell and your post code is not listed, please write below:

……

Q15. What is your gender?

☐ Male

☐ Female

☐ Transgender

☐ Prefer not to say

Q16. If female, are you currently pregnant or have you given birth within the last 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q17. What is your age?

- ☐ 16-24
- ☐ 25-34
- ☐ 35-59
- ☐ 60-74
- ☐ 75+

Q18. What is your ethnic group?

- ☐ Arab
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Gypsy/Romany/Irish traveller
- ☐ Mixed dual heritage
- ☐ White or White British
- ☐ Prefer not to say
- ☐ Other (please specify) ……..

Q19. Do you look after, or give any help or support to family members, friends, neighbours or others. Please note this is not referring to the person you care for if you have specified carer or if you are completing this survey on behalf of someone else?

- ☐ Long-term physical or mental-ill-health/disability
- ☐ Problems related to old age
- ☐ No
- ☐ Prefer not to say
- ☐ Other, please describe ……

Q20. Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)

- ☐ Vision (such as due to blindness or partial sight)
- ☐ Hearing (such as due to deafness or partial hearing)
- ☐ Mobility (such as difficulty walking short distances, climbing stairs)
- ☐ Dexterity (such as lifting and carrying objects, using a keyboard)
- ☐ Ability to concentrate, learn or understand (Learning Disability/Difficulty)
- ☐ Memory
- ☐ Mental ill-health
- ☐ Stamina or breathing difficulty or fatigue
- ☐ Social or behavioural issues (for example, due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Aspergers' Syndrome)
- ☐ No
- ☐ Prefer not to say

Any other condition or illness, please specify .....

Q21. What is your sexual orientation?

- ☐ Bisexual
- ☐ Heterosexual/straight
- ☐ Gay
- ☐ Lesbian
- ☐ Prefer not to say

Any other (please specify) …….....

Please continue

Q23. Are you:

- ☐ Single
- ☐ Never married or partnered
- ☐ Living in a couple
- ☐ Married/civil partnership Co-habiting
- ☐ Not living in a couple
- ☐ Married (but not living with husband/wife/civil partner)
- ☐ Separated (still married or in a civil partnership) Divorced/dissolved civil partnership)
- ☐ Widowed/surviving partner/civil partner
- ☐ Prefer not to say
- ☐ If other, please specify……

Q24. What is your religion and belief?

- ☐ No religion
- ☐ Baha'i
- ☐ Buddhist
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Hindu
- ☐ Jain
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ If other, please specify……

Thank you for taking the time to read this and tell us what you think.

Please send your completed questionnaire to:

Freepost NHS QUESTIONNAIRE RESPONSES

Please ensure that you write the address as shown, so that the Post Office's machines can read the address automatically. You just need this address, which will be delivered to us.

• Alternatively you can complete the questionnaire online by going to

Survey – Black Country Transforming Care Programme 2019

• If you wish to email us in connection to any responses or to get in touch please email: agem.communications@nhs.net.

Jargon Buster

If there are any parts of this document you do not understand, you might find it helpful to read these definitions.

- **Assessment and treatment units:** Specialist assessment and treatment in a therapeutic environment. People placed in Assessment and Treatment Units may be voluntary patients or they may be admitted under the Mental Health Act. They may have mental health problems and/or present seriously challenging behaviours, and they may be admitted from their home or as a 'step-down' from a secure unit. Some have more security features than others. Some are more community-based than others.

- **Autism:** Autism is a lifelong, developmental disability (from birth) that affects how a person communicates with and relates to other people, and how they experience the world around them.

- **Challenging behaviours:** Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.

- **Commissioning:** Commissioning is the planning and purchasing of NHS services to meet the health needs of a local population.

- **Community based assessment and treatment services:** Advice, assessment and short term treatment for mental health concerns.

- **Crisis:** A crisis is an emotional and physical response to some precipitating event or series of events that for a person with a learning disability or autistic spectrum disorder and who displays challenging behaviour, disrupts the current care and support situation. The crisis happens when something is experienced that is so hurtful, challenging, or threatening that the person concerned feels overwhelmed. For a person with a learning disability or autistic spectrum disorder who displays challenging behaviour, a crisis often causes a placement breakdown, with the person unable to continue in their current placement. It may also be a mental health crisis, when the person concerned feels their mental health is at breaking point. For example this may include hitting and kicking, throwing items, severe withdrawal and other behaviours which may result in them coming into contact with the criminal justice system e.g. the police.

- **Inpatient bed:** a hospital patient who occupies a bed for a least one night in the course of treatment, examination or observation.

- **Learning disability:** A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life. People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complex information and interact with other people.

- **Locked and unlocked rehabilitation services:** is a whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by enhancing skills, promoting independence and autonomy in order to give them real

opportunity for the future that may lead to successful community living through appropriate support.

The service provides high levels of therapeutic care underpinned by evidence-based practice in keeping with industry norms, where this is published or is custom and practice. This will include a comprehensive assessment of the needs of the individual in order to devise an individualised treatment programme that will address social, physical, intellectual and mental health needs within a specific and measurable care plan, regularly collated and reviewed through the CPA framework.

The maintenance of a safe, sound and secure environment for all is paramount. It is expected that the level of security will be based on individual patient need, the responsibility to protect others, and/or prevention of harm to self. Service delivery will take account of patient diversity, meeting the needs of gender, cultural and religious diversity through policies and practices that positively respect the patient's gender, cultural, religious and spiritual preferences.

- **Low and medium secure hospitals:** Low secure provision provides a care and treatment environment for individuals who present a less physical danger to others. Security arrangements should impede rather than completely prevent those who wish either to escape or abscond. Low secure provisions will have a greater reliance on staff observation and support rather than physical security measures. Low Secure Services are not Psychiatric Intensive Care Units. Low Secure services should emphasise access to community services, and promote a philosophy of community integration.

  Medium secure provision provides a care and treatment environment for individuals who present a serious but less immediate danger to others. Physical security with security protocols and procedures, supported by high levels of staff should be sufficient to deter all but the most determined to escape or abscond. These environments should meet the needs of those who are not yet ready for leave into the community, but with an emphasis on graduated use of community facilities when possible.

  Each secure mental health provider will ensure, though the Care Programme Approach process that each individual patient will receive high-quality care and treatment which meets their needs and supports their recovery.

- **Mental health condition:** Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions.

- **NHS clinical commissioning groups:** NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

- **NHS England Specialised Commissioning:** Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

- **Quality of life:** the standard of health, comfort, and happiness experienced by an individual or Group.

- **Rehabilitation:** Intensive rehabilitation support for people with severe and enduring mental health problems, in a community setting. Service users are supported to engage in recovery focused interventions which include: practical assessment of activities of daily living;

tenancy support needs; family education and interventions; symptom management and treatment; medication education and management; developing wellness recovery plans; community engagement.

- **Respite care:** Can mean short term residential care – where the person you care for goes to stay in a care home or other residential setting for a short time; getting more paid help at home – this could be via paid workers helping with care or getting more help with tasks around the home; getting someone to keep the person you care for company whilst you go out - sitting and befriending services; doing something you enjoy; the person you care for taking part in activities outside the home taking a holiday with or without the person you care for.

- **Secure hospitals:** The NHS or private organisations run secure hospitals. If you are in a secure hospital, you will usually be under a section of the Mental Health Act. Secure units are gender specific so there will be separate wards for men and women. There are adolescent units too, for people under 18 years. There are different levels of secure hospitals - low, medium and high security.

Thank you…

Thank you for taking the time to read this and tell us what you think.

Please send it to:
Freepost NHS QUESTIONNAIRE RESPONSES

Please ensure that you write the address as shown above, so that the Post Office's machines can read the address automatically. You just need this address, which will be delivered to us.

Alternatively, you can complete the questionnaire online by going to any of the four CCGs involved in this engagement:

- Dudley CCG
- Sandwell and West Birmingham CCG
- Walsall CCG
- Wolverhampton CCG.

If you wish to email us in connection to any responses or to get in touch, please email agem.communications@nhs.net.

Do you need any further help?

We can provide versions of this document in other languages and formats such as Braille and large print on request. If you need this document presented in another format please telephone 0121 611 0611**.**

Dudley CCG
Sandwell and West Birmingham CCG
Walsall CCG
Wolverhampton CCG.

Engagement Report: Black Country Transforming Care Programme

June 2019

Contents

Appendices:
Appendix A- Engagement document
Appendix B- Easy read document
Appendix C- All feedback from engagement events
Appendix D- Equality data collected from surveys

1. Executive Summary

Introduction

Following the investigation into abuse at Winterbourne View in 2015 and other similar hospitals, there has been a cross-government commitment to move all people with learning disabilities who were inappropriately placed in such institutions into community care. To achieve reduced hospital admissions and shorter in patient stay more people need to be supported to receive health assessment and treatment in the community and close to home wherever this is possible.

The Black Country Transforming Care Partnership (BCTCP) has been working with people with learning disabilities, their families and carers to develop and deliver a new community model of care that maintains their rights, respect and dignity. This work has been informed by feedback from previous engagement undertaken by BCTCP between April 2016 and July 2018.

The new proposed model of care means investment is in a community model and, as a result, fewer assessment and treatment beds will be needed. Clinicians and other experts have analysed the existing assessment and treatment units and believe the unit that best meets the requirements for a safe and effective service is Penrose House in Sandwell.

An engagement exercise was undertaken by the CCGs from Thursday 21 March to Thursday 23 May 2019.

The purpose of the engagement process undertaken was to seek the views of stakeholders, service users, carers and family members on the following:

- The introduction of a new community model for people with learning disabilities that provides enhanced support in the community.
- The permanent closure of specialist inpatient beds at Ridge Hill Hospital, Dudley and Orchard Hills/Daisy Bank, Walsall. (These are beds that are reserved for assessing and treating people with learning disabilities and are not connected to general hospital services).

1.1 Engagement process

- The CCGs managed all stakeholder engagement across the Black Country and West Birmingham.
- **Dudley Voices for Choices (DVC)** is an advocacy group for people who have a learning disability or autism. DVC is a member of the TCP programme board to ensure that people with learning disabilities are represented at programme level.

- The CCGs commissioned NHS Arden and GEM CSU to support the engagement by: producing an engagement document to promote understanding of the TCP programme and the proposed new model; producing a questionnaire to allow feedback (see appendix A); to advise on the format of the stakeholder events and to capture all feedback at those events.
- As DVC supports people with learning disabilities and autism to speak up for themselves, they were also commissioned to undertake outreach engagement in the community and produce an easy read version of the engagement document and questionnaire (see appendix B).
- Arden and GEM were also commissioned to analyse all feedback from the engagement process and to produce this engagement report.
- Several thousand stakeholders were contacted by the CCGs and invited to get involved by attending one of the four stakeholder events and/or completing the online questionnaire.
- **Four stakeholder events** (one in each of the Black Country and West Birmingham CCG areas) took place to explain the TCP programme and hear views on the proposed service model. All feedback from the stakeholder events has been collated in this report.
- **Outreach engagement** with service users, their carers and families was undertaken by DVC; 174 conversations took place. DVC undertook interviews across Sandwell, Wolverhampton, Walsall and Dudley.
- A press release and social media also informed people how to get involved by attending one of the four stakeholder events and/or completing the questionnaire.
- Information was published on the CCG websites.

1.2 Key themes from the stakeholder events included:

- Positivity for the community focus offered by the new model.
- The importance of relationship building and maintaining good relationships between, patients, family members, carers and professionals.
- Transport and access to the Penrose site for visitors.
- Consideration for those with autism.
- Consideration for those in transition (aged 16 to 18 years old).
- The response to crisis.
- The number of treatment and assessment beds (10) in the new model.

1.3 Key themes from the outreach engagement included:

- Transport and access to the assessment and treatment centres.
- Cost implications of travelling around the areas.

- Enough beds to meet the needs of all areas.

1.4 Questionnaire analysis (50 surveys completed)

- Most respondents (62%) felt it would have a positive impact if care and support were delivered in the community rather than in a hospital, compared to 10% of respondents who said it would have a negative impact.
- Nearly half of respondents (46%) felt it would have a positive impact if care and support were delivered in the community for a person with a learning disability and/or autism displaying challenging behaviours, compared to just over a quarter (28%) who believed this would have a negative impact.
- Many more family members and carers (44%) felt it would have a positive impact if care and support were delivered in the community, than felt it would have a negative impact (14%).
- When asked: 'If the assessment and treatment centre was based at Penrose House what would the impact be for you?', 28% of respondents felt it would have a negative impact; 22% believed this would have a positive impact. Other responses (36%) included: 14 respondents were not sure; three believed the distance to be an issue; one preferred not to answer this question.
- When families and carers were asked about the impact of having the assessment and treatment centre based at Penrose House, 20.41% felt this would have a negative impact; 18.37% believed the impact would be positive. The largest number of respondents (51.02%) were unsure; 10.20% believe this would have no impact.
- People were asked how important help/support and information and advice were across a range of circumstances. These included: personal support; environments; family carer support; information and advice, for all areas most people selected 'very important' as their answer.
- People answered questions on prevention of crisis admission to hospital. Categories included: support with daily activities; communication; understanding situations that may lead to challenging behaviour and avoidance; personal support; environment; family/care support and information and advice. For all answers most people said it was 'very important' to have support across all categories to prevent crisis.
- People were asked questions on support needed for discharge to prevent readmission. A range of categories were considered: support with daily life; communication; behaviour; personal support; environment; family/carer support and information and advice. Most respondents felt that support for all categories was very important.
- When asked what respondents felt stopped or delayed a person getting the right support in the community areas, responses included:
  - Lack of family support and affordable care homes

    - Lack of funding for services
    - Lack of communication between the different services and professionals.
    - The need for accurate and up to date information about services
    - The need for more qualified staff.
- People were asked to consider their experience of things going wrong with being supported/supporting someone in the community. Responses included:
    - Lack of information for patients being discharged from hospital
    - Lack of support when carers are sick
    - The right support may not be offered
    - Lack of communication and not planning for end of life care which can result in unnecessary hospital admissions
    - Not having appropriate funding in place to support patients.

1.5 Summary of findings and recommendations (please see in full at the end of the evaluation report)

1.5.1 Key themes

- Positivity about the community focus offered by the new model.
- The importance of relationship building and maintaining a good relationship between patients, family members, carers and professionals.
- Transport and access to the Penrose site for visitors.
- Consideration for those with autism.
- Consideration for those in transition (age 16 to 18yrs).
- The response to crisis.
- The number of beds (10) in the new model.
- Concerns about not having enough staff.

1.5.2 Recommendations

To consider all feedback from the engagement process recorded in this report and appendices.

2. Introduction

Following the investigation into abuse at Winterbourne View in 2015 and other similar hospitals, there has been a cross-government commitment to move all people with learning disabilities who were inappropriately placed in such institutions into community care.

The NHS clinical commissioning groups across the country, in partnership with their local authorities, have been working to make improvements in care and support following the Winterbourne investigation.

The Transforming Care Programme was established to build on that work and accelerate progress to transform care and support for people with learning disabilities and/or autism. It is a nationally mandated programme that is being rolled out across the country.

In the Black Country and West Birmingham, the work in this area aims to:

- Improve quality of care for people with learning disabilities
- Improve quality of life for people with learning disabilities
- Enhance community capacity, thereby reducing inappropriate hospital admissions and length of stay.

Work so far has focused on areas such as:

- Early intervention to minimise the development of challenging behaviours
- Crisis prevention to provide the right kind of support to prevent and reduce instances of crisis
- Addressing crises by responding effectively to stabilise an individual's situation
- Ensuring effective discharge to avoid repeat hospital admissions.

The Black Country Transforming Care Programme is about making sure more people are supported to receive health assessment and treatment in the community and close to home wherever this is possible. Assessment and treatment will be provided by community teams with specially trained social workers, nurses, psychologists, psychiatrists and other staff. Service users will only go to hospital because their health needs cannot be met safely in the community at that time. Hospital care will be high quality specialist care and stays will be for the shortest time possible.

The Black Country Transforming Care Partnership (BCTCP) has been working with people with learning disabilities and their families and carers to develop and deliver a new community model of care that maintains their rights, respect and dignity. This work has been informed by feedback from previous engagement undertaken by BCTCP between April 2016 and July 2018. See table below.

Timeline	Activity
April 2016	Black Country Transforming Care Partnership (TCP) established to transform health and care services for people with learning disabilities and/or autism who may display behaviour that challenges
	Equality Impact Assessment of TCP Programme undertaken
	Engagement with carers. Commissioned by Sandwell and West Birmingham CCG and conducted by two independent members of the Care and Treatment Review Panel · six carers took part in half-day feedback session · Informal discussions with 10 people with learning disabilities, with or without autism, who had been discharged from hospital following a Care and Treatment Review
4 July 2016 to 22 August 2016	Public consultation in Wolverhampton on moving three assessment and treatment learning disability in-patient beds at Pond Lane Hospital to existing services in Dudley, Walsall and Sandwell
September 2017	Service user questionnaire – 133 questionnaires were completed by service users who were inpatients or at risk of admission, experts with lived experiences, carers, advocates and their support staff
January 2018 to July 2018	'So, what next?' engagement The 'So what, what next' Project was designed by the national Transforming Care empowerment steering group, a group of people with a learning disability and/or autism, or family carers, with lived experience of long stays in hospital settings. The project worked with 10 people within the Black Country with a learning disability with or without autism who had recently moved out of hospital, alongside the people who support them in the community.

The new proposed model of care prioritises investment in a community model designed to reduce the number of inpatient stays and ensure people with learning disabilities remain close to their communities, friends and families. As a result, fewer assessment and treatment beds will be needed. Clinicians and other experts have undertaken an options appraisal of the existing assessment and treatment units and believe the unit that best meets the requirements for a safe and effective service is Penrose House in Sandwell.

The purpose of the engagement process undertaken from Thursday 21 March to Thursday 23 May was to seek the views of stakeholders, service users, carers and family members on the following:

- The introduction of a new community model for people with learning disabilities that provides enhanced support in the community.
- The permanent closure of specialist inpatient beds at Ridge Hill Hospital, Dudley and Orchard Hills/Daisy Bank, Walsall. (These are beds that are reserved for assessing and treating people with learning disabilities and are not connected to general hospital services).
- The preferred clinical option to locate a single assessment and treatment centre at Penrose House, Sandwell.
- The impact (positive and negative) of proposed changes on service users, family members and carers and the support needed to be in place to make the new model successful.

3. Engagement Process

- The CCGs managed all stakeholder engagement across the Black Country and West Birmingham.
- **Dudley Voices for Choices (DVC)** are an advocacy group for people who have a learning disability or autism. The organisation is a member of the TCP programme board to ensure that people with learning disabilities are represented at programme level.
- As DVC support people with learning disabilities and autism to speak up for themselves, they were also commissioned to undertake outreach engagement in the community and produce an easy read version of the engagement document and questionnaire.
- The CCGs commissioned NHS Arden and GEM CSU to produce an engagement document to promote understanding of the TCP programme and the proposed new model, and a questionnaire to allow feedback. Both were available in hardcopy and online. Arden & GEM were asked to advise on the format of the stakeholder events and to capture all feedback at those events.
- The CSU was also commissioned to analyse all feedback from the engagement process and to produce this engagement report.
- Four stakeholder events took place to explain the transforming care programme and hear views on the proposed service model. All feedback from the stakeholder events has been collated in this report.
- Outreach engagement with service users, their carers and families was undertaken by local charity Dudley Voices for Choices; 174 conversations took place. Interviews were undertaken across Sandwell, Wolverhampton, Walsall and Dudley.
- Several thousand stakeholders were contacted by the CCGs and invited to get involved by attending one of the four stakeholder events and/or completing the online questionnaire.
- A press release and social media also informed people how to get involved by attending one of the four stakeholder events and/or completing the questionnaire.

3.1 Media

A press release was issued on 21 March 2019. There was no media uptake.

3.2 Websites

A dedicated webpage to publicise the consultation was launched on the CCG websites. Page views per CCG were as follows:

Sandwell and West Birmingham CCG webpage: 1,378 views

Wolverhampton CCG webpage: 1,520 views

3.3 Social media

Area	Tweets	Impressions	Retweets
Wolverhampton	30	12,507	34
Sandwell and West Birmingham	28	14,482	19
Walsall	5	5,916	10
Dudley	13	13,726	12
Black Country Partnership Foundation Trust (Black Country-wide)	3	2,195	1

4. Stakeholder Events

The CCGs and the Black Country Partnership Foundation Trust managed all stakeholder engagement. As part of the engagement process four stakeholder events took place across the Black Country and West Birmingham, in Walsall, Dudley, Sandwell and Wolverhampton. The purpose of the events was to explain the background to the Transforming Care Programme from a national and local perspective and to introduce the proposed model developed by the Black County Transforming Care Partnership (BCTCP). Stakeholders were in attendance to find out more and give their views. All feedback was recorded by Arden and GEM CSU.

Each of the stakeholder events followed the same format. In each area the lead CCG commissioner together with a clinician from the provider, presented the journey so far, from the national policy development to the local response. The proposed model for the delivery of TCP for adults with learning disabilities was explained and the following questions were posed to prompt small group discussions:

- What are the positive impacts of the proposed community model?
- Are there any negative impacts you would like to discuss?
- Is there anything else you would like to be taken into consideration?

After the workshop, key discussion points and questions were shared with all attendees. All questions were answered by a clinician or a commissioner from the TCP team. All feedback was collated for inclusion in this report.

Four stakeholder events across the Black Country and West Birmingham

4.1 Stakeholder Event in West Bromwich

Monday 8 April 2019, 1.30-3.30pm

This event was attended by 24 stakeholders from a range of organisations including: Options for Life, SAFS (Sandwell Asian Family Support Service), Sandwell MBC, West Minster School, El Marsh Care, Midway Care, Charnat Care, Careview Services, Sandwell & West Birmingham CCG (additional staff not delivering event). In addition, there were three members of the public, and a student of Wolverhampton University.

Feedback from the group discussions included:

Discussion point 1 - What are the positive impacts of the proposed community model?

- Accessibility

- Out of hours support
- Locality for Sandwell patients and families/carers will be easier
- Family benefits
- Fewer admissions/less time spent/my community
- Working together
- CTR's are key to positive outcomes
- Carefully thought through
- Great that public participation is taking place
- Intensive support site – great to have additional support in the community that you can access quickly
- Valuable to have clear pathway
- Consistency across all areas

Discussion point 2 – Are there any negative impacts you would like to discuss?

- Timeframes – changing delivery model takes time
- Journey time/locality for other areas
- Support for families to visit
- TCP for children – joint working with TCP for adults
- One attendee had a bad experience of treatment and assessment model
- May need an increase in social care hours
- There may be a negative impact on the carer if loved one gets better care. It is difficult for carers to let people move on

Discussion point 3 – Is there anything else you would like to be taken into consideration?

- Do families know what services are out there? Providers could communicate this with carers
- It's more than just a health issue – improved working together between health and social care
- Making sure people have knowledge of how TCPs will work together
- Information on stakeholder events
- Access needs to be prompt and responsive to crisis
- Approval for support service when in crisis
- More information, clearer about 10 beds
- Clear information on the offer of teams, that is updated
- Information for other providers on referral process for the enhanced community model
- Involvement – working together families/users
- Learning and evolution… no time limits

4.2 Stakeholder event in Wolverhampton

Tuesday 9 April 2019, 10am-12pm
Nine stakeholders attended the event from a range of organisations including the University of Wolverhampton, Dudley Voices for Choices, Beacon Vision and Mencap.

Feedback from the group discussions included:

Discussion point 1 – What are the positive impacts of the proposed community model?

- Quality of care
- Community integration
- Good move towards social model instead of medical model
- Bespoke for individual
- Improved efficiency
- No funding cuts/funds reallocated to community services
- Flexible staff movement
- Everyone has same level of care

Discussion point 2 – Are there any negative impacts you would like to discuss?

- Transport/travel to ATU in Sandwell
- Isolation due to ATU venue
- Support for families might not materialise

Discussion point 3 – Is there anything else you would like to be taken into consideration?

- Joint commissioning
- Strong user voice including family

The discussions led into a question and answer session, please see full details at Appendix C.

4.3 Stakeholder event in Walsall

Thursday 11 April; 4pm to 6pm

Fourteen stakeholders attended the event from a variety of organisations such as Healthwatch; Dudley Metropolitan Council; Walsall Council; Dignus Health Care; Care First Ltd and Dudley Voices for Choices.

Feedback from the group discussions included:

Positive Impacts:

- Better integrated working: it was felt that the new model would offer this opportunity but needed time and investment to make it work.
- Patients not having to go out of area was positive.
- Reducing beds was seen overall as positive. It was felt that having fewer beds would drive the community model and would be an impetus for more people to be supported in the community.
- Being supported in the community was felt to be more positive than having to be admitted to hospital unnecessarily for prolonged periods of time.
- Stakeholders saw the location of the proposed community model as positive due to the proximity of more facilities such as shops and community activities.
- Stakeholders felt that Penrose would become a hub of services and felt this was positive. In particular they welcomed the planned flexibility of the unit which would enable it to avoid issues around mixed gender accommodation.
- IST already based at Penrose will aid smooth transition.

Attendees did not express negative impacts but asked questions. For full details please see Appendix C.

Stakeholders also made the following points:

- The importance of working with partners such as the police service, the emergency services, and social care services, particularly to manage crisis situations. The importance of all personnel receiving training so that approach to crisis situations was consistent.
- Closer working together between health and social care across the area to meet patient needs was recommended.
- The importance of training and development for all staff working in the new model. The discussion point was made that if staff are working in both IST and AT4 legal boundaries need to be understood.
- The importance of patient centred services and the specialist support needed.
- Low need patients should be in mainstream services not specialist.
- There should be joint pathways with the mental health team.
- Currently, there are LD specialist nurses in Walsall for dementia and transition, it is important that these posts are maintained in the new model.
- It is important to consider how safeguarding responsibilities will be maintained in the new model e.g. Are the Safeguarding team at Sandwell ready for the impact of the new model?
- The importance of making and maintaining links to local community services. This will enable links to meaningful day opportunities. Community services available in the local area need to be scoped and relationships maintained.

- The importance of reablement skills development for service users.

4.4 Stakeholder event in Dudley

Thursday 2 May 2019, 5.30-7.30pm

Thirteen stakeholders attended the event from a range of organisations including: Dudley Heathwatch, PPGs, Dudley Voices for Choices, Camphill Village Trust, Riverside House. A student nurse also attended and members of the public.

Feedback from the group discussions included:

Positive Impacts:

- Individuals are being considered
- Penrose is well placed
- Transport is on a simple route
- Provides more opportunities to be independent
- Good discharge plans
- Winterbourne must never happen again. This model is the right direction.
- Right treatment, right place, shorter stay.

Attendees did not express negative impacts but asked questions. Please see questions and answers in full at Appendix C.

Attendees also made the following points:

- Autism should not be under mental health, it is neurological not mental health.
- Between the ages of 16 and 18, there is no support available. At 18, I can access adult services, but all young people should be supported with a transition plan (education and health plan), if you are not considered severe you don't get one. There is no access to mental health. There is a big gap in health services for 16- to 18-year-olds. The is needed before people get to crisis. Early intervention is needed. People need activity, purpose, opportunity. A lot has been cut and taken away and this leads to challenging behaviour due to frustration. There are not enough staff to provide the help needed, nurses have far too many patients.
- It is very important to understand that LD people can be very vulnerable in the community. People need to know how to look after themselves; for example, safe place schemes. There also needs to be more education to promote understanding among the community.
- Transport needs to be considered. It is important that access is easy so that relatives can visit.

- It is important that the length of stay in hospital is appropriate. Assessment and treatment centres should be no different than any other episode when you are treated for any other illness. The discharge date should be identified on day of admission.
- The environment and approach are so important. Well trained staff recognise triggers and crisis is prevented.
- The new model may lead to families having more responsibility and it is important not to overburden them. There is a need for relationship building between professionals and the family for some previous experience has made families reluctant to trust professionals. People need to understand what policies and processes are in place to ensure the patient's best interests are at the centre of decision making. carers and parents really know the patients.
- People are viewed in the community more as an individual and not as 'a patient'.
- A de-escalation suite should be considered as part of the new model
- It is important to have access to other services.

4.5 Key themes from all stakeholder events

Across all engagement events the community focus of the new model was received with positivity. Any concerns were shared and discussed, and questions answered. Key themes emerged across all stakeholder events, such as:

Key themes

- The community focus offered by the new model.
- The importance of relationship building and maintaining good relationships between, patients, family members, carers and professionals.
- Transport and access to the Penrose site for visitors.
- Consideration for those with autism.
- Consideration for those in transition (aged 16-18).
- The response to crisis.
- The number of beds (10) in the new model

5. Outreach Engagement

The charity, Dudley Voices for Choices was commissioned by the CCGs to undertake face to face, targeted engagement with potential service users, service users, family members and carers across the Black Country and West Birmingham as part of the Transforming Care Programme engagement process. During the outreach engagement people were encouraged to complete the easy read version of the questionnaire.

- 174 conversations took place.
- Interviews were undertaken across Sandwell, Wolverhampton, Walsall and Dudley.
- 11 community groups were engaged with and 184 easy read questionnaires distributed across the Black Country and West Birmingham.
- Wherever possible, the easy read version of the questionnaire was completed face-to-face. However, due to the complexity of the subject matter for some people with learning disabilities, feedback was limited.
- 39 easy read questionnaires were completed, some fully, some to a limited extent. Please see the findings from the questionnaire feedback in section 5.
- Carers, and family members were also invited to complete the questionnaire.

5.1 Key themes from the 174 conversations

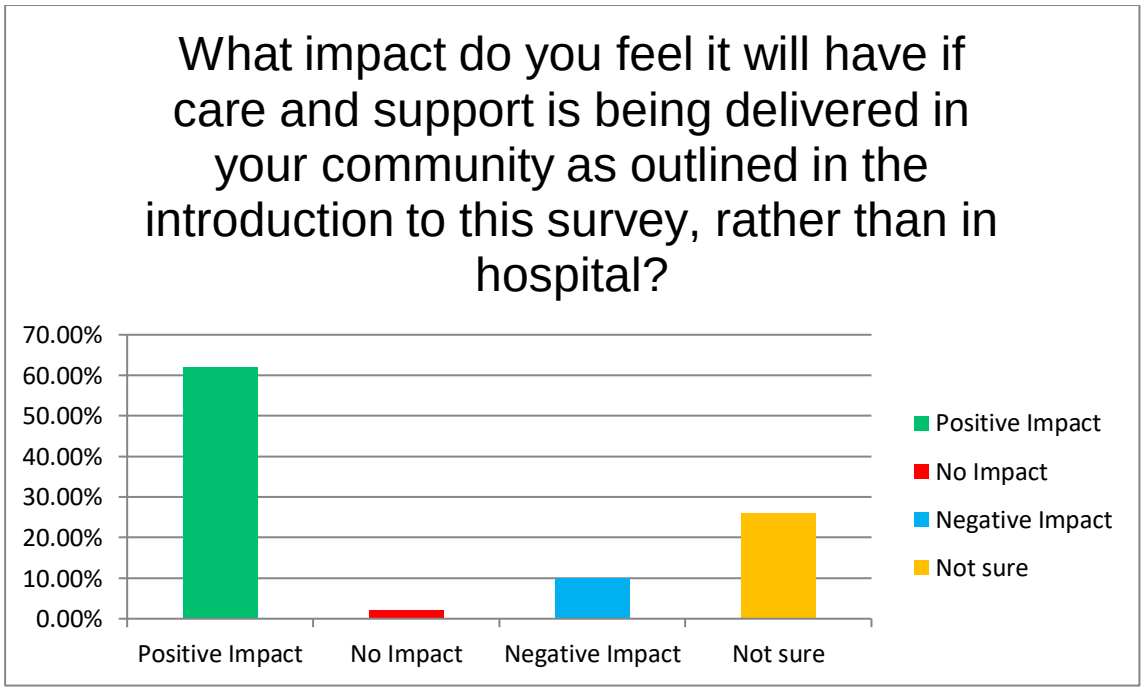
- Transport and access to the assessment and treatment centres.
- Cost implications of travelling around the areas.
- Having enough beds to meet the needs of all areas.

6. Questionnaire Analysis

Responses received are from all four areas and have not been separated due to small numbers and no notable differences in views were presented.

1. What impact do you feel it will have if care and support is being delivered in your community as outlined in the introduction to this survey, rather than in hospital?

Answer Choices	Responses	
Positive Impact	62.00%	31
No Impact	2.00%	1
Negative Impact	10.00%	5
Not sure	26.00%	13
	Answered	**50**
	Skipped	**0**

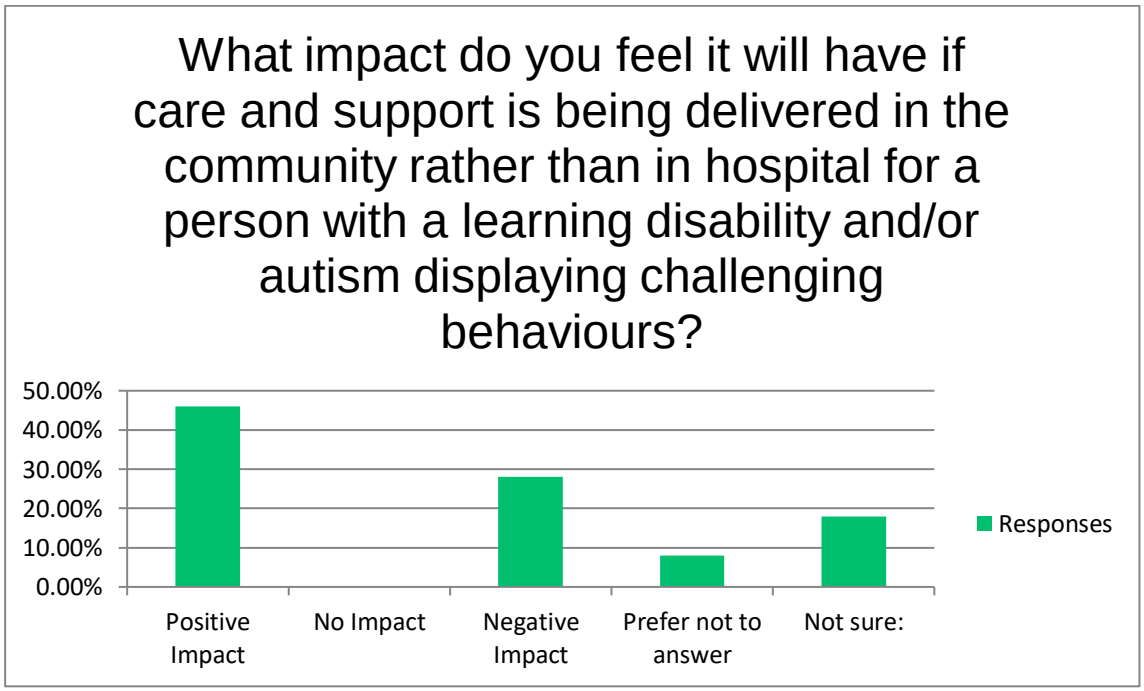


The majority of respondents (62%) felt it would have a positive impact if care and support was delivered in the community rather than in a hospital, this was compared to 10%

stating it would have a negative impact. A further 2% felt this would have no impact and 26% were unsure.

2. What impact do you feel it will have if care and support is being delivered in the community rather than in hospital for a person with a learning disability and/or autism displaying challenging behaviours?

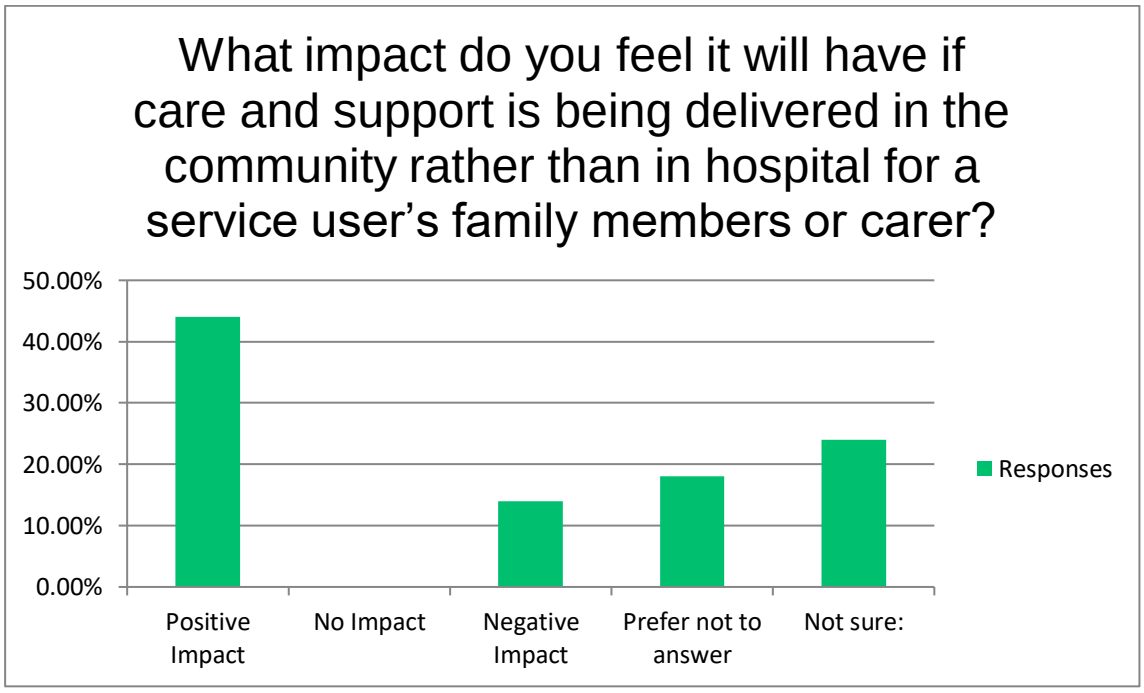
Answer Choices	Responses	
Positive Impact	46.00%	23
No Impact	0.00%	0
Negative Impact	28.00%	14
Prefer not to answer	8.00%	4
Not sure:	18.00%	9
	Answered	**50**
	Skipped	**0**



Nearly half (46%) felt it would have a positive impact if care and support were delivered in the community for a person with a learning disability and/or autism displaying challenging behaviours compared to just over one in four (28%) who believe this would have a negative impact. A further 18% were unsure and 8% preferred not to answer this question.

3. What impact do you feel it will have if care and support is being delivered in the community rather than in hospital for a service user's family members or carer?

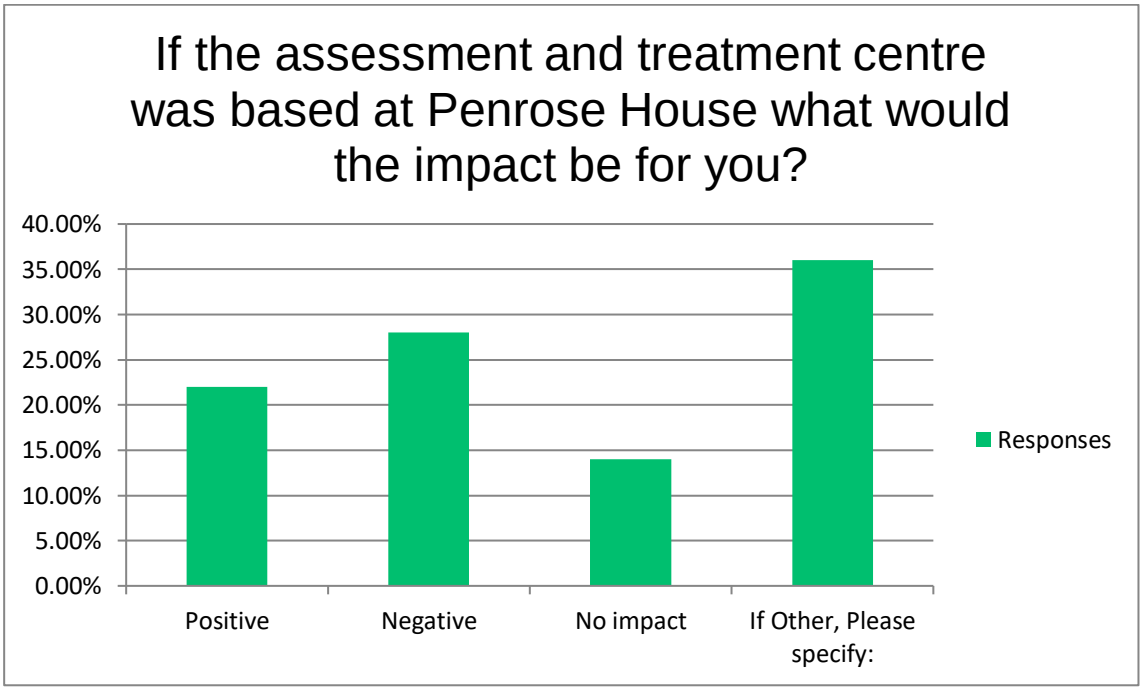
Answer Choices	Responses	
Positive Impact	44.00%	22
No Impact	0.00%	0
Negative Impact	14.00%	7
Prefer not to answer	18.00%	9
Not sure:	24.00%	12
	Answered	**50**
	Skipped	**0**



The greatest response (44%) came from those who felt it would have a positive impact on a user's family members or carers if care and support were delivered in the community compared to 14% who believe this would have a negative impact. A further 24% were unsure and 18% preferred not to answer this question.

4. If the assessment and treatment centre was based at Penrose House what would the impact be for you?

Answer Choices	Responses	
Positive	22.00%	11
Negative	28.00%	14
No impact	14.00%	7
If Other, Please specify:	36.00%	18
	Answered	**50**
	Skipped	**0**

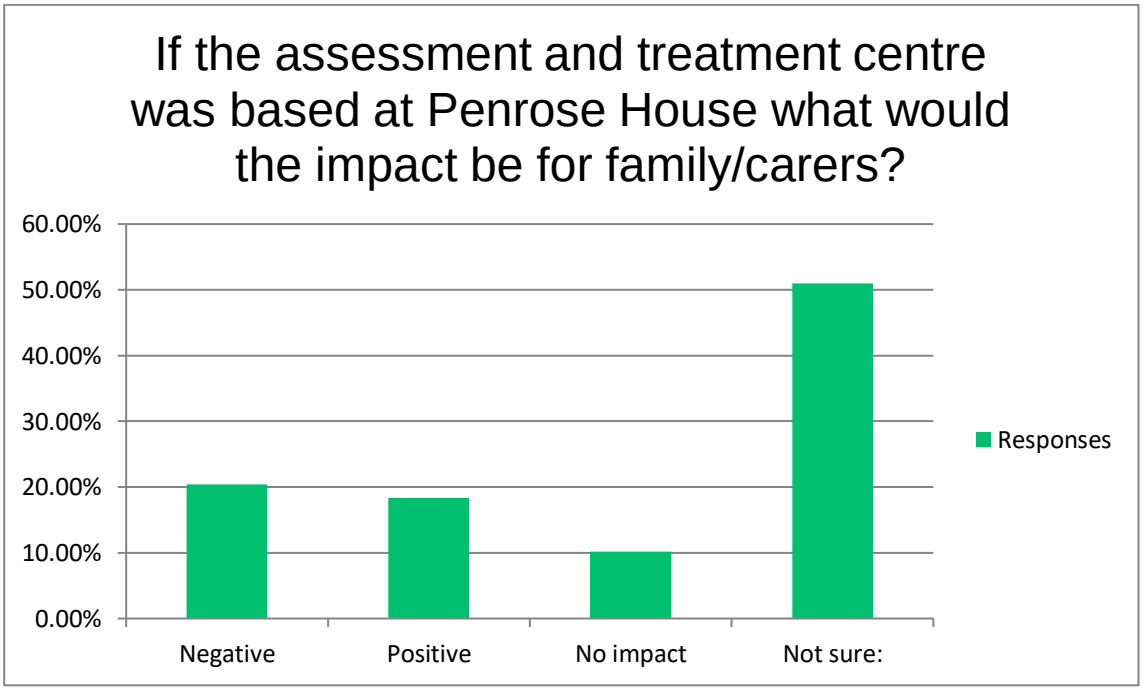


More than one in four respondents (28%) felt it would have a negative impact on them if the assessment and treatment centre was based at Penrose House, compared to 22% who believe this would have a positive impact. Of the 36% of 'other responses' recorded,

14 were unsure, three believed the distance to be an issue and one preferred not to answer this question.

5. If the assessment and treatment centre was based at Penrose House what would the impact be for family/carers?

Answer Choices	Responses	
Negative	20.41%	10
Positive	18.37%	9
No impact	10.20%	5
Not sure:	51.02%	25
	Answered	**49**
	Skipped	**1**



While 20.41% felt this would have a negative impact on families/carers, 18.37% believed this to have a positive impact. The largest number of respondents (51.02%) were not sure while 10.20% believed this would have no impact.

Questions 6 - 8:
Three questions were asked about the importance of specific support for people with learning disabilities in different circumstances. Of these, the majority of respondents felt they were all very important. Full results of these questions can be seen in the table below.

	Very important	**Important**	**Not important**	**Not important at all**	**Skipped question**
Support with daily life activities – help with day to day living e.g. washing, dressing, cooking, shopping	(24) 57.14%	(6) 14.29%	(10) 23.81%	(2) 4.76%	8
Communication – help communicating with people	(24) 54.55%	(7) 15.91%	(10) 22.73%	(3) 6.82%	6
Behaviour – help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse	(21) 51.22%	(11) 26.83%	(9) 21.95%	(0) 0%	9

Questions 9 - 15:
The importance of help and support, and information and advice to reduce:

- The likelihood of challenging behaviour being displayed, and
- The frequency and severity of challenging behaviour.

Of these responses, the majority felt they were very important. Full results of these questions can be seen in the table below.

	Very important	**Important**	**Not important**	**Not important at all**	**Skipped question**
Personal support / being active in the community – help with making relationships and playing a part in family and community life	(19) 45.24%	(11) 26.19%	(10) 23.81%	(2) 4.76%	8
Environment / home life - help with getting a good quality of life e.g. participating in wider activities, the opportunity to follow interests, trying new things	(24) 57.14%	(5) 11.90%	(9) 21.43%	(4) 9.52%	8
Help to have the best physical environment eg housing	(18) 42.86%	(10) 23.81%	(9) 21.43%	(5) 11.90%	8
Help to deal with changing environments eg moving home, moving out of hospital, the right kind of housing	(25) 59.52%	(7) 16.67%	(9) 21.43%	(1) 2.38%	8
Family carer support/ additional support - giving breaks to those	(21) 48.84%	(7) 16.28%	(15) 34.88%	(0) 0%	7

being cared for, and their carers					
Information and advice – good information and advice to help make good decisions and to know what support is available	(22) 50%	(5) 11.36%	(14) 31.82%	(3) 6.82%	6

16. Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference:

Seven out of 50 respondents provided further details about particular areas of support they felt would make a difference, these comments include:

Responses
All the above important but difficult to get the right trained people to carry out the above so many different words and swings in these peoples lives and obviously some more severe than others.
Money
Palliative and end of life care for people with learning disabilities needs to be considered, enabling people to live well until they die. Support with planning for end of life for people with LD and their carers. Please contact Gemma Allen at Mary Stevens Hospice for further information regarding our current work.
My GP surgery often registers patients who have come to study at Glasshouse College. Patients with Mod LD can be seen at Ridge Hill but those with primary ASD without LD end up with an inferior service as have to access mainstream mental health, often getting discharged when someone decides their ASD is the main issue and this is not commissioned. However often the needs of both ASD and LD patients are very similar, often the two conditions coexist. Can this unfair situation be addressed as part of these changes?
I believe all individuals need to have a quality of life regardless of their physical or emotional condition.
A single point of contact for families would be very useful

Questions 17- 25:
When a crisis happens, how important are the following services to prevent hospital admission?

The importance of different services to prevent hospital admissions were commented on, of which the majority felt these were all very important. Full results of these questions can be seen in the table below.

	Very important	**Important**	**Not important**	**Not important at all**	**Skipped question**
Support with daily life activities – help with day to day living e.g. washing, dressing, cooking, shopping	(6) 75%	(2) 25%	(0) 0%	(0) 0%	42
Communication – help communicating with people	(7) 87.50%	(1) 12.50%	(0) 0%	(0) 0%	42
Behaviour – help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse	(7) 87.50%	(1) 12.50%	(0) 0%	(0) 0%	42
Personal support / being active in the community – help with making relationships and playing a part in family and community life	(6) 85.71%	(1) 14.29%	(0) 0%	(0) 0%	43
Environment / home life - help with getting a good quality of life e.g. participating in wider activities, the	(6) 75%	(2) 25%	(0) 0%	(0) 0%	42

opportunity to follow interests, trying new things					
Help to have the best physical environment eg housing	(7) 87.50%	(1) 12.50%	(0) 0%	(0) 0%	42
	Very important	**Important**	**Not important**	**Not important at all**	**Skipped question**
Help to deal with changing environments eg moving home, moving out of hospital, the right kind of housing	(8) 100%	(0) 0%	(0) 0%	(0) 0%	42
Family carer support/ additional support - giving breaks to those being cared for, and their carers	(7) 87.50%	(1) 12.50%	(0) 0%	(0) 0%	42
Information and advice – good information and advice to help make good decisions and to know what support is available	(7) 87.50%	(1) 12.50%	(0) 0%	(0) 0%	42

26. Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference:

Three out of 50 respondents provided further details about particular areas of support that they felt would make a difference, these comments include:

Responses
I think breaks for family and carers very important because of stress seems difficult to always get up to date advice.
Everyone has the right to develop.
Once again a single point of contact would be very useful so that families/carers do not have to keep repeating the information and they have an advocate to help them.

Question 27 - 34:
When someone is discharged from hospital, how important are the following services to prevent them going back in?

The importance of different services in preventing someone from going back into hospital were commented on. Of those responding, all felt these were very important and important. Full results of these questions can be seen in the table below.

	Very important	Important	Not important	Not important at all	Skipped question
Support with daily life activities – help with day to day living e.g. washing, dressing, cooking, shopping	(7) 100%	(0) 0%	(0) 0%	(0) 0%	43
Communication – help communicating with people	(7) 100%	(0) 0%	(0) 0%	(0) 0%	43
Behaviour – help to understand which situations lead to challenging behaviour and how to avoid them or stop them getting worse	(6) 100%	(0) 0%	(0) 0%	(0) 0%	44
Personal support / being active in the community – help with making relationships and playing a part in family and community life	(5) 83.33%	(1) 16.67%	(0) 0%	(0) 0%	44
Environment / home life - help with getting a good quality of life e.g. participating in wider activities, the	(5) 83.33%	(1) 16.67%	(0) 0%	(0) 0%	44

opportunity to follow interests, try new things					
Help to deal with changing environments eg moving home, moving out of hospital, the right kind of housing	(6) 100%	(0) 0%	(0) 0%	(0) 0%	44
	Very important	**Important**	**Not important**	**Not important at all**	**Skipped question**
Help to have the best physical environment eg housing	(6) 100%	(0) 0%	(0) 0%	(0) 0%	44
Family carer support/ additional support - giving breaks to those being cared for, and their carers	(6) 100%	(0) 0%	(0) 0%	(0) 0%	44
Information and advice – good information and advice to help make good decisions and to know what support is available	(6) 100%	(0) 0%	(0) 0%	(0) 0%	44

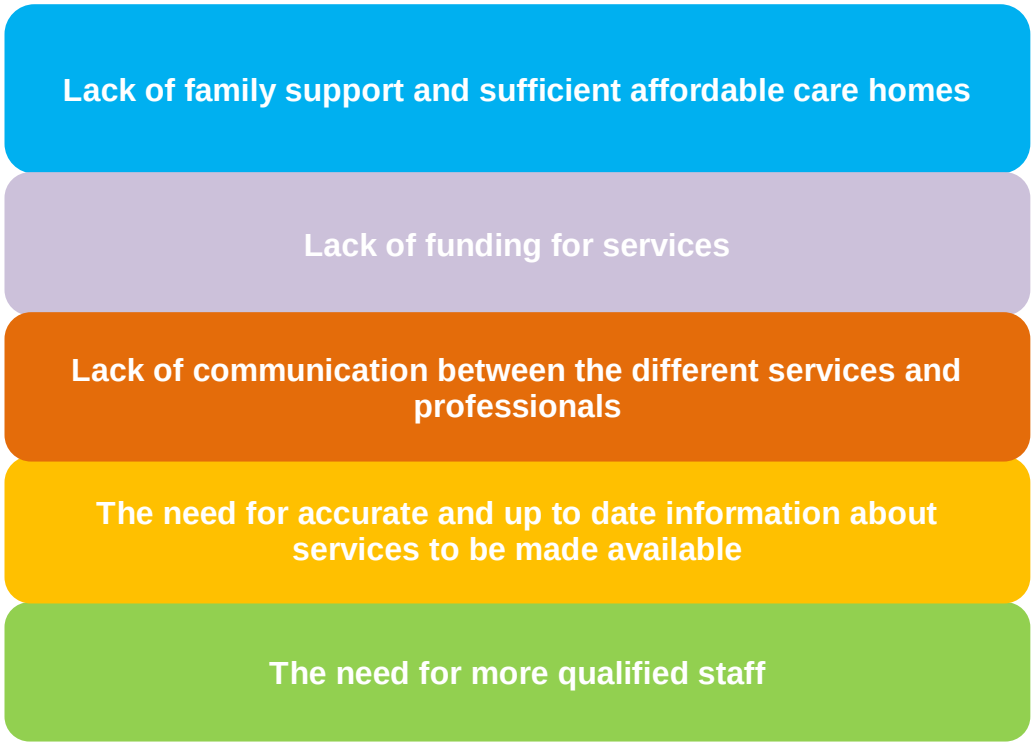
35. Please provide further details about your answers above and also tell us about any particular support that you feel would make a real difference for people when they are moving out of hospital and into the community:

Four out of 50 respondents provided further details about particular areas of support they felt would make a difference, these comments include:

Responses
The above important but not enough specialist people about, certainly suitable accommodation in friendly should be available for carers or family get sufficient breaks.
Travel
Doctors *No house*
Everyone deserves to feel safe and secure and able to develop.

36. In your experience what stops or delays a person getting the right support in the community? (For example, not enough funding for community services being available or in place).

    Many respondents expressed areas that they felt stopped a patient getting the right support in the community. They include:



37. From your experience, please tell us what can go wrong with being supported/ supporting someone in the community? (For example, not having the support in place for the person early on).

Many respondents expressed areas that can go wrong if supported/supporting someone in the community, this includes:

Lack of information for patients being discharged from hospital

Lack of support when carers are sick

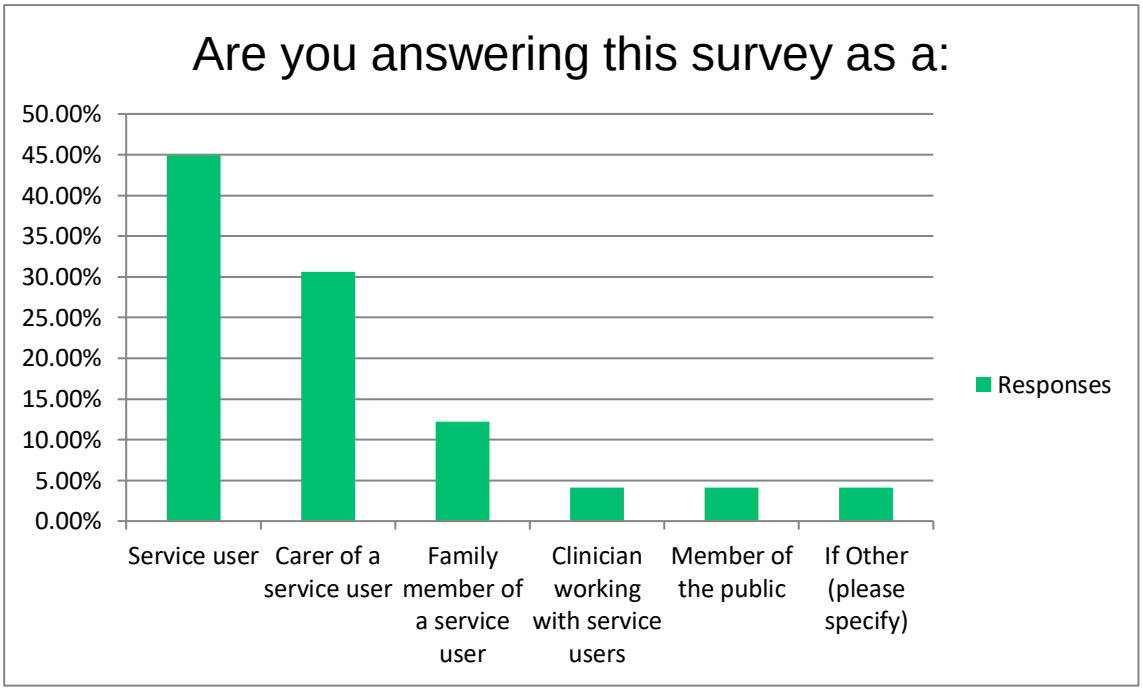
The right support might not be offered

Lack of communication and not planning for end of life care which can result in unnecessary hospital admissions

Not having appropriate funding in place to support patients

38. Are you answering this survey as a:

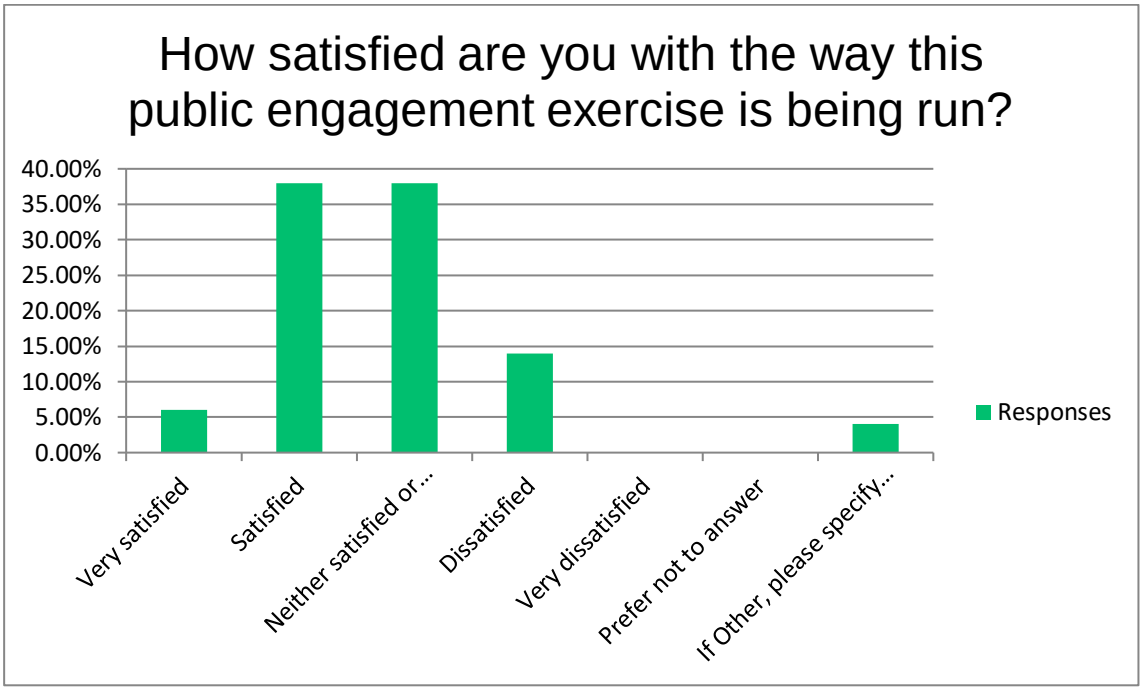
Answer Choices	Responses	
Service user	44.90%	22
Carer of a service user	30.61%	15
Family member of a service user	12.24%	6
Clinician working with service users	4.08%	2
Member of the public	4.08%	2
If Other (please specify)	4.08%	2
	Answered	**49**
	Skipped	**1**



The largest group of respondents completing the survey (44.90%) were service users followed by carers of a service user (30.61%).

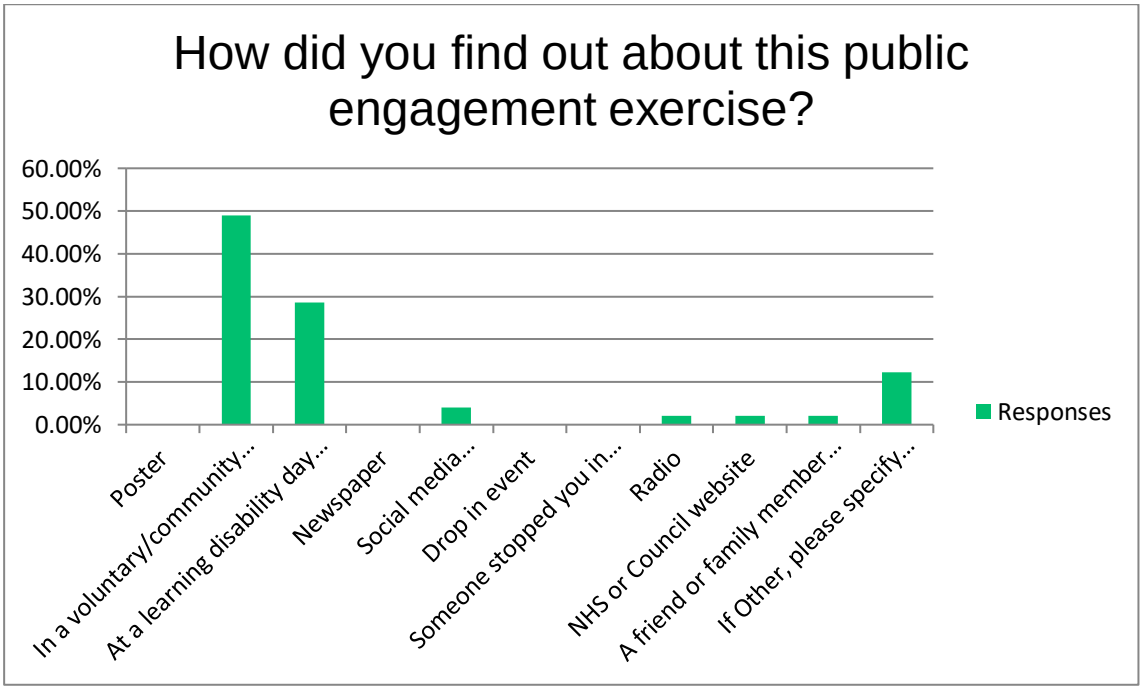
39 How satisfied are you with the way this public engagement exercise is being run?

Answer Choices	Responses	
Very satisfied	6.00%	3
Satisfied	38.00%	19
Neither satisfied or dissatisfied	38.00%	19
Dissatisfied	14.00%	7
Very dissatisfied	0.00%	0
Prefer not to answer	0.00%	0
If Other, please specify below:	4.00%	2
	Answered	**50**
	Skipped	**0**



40. How did you find out about this public engagement exercise?

Answer Choices	Responses	
Poster	0.00%	0
In a voluntary/community organisation	48.98%	24
At a learning disability day service	28.57%	14
Newspaper	0.00%	0
Social media (Facebook/Twitter)	4.08%	2
Drop in event	0.00%	0
Someone stopped you in the street (NHS Outreach Engagement Team)	0.00%	0
Radio	2.04%	1
NHS or Council website	2.04%	1
A friend or family member told me	2.04%	1
If Other, please specify below:	12.24%	6
	Answered	**49**
	Skipped	**1**



To view all equality data recorded see Appendix D.

7. Summary of Findings and Recommendations

7.1 Key themes

- **Positivity about the community focus offered by the new model**.
  Most people were positive about the community focus of the new model. However, when asked about the location of the assessment and treatment centre, more people (28% of respondents) felt it would have a negative impact if the centre was based at the Penrose site; (22% believed this would have a positive impact). When carers and families were asked about Penrose as the preferred site, 20.41% felt this location would have negative impact; 18.37% believed the impact would be positive. The negative response to these questions will need to be mitigated if the final decision made is to have the treatment and assessment centre based at Penrose. It is recommended that the provider communicates the outcomes of this engagement process and continues to involve service users in the future developments of the community service model, for example in the design of any new buildings/facilities.

- **Relationship building**
  The importance of relationship building and maintaining a good relationship between, patients, family members, carers and professionals.

- **Transport and access to the Penrose site for visitors**
  Many people were concerned about travel to the Penrose site. It is recommended that the equality impact assessment is revisited, and travel and access for all reviewed.

- **Consideration for those with autism**.
  It is recommended that a plan is developed to take into consideration the needs of adults with LD and autism

- **Consideration for those in transition (age 16 to 18yrs).**
  It is recommended that a plan is developed to take into consideration the needs of those in transition.

- **The response to crisis**
  It is recommended that consideration is given to the response to crisis.

- **The number of beds (10) in the new model**
  Ongoing communication with patients and the public is recommended to mitigate concerns that ten beds will be enough for service delivery going forward.

- **Concerns about not having enough staff**
  Ongoing communication with patients and the public is recommended to mitigate concerns about not having enough staff.

- To consider all feedback from the engagement process recorded in this report and appendices.

NHS Arden & GEM CSU

Engagement, Communications and Marketing

June 2019

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
10th September 2019

Agenda item 11

TITLE OF REPORT:	Update and Progress report for the Integrated Care Alliance (ICA)
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning Karen Evans, Strategic Transformation Manager
MANAGEMENT LEAD:	Steven Marshall
PURPOSE OF REPORT:	To provide an update on progress of the Wolverhampton Integrated Care Alliance
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• This report provides key highlights, risks and Issues across the programme
RECOMMENDATION:	To note the work being undertaken within the Wolverhampton Integrated Care Alliance
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Within the ICA workstreams we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both the quality and the patient experience.
2. Reducing Health Inequalities in Wolverhampton	The ICA will strive to ensure that health inequalities are reduced across the City. Pathway developments are 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 ICA is a mechanism to enable money and resource to move within the Wolverhampton system appropriately in order to deliver effective services to people.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Development of the ICA has been ongoing for approximately 18 months.

1.2. The ICA is represented by key partners and stakeholders across the City of Wolverhampton including Wolverhampton CCG (WCCG), City of Wolverhampton Council (CWC), Royal Wolverhampton Trust (RWT), Black Country Partnership Foundation Trust (BCPFT), Compton Hospice and Healthwatch.

1.3. The Wolverhampton ICA is not a “procured” hard solution but is a collaborative approach based on a shared vision and clinical alignment.

1.4. The principles of the developing Integrated Care Alliance are agreed as:-

- Our strategy must be clinically led. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between “primary” and “secondary” care clinicians. We will support the professional development of all existing staff. There is strong clinical support across the health system to work in this way
- We will create a shared governance system across the parties which will provide system leadership
- We will provide a clear vision for our system that will be a joint public commitment, and hold ourselves mutually accountable for delivering this. The accountability will be managed by both external and internal accounting mechanisms which will follow the principles of ‘Open Book’ approach.
- The alliance partnership work will be patient-centred. We will focus services around the patient, developing innovative unified pathways that provide a more consistent quality of care across Wolverhampton
- We will shift resources from hospital to out of hospital services so that more patients are supported proactively in their home and communities. This shift will be based on assessment which ensures equitable distribution of resources within community and primary care to manage this new work. The investment will be accounted for by ‘open book’ approach on both external and internal audit mechanisms.
- We will focus on health and care, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide
- We must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current funding flows as they do not always incentivise best practice

1.5 The development of the ICA is managed by two oversight groups; ICA Clinical Prioirities Group and the ICA Governance Group. Within this are a number of sub groups or workstreams which are shown in the tables below.

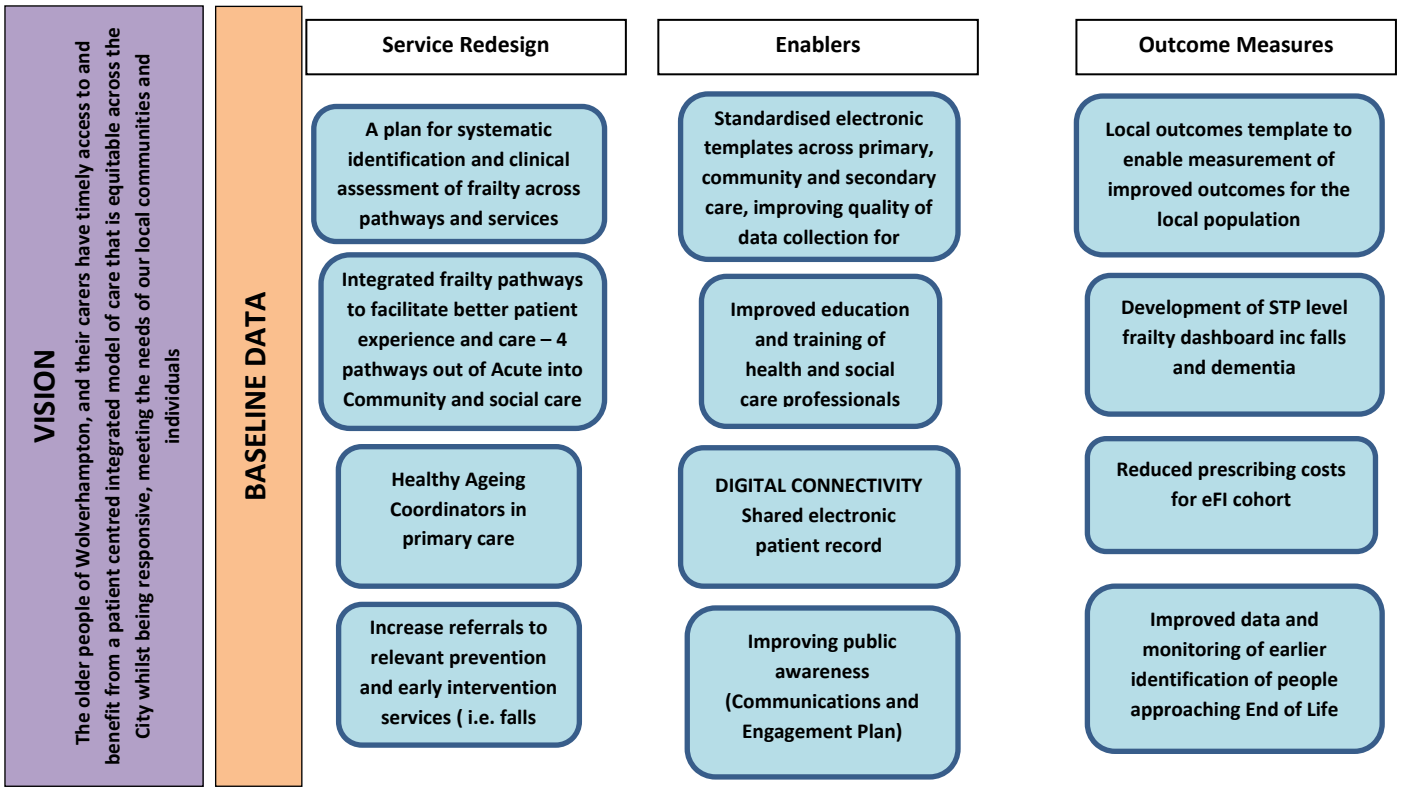
ICA Clinical Priorities Group	
ICA Clinical Frailty	The development of frailty pathway pathways that focus on the whole system to capture those living with mild/moderate frailty and, in partnership with the End of Life group, those who are classed as severely frail. This includes pathways redesign, workforce analysis, process redesign and the development of person centred success measures,
ICA Clinical Mental Health	Focussing on Primary care (PCN's) aligning workforce and mapping pathways, Physical Health/Mental Health interfaces, Accessing timely care and community provision
ICA Clinical Palliative Care & End Of Life	Development, commissioning and implementation of a transformed Wolverhampton End Of Life care pathway across the whole system, including the implementation of an electronic shared care record across the whole system.
ICA Clinical Children and young people	Standardising parent and clinician facing processes and information around the Wolverhampton "Big 6" which will support a reduction in NEL admissions to hospital, the implementation of joint specialist and generalist clinics in Primary Care, and the review and redesign of community paediatric services
ICA Governance Group	
ICA Governance BI/IG/IT	Ensure that the ICA has the right information to inform its clinical pathways, To ensure/enable appropriate information sharing between organisations, Find solutions to issues that arise regarding IG/IT
ICA Governance Commissioning and Contracting	To develop a contracting mechanism which allows activity and finance to move around the system appropriately aligned with the clinical pathways and principles of the ICA
ICA Governance Outcomes	To develop and agree a set of outcomes for which the ICA clinical pathways can be measured, and also to measure the success of the ICA as a system.

2. Clinical Sub Group Plans

Each of the Clinical sub groups has agreed a plan on a page which they are working towards delivering. These are detailed below.

2.1 Frailty

A plan on a page – Frailty

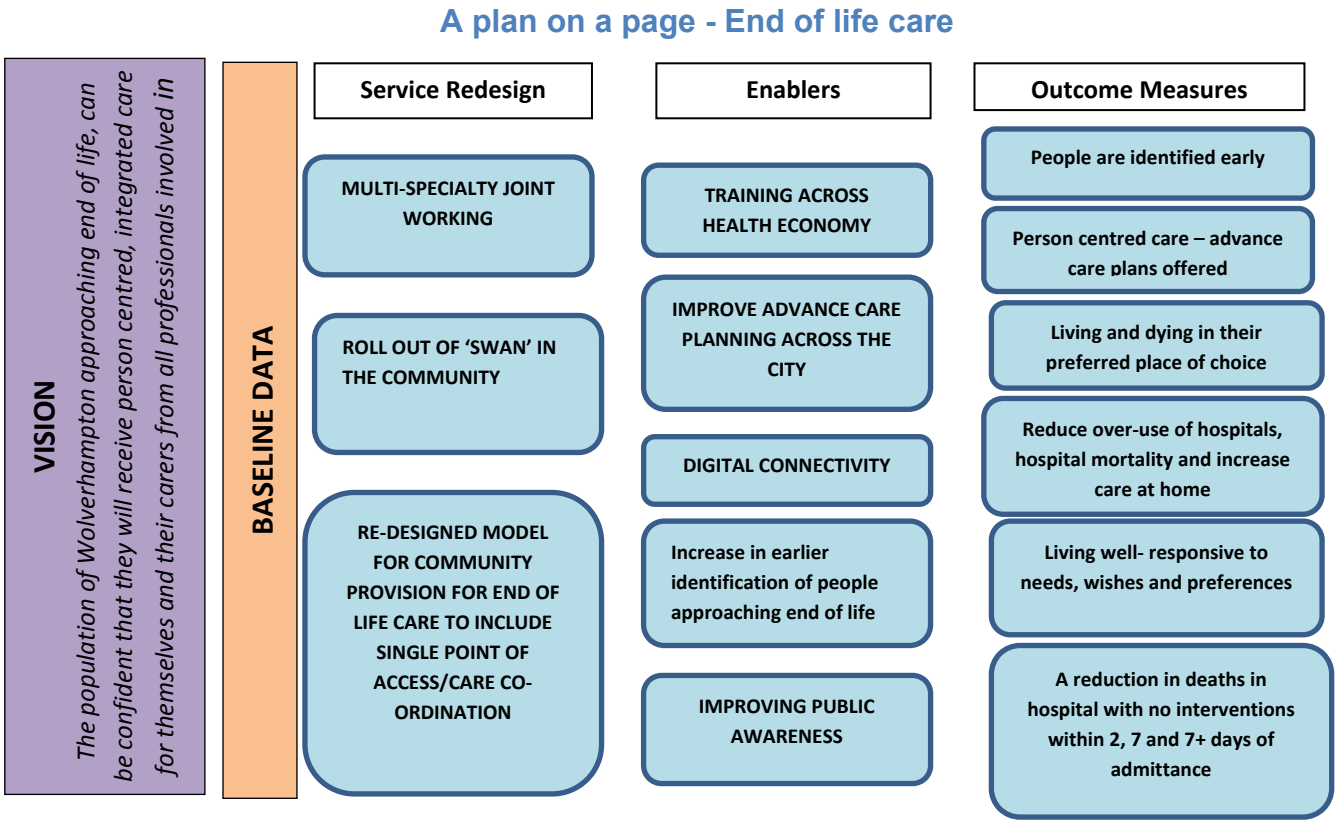


The Frailty work stream is progressing well and has developed a comprehensive frailty pathway, detailing all levels of frailty from mild to severe.

A key success of the group is the design and modelling of a team of Healthy Ageing Co-ordinators. The Healthy Ageing co-ordinators will proactively identify patients through primary care clinical systems, and provide follow up of patients that have been discharged by the Acute ED Frailty team. The service will offer a Healthy Ageing Assessment, providing appropriate interventions/ signposting and personalised care planning to the individual patient. The coordinators will follow up with patients to review actions and their care plan, ultimately to improve their health and wellbeing.

This model of care, through the ICA, has been co-produced between the WCCG, Royal Wolverhampton Trust and the City of Wolverhampton Council. The co-ordinators will be employed by each Primary Care Network (PCN) and recruitment is currently underway.

2.2 End of Life



The work stream (and previous groups) has developed a system wide, patient centred, Palliative & End of Life care Pathway. The pathway has been co-produced by all partners and is currently being approved through each organisations governance processes.

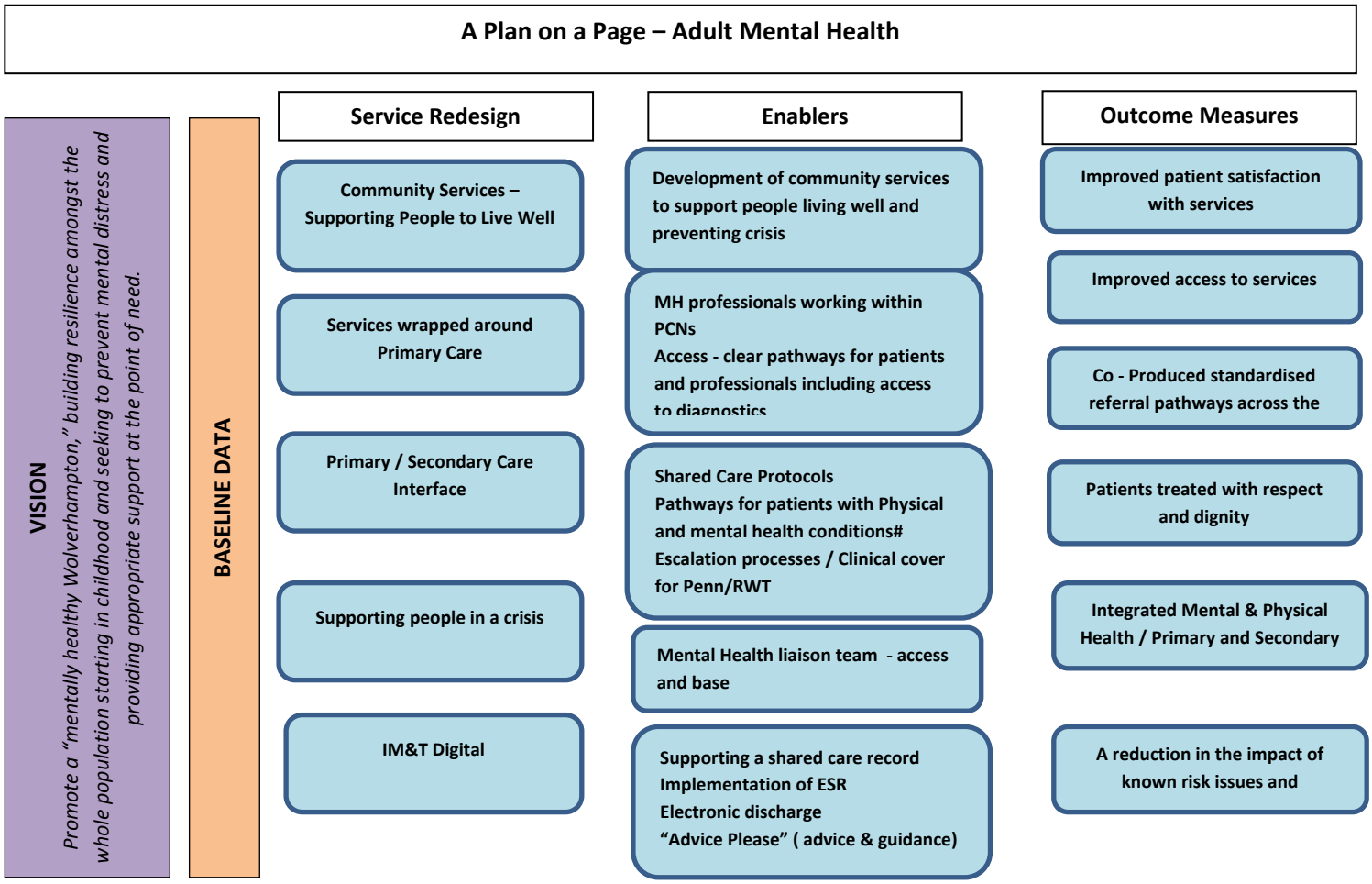
The model will then be presented to the Clinical Priorities oversight group and when approved taken to the Commissioning and Contracting sub group to develop the mechanisms required for funding shifts and implementation.

The group is also piloting the Electronic Palliative Care Co-ordination System (EPaCC). This system enables the recording and sharing of people's **care** preferences and key details about their **care** as they approach the end of life, across teams and organisations.

The End of Life group is working with the University of Wolverhampton to develop a local set of Family Reported Experience Measures to enable providers to be able to measure and improve services based on what local people tell us about the care their loved ones have received.

The workstream commissioned Healthwatch to undertake some targeted engagement across the City and the feedback form this and other engagement work previously undertaken, has been used to inform the service re-design

2.3 Mental Health

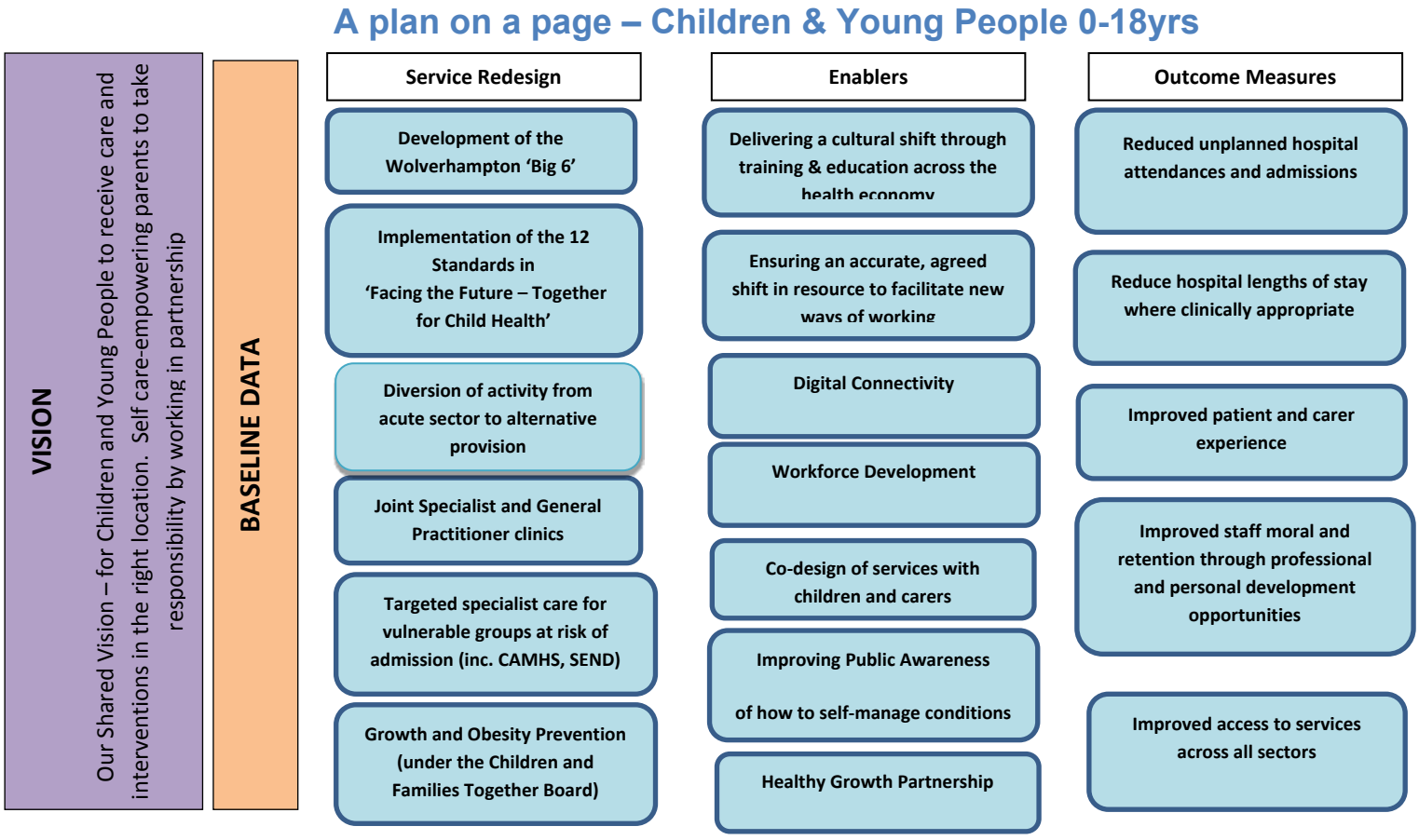


The Mental Health group has recently confirmed its programme of work which will focus on the areas above, but in particular improving the interface between primary care and secondary care so that referral pathways are more streamlined for both professionals and patients, reducing duplication and confusion in the system, and negating the risk of patients "falling though gaps".

Partners will work together to design an enhanced model of a community based service which will aim to provide support to those people living with a mental health condition, and reducing the risk of them entering crisis.

A number of workshops and "MapJams" have taken place. These sessions have seen good input from a wide representation of the organisations both statutory and community and third sector to map services already in place and subsequently identify gaps.

2.4 Children and Young People



The C&YP group has been working on developing information, advice and guidance on the Wolverhampton "Big 6". This is based on national and other local information and aims to support both Primary Care and patients and their families on how to manage the "Big 6" / most popular conditions that are cause for hospital attendance and admission.

The process of GPs being able to contact an on-call paediatrician for advice has been widely publicised and utilisation of this service is improving.

Primary and Secondary care clinicians are working together to develop joint clinics that will be both beneficial to patients and will create an educational environment for primary care clinicians.

3 ICA Governance Sub Groups

3.1 Commissioning and Contracting

This group is working to develop the mechanisms that will enable the clinical pathways to be implemented. This includes where within the system the activity will take place, who will provide the elements of the pathway and how the resources will be allocated within the system.

This will most definitely be different for each clinical pathway and it is important that this is done within the principles of the ICA agreement and that no one organisation is destabilised during the process.

3.2 Outcomes

Earlier this month the Outcomes group led a workshop with the member of the Governance and Clinical priorities oversight groups and the clinical leads to begin the development of an Outcomes Framework for the Wolverhampton ICA.

The workshop was facilitated by the CSU Strategy Unit and a follow up session will take place in September.

The outcomes framework will provide a consistent understanding and approach and common goals for all of the work being developed within the ICA.

3.3 BI/IG/IT

This sub-group is well underway to the development of a Shared Care Data Unit (SCDU). Data has been mapped from the key organisations within the ICA (RWT, BCPFT, CWC and Primary Care) and also considering Compton Care and Housing.

The SCDU will have multiple purposes. It will enable a shared care record for clinical and professional staff for Primary use and will also serve as a data source for secondary purposes, to inform commissioning decisions and to inform population health management.

The group is also working on a data sharing agreement with each organisation completing a DPIA.

A project manager has been assigned to support this work.

3.7 CLINICAL VIEW

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

3 PATIENT AND PUBLIC VIEW

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

4 KEY RISKS AND MITIGATIONS

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

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

5 IMPACT ASSESSMENT

Financial and Resource Implications

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

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

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

Other Implications

5.7 N/A

Name: Andrea Smith
Title: Head of Integrated Commissioning
Date: 30/04/2019

ATTACHED:

RELEVANT BACKGROUND PAPERS
Wolverhampton Integration and Better Care Fund Plan 2017-19
BCF Policy Framework 2019/20

REPORT SIGN-OFF CHECKLIST

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

Complex Governance Proposal for ICA/BCF

This paper outlines a proposal to bring together the Better Care Fund Programme of work and the development of the Wolverhampton ICA into one manageable programme of work to avoid duplication and make best use of the resources available

1 Better Care Fund Programme (BCF)

The Better Care Fund Programme in Wolverhampton is a well-established programme that has been running since 2014. The programme is underpinned by a Pooled budget between Wolverhampton CCG and the City of Wolverhampton Council and brings together key organisations to work collaboratively on a number of projects with the main aim of streamlining pathways for patients, providing a more individualised approach and delivering Care Closer to Home.

1.1 BCF Workstreams

There are 5 workstreams that sit within the BCF programme, each with a number of projects that they are responsible for delivering:-

Adult Community Care	People Living With Frailty Programme, Review & Redesign of Integrated Community Services, GP Home Visiting Service, Redesign of Community Model for EoLc, Night Comfort/Re-positioning Service, Admission Avoidance, Emergency Care Passport, Social Prescribing/Community Connections, Primary Care Multi-Disciplinary Team Meetings
Mental Health	Prevention - mapping of services, Community pathways for patients with a mental health condition to prevent crisis
Dementia	Implementation of the Wolverhampton Dementia Strategy
CAMHS	Implementation of the CAMHS Transformation strategy which aims to transform our local system by developing care pathways, services and initiatives across health, education, criminal justice and social care with a unified set of values. Ensure children and young people are seen at the right place, at the right time and by the right person, Increase capacity and capability across the system so everyone can support CYP and their emotional mental health and wellbeing, Clear pathways across all areas of the system for CYP and across all commissioned services including specialist, Ensure CYP who require inpatient beds can access beds quickly and in an appropriate location.
Integration	Information Governance, IT, Estates, Monitoring and Reporting and Finance

The future of BCF is unclear post March 2020 as the national planning guidance for 2019/20 is yet to be published and there is a national review of the programme underway.

2 Development of the Wolverhanpton Integrated Care Alliance (ICA)

The development of the Wolverhampton ICA has been ongoing for approximately 12 months.

There are 2 Oversight Groups, the ICA Governance and ICA Clinical Pathways groups. Within each of these are a number of sub-groups which are shown below:-

2.1 ICA Governance Sub-Groups

ICA Governance BI/IG/IT	Ensure that the ICA has the right information to inform its clinical pathways, To ensure/enable appropriate information sharing between organisations, Find solutions to issues that arise regarding IG/IT
ICA Governance Commissioning and Contracting	To develop a contracting mechanism which aligns the clinical pathways to the principles of the ICA
ICA Governance Outcomes	To develop and agree a set of outcomes for which the ICA clinical pathways can be measured, and also to measure the success of the ICA

2.2 ICA Clinical Pathways sub-groups

ICA Clinical Frailty	Development of frailty pathway pathways that focus on the whole system to capture those living with mild/moderate and in partnership with the End of Life group, those who are classed as severely frail. This includes pathways redesign, workforce analysis, process redesign and the development of person centred success measures,
ICA Clinical Mental Health	Focussing on Primary care (PCN's) aligning workforce and mapping pathways, Physical Health/Mental Health interfaces, Accessing timely care, current processes and systems and some service re-design
ICA Clinical Palliative Care & End Of Life	Development, commissioning and implementation of a transformed Wolverhampton End Of Life pathway across the whole system, including an electronic shared care record.

ICA Clinical Children and young people	Standardising parent and clinician facing processes and information around the Wolverhampton "Big 6" which will support a reduction in NEL admissions to hospital, the implementation of joint clinics in Primary Care, and the review and redesign of community paediatric services

3 Interdependent Programmes

3.1 Community Transformation

It should be noted that there is also a **Community Transformation programme** being undertaken at RWT which is mainly reviewing its model of delivery of community services across the City. The 10 year plan placed Primary Care Networks (PCNs) clearly in the spotlight for revamping current models of care and revitalising General Practice Primary Care. Core to the PCN approach is ensuring that there is an appropriate Community Nursing infrastructure which is wrapped around these PCN, which makes for greater multi-disciplinary and cross agency team working to ensure the prevention and admission avoidance agenda can be delivered against.

In order for this to happen, the transformation of Community services needs to be especially addressed with a sense of considered and planned urgency and accelerate, in particular, those services which would be part of the multi-disciplinary PCN infrastructure. Clearly there needs to be synergy in any newly designed delivery model with the work being undertaken in both BCF and ICA.

3.2 STP

In line with the NHS Long Term plan, the Black Country and West Birmingham STP is working towards becoming an Integrated Care System (ICS). The STP plans recognise the importance of building the Black Country wide ICS on locally developing arrangements such as the ICA. There will also be further interdependencies with specific STP clinical workstreams that may impact on the local ICA development which need to be considered.

3.3 Primary Care Networks

3.3.1 The current Primary Care Situation in Wolverhampton

Six PCNs have been agreed by the CCG, with an average size of about 50,000 patients. The current PCN clinical leads are also representatives on the clinical and governance oversight groups of the Integrated Care Alliance (ICA) in Wolverhampton which is the mechanism to drive collaborative and joined up working as part of the longer term structural plan to create a local Integrated Care Provider (ICP) approach.

4 Opportunity

As can be seen by the information above there are a number of duplications in both the projects within each programme which presents a risk of conflicting approaches to clinical pathways. There is also duplication with the individuals involved in both programmes of work which creates demand on an already stretched workforce resource.

Substantial preparation and engagement has been invested in creating collaborative working between Primary and Secondary Care clinicians as part of this and a number of workstreams are active and have developed preliminary clinical models. The leading ones are:

- Frailty
- End of Life (EoL)

The Commissioner has committed to invest additional community based funding into these areas to address the service and quality improvement of community based solutions for these cohorts of patients.

There is a common and strongly held view by clinicians and managers that the value of the investment (reduction in admissions; improvements in quality of care; better experience for patients) will be enhanced through ensuring that the community nursing infrastructure is appropriately delivered with PCN collaboration to ensure service clarity, integrity and quality.

The Commissioners have re-written the service specifications for core Community Nursing and the PCN wrap around infrastructure to accommodate these changes

All of this preparatory work creates an opportunity to address the common deficits we have as a 'system' in the ICA and the BCF programme of work i.e. the ICA is mainly clinically driven and has a deficit of operational representation/delivery resource; the BCF is mainly operationally led and has a deficit of clinical input; the LA are integral to the success of both the BCF and the ICA but are more engaged within the BCF Programme They are for the major programmes of work clearly part of the solution (Frailty, EoL, Adult MH); health front line teams are not actively engaged in operationalising the new ICA models. The BCF workstreams could become the delivery vehicles for the ICA (and can be rebranded as ICA delivery vehicles). The programme and project documentation used by the ICA and the BCF are similar so little would need to be transferred over. The resources (people) are largely the same working in those areas and the attached analysis clearly shows where and how the deficit could be closed. There is limited project management resource in the BCF workstreams.

5 Current Programme Resource

As an established programme, the **BCF** has a PMO that consists of:-

BCF – Programme Manager / Lead (permanently funded), CCG Project Manager (permanently funded), CWC Project Manager (funded for 2 years), (Joint CCG/CWC) Project Support Officer (funded until March 2021).

In November 2019 there will be a Graduate Management Trainee working at the CCG and aligned to the BCF Programme as a Project Manager/Delivery Lead.

The ICA has not identified additional Programme support and is currently supported by existing members of staff from CCG (one for Clinical pathways and one for Governance) and a full time Integration Manager from Royal Wolverhampton Trust. There is no dedicated Project Manager or Project / Admin support other than a PA who schedules meetings and distributes papers.

An initial mapping of projects can be seen in section 9.

6 Proposal

In order to reduce duplication, identify gaps and to make best use of the resource available it is proposed to merge the two programmes (BCF and ICA) to enable the clinical review and redesign of pathways and to facilitate the operational delivery of the programme of work.

6.1 BCF Programme Board

Under national policy the BCF Programme Board has to be retained and therefore will continue with a role to monitor and review the Pooled Budget and BCF National conditions and metrics. The BCF Programme Board will continue to meet on a monthly basis (as the Partnership Board) with key membership from CWC and WCCG, and with BCPFT and RWT provider partners as attendees. As the purpose of this group will change to purely a monitoring role, representatives from Housing, Health watch and the voluntary sector will be stood down from the BCF Programme Board, but subsequently invited to the relevant ICA groups for their valuable input into the design of pathways, structures and outcomes of the ICA. Chairing of the BCF Programme Board will remain the same with co-chairs from WCCG and CWC

6.1.1 The BCF Integration workstream

This workstream will continue to support the BCF Programme Board with financial issues, national and local reporting and Estates, whilst the IT and Data sharing elements will move into the BI/IG/IT sub-group for ICA.

6.1.2 BCF Adult Community Care workstream (ACC)

The ACC will become the mobilisation and delivery group for the current projects sitting within it and for the outputs of the ICA clinical priority groups – Frailty, End of Life and Community Nursing.

Sitting within the Adult Community Care workstream is a D2A project. This project has been implemented and an evaluation is currently underway with a proposal being drafted to ensure that the project becomes business as usual within the next 3 months. It is recommended, therefore, that this group continues to complete this piece of work and will then cease upon project closure.

6.1.3 BCF Mental Health Workstream

This workstream will be merged with the ICA Mental Health group (?) to facilitate the design of clinical pathways and subsequent implementation and delivery.

6.1.4 BCF CAMHS

The CAMHS BCF work stream already reports directly into the CAMHS Transformation board and as the Children and young people ICA group is mainly prioritising physical health it is proposed that the CAMHS workstream is removed from the BCF Programme

Associated budgets will be removed from the BCF Pooled budget

6.1.5 BCF Dementia workstream

It is acknowledged that Dementia cuts across all of the ICA clinical pathways (with the exception of CYP) and therefore consideration of this should be taken into account in the development of pathways in these areas with the appropriate sources of knowledge included in the design. The Dementia BCF Workstream is responsible for implementing the Joint Dementia Strategy and therefore will remain with this single remit and will report into the ICA Clinical priorities group.

6.2 Integrated Care Alliance (ICA)

6.2.1 ICA Oversight Groups

The ICA Governance Group and Clinical oversight group will continue in their current form but will merge into one meeting with a split agenda. There is currently a number of people who sit on both meetings and there is a duplication of information and discussion, for example when the Governance Group receives updates from the Clinical group. Having a split agenda will enable a single discussion and for those clinicians who only wish to be part of the clinical group to leave at an appropriate juncture in the meeting.

6.2.2 ICA Governance Sub Groups

The ICA Governance sub groups will continue to support the development of the ICA and also the projects within the Mobilisation and Delivery Groups which will include some projects which were previously within the BCF Programme only. For example; data sharing agreements for MDTs and IT solutions etc.

6.2.3 ICA Clinical Sub Groups

The ICA clinical sub-groups will continue to develop clinically led design of pathways and services and will feed into the Mobilisation and Delivery groups for operational delivery A full list of projects will be presented to the clinical groups and overarching clinical pathways.

The exception to this will be the Mental Health workstream which will go forward as one clinical group with the membership reviewed to ensure that the most appropriate people are involved that can influence the operational delivery. The main reason for this is that there are a number of Mental Health meetings/forums outside of the BCF and ICA and this is an opportunity to rationalise meetings.

6.2.4 Reporting and Monitoring

Within the BCF Programme each workstream produces a monthly highlight report which is presented to BCF Programme Board. These reports will be reviewed to include a brief update for each project, risks and issues and slippage escalation within each workstream and will be presented by the clinical leads to the Clinical Oversight Group.

The Governance Sub groups will report into the ICA Governance oversight group. The Clinical Development sub groups will report into the Clinical Pathways Oversight Group

The Mobilisation and Delivery Groups will report into the Clinical Pathways Oversight Group and the Governance Group.

6.2.5 Requests for Funding

On occasions business cases are presented to the BCF Programme Board for funding of projects. These would need to go to the Clinical oversight group for clinical approval to ensure that they are aligned to the pathways and then to the ICA Governance group to determine approval and source of funding.

7 Programme Resource

The combined resource outlined in Section 5 could be allocated to support the Oversight and mobilisation and delivery groups. However, given the significant number of projects within both programmes, prioritisation will be needed to be undertaken, ideally by the Clinical Pathways oversight group, to ensure delivery.

It is proposed that Project/Delivery Managers will be aligned to a specific pathway i.e. End Of Life and manage the delivery of that pathway, ensuring that the clinical proposals are linked to the Governance groups with regard to developing Outcomes and enabling funding and activity flows etc.

There will still be a need for dedicated Project Support/Admin to support the programmes and the demand on this role will increase with the merging of the programmes and therefore additional resource will be required.

Strategic Direction and Overview Care Pathways and Governance	RWT	1.0 WTE
Strategic Direction and Overview Care Pathways	WCCG	0.4 WTE
Strategic Direction and Overview Governance	WCCG	0.4 WTE
Project/Delivery Manager	WCCG	1.0 WTE
Project/Delivery Manager	CWC	1.0 WTE
Graduate Management Trainees	WCCG	2.0 WTE (until July 2020)
Project Support	WCCG/CWC	1.0 WTE

The successful delivery of the BCF Programme and the successful development of the Wolverhampton ICA is dependent upon the appropriate resourcing being made available. Even with the resource outline above being available, it will still be necessary to prioritise projects and the resources allocated to them.

8 Risks

- Capacity to deliver against timelines – prioritisation will be needed across existing BCF projects and ICA delivery
- Project management and support capacity – medium and long term
- Interdependencies with STP programmes of work

9 Mapping of Projects

BCF	ICA Clinical / Governance sub groups							Mobilisation and Delivery Groups				
ACC Workstream	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Frailty												
Evaluation of Primary Care Frailty Clinic		√			√	√		√				
Evaluation of OT in Primary Care		√			√	√		√				
Approval for implementation of Healthy Ageing Coordinators		√				√	√	√				
Implementation of healthy ageing coordinators		√			√		√	√				
Evaluation of carer support into frailty clinics		√			√	√		√				
Roll out of carer support model in frailty clinics & ED (and other opportunities)		√			√	√	√	√				
Woundcare												
Further development of woundcare business case			√		√	√		√				
	End of	Frailty	Community	Mental	BI/IG/IT	Outcomes	Commissioning	ACC	D2A	MH	Dementia	Integration

	Life		Nursing	Health			and Contracting					
Final approval of woundcare business case			√				√	√				
Roll out of redesigned woundcare service			√		√	√	√	√				
Evaluation of redesigned woundcare service			√		√	√		√				
Re-design of Community Nursing												
Review and redesign of Community Nursing Services to align with PCN's			√		√	√	√	√				
Develop updated specification for District Nursing Service			√		√	√		√				
CV amended specification into contract			√				√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Develop update specification for Community Matron service			√		√	√		√				
CV amended specification into contract			√				√	√				

Redesign of CICT services to align with PCN's			√		√	√	√	√				
CV amended specification into contract			√				√	√				
Integrated Working												
Evaluate co-location of North Locality Teams		?	?		√	√		√				
Develop framework for measuring success		?	?			√		√				
Based on outcome of evaluation - develop Business case for roll out of model		?	?		√	√		√				
Obtain resources to roll out model							√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Identify suitable location												√
Floor Plans and costs												√
Approval of suitable premises												√
PM estates / refurb												√

PM move/change management												√
Palliative & EoL care												
Develop redesigned model for Community End of Life care service	√				√	√	√	√				
Develop specification for redesigned Community EoL service	√				√	√		√				
Obtain approval for Community EoL redesigned service	√						√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Ensure resource is approved for shift of activity into Community EoL service	√						√	√				
Roll out redesigned model for Community EoL	√				√			√				

service												
Evaluate new Community EoL service	√				√	√		√				
GPHV Service												
Evaluate 6 month Pilot of GP Home Visiting Service			√		√	√		√				
Amend specification for service based on evaluation findings			√		√	√	√	√				
Based on evaluation and Board approval - roll out service across the City			√		√			√				
Evaluate 12 month Pilot of GP Home Visiting Service			√		√	√		√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
MDT's												
Engage with Primary Care to ensure all practices are ready to initiate this new way of working		?	?		√			√				
Roll out prototypes			√					√				

as per individual practice preferences												
Align MDT Coordinators to Localities			√					√				
Work with Practice to wrap MDT's around PCN populations			√		√	√		√				
Amend MDT's to align with PCN populations			√		√	√	√	√				
RiTS												
Develop model for RiTS service 24 hrs per day			√		√	√		√				
Develop Business case for amended model			√		√	√		√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Obtain resources and approval for redesigned service			√				√	√				
Develop implementation plan for redesigned service			√					√				
Implement new			√		√			√				

model												
Evaluate new model			√		√	√		√				
Emergency Care Passport												
Undertake Scoping Exercise of current uptake and usage			√		√			√				
Develop roll out plan to improve usage			√					√				
Monitor improvement in usage and impact			√		√	√		√				
D2A (temporary Delivery Group)												
Evaluate D2A process					√	√			√			
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Evaluate Care Home Trusted assessor					√	√			√			
Evaluate Trusted assessor documentation									√			
Evaluate impact of D2A on Community					√	√			√			

Services												
Social Prescribing												
Develop preferred model for Social Prescribing attached to PCN's												
Obtain appropriate approval for preferred model												
Roll out preferred model												
Community Connections												
Profiling the WV10 area, understanding need and demand		?	?	?	?			√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Analyse maps and identify areas of high need and demand		?	?		√			√				
Testing out ways of connecting people with each other and their		?	?					√				

communities												
Run a number of "Love your community" events		?	?					√				
Develop and establish regular Talking Points in a variety of settings		?	?					√				
Identify and agree indicators for identifying where lonely and isolated people might live		?	?		√	√		√				
Trial a scheme to reduce loneliness and social isolation		?	?					√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Telecare												
Evaluate the impact of new Telecare Response Service with SJA and it's impact on admission avoidance					√	√		√				

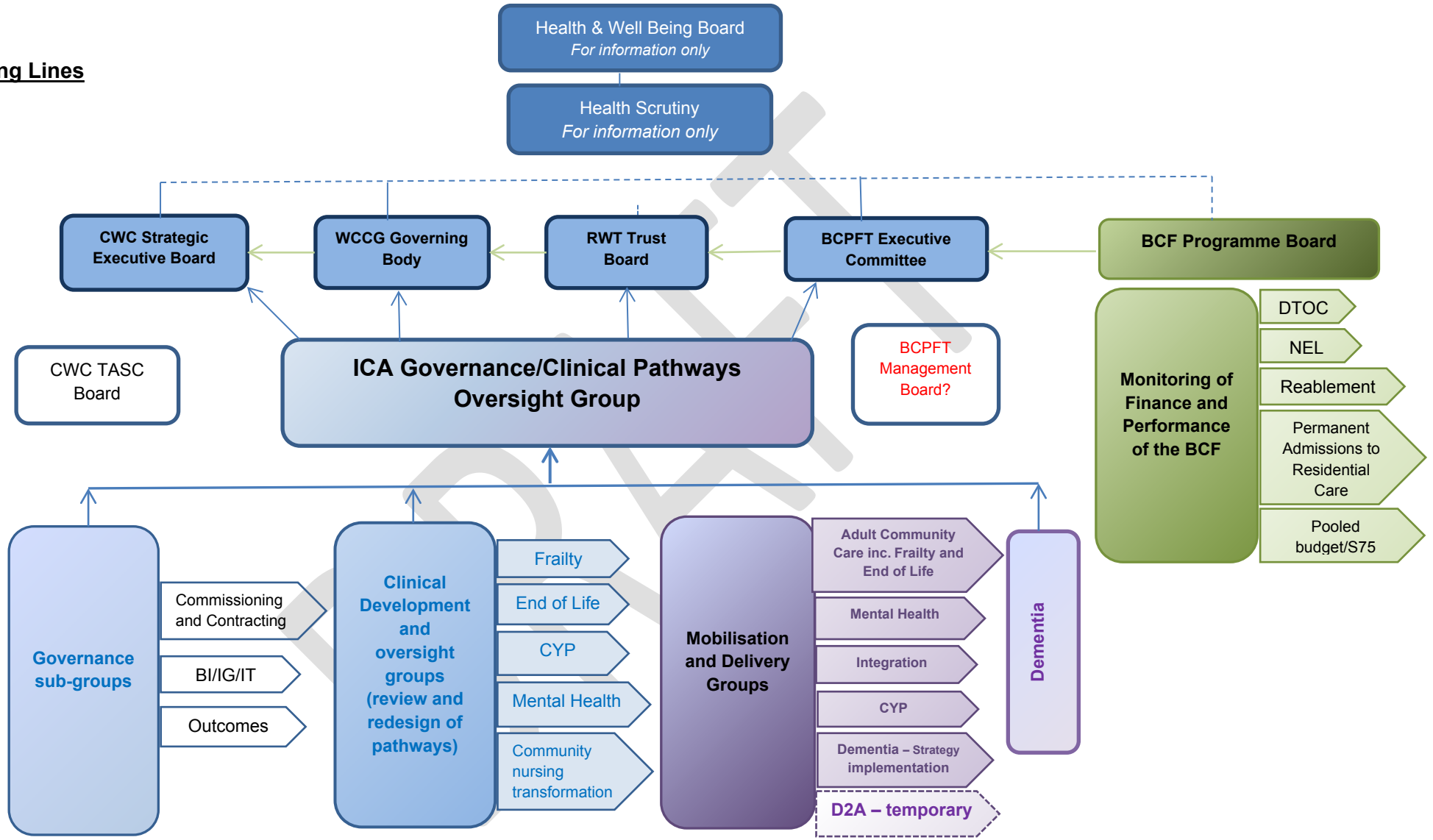
Increase the number of referral for Telecare (free for 6 weeks) within D2A and Admission Avoidance Services	√	√	√					√				
Develop a digital Telecare service offer which does not relay on a landline telephone					√			√				
Scope the demand for urgent Telecare packages 'out of hours					√			√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Explore the possibility for a proactive telecare telephone welfare check call service to support D2A						√		√				
Explore the benefits of using a connected care					√	√		√				

platform to support D2A/reablement												
Fibonacci												
Set up steering group					√							√
Further development of model to localise templates					√							√
Development of roll out plan to other users								√				
Roll out across other identified users								√				
Red Bag Scheme												
Obtain resource for Project Support (post to be advertised)		√					√	√				
	End of Life	Frailty	Community Nursing	Mental Health	BI/IG/IT	Outcomes	Commissioning and Contracting	ACC	D2A	MH	Dementia	Integration
Develop milestones for delivery		√						√				
Mental Health workstream												
Prevention - mapping of services,										√		
Community pathways for										√		

patients with a mental health condition to prevent crisis												
Dementia workstream												
Implementation of the Dementia Strategy											√	

The table below maps the current BCF work programmes and offers a suggested “home” within the ICA structure

Reporting Lines



Current Resources

Programme Manager BCF – Andrea Smith
Programme Leads – ICA Governance (Andrea Smith, Steph Poulter) and Clinical Oversight (Karen Evans, Steph Poulter)
Project Management/Delivery Leads – Michael Holden, Sheeba Mir (until December 2019), Graduate Managament Trainee (from October 2019), Graduate Management Trainee (from November 2019)
Project Support – Cate Chislett

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
10th September 2019

Agenda item 12

TITLE OF REPORT:	Quarterly Update Better Care Fund Programme
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning
MANAGEMENT LEAD:	Andrea Smith
PURPOSE OF REPORT:	To provide an update on progress of the Better Care Fund Programme
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• This report provides key highlights, risks and Issues across the programme • This report details progress against national metrics • This report presents the 2019/20 BCF Plan and Pooled Budget
RECOMMENDATION:	To inform the Governing Body on the work being undertaken within the Better Care Fund Programme To note the 2019/20 BCF Plan and Pooled Budget arrangements
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both the quality and the patient experience.
2. Reducing Health Inequalities in Wolverhampton	The BCF programme strives to ensure that health inequalities are reduced across the City. The plan is based on data and evidence which allows us to understand the health inequalities that we are aiming to address
3. System effectiveness	The Better Care fund programme is supported by a pooled budget with the City of Wolverhampton Council. The pooling of resources

delivered within our financial envelope	gives us the opportunity to use our resources more effectively together

1. BACKGROUND AND CURRENT SITUATION

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

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

1.3.

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

1.5. This is visualised below:-

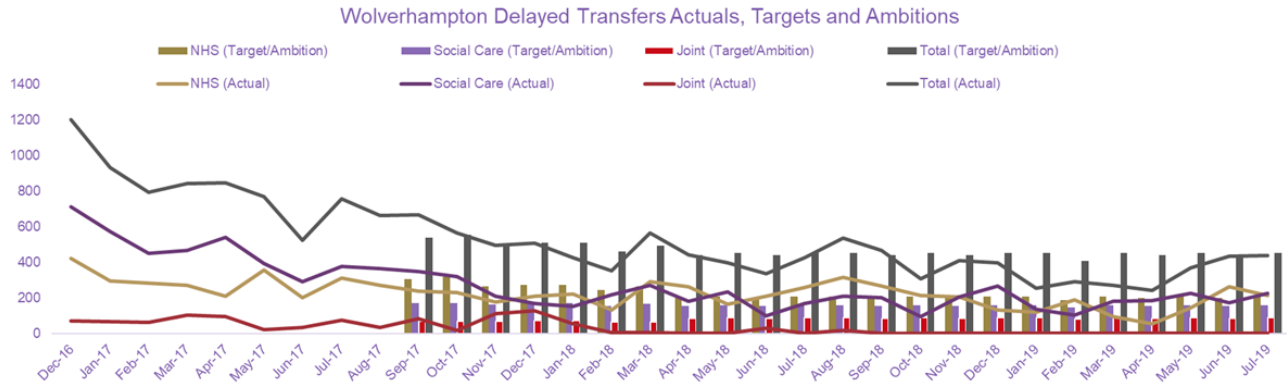
Figure 1 BCF Vision

1.5 The Programme consists of 5 Workstreams; Adult Community Care, Mental Health, CAMHS, Dementia and Integration. Each workstream has a lead from WCCG and CWC and a

Provider lead and members from all key stakeholders appropriate to the work being undertaken.

2. NATIONAL METRICS

2.1 Delayed Transfers of Care.



2.1.1 We continue to meet the DTOC ambition. The total delayed days reported so far for July are **439** and therefore the NHS based 'Ambition' (**453 over 31 days**) was again achieved as the total for the month was under the target figure by 14 delayed days**.** This figure is equivalent to a rate of **7.1 daily delays per 100,000 population 18+** against an NHSE target of **7.4**

July has seen a fall in the number of delays attributable to Health against a rise in those attributable to Social Care when compared with the figures in June and reflects rising overall delays over the last three months.

There has been a perceived increase in the daily DTOC numbers from 1st April which is due to including both acute and non-acute on the notifications whereas the daily numbers were just acute prior to this date.

However there has also been an important minor change in that 'discharge delays' when transferring patients from New Cross to West Park or Cannock do now count as attributable to 'Further Non Acute' delays in the totals but before April they were not counted as they were being treated as 'internal delays'. However these numbers involved are not contributing significantly to the overall totals.

2.2 Reduction of Non-Elective Admissions.

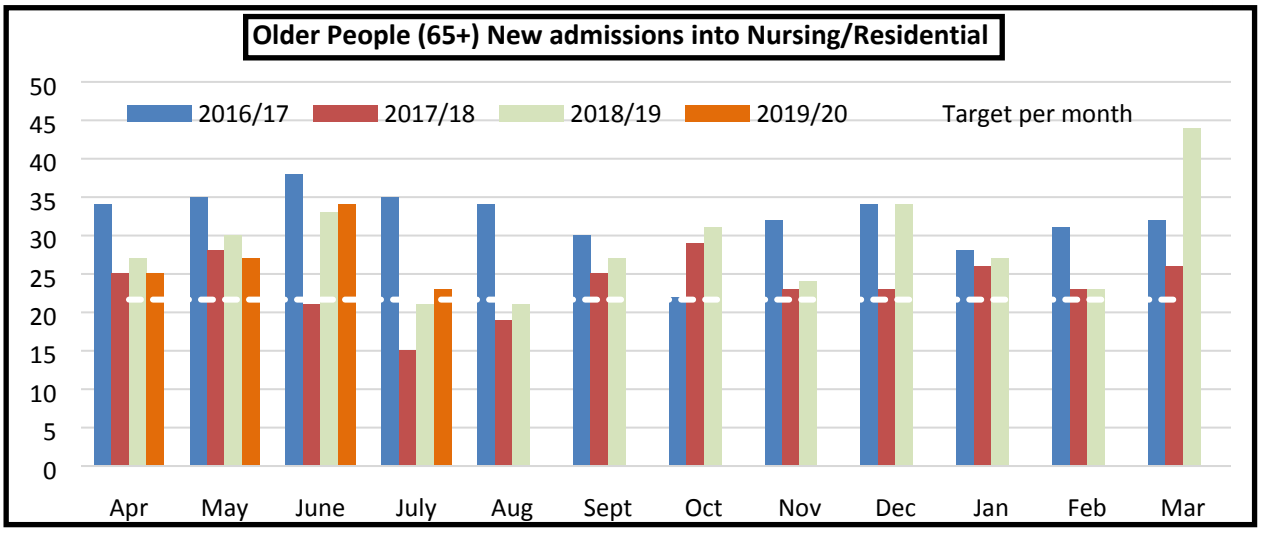
There is a reduction of non-elective admissions that are aligned to some of the schemes within the BCF Programme. For Care Closer to Home there has been a reduction of 592 admissions in the first quarter alone against the Gross Plan. This is a demonstration that the admission avoidance schemes, in part, are successful and are targeting an appropriate cohort of people.

We are seeing an increasing number of non-elective admissions in other areas however, such as Respiratory and in particular pneumonia related conditions. This is being investigated further to establish if variations in pathways may support admission avoidance in this area.

2.3 Permanent Admissions to Residential Homes.

2.3.1 The latest reported number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of June of 23 is slightly higher than in the previous year. However, this highlights the overall rise in admissions since the start of the 2018-19 reporting year with the monthly target of just under 22 admissions, equivalent to 260 in the year, only being achieved twice. This target is carried over into the current financial year.

The year-end total for 2018-19 was 341 which was 31% above the target figure of 260 and 58 admissions (20%) above 2017-18. The year-end total in 2016-17 was 385. Reflecting these trends over the last sixteen months the total number of people resident in care homes has risen 6.7%. the numbers in residential care in May 2019 are 3% higher (+15) than in March last year and this is due in the most part to a rise in short term placements. In contrast the numbers in Nursing Care have steadily increased and are currently 13.6% more (+36) than March last year



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

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

3 HIGHLIGHTS

3.1 Adult Community Care (Co-Location of Community Neighbourhood teams)

Work continues on identifying suitable accommodation for the SE team. Space has been identified at Bilston Health Centre and floor plans are currently being drawn up. A number of options are being explored, however each option will result in a cost to some part of the Wolverhampton system, be that Health or Social Care or both. The options and cost implications will be presented to the BCF Programme Board once available.

3.2 Adult Community Care (MDT working)

Primary Care based MDTs continue to be rolled out across the City. There are currently 22 MDTs in place and we are aware that any future modelling of community teams needs to be aligned to RWTs Community Transformation Programme and to the development of Primary Care Networks.

3.3 D2A Evaluation

The D2A Evaluation report was presented to both BCF Programme Board and A&E Delivery Board in July. Overall the evaluation demonstrated that the Wolverhampton D2A Model has had a positive impact on DToC, and there is no doubt that partners across the organisation have developed good relations and networks that support the process. There are still some challenges that continue to be worked through and further work is being undertaken to analyse the financial impact across all elements of the system.

A project closure report is being produced with the project due to formally close, following transition, in November.

3.4 Dementia

The Joint Dementia strategy for Wolverhampton has now been approved by Health and Wellbeing Board. The BCF Dementia workstream is planning the work required to implement the strategy.

3.5 Mental Health

The Mental Health workstream have undertaken a number of workshops (MapJams) to ascertain the gaps in service provision across the City. This work will inform the development of sustainable community services to support people with a mental health condition in the future.

3.6 BCF Planning

The national guidance and planning template is now available and the submission date for the 2019/20 plan is 27th September 2019. Unlike previous years we are just asked to submit the planning template with some narrative sections, rather than a lengthy narrative document.

The planning template is due to be submitted to BCF Programme Board on 5th September and to Councillor Jaspal, Chair of the Health and Well Being Board for approval on 10th September.

The table below outlines the contribution to the Pooled Budget

	CCG	CWC	Total
Adult Community Care	£31,095,414	£25,591,066	£56,686,480
Dementia	£3,581,121	£280,229	£3,861,350
Mental Health	£10,417,646	£3,675,002	£14,092,648
DFG		£3,147,482	£3,147,482
Total	**£45,094,181**	**£32,693,779**	**£77,787,960**

The Governing Body have previously given delegated authority to the Chair and Accountable Officer to sign the BCF Plan off on behalf of the CCG prior to submission to the Health and Wellbeing Board. The Planning template is attached for information.

3.7 Future Delivery of BCF

It has become apparent that there is significant cross over between the BCF Programme and the development of the Wolverhampton Integrated Care Alliance. A Proposal has been produced and presented and supported at both BCF Programme Board and ICA Governance group.

This proposal is on the Governing Body Agenda today.

4 CLINICAL VIEW

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

5 PATIENT AND PUBLIC VIEW

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

6 KEY RISKS AND MITIGATIONS

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

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

7 IMPACT ASSESSMENT

Financial and Resource Implications

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

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

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

Other Implications

7.7 N/A

Name: Andrea Smith
Title: Head of Integrated Commissioning
Date: 29.08.19

ATTACHED:

RELEVANT BACKGROUND PAPERS

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
10 September 2019

Agenda item 13

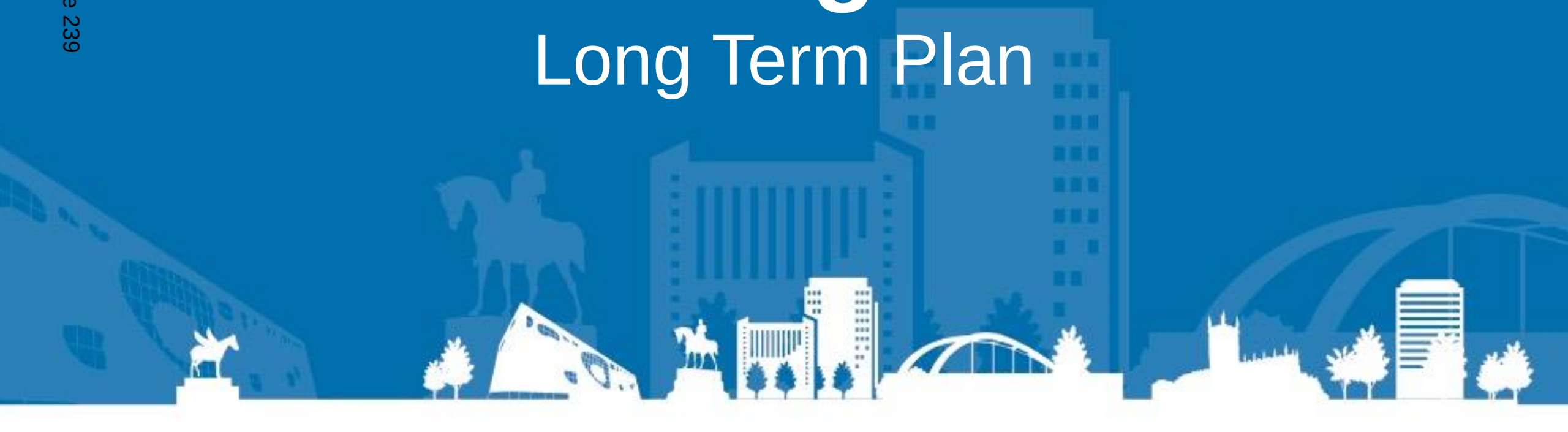
TITLE OF REPORT:	Black Country West Birmingham Sustainability & Transformation Partnerships (STP) Long Term Plan (Update)
AUTHOR(s) OF REPORT:	Wendy MacMillan (STP Programme Manager)
MANAGEMENT LEAD:	
PURPOSE OF REPORT:	To update on the current progress and content for the STPs response to the Long Term Plan (LTP)
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• The Black Country & West Birmingham STP is working to deliver both the 'Strategic Planning Tool' (combined finance, activity and workforce plan for STP) and the STP 5-year plan (the STP's response to the NHS Long Term Plan). • The draft narrative is currently under development with each organisation contributing to and collaborating on the plan. Each CCG will be seeking the views of patients and the public during September, along with working with local authority partners to present to Health and Wellbeing Boards in September/October. This should ensure that while the plan is being developed at an STP level it is being locally owned. • The final draft of the plan will go to Governing Bodies during November 2019, with a launch and publication date by the end of November 2019.
RECOMMENDATION:	To be noted by attendees and also provide feedback for inclusion in the plan
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	

1. Improving the quality and safety of the services we commission	Ensuring the on-going improvement in quality, safety and performance of the services in the STP is a key priority of the STP partners and a common theme in the Strategy.
2. Reducing Health Inequalities in Wolverhampton	By developing a system level strategy for the STP, where it is appropriate to do so, resources can be used to focus on innovation and transforming the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships.
3. System effectiveness delivered within our financial envelope	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.

See presentation attached

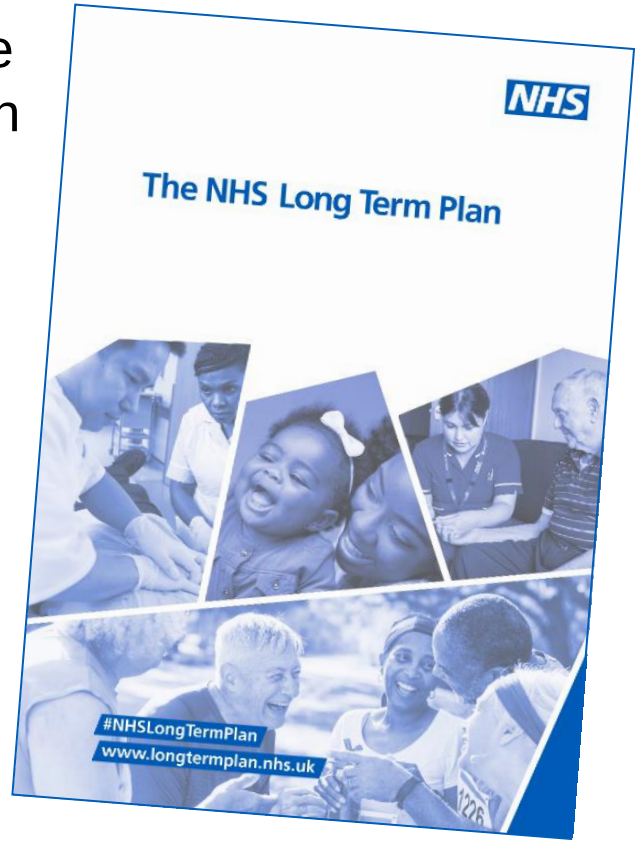
Black Country and West Birmingham

Long Term Plan



NHS Long Term Plan

- In June 2018, the Prime Minister made a commitment that the Government would provide more funding for the NHS for each of the next five years, with an average increase of 3.4% a year.
- In return, the NHS was asked to come together to develop a long term plan for the future of the service, detailing our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement.
- The plan was published 7 January 2019.



Long Term Plan priorities

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well.

How will the NHS deliver the ambitions:

- Doing things differently
- Preventing illness and tackling health inequalities
- Backing our workforce
- Making better use of data and digital technology
- Getting the most out of taxpayers' investment in the NHS.

What does this mean for the Black Country and West Birmingham?

- Opportunity to work with local people, our health and care partners and staff to develop a plan that is locally owned and delivers the national ambitions
- Making health and care in the Black Country and West Birmingham sustainable
- To support a workforce that is fit for the future and create a system of health and care organisations that are seen as employers of choice
- To support local people with the knowledge and skills to have more choice and control over their own health and care
- Recognising our collective strength in working together to resolve our common challenges.

Our health and care partnership

- **1.4 million population** across the Black Country and West Birmingham
- **18 partners** (4 Hospitals, 2 Mental Health Trusts, 5 Local Authorities, 4 Clinical Commissioning Groups, Community Trust, Ambulance Service, NHS Midlands)
- **Five localities**
- **216 GP Practices** (34 Primary Care Networks)
- **Shared vision** for improving health and care.

Our vision

Working together to improve the health and wellbeing of local people.

Our commitment

For our population:

- People wont see organisational boundaries, services will be seamless
- People will have access to services in the right place, at the right time including new digital options
- People will only need to tell their story once
- People will be empowered to look after their own health
- People will be supported to look after others.

For our staff:

- The work environment will be experienced as positive
- Organisational boundaries will not be obstacles to overcome
- Staff health and wellbeing will be well looked after
- Opportunities to develop.

For our system:

- We will transition towards being an Integrated Care System by April 2021
- We will commission with one voice, with one Accountable Officer
- Each of our places will have an integrated provider
- Hospital will work together to deliver services
- There will be a single Mental Health Trust across the Black Country and West Birmingham
- Our system will be supported through values-driven recruitment.

Our service quality challenges

- Timely access to services challenged by increasing demands – for example access to GP appointments, mental health services and some cancer services
- Requirement to deliver high quality services across seven days
- Provide care and treatment focusing on the whole person, including their physical and mental health needs
- Clinical workforce challenges that may lead to some services not being sustainable in the future
- All our services need to be of high quality.

Highest quality services, in the right place at the right time.

Our financial challenges

- If we continue with our current service model, the system will be financially unstable in five years
- Historical underinvestment in estates and infrastructure
- Service demand and costs have risen for hospital based care
- Subsequent underinvestment in mental health, community and primary care services.

Our priorities

1. We will ensure our local health and care system is fit for the future

- Develop our Primary Care Networks
- Organise health and care delivery around our five ‘places’
- NHS organisations will work closer together provide services
- Commissioning with a single voice
- Become an Integrated Care System

2. We will deliver the best quality of care for our population

- Deliver the clinical priorities set out in our Clinical Strategy
- Implement a new quality framework to improve consistency and reduce inequalities
- Collaboration of NHS organisations to provide services facing sustainability challenges

3. We will work together to be a sustainable health and care system

- Sustainable people and communities
- Financially sustainable
- Sustainable workforce

Our principles

In order to deliver our system priorities, we have drafted a set of five principles that will support and guide our approach. These are:

- Create a culture of stewardship (doing things together, shared responsibility)
- Health and social care act as one
- All services will work together as a network, delivering care and treatment around an identified need
- Provide local people with the information and support to empower them to optimise their own health and wellbeing
- We will take collective responsibility for delivering our Long Term Plan.

Developing our local plan

NHS **Long Term Plan** published January 2019

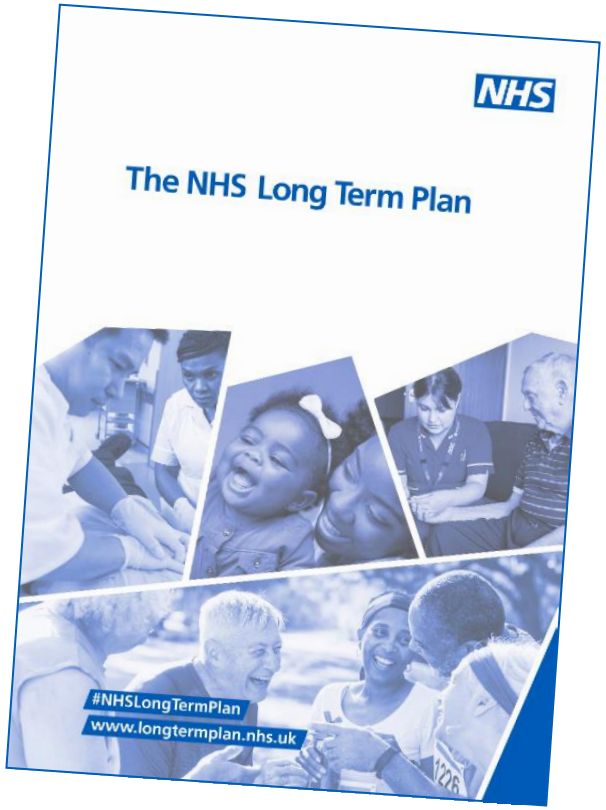
- Real focus on collaboration, moving away from market, competition and transacting

Engagement

- Healthwatch led engagement (1500 surveys, 200 people attending events)
- Staff engagement (events and survey)
- Introducing the draft plan (public events, Health and Wellbeing Boards, Governing Bodies)

Final version production (October)

Publication (November)



Public views shaping our plan

During April and May, each Local Healthwatch across Black Country and Birmingham engaged with the public. (Over 1500 surveys were completed & Over 200 people took part in focus groups). The key themes were:

- **Information, signposting and health education -** People told us that they needed improved access to timely information and signposting to support them to self-care. This includes more accessible information which meets their needs i.e. easy read, no jargon.
- **Access to Services -** People want quick, timely access to professionals for diagnosis, treatment and support. This includes improved access to GP appointments and mental health services. Following diagnosis individuals want effective signposting to information and services that empower them to self-care.
- **Support in their communities -** People valued support and services in their areas through the voluntary and community services and want this to be supported and increased utilising community assets. Individuals identified key roles or ‘one stop shops’ as important to access information and services quickly.
- **Ongoing Engagement and Involvement -** People value being involved and welcome ongoing conversations about health and social care. Individuals want to see more engagement take place to share their experiences and ideas.

A new service model for the 21st century

Five major/practical changes to the service model over next five years:

1. Boosting ‘out-of-hospital’ care
2. Redesigning/reducing pressure on emergency hospital services
3. Care to be more personalised/more control for people over their own care
4. Digitally-enabled primary/outpatient care
5. Local organisations to increasingly focus on population health, with new Integrated Care Systems everywhere.

Future model for delivering integrated care

People	People empowered to look after their own health and each other.
Neighbourhood	Services wrapped around 30-50,000 GP neighbourhoods
Place	Our five places support the integration of health and care services focussed around the patient. This includes: acute, community mental health, local authority and voluntary sector services.
System	Partnership sets the vision, strategy and pace of system wide development. It will oversea the delivery of the Partnership and ensures effective collaborative working. Working as a system to tackle the health, quality and experience gaps.
Region	NHS England & NHS Improvement working together to directly commission some services at a national and regional level, including most specialised services. (Midlands and East)

More NHS action on prevention and health inequalities

Specific, measurable goals for narrowing inequalities, including those related to poverty:

Smoking

- By 2023/4 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services, with adapted model for expectant mothers/partners
- New universal smoking cessation offer will be available as part of specialist mental health services for their long-term users and in learning disability services.

Obesity

- Action on weight management, diabetes prevention and low-calorie diets
- NHS to continue to take action on healthy NHS premises
- Ensuring nutrition has greater place in professional education training.

Alcohol

- Hospitals with highest rate of alcohol dependence-related admissions will be supported to establish specialist Alcohol Care Teams.

Air pollution

- NHS will cut business mileages and fleet air pollutant emissions by 20% by 2023/24.

Antimicrobial Resistance

- Will continue to support implementation and delivery of government's five-year action plan on Antimicrobial Resistance.

Further progress on care quality and outcomes

A strong start in life for children and young people:

Maternity and neonatal services

- Better Births Strategy to improve safety and experience
- New Perinatal Community Mental Health Service
- Personalised birth plans.

Children and young people's mental health services

- Ensuring that inpatient stays for children and young people will only take place where clinically appropriate,
- Development of School or college-based Mental Health support Teams
- Development of keyworkers for children and young people with most complex needs and their families and carers.

Learning disability and autism

- Ensuring that inpatient stays for people with learning disabilities and autism will only take place where clinically appropriate
- Provide coordinated care – SEND, youth and justice, health and care services.

Further progress on care quality and outcomes

A strong start in life for children and young people:

Children and young people with cancer

- Strengthening of children and young people cancer networks, ensuring care and treatment is delivered in a personalised way
- Genome sequencing for all children with cancer.

Redesigning other health services for children and young people

- Work with Primary Care Networks to increase screening and immunisation.

Further progress on care quality and outcomes

Better care for major health conditions:

- Cancer
- Cardiovascular disease
- Stroke care
- Diabetes
- Respiratory disease
- Mental Health services
- Short waits for planned care
- Research and innovation to drive future outcomes improvement
- Learning Disability and Autism Services

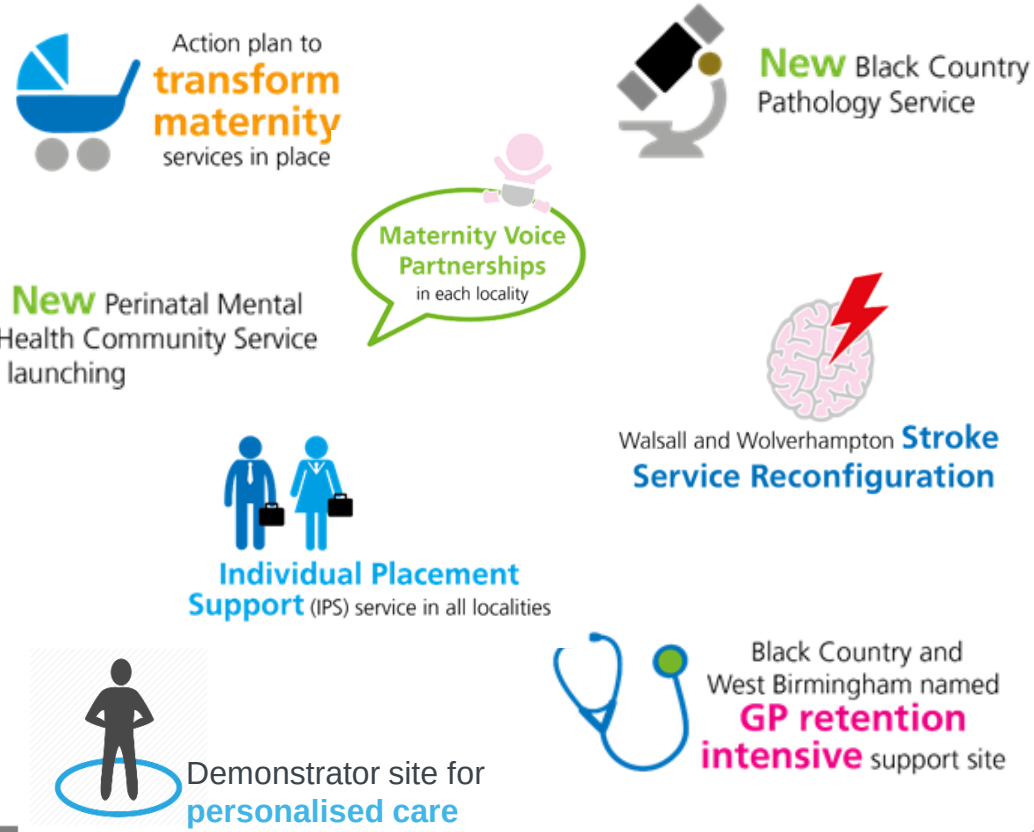
Local priorities:

- Musculoskeletal
- Frailty
- Medicines optimisation

Clinical engagement and service redesign

We are currently working with clinical leads to:

- Develop an integrated frailty pathway
- Better support in care homes
- Develop end of life services
- Cancer- Clinical leadership informing and driving a system response
- Vulnerable Services Review
- Medicines Management - working at scale to deliver efficiencies



NHS staff will get the backing they need

- Comprehensive new workforce implementation plan
- Expand the number of nurses, midwives, AHPs and other staff
- Grow the medical workforce
- International recruitment
- Support our current NHS staff
- Enable productive working
- Leadership and talent management
- Volunteers

Digitally-enabled care will go mainstream across the NHS

- Empower people
- Support health and care professionals
- Support clinical care
- Improve population health
- Improve clinical efficiency and safety

Supporting wider social goals

- Employment
- Justice system
- Veterans and the Armed Forces
- Care leavers
- The environment
- Investing in ‘local’ (Anchor Institutions)

Comments?

Views?

Questions?

Concerns?

Help us to finalise this plan

As we move to produce a final plan for submission to the national team and eventual publication in November we are keen to hear your thoughts:

- **Are we representing the challenges correctly?**
- **What is the area that you feel will make the most difference to the health and wellbeing of local people and why?**
- **Are we missing anything?**
- **What is the role of people and communities in delivering this plan?**

Thank you.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
10 SEPTEMBER 2019

Agenda item 14

TITLE OF REPORT:	**Governing Body Assurance Framework and Risk Register**
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide assurance to the Committee on the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
KEY POINTS:	• This report outlines the current work underway to support risk management across the CCG, including the work of the Governing Body Committees. • The latest updated version of the GBAF and Strategic risk register, is appended following consideration at the Audit and Governance Committee in July 2019. • The GBAF has been updated following the Governing Body's review of the organisation's strategic objectives in May 2019.
RECOMMENDATION:	That the Governing Body • Considers the report and updated risk profile for the CCG • Comments on any matters relating to risk management.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives.

1. BACKGROUND AND CURRENT SITUATION

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

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

2. ASSURANCE FRAMEWORK UPDATE

2.1. Following the Governing Body agreement of a new structure for the GBAF the Audit and Governance Committee have reviewed an updated version of the GBAF.. This was produced with the input of the Executive and Senior Management Team and is appended. The Committee have provided assurance to the Governing Body that the approach and scoring (an indicative score from the management team is given) based on the updated risk profile, including the identified Corporate Risks which impact on the achievement of each objective is appropriate. Following feedback from the committee, details of sources of assurance have been added to the GBAF to support the committee and Governing Body in identifying any gaps in controls.

2.2. A key support for the development of the GBAF is the CCG's Strategic Risk Register, which includes an update on each of the identified risks, including those reviewed by the Governing Body Committees, which take place at each meeting. This has also been reviewed by the management team. No new Corporate risks have been identified and the Governing Body are asked to note that the risk level for Risks CR01 (Failure to Achieve QIPP targets) and CR18 (Failure to Deliver Long Term Financial Strategy) has been raised as a consequence of the need to amend the CCG's financial plans for 2019/20. The risk level has also increased for CR08 (New ways of working across the STP) to reflect the impact of work to develop a shared management team across the Black Country and West Birmingham CCGs and for Risk CR22 (EU Exit) to reflect the increased work to prepare in advance of a potential exit date on 31 October 2019.

3. COMMITTEE RISK REVIEWS

3.1. In addition to supporting the Governing Body with their review of the Strategic Risk Register, Committees have also continued to review their own assigned risk registers at each meeting. These discussions are supported by work in CCG teams to identify operational risks and discussion at team meetings to escalate risks as appropriate to committees.

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

Committee	Number of Risks				
	Red	Amber	Yellow	Green	TOTAL
Commissioning Committee	1 (1)	2 (2)	0 (0)	0 (0)	3 (3)
Finance and Performance Committee	0 (0)	2 (1)	6 (8)	0 (0)	8 (9)
Primary Care Commissioning Committee	0 (0)	5 (6)	0 (0)	0 (0)	5 (6)
Quality and Safety Committee	2 (1)	4 (2)	1 (1)	0 (0)	7 (4)
TOTAL	**3 (2)**	**13 (11)**	**7 (9)**	**0 (0)**	**23 (22)**

3.3. Work continues to ensure that discussions of the risk profile at committees is an embedded part of the committees operation. This includes not just discussing the risks outlined on the committee's risk register, but also considering whether risks are identified as a result of issues discussed throughout the meeting. Following discussions around the risk appetite for committees the Governance and Risk team are reviewing the templates used for committee risk registers.

4. RISK MANAGEMENT ARRANGEMENTS

4.1. The Audit and Governance committee were advised that the planned deep dive into Primary Care has been delayed as the work to refresh of the CCG's Primary Care Strategy has been delayed. This will enable the deep dive to review any risks to the delivery of newly identified milestones once the new strategy is complete. This means that the deep dive can be aligned to the domain in the new GBAF structure when it is undertaken.

4.2. The work to refresh the GBAF has involved a review of the overall risk profile of the organisation and, in addition to recognising the continuing need to review the risks associated with Primary Care, has identified further actions which are being progressed. In particular, work will be undertaken to assess the impact of risks associated with the transition programme across the four Black Country and West Birmingham CCGs to support the development of a single commissioning voice in line with the NHS long term plan. This includes the impact on staff as well as the

need to understand how the single commissioning voice will reflect and build on local relationships and working arrangements in the five distinct places that will ultimately make up the Black Country and West Birmingham Integrated Care System.

4.3. The Governance and Risk Team are continuing to engage with colleagues from across the Black Country and West Birmingham to ensure that the interface between the CCG's risk management arrangements and those of the STP and transition programme work effectively. This has included supporting the development of a governance framework for the STP and highlighting the need to understand how risks identified at a system level are managed both within partnership structures and within organisations. This work will continue as the programmes of work in these areas continue to develop and clarify. The team are also planning to review the CCG's risk management strategy in the Autumn.

5. CLINICAL VIEW

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

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable for the purpose of this report.

7. KEY RISKS AND MITIGATIONS

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

8. IMPACT ASSESFSMENT

Financial and Resource Implications

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

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

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

Other Implications

8.5. There are no other implications arising from this report

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

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	Not Applicable	
Public/ Patient View	Not Applicable	
Finance Implications discussed with Finance Team	Not Applicable	
Quality Implications discussed with Quality and Risk Team	Not Applicable	
Equality Implications discussed with CSU Equality and Inclusion Service	Not Applicable	
Information Governance implications discussed with IG Support Officer	Not Applicable	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Owner	August 2019
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**14/08/2019**

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Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Sources of Assurance	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation
1. Improving the quality and safety of the services we commission							
a. Continue to commission high quality, safe healthcare services 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	CR02 - Cyber Attacks CR03 - NHS Constitutional Targets CR15 - CCG Staff Capacity Challenges CR19 - Transforming Care Partnership CR22 - Exiting the European Union	There are a number of high level risks associated with provider safety concerns listed on the Risk Register. In particular, cancer outcomes at RWT and mortality statistics have the potential to have a significant impact. In addition there is an underlying risk that mitigating action to address these concerns may divert resources from overall systemic improvement.	No new strategic risks have been identified. The Quality and Safety Committee continue to monitor the risk in relation to cancer performance at RWT and have identified a new risk in relation to two week waits for breast cancer. Recovery action plans are in place, with actions both locally and across the STP. Regular monitoring of preparations for EU Exit continues.	The CCG continues to actively monitor the quality of provision at all its providers. The CCG is engaged with a multiagency improvement board to support improvements at the Urgent Care Centre and is working with other CCGs across the STP to ensure a system level approach is taken to issues with Maternity services. Existing monitoring systems are in place to ensure that concerns about Quality are addressed at the earliest possible opportunity and to ensure that appropriate contractual levers can be used if necessary	Monthly Quality Reporting via QSC CQRM Meetings with main providers Quality Monitoring Visits Information from Regulators (CQC, NHSE/NHSI, Ofsted etc.)	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 3 Impact - 4 12 High
b. Ensure that services perform effectively so that the CCG can continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality physical and mental health and care services for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework	CR03 - NHS Constitutional Targets CR05 - Mass Casualty Planning CR15 - CCG Staff Capacity Challenges CR22 - Exiting the European Union	In a period of change across the health service, it is important that the CCG is able to maintain a focus on delivering its core duties and responsibilities within the available capacity. This includes meeting our corporate responsibilities in law for areas such as Equality and Diversity, Data Protection and Health and Safety. In particular, the CCG must ensure that it works to ensure our local providers deliver on commitments in the NHS Constitution in the face of considerable national and local challenges, including rising demand for services and the need to respond to unforeseen or unpredictable events.	No new strategic risks have been identified. The risk in relation to staff capacity is being reviewed to take into account the impact of the ongoing CCG transition programme. Agreement has now been reached to appoint a single Accountable Officer across the 4 CCGs as a first stage to closer collaboration across the Black Country. The CCG met all of its regulatory requirements at year end and has been rated as Outstanding by NHS England for the fourth year in a row through the CCG Improvement and Assessment Framework. As highlighted above, performance in some areas - particularly in meeting cancer targets remains challenging with actions both locally and system wide to address these issues.	The CCG has clear accountability mechanisms in place for the delivery of statutory duties and uses robust performance management frameworks to ensure that providers are meeting their statutory responsibilities, particularly those relating to the NHS Constitution. This includes the use of a range of contractual mechanisms when appropriate.	NHS England CCG Improvement and Assessment Framework Monthly Performance reporting via F&PC Internal and External Audit work Contract Review mechanisms Statutory and Regulatory reporting (e.g. Data Security and Protection Toolkit, Workforce Race Equality Standards)	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 3 Impact - 4 12 High
2.Reducing health inequalities in Wolverhampton							
a. Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions Work with partners across the City to support the development and delivery of the emerging vision for transformation towards services wrapped around the patient that will lead to improved outcomes.	CR09 - Better Care Fund CR14 - Developing Local Accountable Care Models CR17 - Failure to secure appropriate estates and infrastructure funding CR20 - Governance for Insight Shared Care record CR21 - Impact of potential funding withdrawal by City of Wolverhampton Council	The CCG is working with partners in the City to support the development of an Integrated Care Alliance for Wolverhampton. This creates a number of significant risks as each organisation needs to balances their own priorities and challenges to deliver systemic change and understand the interface between the local programme of work and its contribution to the Black Country and West Birmingham STP becoming and integrated Care System. In particular, there is a risk that relationships between partners may become strained as differing priorities are encountered. There are also significant challenges for CCG staff delivering these changes in addition to their existing responsibilities, particularly as they need to build their understanding of the impact of new models.	No new strategic risks identified. Work continues to ensure that the work streams supporting the ICA are operating effectively including linking the governance and project support to the existing Better Care Fund structure. Work also continues to ensure the newly established Primary Care Networks are fully embedded in the on-going development of the ICS.	The CCG is working in partnership with the other organisations and is ensuring all work on new models is done collaboratively. Clear lines of responsibility for developing clinical and governance workstreams to support these priorities have been developed. Communication lines with staff are prioritised to ensure that all staff are briefed on the trajectory of work and that there are opportunities for questions to be raised to allay any concerns.	Better Care Fund performance and assurance reports to Governing Body and Health and Wellbeing Board Developing ICA governance framework Risk Share Arrangement with RWT	Likelihood - 4 Impact - 3 **12** High	Likelihood - 2 Impact - 3 6 Moderate
b. Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them Working with our members and other key partners to ensure that primary care and the developing PCNs are at the heart of improving how local healthcare services are delivered, including encouraging 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.	CR12 - New Ways of Working in Primary Care CR14 - Developing Local Accountable Care Models	The CCG's Primary Care strategy sets an ambitious programme in partnership with GP practices and Primary Care Networks to deliver significant improvements in care for patients in primary care in Wolverhampton. The scale of change itself has a number of inherent risks as it involves CCG Staff, GPs and practice staff considering significant changes to their ways of working. This comes on top of existing high demand for services and a recognised workforce challenge in Wolverhampton. The most significant risks identified relate to the ongoing transition into networks able to deliver new services, at scale.	No new strategic risks have been identified, the Primary Care Commissioning Committee recognised and managed a risk associated with the establishment of PCNs and are assessing risks associated with practice funding for estates through NHS Property services. An STP primary care strategy is being developed to recognise the increased alignment of GP forward View programmes of work across the Black Country and West Birmingham, including work to address ongoing work force concerns. To compliment this, the CCG Primary Care Strategy is being refreshed to reflect local ambitions and, once these strategies have been completed they will be supported by implementation plans and any subsequent risks identified and assessed.	The CCG continues to support the development of PSNs with staff in the Primary Care team providing direct support. Progress with the Primary Care Strategy is being measured by a milestone plan through monthly checks and quarterly review meetings now reported to the Primary Care Committee. Significant work continues to take place both locally and at an STP level to ensure that workforce challenges are addressed through both recruitment and upskilling of the existing workforce.	Primary Care Contracts Primary Care Network Directed Enhanced Service NHSE PCN assurance framework Primary Care Strategy Milestone Review	Likelihood - 3 Impact - 4 **12** High	Likelihood - 2 Impact - 4 **8** High

Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Sources of Assurance	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation
3. System effectiveness delivered within our financial envelope							
a. Proactively drive our contribution to the Black Country and West Birmingham STP Aligning our Clinical Priorities, as appropriate, to STP/ ICS plans to ensure resources are used to deliver material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country and West Birmingham footprint.	CR08 - New Ways of Working across the STP CR14 - Developing Local Accountable Care Models CR15 - CCG Staff Capacity Challenges CR19 - Transforming Care Partnership	As the STP seeks to transition to become an Integrated Care System (ICS), a number of risks emerge. In particular, as highlighted above, there is the potential for tensions in relation to the interface between efforts to develop locally appropriate models of care and strategic commissioning across the wider footprint, which could create risks associated with the relationships between organisations within the system. In addition, the transition to become an ICS involves a programme of closer collaboration across the CCGs in order to form a single commissioning voice, this has a significant impact on the overall risk related to CCG staff capacity in an uncertain environment.	No new strategic risks have been identified. The CCG continues to play a leading role in the STP, with the Accountable Officer working as SRO and other staff providing leadership and working across STP workstreams. As highlighted, this does have the potential to impact on overall capacity, particularly the work to collaborate across the four CCGs. Risks around this area continue to be assessed by the Executive Team as the work develops through the CCG Transition Board. A milestone plan for the Transition Board is being updated, with the appointment of a Single Accountable Officer a first significant milestone in this process.	The CCG is ensuring that it remains fully engaged with the STP process as it continues to develop. CCG staff contribute to strategic leadership groups and all staff are briefed as part of ongoing internal communication plans. The STP has developed an MOU and governance framework to provide clarity about the aims and objectives of the STP and how it links into other ongoing work streams. Proposals for the development of an ICS and closer working between the CCGs are being developed via the CCG's Governing Body	STP Governance Framework and Assurance reporting Transition Board Assurance Reports	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 4 Impact - 3 12 High
b. Ensuring our services are cost effective and sustainable Working across all of the services we commission to ensure that the CCG meets its financial duties and responsibilities and achieves the best possible value for the money it spends.	CR01 - Failure to meet QIPP targets CR07 - Failure to meet overall financial targets CR18 - Long Term Financial Strategy	The CCG faces, in common with other health service organisations, a number of financial challenges. This includes continuing to meet QIPP targets and planned reductions in running costs whilst managing the challenges of maintaining performance and quality in the face of increasing demand. In addition, as financial planning increasingly moves to the STP footprint with shared control totals , work to deliver these targets will need to be based on closer collaboration, both between CCGs and commissioners and providers.	No new strategic risks have been identified, but the risk to both achieving QIPP and the long term financial strategy have increased. This reflects the need to find additional savings, which is being mitigated by a risk share arrangement across the four CCGs . Work continues through the CCG's QIPP programme to monitor and assess programmes of work and robust financial plans are in place to meet other financial duties, including the requirement to reduce management costs by 20% in 2019/20.	The CCG has a robust financial planning process in place, supported by PMO processes to manage key areas including QIPP delivery. Financial performance is monitored through the F&P Committee on a monthly basis. The CCG is a core and key participant in STP financial planning processes	Financial reporting mechanisms Internal and External Audit work	Likelihood - 3 Impact - 4 12 High	Likelihood - 2 Impact - 3 6 Moderate

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR01	PCPB14 - QIPP: Delivery of Targeted GP Peer Review Scheme	**Failure to meet QIPP Targets** QIPP Delivery is vital to ensuring that the CCG meets its financial targets. A challenging QIPP target of 3.5% has been set equivalent to £14m in 2018-19	Robust QIPP Process is in place, progress is being made towards identifying new schemes to deliver QIPP targets. **Update** QIPP Plans in place for 2019/20 following NHSE Scrutiny of Planning Process. The CCG has fully identified QIPP schemes to meet the revised target. An initial assessment of deliverability risk has been undertaken and the consequences of which can be met through reserves - this will continue to be the focus of close scrutiny	12/08/2016	Jul-19	3c - Meeting our Statutory Duties (Delivery of Financial duties)	Finance and Performance	Tony Gallagher	12	High	12	High	⇧
CR02		**Cyber Attacks** Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.	Robust SLA in place with RWT for IT systems Proactive approach to Cyber Security with consequent investment in cyber security approaches CCG EPPR and Business Continuity plans in place to address any issues should they arise **Update** Cyber security arrangements are on the Internal audit plan for 2019/20 and the Audit and Governance Committee will be reviewing the risk level in line with national best practice around the top ten identified risks	31/01/2014	Jul-19	1a - Monitoring ongoing safety and performance in the system	Executives	Mike Hastings	4	Moderate	4	Moderate	⇔
CR03	FP04 - Increased Activity at RWT FP11 - System Pressuires A&E Performance QS06 - Cancer Target	**NHS Constitutional Targets** There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes	CCG Performance Management Framework ensures robust monitoring of Constitutional Targets through meetings with providers, analysis of performance data and rigorous reporting through the Committee structures). Contract Management applied when necessary Whilst providers are not yet meeting all targets, performance is improving on key indicators **Update** Cancer performance continues to be scrutinised by NHS England, Recovery Action Plan is in place and is being monitored by NHSE and the Cancer Alliance via weekly assurance calls and monthly face to face meetings. Recent impact of month on month increase in breast referrals on to the Urgent (2WW) referral pathway has impacted on performance. High levels of scrutiny remain in place with support from IST and NHSE. Coordinated approach involving Quality, Commissioning, Contracting and Performance team are driving CCG approach. Finance and Performance Committee have assessed the risk associated with RTT targets	28/02/2017	Jul-19	1a - Monitoring ongoing safety and performance in the system	Finance and Performance	Mike Hastings	8	High	12	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR05		**EPPR Support** There is a risk that effective plans will not be in place for CCG and other agencies will not be in place	CCG is working in conjunction with other CCGs to ensure that there is regional capacity sharing and resilience. WCCG has been working closely internally and with all stakeholders on EU Exit preparations. **Update** Public Health staffing resource has reduced. However meetings with PH continue to take place locally. Work continues with Public Health and other partners to ensure key work is prioritised regionally.	01/05/2014	Apr-19	3c - Continue to meet statutory duties and responsibilities (Emergency Planning)	Quality and Safety	Mike Hastings	8	High	6	Moderate	⇔
CR08	Execs	**New Ways of Working across the STP** The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system	Relationships across the STP continue to develop, an MOU is being put into place and clear leadership for individual work streams are being identified and put into place. **Update** Independent Chair, Programme Director and PMO staff in place. Clear intent for the STP to become a Integrated Care System (ICS), with plans to support this being developed. The Governing Bodies across the four CCGs have appointed a Transition Board to move to a single management team, risks associated with this will continue to be reviewed.	21/06/2017	Jul-19	3a - Proactively drive the CCG's Contribution to the Black Country STP	Governing Body	Helen Hibbs	16	Very High	9	High	⇧
CR10		**BCF Programme Success** The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes	Programmes are being put into place and work continues to ensure that the impact of this work can be measured in an efficient and effective way. **Update** Section 75 for 19/20 has now been signed and we continue to develop and put in place full plans and actions in line with national planning guidance. Work is also taking place to align governance and programme support for the ICA with linked BCF programmes.	12/09/2017	Jul-19	3b - Greater Integration of health and Social Care Services across Wolverhampton	Commissioning Committee	Steven Marshall	12	High	9	High	⇔
CR12		**New Ways of Working in Primary Care** There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change	Substantive appointments now made in the Primary Care Team to support group working. Milestone plans developed to support the overall delivery of the Primary Care Strategy. Primary Care groups are actively involved in discussions to develop accountable care models in Wolverhampton. **Update** Milestone Review Board continues to review progress with Primary Care Strategy implementation including completion of key projects including Extended Access and remote consultation. Six Primary Care Networks are now in place and a refreshed Primary Care Strategy is being developed and a review of risks will take place when this is completed.		Jul-19	2a - Improve and develop Primary Care in Wolverhampton	Primary Care Commissioning Committee	Steven Marshall	12	High	8	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR14	Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	**Developing Local Accountable Care Models** The potential complexity of the developing new models locally will mean having to balance competing priorities for different organisations and against other drivers in the system to clearly articulate the rationale for change and the direction of travel. This means that there is a risk that the objectives of improving patient care and delivering financial stability across the system will not be realised	The CCG is working collaboratively with partners in the system to develop plans to ensure that they are produced in an open and constructive way. Ernst Young are supporting the development of clear plans and proposals for discussion. **Update** Risk share agreement contract is signed. Clinical priorities pathways are being finalised. Agreement has been reached with regard to IG and shared data governance processes. Outcomes framework is still under development and there remains much work to be done on the 'shared' virtual contract concept.	12/09/2017	Jul-19	2b - Delivering new models of care that support care closer to home	Commissioning Committee	Steven Marshall	16	Very High	12	High	⇔
CR15	Workload pressures of STP Workload pressures - Black Country Joint Commissioning Committee Impact of unexpected events on overall workload CSU Capacity	**CCG Staff Capacity Challenges** The level of change across the system means that existing staff resources are stretched to contribute to change based work streams including Black Country Joint Commissioning, STP and local models of care in addition to existing responsibilities. This creates a risk that gaps will be created as well as the existing risk of recruiting sufficiently skilled staff to fill any vacancies that arise in an uncertain environment.	Open lines of communication are being provided to staff through regular updates from STP and Joint Commissioning Committee meetings and through CCG staff briefings **Update** Following Deep Dive discussion meetings with staff, including a workshop with team managers and Director lead meetings with all staff have taken place. This continues to allow staff issues to be raised and understood as they arise. ICS development proposals will continue to have an impact as more details emerge, including the CCG's approach to meeting the planning requirement to achieve a 20% reduction in its running costs. The transition board established by the Governing Bodies across the 4 CCGs is developing proposals for the development of a single management team.	12/09/2017	Jul-19	3c - Meeting our statutory duties and responsibilities	Executives	Helen Hibbs	12	High	9	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR17	Primary Care estate improvements	**Failure to secure appropriate Estates Infrastructure Funding** Much of the plans to improve services, particularly in Primary Care, is dependent on securing improvements in the facilities across Wolverhampton. There are a number of possible avenues for funding these improvements but there is a risk that the complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk	The CCG is working with partners across the local health economy to develop collaborative and strategic plans for estates developments. GP practices are key partners and the CCG is working with a number of individual practices with identified needs to address these issues in a targeted manner. **Update** Funding sources have been identified for a number of proposed improvements in GP practices and the CCG continues to work with other partners to identify alternative sources of funding. Strategic plans are developing in conjunction with relevant practices in key areas. Two improvement schemes have been approved and work has begun on those schemes. Further work is being carried out across w'ton following a number of practice mergers. WCCG continue to support hub working across multi-provider setting and a number of funding sources around proposals are being explored.	12/09/2017	Dec-18	3d - Deliver improvements in the infrastructure for health and care across Wolverhampton	Primary Care Commissioning Committee	Mike Hastings	8	High	8	High	⇔
CR18	FP05 - Over Performance Acute Contract FP06 - Prescribing Budget FP07 - CHC Budget	**Failure to Deliver Long Term Financial Strategy** Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years	Proactive approach to identifying QIPP schemes and embedding them in contracts. Work with partners to support alliance working with risk/ gain share. Proactive approach to financial planning to identify potential gaps and develop mitigating actions **Update** Financial Plan for 19/20 had risks of approximately £6.3m following the requirement to identify additional QIPP of £3.1m to support the Regional financial control total. Mitigations have been identified but the plan included a significant revised QIPP target of £16.7m (equivalent to 4.1%) and the use of nonrecurrent contingencies to meet financial targets There is an expectation that the Black Country CCG Risk share arrangements will be enacted to provide additional mitigation as a consequence of Wolverhampton CCG meeting a disproportionate share of the overall Black Country requirement of £8.4m . The CCG in accordance with national guidance will produce a revised long term financial plan for the period 2019-20 to 2024-25 to inform the STP financial plan for consideration by the the Governing Body prior to September. This will need to reflect the requirement for the CCG to achieve a 20% reduction in its running costs.	31/03/2019	Jul-19	3c - Meeting our statutory duties and responsibilities	Finance and Performance	Tony Gallagher	20	Very High	12	High	⇧
CR19	FP14 - Transforming Care - Financial Impact	**Transforming Care Partnership** There are a number of risks to the delivery of the Black Country Transforming Care Partnership's programme of work that cause result in a failure to deliver improvements in the quality of service for patients with Learning Disabilities	Black Country Joint Commissioning Committee has delegated authority for oversight of the programme of work across the four CCGs Programme Management for the partnership resourced by Sandwell and West Birmingham CCG with Wolverhampton AO acting as SRO Collaborative work underway to understand patient cohort and their needs Joint finance work to understand financial impacts on CCG. **Update** The risk sharing agreement with partners to support the funding transfer arrangement has been finalised. The financial risk is fully mitigated through the application of non-recurrent reserves in 2019-20	27/02/2018	Jul-19	1a - Monitoring ongoing safety and performance in the system	Finance and Performance	Tony Gallagher	16	Very High	6	Moderate	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR20		**Insight Shared Care Record – Governance Arrangements** If robust governance arrangements are not put in place to support the implementation of the Insight Shared Care record then it may not be possible to deliver the intended benefits of the programme to support direct care for patients and improved population health planning in order to support overall strategic aims across the health economy.	Technical Project Group in place discussing the implementation. ICA Sub-group established to support developing governance arrangements. Clear project mandate and timelines being developed. **Update** ICA IG & BI Sub-group has been established to support the work going forward including developing DSA and DPIA for all Data controllers. Project resource has been identified to support the development of the project which will continue to require input from all parties.	19/07/2018	Jul-19	1a - Monitoring ongoing safety and performance in the system	Executives	Mike Hastings	12	High	12	High	⇔
CR21	BICPB - Reduction in funding to BCPFT as a result of City of Wolverhampton council withdrawing their current funding to specialist CAMHS.	**Impact of potential funding withdrawal by City of Wolverhampton Council (CWC) following consultation process.** As CWC formally consult on budgets for 2019/20 the CCG must consider the quality, safety, and financial impact of funding withdrawal for the delivery of statutory & specialist services across Wolverhampton for service users.	Reduction in funding to BCPFT as a result of City of Wolverhampton council withdrawing their current funding to specialist CAMHS. Potential for impact if a similar approach is taken to other services. CWC have been asked to look to reduce budgets across the services which are not impacting on statutory provision and as a result it may be that no actions undertaken by the CCG will result in funding not being removed from BCPFT. • Meetings to be arranged with CWC to discuss funding • Alternative method for funding EPP has potentially been agreed with CWC and this funding could be used to support the gap in funding from CWC. **Update** The City of Wolverhampton Council have met with BCPFT and confirmed that they will be removing all of the funding from the contract. Impact assessment to be completed by BCPFT about what will happen if the funding is removed. Meeting took place with Children's Commissioner and Executive Director for Transformation and Strategy for CCG and the Director for CAMHS and Consultant Transformation Nurse for BCPFT to discuss that BCPFT need to clearly identify what services they will not be providing as a result of this reduction in funding particularly from a council's statutory point of view.	20/11/2018	Mar-19	1a - Monitoring ongoing safety and performance in the system	Commissioning Committee	Steven Marshall	12	High	12	High	⇔
CR22		**Leaving the European Union (EU-Exit)** A No-Deal Brexit scenario could impact Primary care services including GPs, Pharmacies, Ambulance service and Hospital trusts. Medical/non-medical supplies, medicine/vaccine and workforce could all potentially not be available at business as usual levels posing a risk to service delivery.	Regular communication with all relevant organisations have taken place and assurance calls are regularly taking place in line with national guidance. Work with Primary Care providers, Acute trust and other stakeholders to ensure appropriate actions and planning for eventualities continues. **Update** CCG's were originally asked to complete Sit Rep reports and return to NHSE. These have since been stood down. Due to the changes in Government leadership the risk score has not been changed. The plan to leave the EU by October 2019 still stands. Meetings and communication with relevant providers and staff is still taking place where necessary. Continue to monitor the Government strategy/updates regarding Brexit. Although NHS sit rips have been stood down, these could be restarted at any point before October 2019. All actions will be monitored and resourced through the CCG's Operations Department.	25/03/2019	Jun-19	1a - Monitoring ongoing safety and performance in the system	Executives	Mike Hastings	9	High	9	High	⇧

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
10th September 2019

Agenda item 15

TITLE OF REPORT:	**Commissioning Committee – July 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 July 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:	
5. System effectiveness delivered within our financial envelope	Meeting our Statutory Duties and Responsibilities 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.

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 July19 meeting.

2. MAIN BODY OF REPORT – July 2019

2.1 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

Activity/ Performance

The Committee was updated on the current over performance of the Trust as at July 2019. It was noted that this was based on limited data early in the financial year; a more robust activity pattern will emerge throughout the year.

Contract Performance

- Referral to Treatment – Activity to achieve cancer targets is impacting on performance in other specialities. Further detailed information by speciality is awaited from the Trust.
- Dermatology – revised figures for stranded costs are to be discussed by the Directors of Finance.
- Phoenix Walk In Centre – approval had been given for the expansion to an Urgent Care Centre

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

- Improving Access to IAPT – A Contract Performance Notice had been issued. Work is continuing to resolve accommodation issues.

Other contracts

- Accord Housing Association Ltd (Probert Court) – This contract ended on 30th June 2019 and been replaced by two alternative nursing homes.

Action - The Governing Body notes the updates provided

2.2 Review of Risks

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

The Committee noted the update report

3. RECOMMENDATIONS

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

Name: **Dr Manjit Kainth**

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

Date: **26th July 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
10th September 2019

Agenda item 15

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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 July19 meeting.

2. MAIN BODY OF REPORT – August 2019

2.1 Better Care Fund (BCF) – Carers Budget

The committee endorsed the following schemes, Carers 'Information Pop-ups' and Emergency Home Based Respite Care, and that these schemes are funded from the budget within the BCF Programme allocated to supporting carers.

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

2.2 Fixed term investment for Autism Spectrum Disorder (ASD) over 5s pathway to reduce waiting times of those on existing waiting list and assurance around training of staff in Children and Young People (CYP) Improving Access to Psychological Therapies (IAPT).

The committee endorsed providing additional funding to RWT, BCPFT and WCC to provide additional clinical psychology, educational psychology and SLT to support the diagnostic process for ASD for those CYP on the waiting list. It was noted that this will allow the new diagnostic service to have clear understanding of future demand for referrals.

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

2.3 Investing in Speech and Language Therapy (SLT) to provide a service to Youth Offending Team (YOT)

The committee endorsed providing additional funding to RWT to provide an SLT service specifically for those CYP who have become involved in the criminal justice system and have been allocated to the YOT to undertake assessments and interventions for their speech, language and communication needs.

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

2.4 Trauma Counselling Business Case

The committee reviewed service specification for Trauma and Abuse Counselling agreed in principle - and subject to further information being approved by the CCG Executive - funding for specialist trauma focussed support for a cohort of patients requiring access that is not currently provided by the Black Country Partnership NHS Foundation Trust (BCPFT).

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

2.5 Black Country and West Birmingham Eating Disorder Service Specification

The committee reviewed and agreed this service specification developed following a joint programme of work managed through the STP MH work programme. The aim of the new specification is to provide a higher quality service for the population and in line with STP footprint partners.

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

2.6 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

- Dermatology – the procurement process was complete and the contract award. A first meeting had taken place with the focus on mobilisation and transition. The final figure for stranded costs was close to agreement.
- Breast cancer 2 week waits remain a major concern. Significant work is being undertaken to support RWT, including increasing communication with primary care to promote patient choice at point of referral.
- The CCG has confirmed acceptance of RWT's business case to expand Phoenix Walk In Centre to meet the requirements of transitioning to an Urgent Treatment Centre by 1st December 2019, and RWT have been informed accordingly

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

- Improving Access to IAPT –failed to achieve target three months running. A remedial action plan has been agreed
- Further progress is being made on transferring the budget for acute overspill patients to BCPFT.

Action - The Governing Body notes the updates provided

2.2 Review of Risks

The Committee received an update of the risk register highlighting the current risks. The Committee agreed to close committee level risks relating to the Dermatology procurement and the linked stranded costs.

Action - The Governing Body notes the updates provided

3. RECOMMENDATIONS

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

Name: **Dr Manjit Kainth**

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

Date: **29th August 2019**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY MEETING
Tuesday 10th September 2019

Agenda item 16

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). May/June 2019 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, with further deterioration of all cancer targets except 31 day sub-treatment surgery and anti-cancer drug. There is particular and significant concern in relation to the 2 week wait target and the impact on performance relating to 2 week wait Breast Symptomatic. This is now having an impact on the overall 62 day performance and also RTT. A collaborative Black Country and West Birmingham STP system-wide approach has been developed in response to the 2 week wait Breast Symptomatic performance at RWT. A targeted referral diversion commenced on 1st July with an aim of improving waiting times for patients. The plan was approved by the STP Health Partnership group. • Mortality indicators for SHMI remain above national expected rates. The SHMI figure is currently 1.192 (period of reporting March 2018-Feb 2019), which is lower than previously reported. The crude mortality rate has also further decreased to 2.47% for the third successive month. In light of improving performance the Quality and Safety committee made the decision to reduce the risk rating for mortality. • A themed spotlight session on mortality, sepsis and recognition and response to deteriorating patients was presented by the Trust at the July CQRM. The session highlighted the actions taken by the Trust to address key challenges within these areas, such as recruiting mortality reviewers and introduction of the Medical Examiners role, increased establishment for the Critical Care Outreach team

	and implementation of a sepsis monitoring dashboard. The themed spotlight on effective recognition of the deteriorating patient gave assurance on the implementation of an electronic data capture system for the Critical Care Outreach Team. Further assurance was requested in relation to comparison benchmarking data from the national cardiac arrest data and timeliness of medical review post NEWS2 trigger. • There has been a slight increase in the number of self-harm/suicide serious incidents reported by BCPFT and a thematic review of these SI's is being undertaken by the CCG to identify any common themes and trends to discuss with the provider. However, the initial findings have not identified any increase in the number of self-harm/suicide SI's for the Wolverhampton population. • Further analysis continues in relation to the regional comparison of 12-hour breach data in relation to mental health patients. A system wide meeting has been convened to identify any emerging issues or actions which can be implemented. • Two Nursing Homes are currently rated "Inadequate" by CQC. Comprehensive action plans are in place. The homes are being supported to make improvement by the CCG QNA and City Council QACO teams. • An issue was highlighted to WCCG relating to transcribing medication within a care home who is our current D2A provider. The provider informed us that this is against their policy. This issue was raised with WCCG Chief Nurse, Medicine Optimisation and contracts team for advice. Further discussions took place and the provider agreed to transcribe if the bespoke transcribing training was provided to their staff. The bespoke transcribing training has now been delivered and the issue has been resolved. The Quality Nurse Advisor team are also supporting the home from a quality improvement perspective. • Lotus Clinical Therapy Services came to WCCG's attention following an issue raised by a Wolverhampton GP through quality matters at the end of May, as they had written to the GP requesting patient information. There were number of issues raised in relation to governance and processes which have now been addressed. Going forwards, to strengthen governance processes and to ensure referrals are appropriately screened, all referrals to Lotus will go through BCPFT Healthy Minds. • In addition assurance and update was received by committee relating to Safeguarding activities and arrangements, NICE assurance, SEND, E&D, Health and Safety, Medicine Optimisation.

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.	Performance of all cancer targets at RWT remains significantly challenged with further deterioration of all cancer targets except 31 day sub-treatment surgery and anti-cancer drug. Concern remains in relation to the 2 week wait target, which decreased to 67.08% in April 2019 and particularly for performance relating to 2 week wait Breast Symptomatic, which has further declined to 3.77% in April, this performance is now having an impact on the overall 62 day performance. Pathways where demand and capacity are challenged include Upper GI, Colorectal and Head & Neck. Improvement has been observed in Urology, with increased waiting list initiatives supporting the additional work required for RALPh. Assurance is now provided relating to the actual or potential impact of harm to patients as a result of any delay. The Trust is supporting the 28 day faster diagnosis pathway, all breast referrals now go through the “one-stop clinic appointment” whereby patients are seen by a consultant and have diagnostic testing performed on the same day. At the time of writing this report, the waiting times for one stop clinic for all breast referrals pathways has further deteriorated to 45 days. A collaborative Black Country and West Birmingham STP system-wide approach has been developed in response to the 2 week wait Breast Symptomatic performance at RWT. A targeted referral diversion commenced on 1st July with an aim of improving waiting times for patients. The plan was approved by the STP Health Partnership group. Practices with high volume referrers within close proximity to other providers, mainly Dudley and Walsall, have been identified. These practices have been asked to consider with patients, at the point of referral, whether they would be willing to be referred to the alternative provider. Daily information on waiting times for the four providers across the Black Country will be provided to help practices to inform patients’ choice. For the targeted practices the additional distance to the alternative provider compared to RWT is no more than three miles. Information of the proposals has been communicated to all GPs within Wolverhampton. **Risk Mitigation:** • A targeted 2-week breast symptomatic referral diversion commenced on the 1st July 2019 for 10 practices. As impact was minimal, an extension of the scope of the referral diversion was agreed and commenced on 22nd July. A total of 39 practices from Wolverhampton, Walsall, Cannock Staffordshire and Telford and Wrekin CCGs, are now included. Daily information on waiting times for the four	

Key issue	Comments	RAG
	providers across the Black Country continues to be provided to help practices to inform patients' choice. • During the first 5 weeks of the referral diversion, 21 patients were referred to Walsall Healthcare Trust, 6 to Dudley Group of Hospitals and 82 to Royal Wolverhampton Trust • The Trust continue to review radiotherapy pathways and a quality checklist has been developed with Medical Physics and Radiotherapy. Additional slots have been added through additional capacity made available and new radiologists post come in place from July through to September. • For April 2019, 22 patients were treated at 104+ days on a cancer pathway during the month, all of these patients had a harm review and no harm was identified. 14 of the 22 patients were late tertiary referrals. • For May 2019, 10 patients were treated at 104+ days on a cancer pathway during the month, all of these patients had a harm review and no harm was identified. Of the tertiary referrals received none were received before day 40 of the pathway, and 6 were received on or after day 62 of the patient pathway. NHSI/E and the Cancer Alliance continue to support improvements to drive improvements in the timeliness of tertiary referrals. • The inaugural STP cancer board took place on 5th August with CCG attendance.	
Mortality: RWT is currently reporting one of the highest Standardised Hospital Mortality Index in the country	RWT is currently reporting one of the highest Standardised Hospital Mortality Index in the country. The SHMI figure is currently 1.192 (period of reporting March 2018-Feb 2019), which is lower than previously reported. The crude mortality rate has also further decreased to 2.47% for the third successive month. Significant work has been undertaken with the Trust and an independent company to review the coding arrangements. This includes additional training for clinical coders, with training related to appropriate coding now being delivered to clinician. The expectation is that this will impact positively on current SHMI reporting. A number of initiatives are underway to ensure that end of life care is appropriate and sensitive to patient and family needs. A quality improvement project (QIP) with the Renal Directorate, Palliate Care Team and Continuous Quality Improvement leads, to develop excellence in an inpatient environment, is being devised. Themes identified within mortality reviews remain consistent including recognition of deteriorating patient, documentation, and end of life care. Actions to address these themes are outlined in the Quality Improvement Programme for mortality. WCCG closely monitors the progress of this improvement plan through monthly CQRM's, Trust and system wide mortality improvement groups and attendance at the mortality review group. **Risk Mitigation:** • The number of alerting diagnosis diagnoses groups that have a higher than expected estimated SHMI for March 2018 –Feb 2019 has reduced. The Trust has received a request from the CQC for investigation of	

Key issue	Comments	RAG
	COPD cases (Feb to Dec 2018) in response to a SHMI outlier alert. The Mortality Review Group (MRG) had pre-empted this request and have already begun an internal data quality investigation, trends analysis and case note review. The Trust has also commissioned Price Waterhouse Cooper to undertake an independent trends analysis review. The Trust response will be ready for September. • A themed spotlight session on mortality, sepsis and deteriorating patients was presented by the Trust at the July CQRM. The session highlighted the actions taken by the Trust to address key challenges, such as recruiting mortality reviewers and introduction of the Medical Examiners role to ensure timely mortality reviews (SJR) within 4 weeks, timely learning and sharing and data quality improvement. • A Learning from Deaths (LfD) IT platform and web page has been developed, along with a mortality dashboard to enable effective measurement of hospital mortality improvements. • The Trust continues to implement the Mortality Strategy and Mortality Improvement Plan, with a clear focus on improving the quality of clinical care and preventing avoidable patient deaths. • The themed spotlight on effective recognition of the deteriorating patient gave assurance on the implementation of an electronic data capture system for the Critical Care Outreach Team. Further assurance was requested in relation to comparison benchmarking data from the national cardiac arrest data and timeliness of medical review post NEWS2 trigger.	
Concerns around sepsis pathways	Following the CQC mortality outlier alert in relation to sepsis and sepsis CQUIN performance, the CCG required further assurance in relation to sepsis pathways. Assurance was gained at CQRM in July and key initiatives to drive improvement implemented. **Risk Mitigation:** • A themed spotlight session on sepsis was held at July's CQRM. • The Trust continues the Sepsis Quality Improvement Project by process mapping procedures to identify key areas of delay and for potential improvement. Following this PGDs have been introduced, in an attempt to improve timeliness of intravenous antibiotics administration for patients who trigger the Sepsis tool or Neutropenic sepsis pathway. • The use of a 'red phone' has been initiated whereby a clinician is available 24/7 to review any patients who are triaged as 'Category 2'. • There is an improved focus on inpatient areas with weekly sepsis rounds undertaken which support education.	
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. Since April 2019 RWT has reported three 12-hours ED breaches and all these breaches related to mental health patients. The common cause of these breaches has been identified as MH bed capacity issues, transport delays and unavailability of section12 approved social worker.	

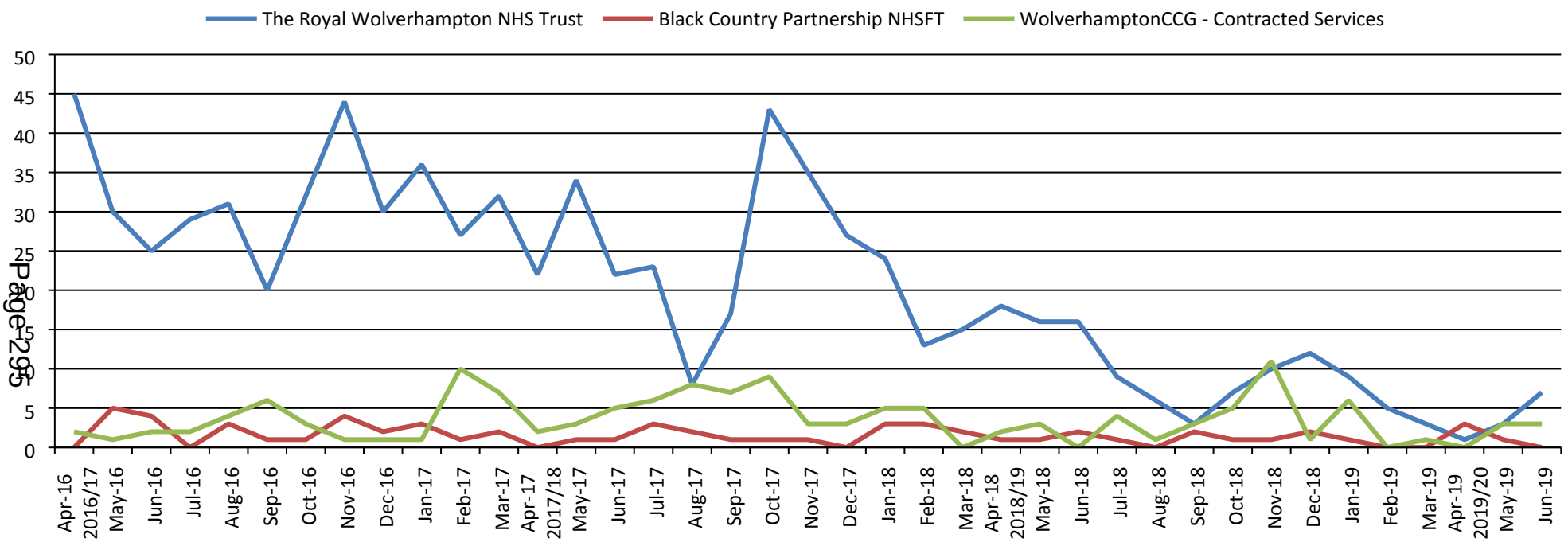
Key issue	Comments	RAG
	Risk Mitigation: • WCCG conducted a Duty of Candour (DOC) assurance visit and identified concerns in relation to DOC process. Further clarification has been requested and confirmation is awaited. A meeting with the provider has been arranged for 22nd August 2019. • Further analysis continues in relation to the regional comparison of 12-hour breach data in relation to mental health patients. This continues to be of concern given the low numbers but regularity of 12 hour breaches of MH patients awaiting a bed in ED. • There has been a slight increase in the number of self-harm/suicide serious incidents reported for BCPFT and WCCG is currently undertaking a thematic review of these SI's to identify common themes and trends to discuss with the provider. However, the initial findings have not identified any increase in the number of self-harm/suicide SI's for the Wolverhampton population. • Overall sickness absence rate has increased to 6.15% in June and remains red against a trust threshold of 4.5%. The vacancy rate has also increased to 14.55% and remains red rated against the target, however, the staff turnover rate has reduced to 13.25% and remains within the target range. Ongoing work continues through the Health & Wellbeing Group to implement proactive measures to reduce sickness absence such as health checks, staff training/education and manager training. • The Trust is also exploring the opportunity to work with Royal Wolverhampton Acute NHS Trust in a new programme they have developed for international nurse recruitment.	
Reduced CQC rating of W-ton Nursing Home	Due to failures in the Well Led and Safe domains identified at a recent CQC inspection, a Wolverhampton Nursing home is expected to receive a reduced CQC rating. CQC Report has now been published. Care home rated inadequate in Well Led and Safe domains and requires improvement in caring, effective and responsive domains. CHC funded residents reviewed and no concerns identified. QNA team will continue to work with the home on QI and training. The LA QACO team has been asked to support joint quality monitoring visits with the QNA team. **Risk Mitigation** • Robust action plan in place with monthly reporting back to CQC. • LA and CCG quality teams are monitoring progress via the CQC returns. • Improvements are being made in Health & Safety concerns. • QNA continues to support the home with identifying any training needs.	
Concerns identified in relation to Lotus Clinical Therapy Service	Lotus Clinical Services came to WCCG's attention following an issue raised by a Wolverhampton GP through Quality Matters at the end of May, as they had written to the GP requesting patient information. There were a number of issues raised in regard to this service provider and the assurance process in place. Lotus is a specialised supported housing provider with a Local Authority contract (City of Wolverhampton	

Key issue	Comments	RAG
	Council). The organisation provides specialist housing with 24/7 support for very vulnerable women who have long histories of abuse, trauma and mental health and substance misuse difficulties. Lotus is now providing counselling for this cohort of women, including women who are community based and are mothers and in receipt of early help from Wolverhampton City Council – a gap that is not covered by Healthy Minds or the Well-Being Service. **Risk Mitigation** • As it is a spot purchase there is no service specification. However, our MH commissioner has assessed the company against the NHSE counselling guidance and they are registered with all the required organisations. • We have met with Lotus on a number of occasions with Black Country Partnership Foundation Trust (BCPFT), to ensure that there is collaborative working and integrated care pathways where appropriate. We are ensuring that the organisations work in partnership with connectivity across their services. BCPFT and Lotus are developing an information sharing agreement to improve shared / joint governance and referral pathways. • Going forwards, to strengthen governance processes and to ensure referrals are appropriately screened, all referrals to Lotus will go through BCPFT Healthy Minds.	

2. PATIENT SAFETY

2.1 Serious Incidents

Chart 1: Serious Incidents Reported by Month



In total, seven Serious Incidents (SIs) were reported in May 2019. Of these three related to RWT, one to BCPFT and three to WCCG.

There were ten Serious Incidents (SIs) reported in June 2019. 7 related to RWT and 3 to WCCG. There were no incidents reported for BCPFT in June.

Chart 2: Serious Incident Types Reported May 2019

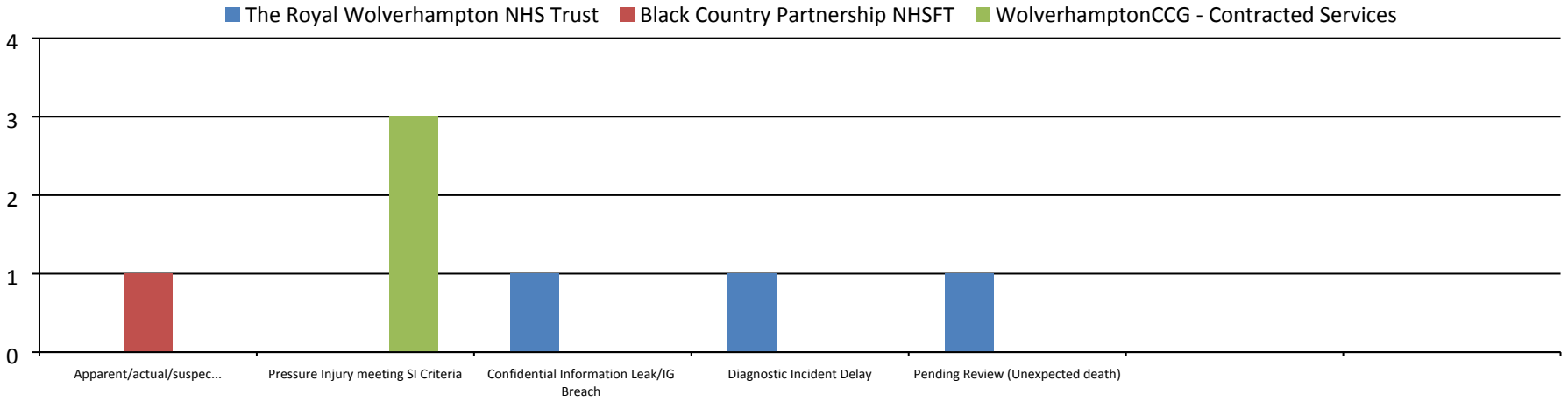
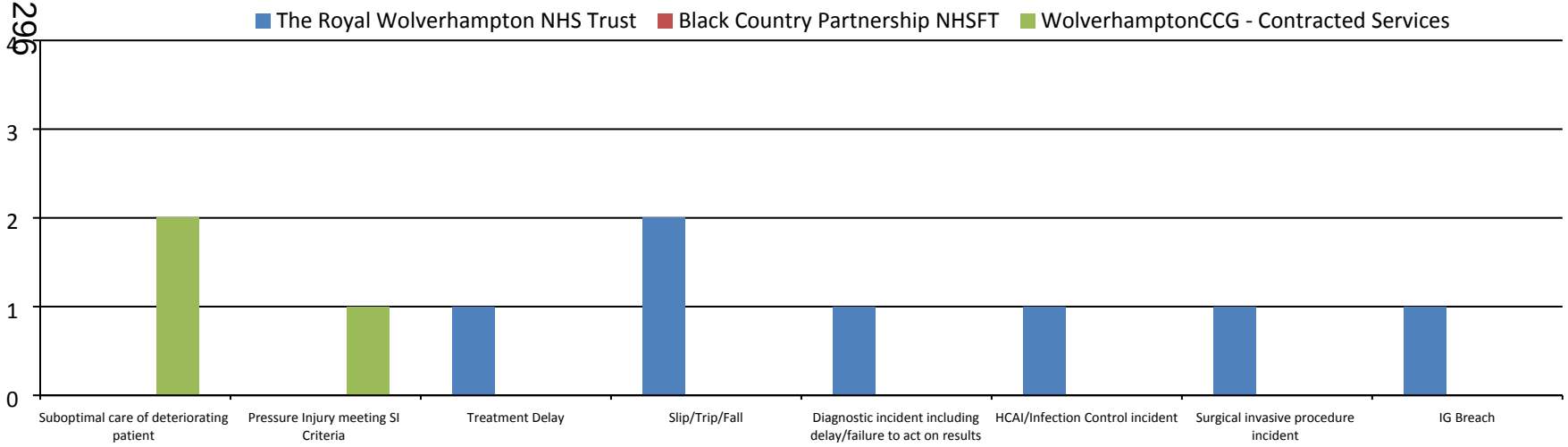


Chart 3: Serious Incident Types Reported June 2019



Charts 2 and 3 above show the breakdown of serious incident types reported by each provider for May and June 2019.

2.2 RWT Endoscopy Surveillance Serious incident July 2019 Update

A final root cause analysis report for this serious incident has been received and reviewed by the WCCG Serious Incident Scrutiny Group. The RCA has identified that lack of robust administration process for monitoring surveillance patients as a root cause for this SI. The trust has developed a comprehensive action plan to mitigate any identified risks and to prevent reoccurrence of similar incidents. This SI has now been closed on STEIS.

RWT Duty of Candour Visit 17th July 2019

A planned DOC visit by WCCG quality team was carried out for RWT on the 17th July 2019. Overall, it was positive and assuring visit and the provider was able to demonstrate that there were robust DOC systems and processes in place. A formal feedback from this visit has been shared with the provider.

2.3 Never Events

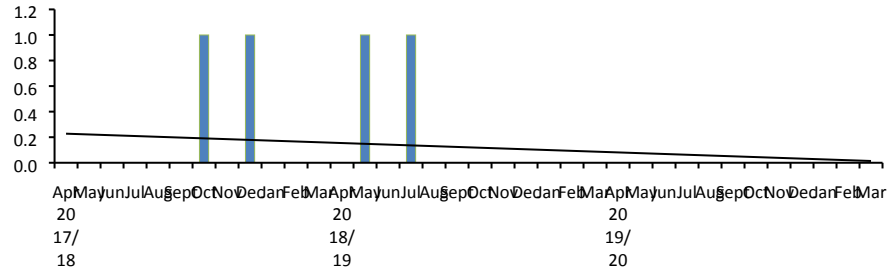
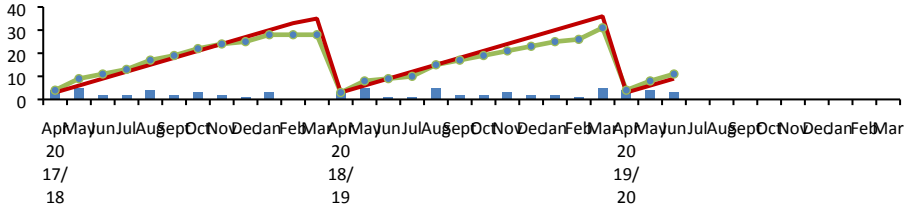
Table 1: Reported Never Events

	Yr 16-17	Yr 17-18	Yr 18-19	April 19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Yr to date
Royal Wolverhampton	**5**	**4**	**4**	0	0	1	0									1
Black Country Partnership	**0**	**0**	**0**	0	0	0	0									0
Other providers	**0**	**1**	**0**	0	0	0	0									0
Total Reported	**5**	**5**	**4**	0	0	1	0									1

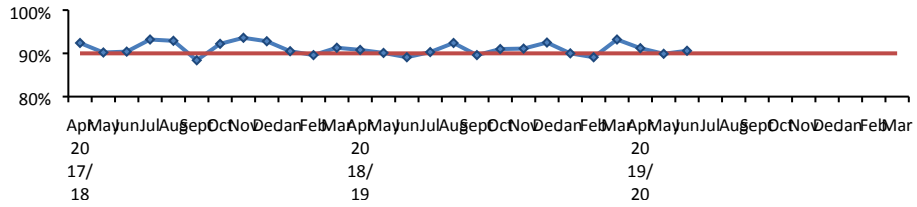
A Never Event was reported on June 2019 for Royal Wolverhampton Hospitals. This incident relates to a patient who went to the theatre for the repair of Left Neck of Femur under spinal anaesthesia and block. The Spinal anaesthesia was introduced with the patient in the lateral position. The patient was then turned back to the supine position and a fascia iliaca block was performed on the right side (wrong side). However, this was immediately realised that the wrong side block has been performed on the patient. The consequence of this wrong side block was minimal for the patient; therefore, the surgeons proceeded with planned surgery on the left side. The patient would not be mobilised as they had spinal anaesthesia, so the block did not affect this aspect of care. Trust is currently undertaking a full RCA into this SI to identify the root cause and to identify learning.

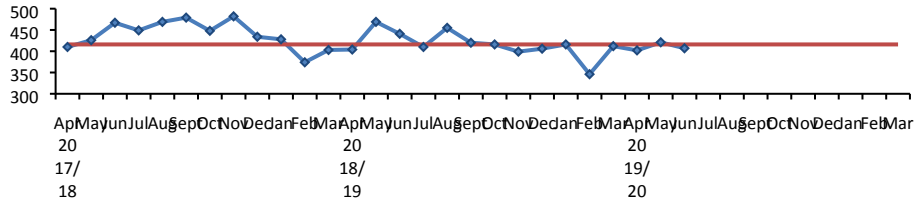
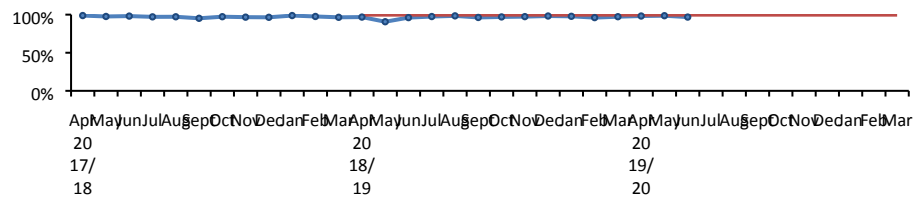
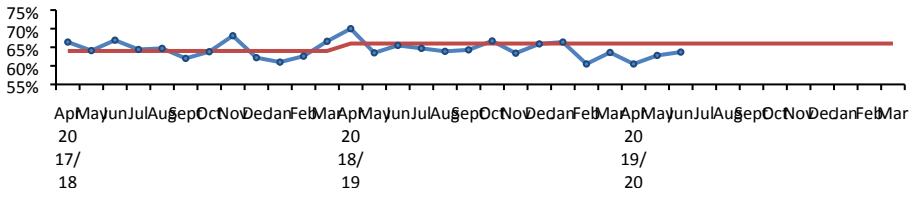
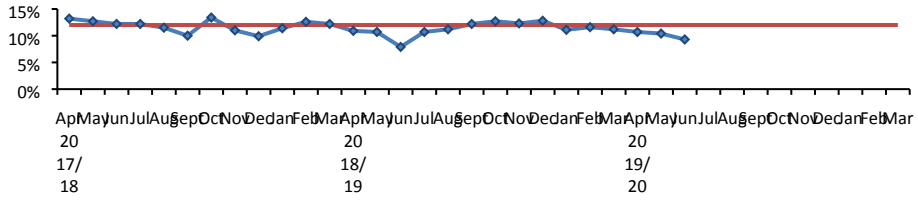
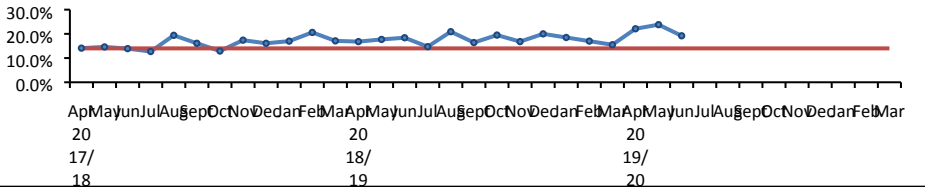
3. ROYAL WOLVERHAMPTON HOSPITAL TRUST

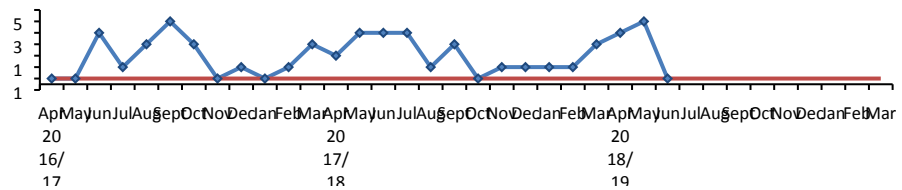
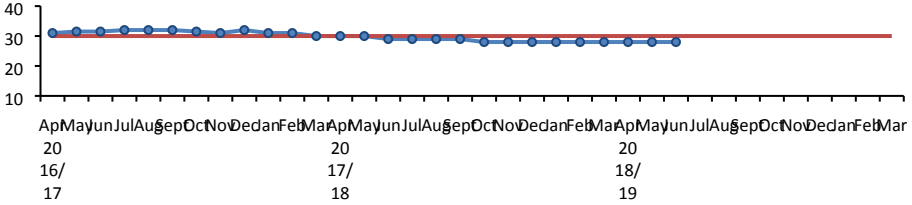
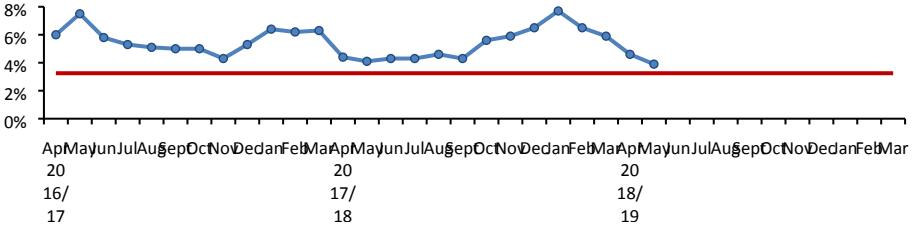
3.1 Infection Prevention

Measure	Trend	Target	Assurance/Analysis
MRSA		**0**	No new MRSA cases reported in June 2019.
C. Diff		**<35**	The Trust reported another three cases in June 2019. The cumulative figure for 2019/20 is 11. New NHSI Clostridium difficile case assignment definitions for 2019/20 commenced in April 2019, this has impacted on CDI numbers, creating a rise in Trust attributable cases. Efforts are underway to address this. The deep clean programme for 2019/20 is underway. Further analysis is required into the post discharge cases to identify if any additional actions are required.

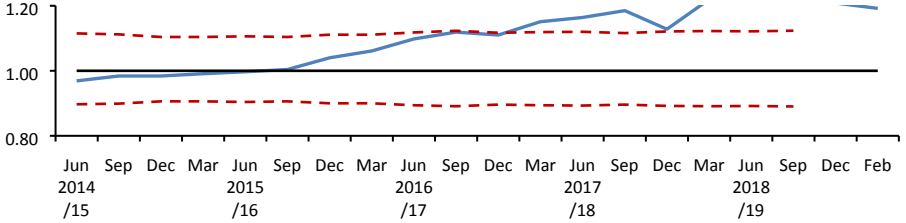
3.2 Maternity

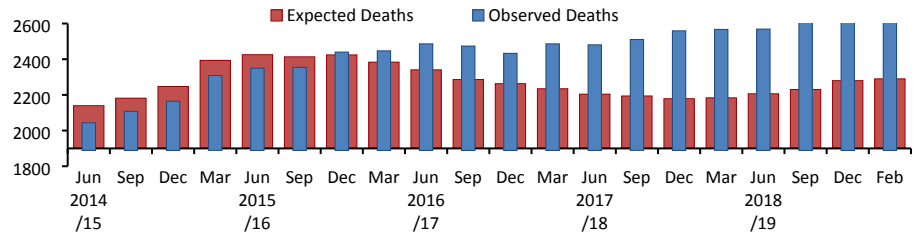
Measure	Trend	Target	Assurance/Analysis
Bookings at 12+6 weeks		>90%	Bookings at 12+6 weeks for June remain steady at 90% meeting target.

Measure	Trend	Target	Assurance/Analysis
Number of Deliveries (mothers delivered)		<416	Number of mothers delivered decreased slightly in June to 407 from 421 in May.
One to One care in established labour		100%	June = 96.8% showing a decrease compared to May at 98.6%.
Breastfeeding (initiated within 48 hours)		>=66%	June showed an increase to 63.7% up from 62.8% in May and 60.5% in April.
C-Section – Elective (Births)		<12%	The rate for elective C-Sections decreased in June to 9.3% from 12% in May and remains under the threshold.
C-Section – Emergency (Births)		<14%	Emergency C-section case rate has seen a decrease for the first time since March, down to 19.2%; however, it remains above target.

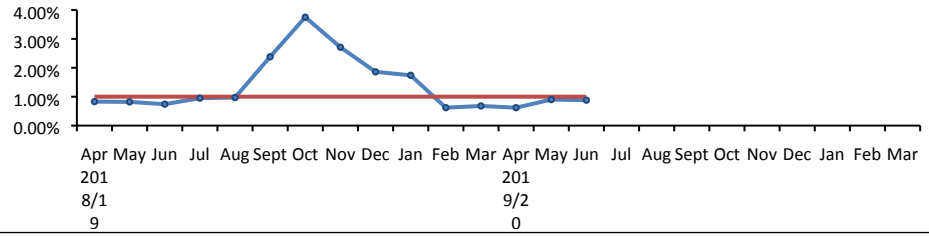
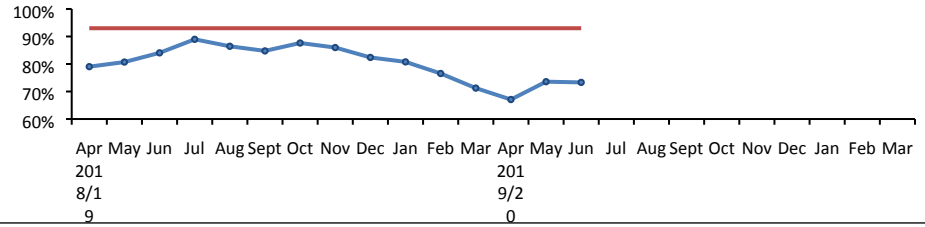
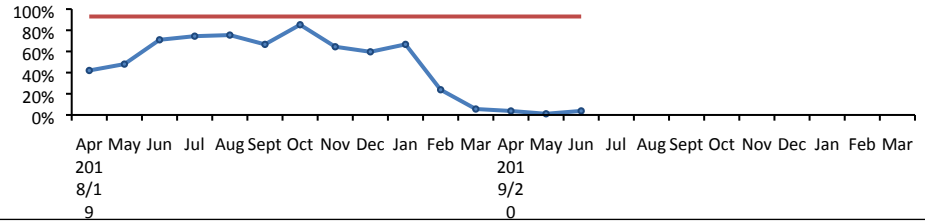
Measure	Trend	Target	Assurance/Analysis
Admission of full term babies to Neonatal Unit		0	There were no full term babies admitted to neonatal unit during June 2019.
Midwife to Birth Ratio (Worked)		<=30	The Midwife to birth ratio remains stable and currently stands at 1:28 which is within national standards.
Maternity – Sickness Absence		<3.25%	Maternity sickness absence has shown a further downward trend declining to 3.9% from 4.6% in April.

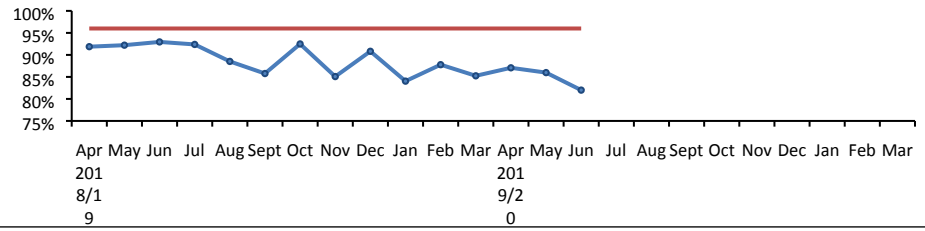
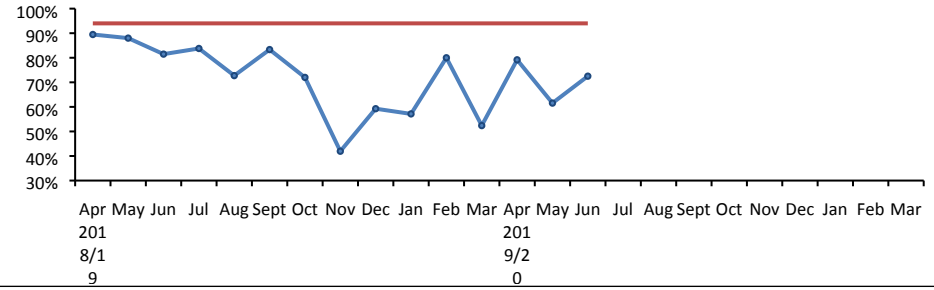
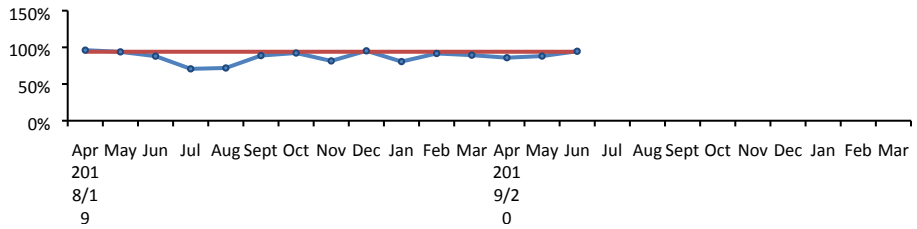
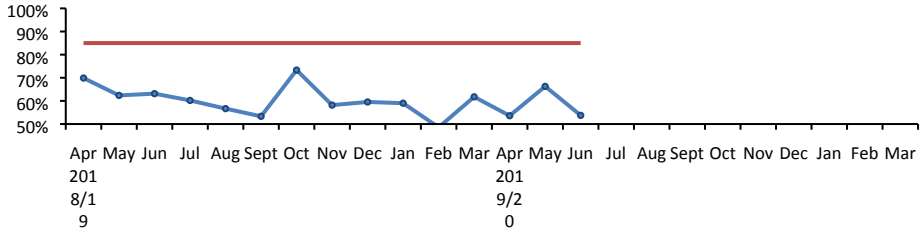
3.3 Mortality

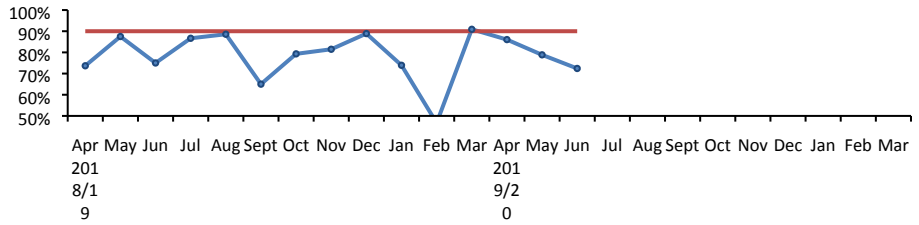
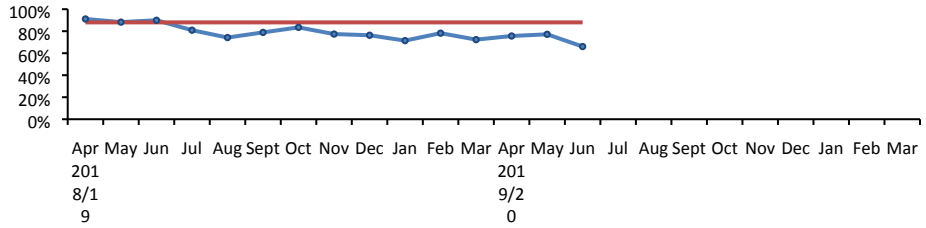
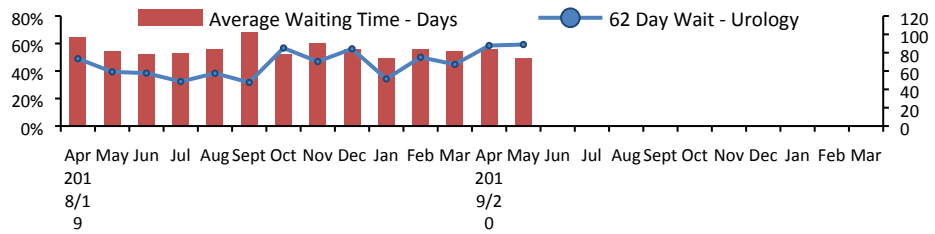
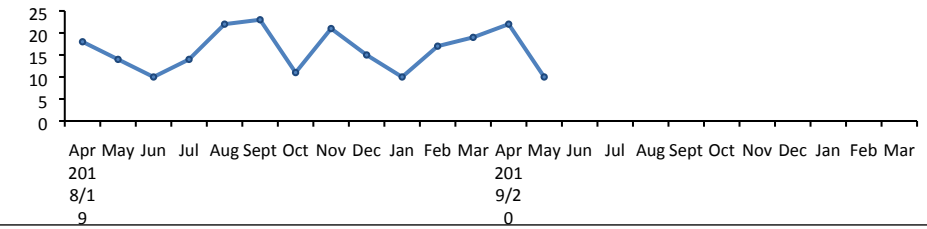
Measure	Trend	Target	Assurance/Analysis
Mortality – SHMI (NHS Digital)		**N/A**	The SHMI for March 2018 to February 2019 is 1.192. The SHMI figure is now reported monthly. The Trust has developed Mortality Strategy 2019-2022 to ensure that the organisation is learning from mortality through the development of a strong mortality governance framework with a clear focus on improving the quality of clinical care. The Trust is making good progress on the Mortality Improvement Action Plan which looks to address the governance arrangements, a city wide approach, clinical

Measure	Trend	Target	Assurance/Analysis
Mortality – SHMI Observed vs. Expected Deaths		**N/A**	documentation, coding, clinical analysis and associated learning and overarching staffing. WCCG monitors this action plan via the monthly CQRM.

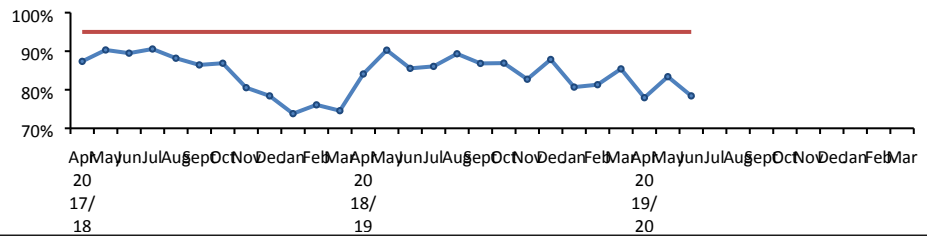
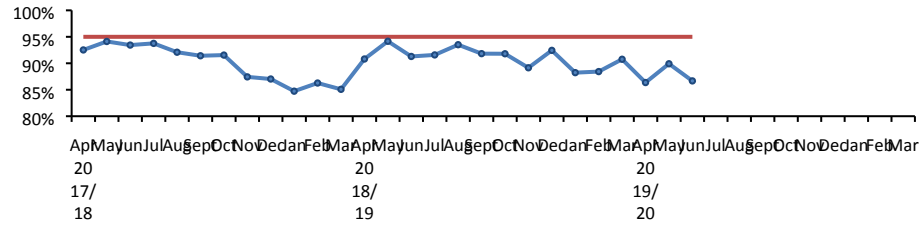
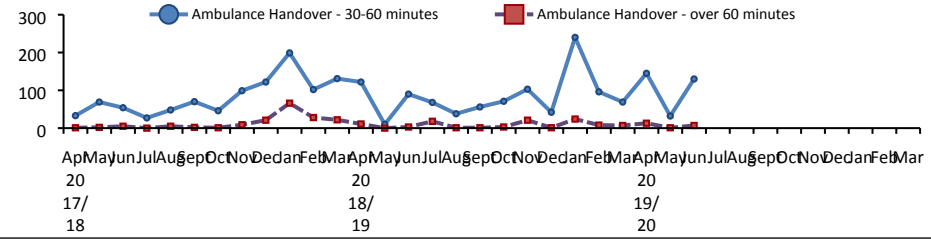
3.4 Cancer Waiting Times

Measure	Trend	Target	Assurance/Analysis
6 Week Diagnostic Test		**<1%**	Figure for June shows 1.0% and meets the target.
2 Week Wait Cancer		**93%**	The 2 week wait cancer performance position in June is 73.31% and remains below target. 76.1% of these breaches were due to capacity and 23.9% of these breaches were due to patient choice.
2 Week Wait Breast Symptomatic		**93%**	June's figure shows an increase to 3.82% compared to 1.10% in May. 94.4% of these breaches were due to capacity and 5.9% of these breaches were due to patient choice.

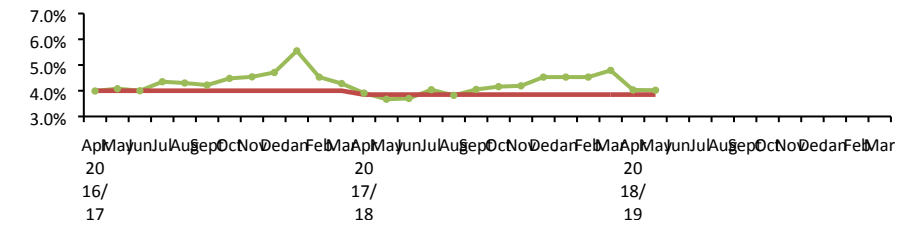
Measure	Trend	Target	Assurance/Analysis
31 Day to First Treatment		**96%**	June data shows a further decline to 82% down from 85.98% in May. 34 of these breaches were due to capacity and 5 of these breaches were due to patient choice and 1 breach was due to complex case.
31 Day Sub Treatment - Surgery		**94%**	The figure continues to fluctuate and shows a slight increase in June to 72.5% from 61.54% in May. All breaches were due to capacity issues.
31 Day Sub Treatment - Radiotherapy		**94%**	31 day sub treatment radiotherapy met the target in June, 94.68% against a target of 94%. 3 of these breaches were due to capacity and 2 of these breaches were due to patient choice.
62 Day Wait for First Treatment		**85%**	Performance has fluctuated over the past four months. Figure for June shows 53.75% compared to May at 66.28%. 12 of these breaches were due to capacity issues, 13 complex cases, 8 patient choice and 15 tertiary referrals received between day 42 and 167.

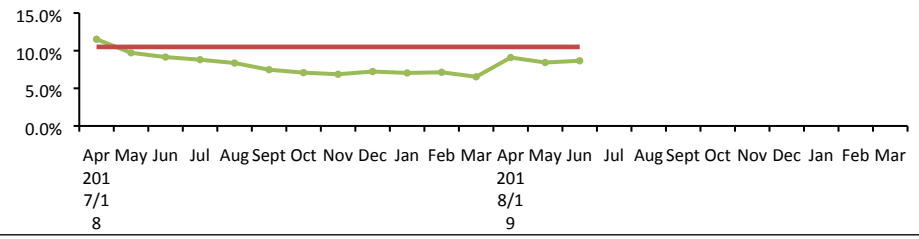
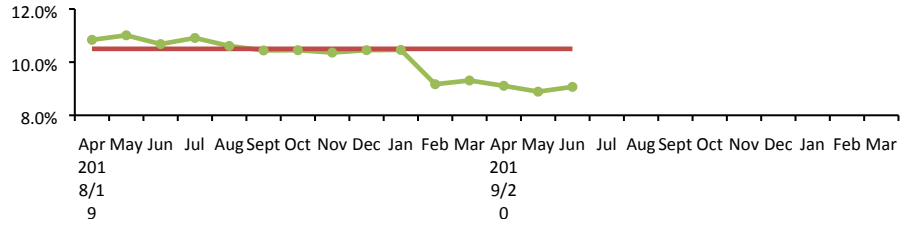
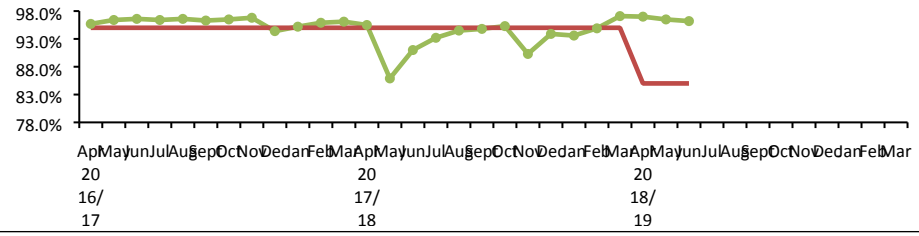
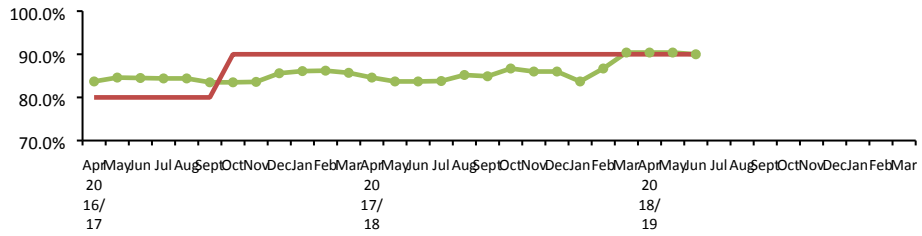
Measure	Trend	Target	Assurance/Analysis
62 Day Wait - Screening		**90%**	62-day wait showed a further decline in June to 72.41% compared to May at 78.85% and down from 86.05% in April.
62 Day Wait - Consultant Upgrade (local target)		**88%**	The 62-day wait consultant upgrade (local target) performance declined in June to 66.05% compared to 77.18% in May but remains under target.
62 Day Wait - Urology		**85%**	The average waiting time in May decreased to 74 compared to April at 84 days (reported one month behind). Performance for Urology in May was 59.26%.
Patients over 104 days		**N/A**	10 patients identified over 104 days in May 2019 compared to 22 in April 2019 (reported one month behind).

3.5 Total Time Spent in Emergency Department (4 hours)

Measure	Trend	Target	Assurance/Analysis
Time Spent in ED (4 hours) - New Cross		**92%**	Performance for RWT ED declined in June to 78.41% from 83.39% in May.
Time Spent in ED (4 hours) - Combined		**95%**	Overall performance also declined slightly in June, 86.67% compared to 89.91% in May.
Ambulance Handover		**N/A**	130 ambulances breached the 30-60 minute ambulance handover target during June compared with 90 for the same period last year. 7 ambulances breached the >60 minutes handover target during the month compared with 3 for the same period last year.

3.6 Workforce and Staffing

Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**3.85%**	Data for June was not published at the time of writing this report and is awaited.

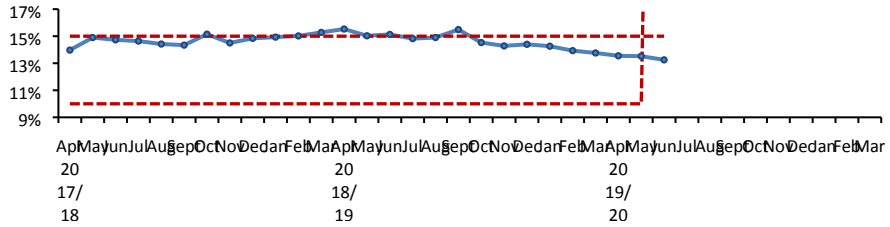
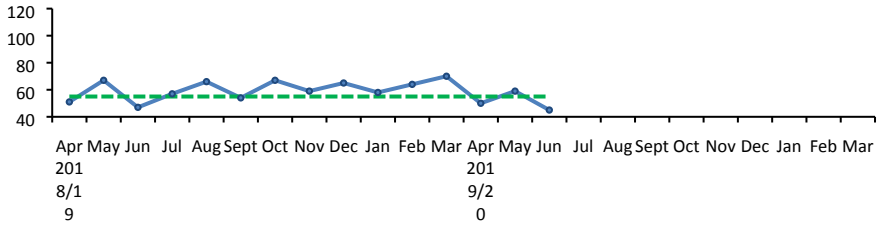
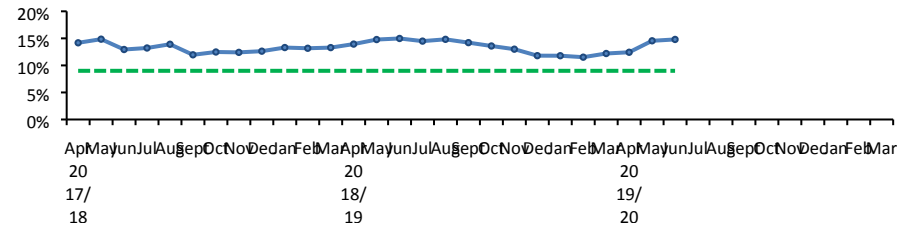
Measure	Trend	Target	Assurance/Analysis
Vacancy Rates (%)		**10.5%**	The vacancy rate remains within the 10.5% target, in June it was 8.6% rising from 8.4% in May 2019.
Staff Turnover Rates (%)		**10.5%**	Turnover rates remain fairly static at 9.07% for June.
Mandatory Training Rate (%)		**85%**	Mandatory training (generic) compliance rates have remained steady in month and continue to meet the 85% target which changed from April 2019.
Appraisal Rate (%)		**90%**	The target for appraisal compliance for June has been achieved.

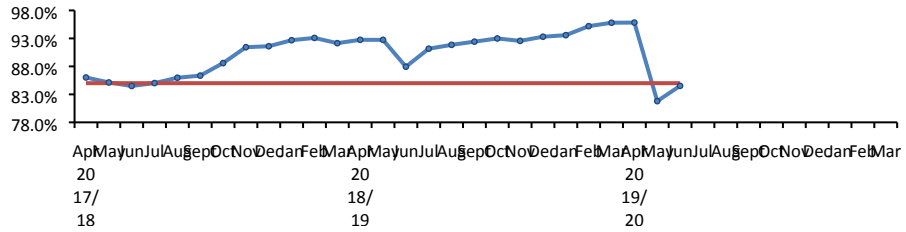
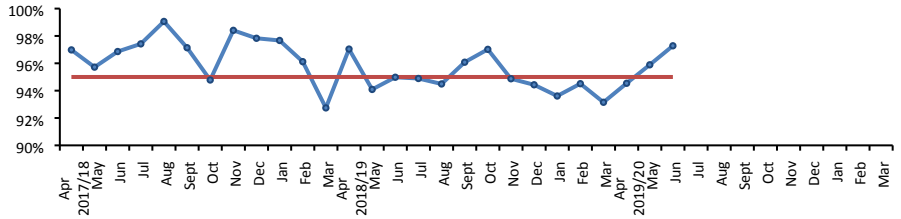
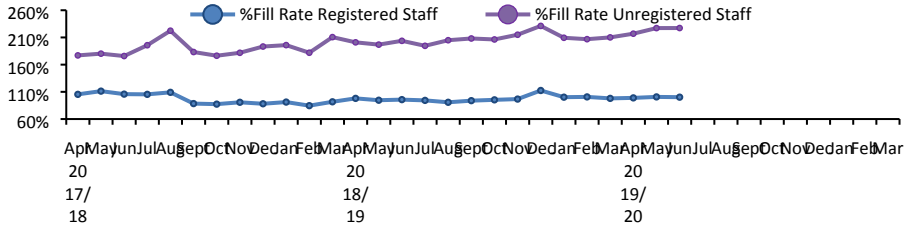
4. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

No Serious incidents were reported by the trust for this reporting period.

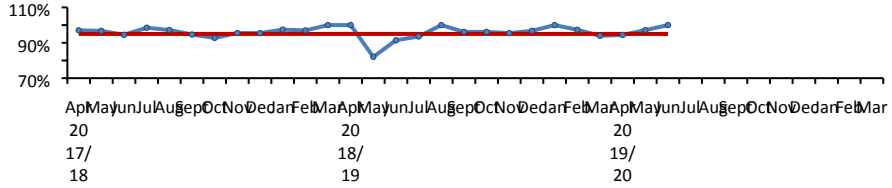
A planned Duty of Candour assurance visit to BCPFT took place on 17th June 2019.The visit identified some issues around decision making process for DOC application for the serious incidents reported on the STEIS and how the DOC records or relevant correspondence is linked to the Datix. The WCCG quality team has further analysed the DOC records and has arranged a meeting with the provider for 22nd August 2019 to discuss the issues highlighted during this visit.

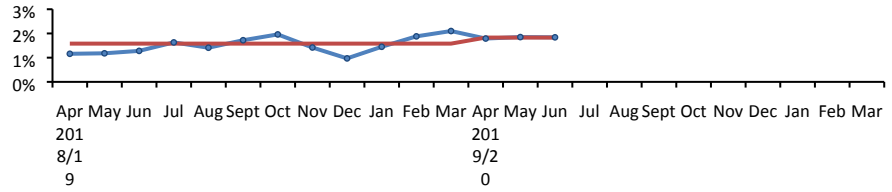
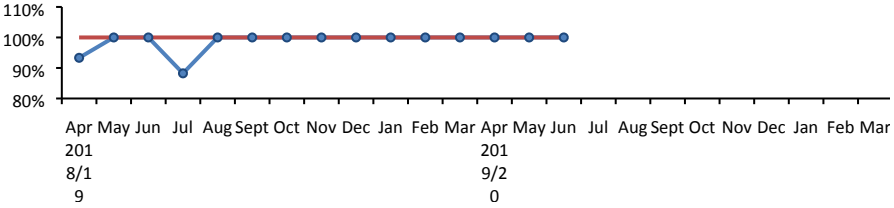
4.1 Workforce and Staffing

Measure	Trend	Target	Assurance/Analysis
Staff Turnover Rates (%)		**10-15%**	Turnover rate 13.25% in June and remains within the target range.
Average Time to Recruit		**55**	Average time to recruit KPI has shown a decrease during June to 45 working days and remains within target.
Vacancy rate (%)		**<9%**	Vacancy rate increased again slightly in June to 14.8 % and remains red rated against the target.

Measure	Trend	Target	Assurance/Analysis
Mandatory Training Rate (%)		**85%**	Annual specialist mandatory training performance increased to 85%.
% of Shifts filled (Bank and Rostered)		**95%**	Overall figure for June was 97.89% Registered fill rate for June was 100.2%. Unregistered fill rate was 227.20%.
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%**	This indicator was achieved in both May and June (target 95%).

Measure	Trend	Target	Assurance/Analysis
% of people with anxiety or depression entering treatment		**1.83%**	Target for this KPI has increased to 1.83% (previously 1.40%) following contract negotiations between WCCG and the Trust for the financial year 19/20. Target achieved for both May and June at 1.85%.
% of inpatients with Crisis Management plan on discharge from secondary care		**100%**	Trust continues to achieve target of 100% for June 2019.

5.0 PRIVATE SECTOR PROVIDERS

5.1 Vocare

There have been no quality matters, serious incidents or any quality and safety concerns for this reporting period. CQRM held and assurance gained in relation to key quality areas.

WCCG Responsive Visit to Vocare on 18th July 2019

On 17th July 2019, WCCG received some intelligence in regards to issues relating to medication safety, safe and secure storage of stock drugs, drugs dispensing issues & missing drugs at Vocare UCC. The quality team undertook a responsive visit with the medicine optimisation team to seek immediate assurance on medication safety practices at Vocare Urgent Treatment Centre and a responsive visit to Vocare was conducted on 18th July 2019.

Key findings:

- No immediate concerns were identified in regards to medication safety and all medicines. CD's, stock drugs were stored in a safe and secure manner in an access-controlled locked room. The lock in question was in working order and we were informed that the lock has been fixed recently.
- Robust systems and processes are in place for room a drug fridge temperature checks, ordering and receiving medicine stock delivery, twice-weekly medicine stock levels and CD checks, drugs dispensing etc. Further clarification will be gained at the next CQRM.

6.0 SAFEGUARDING

6.1 Safeguarding Adults and Children

A comprehensive Quarter 1, 2019/20 Adults', Children's and Children/Young People in Care Report was presented to Quality and Safety Committee in July. The report was agreed and accepted by the Committee – there were no major issues highlighted.

6.2 Care Homes

A comprehensive Quarter 1, 2019/20 report was provided at Quality & Safety Committee in July 2019. Highlights include:

- There were 6 SIs reported in care homes during Quarter 1, a slight decrease compared to Quarter 4 when 9 were reported.
- Of these, four were pressure ulcers (2 x Cat 4 and 2 x Cat 3) and the other two related to sub-optimal care of the deteriorating patient meeting SI criteria. Three of the four STEIS reportable pressure ulcers reported in Quarter 1 were deemed to be avoidable following discussion at Scrutiny Group. One incident was deferred awaiting further information from the Provider.
- There were no slips/trips/falls with serious injury reported for Quarter 1, 2019-20 demonstrating that fall prevention training and quality improvement initiatives are having an impact.
- Bentley Court rated "Inadequate" by CQC report published 12th March 2019 has had a further unannounced re-inspection. Report outcome is pending.
- Newlyn Court also rated "inadequate" by CQC with report published 19th June 2019. Inspection found them to be inadequate in safe and well led domains due to multiple health and safety breaches. The care of resident has not been compromised and the home is working to a robust improvement action plan.
- 34 SA1s relating to nursing homes were received during Quarter 1, a similar number compared to the previous quarter when 33 SA1s were received regarding nursing homes.
- Of these 34 referrals, 12 related to pressure ulcers acquired within the homes. Managers are leading on the investigation and enquires supported by the QNAT. Lessons learnt are being shared internally with the staff in the home and also wider, to ensure learning across the sector. Probert Court (who had the highest number of safeguarding referrals) closed at the end of Q1 and residents were safely transferred to alternative placements.

7.0 PRIMARY CARE QUALITY DASHBOARD

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

Issue	Comments	Highlights for June 2019	Mitigation for July 2019	Date of expected achievement of performance	RAG rating
Serious Incidents	All RCAs are reviewed at SISG and escalated to PPIGG if appropriate.	Serious incident escalated to PPIGG – closed no further actions as it had already been reviewed by PAG	Four further incidents reported to PPIGG	Awaiting outcomes	1b
Quality Matters	All issues being addressed by appropriate teams at the CCG and trust that has raised the issue. For review at PPIGG as relevant	Currently up to date • 4 open • 8 closed	Six incidents are open all relating to IG breaches re: blood forms	Five due for response in July and one in August	1a
Practice Issues	No issues at present	No issues at present	No issues noted at present	No further actions at present	1a
Escalation to NHSE	Four incidents due to be reviewed at PPIGG from Quality Matters	Four incidents referred into PPIGG with four more pending review this month	Four incidents referred to PPIGG this month.	Expected completion by end of July 2019	1a
Infection Prevention	IP audit cycle has recommenced for 2019/20	No issues at present	New audit cycle has commenced	No further actions at present Training to be completed by end of November	1a
Flu Programme	Flu planning meetings have recommenced for 2019/20 flu season	No issues at present	All practices have active orders for all vaccines. It has been noted nationally that there will be a delay in delivery of QIV – NHSE and flu planning group to support practices with contingency	Risk identified and added to register. Flu planning group will meet at least monthly from now until March 2020	1b
Vaccination Programme	Vaccination programmes continue to be monitored	Wolverhampton continue to have low uptake for some vaccines	NHSE/PHE meeting identified issues with MMR uptake and susceptibility. Risk identified to discuss and	Ongoing issue at present, to review in 3 months	1a

			consider adding to risk register. Continue to work with colleagues in PH and other CCGs		
Sepsis	Planning continues around training for practices in reduction of gram negative infection – collaboration with IP team, prescribing and continence teams. Some practices have still not identified a sepsis lead and this is being chased.	Awaiting commencement of new IP audit cycle Training for practice nurses arranged for November	Continue to work with Medicines Optimisation and IP teams	No further actions at present Training to be completed by end of November	
MHRA	No issues at present.	No further update	No further update	No further actions at present	1a
Complaints	No issues at present – quarterly report due July 2019	Quarter 4 complaints data not yet available	No further update – awaiting NHSE data	No further actions at present	1a
FFT Page 311	Quarterly full report due in July 2019 Practices who were unable to submit via CQRS or who had submitted but data was not showing on NHSE return have had their data added manually	In May 2019 • 5 practices did not submit – there appeared to be an issue with CQRS in some sites and one has submitted late • 1 practice submitted fewer than 5 responses • Uptake was 1.8% compared to 0.8% regionally and 0.6% nationally	In June 2019 • 2 practices did not submit • 1 submitted fewer than 5 responses • Uptake was 2.5% compared with 0.8% regionally and 0.6% nationally.	No further actions at present	1a
NICE Assurance	No actions at present – next NICE meeting in August 2019	New NICE guidance for primary care discussed in May 2019 – available to providers	Next meeting in August	No further actions at present	1a
Collaborative contracting visits	11 practice visits are outstanding; this will be completed by late summer in line with recent audit.	Visit schedule now available with all practices allocated a visit	As of 23rd July 2019 two practices are outstanding in this visit cycle – due to restart in September	Expected completion by end of July 2019	1b
CQC	No issues at present	One practice identified as being requires improvement –	Practices now undergoing their annual reviews by	On-going process	1b

		meeting arranged with practice and CCG to discuss action plan	telephone. CQC reporting issues as they occur.		
Workforce Activity	Work continues to promote primary care as a desirable place to work and to promote current programmes	Awaiting approval of GPN strategy in Dudley and Sandwell and then to arrange launch	GPN strategy launch booked for 6th October 2019 at Science Park Retention and apprenticeship programmes continue. Regional GPN meeting now set up with rolling chair	On-going	1a
Workforce Numbers	Awaiting NHS Digital workforce data release.	Workforce figures are still pending due to changes in data collection	No change to status	Awaiting further information	1b
Training and Development	None flagged at present	Training continues across the workforce for: GPs – retention work GPNs – strategy launch and retention work, flu training ARTP spirometry and diabetes training Other professions – pharmacy network meetings and PA Fellowships to commence Practice manager update sessions planned	Training continues across the workforce for: GPs – retention work GPNs – strategy launch and retention steering group Flu and spirometry training Pharmacy network meetings Practice manager update sessions Medical assistant training	To continue planning GPN retention and strategy launches Complete by October 2019	1a
Training Hub/HEE/HEI update	To continue monitoring, risk remains open.	Work to reconfigure the Training Hub provision continues. Primary Care Board due to meet in June 2019 to discuss the work plan for hubs and PCNs	Training Hub cover now identified to continue with work as planned	This action is on-going and will be updated as new information is available.	1b

WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 17

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 27th August2019**
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	£13.178m surplus	£13.178m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£447.069m	£433.891m	(£13.178m)	G
Revenue Administration Resource not exceeded	£5.516m	£5.316m	(£0.2m)	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£413k	£52k	(£361k)	G
Maximum closing cash balance %	1.25%	0.15%	(1.10%)	G
BPPC NHS by No. Invoices (cum)	95%	100%	(5%)	G
BPPC non-NHS by No. Invoices (cum)	95%	100%	(5%)	G
QIPP	£16.686m	£16.686m	Nil	G
Programme Cost *	£141,393k	£142,362k	£969k	G
Reserves *	£901k	£0k	(£901k)	G
Running Cost *	£1,839k	£1,771k	(£67k)	G

- The net effect of the three identified lines (*) is break even.
- Underlying recurrent surplus metric of 1% has been maintained.
- Programme Costs inclusive of reserves is showing a small overspend.
- Royal Wolverhampton Trust (RWT) M3 data requires further analysis.
- The CCG control total of £13.178m includes £3.15m of additional surplus as required by NHSEI.
- The CCG is reporting achieving its QIPP target of £16.686m.

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

	Annual Budget £'000	YTD Performance M04							In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o/(u)
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)			
Acute Services	210,731	70,244	70,834	591	0.8%	212,683	1,952	0.9%		0	1,952
Mental Health Services	42,238	13,582	13,695	113	0.8%	42,381	143	0.3%		0	143
Community Services	45,628	15,209	15,238	29	0.2%	45,595	(33)	(0.1%)		0	(33)
Continuing Care	16,006	5,335	5,224	(111)	(2.1%)	15,973	(33)	(0.2%)		0	(33)
Primary Care Services	58,702	19,567	19,750	183	0.9%	59,065	363	0.6%		0	363
Delegated Primary Care	37,573	12,524	12,715	191	1.5%	37,573	0	0.0%		0	0
Other Programme	14,793	4,931	4,905	(26)	(0.5%)	14,734	(60)	(0.4%)		0	(60)
Total Programme	**425,671**	**141,393**	**142,362**	**969**	**0.7%**	**428,003**	**2,332**	**0.5%**		**0**	**2,332**
Running Costs	5,516	1,839	1,771	(67)	(3.7%)	5,316	(200)	(3.6%)		(200)	0
Reserves	2,704	901	0	(901)	(100.0%)	572	(2,132)	(78.8%)		0	(2,132)
Total Mandate	**433,891**	**144,133**	**144,133**	**(0)**	(0.0%)	**433,891**	**0**	**0.0%**		**(200)**	**200**
Target Surplus	13,178	4,393	0	(4,393)	(100.0%)	0	(13,178)	(100.0%)		0	(13,178)
Total	**447,069**	**148,526**	**144,133**	**(4,393)**	(3.0%)	**433,891**	**(13,178)**	(2.9%)		**(200)**	**(13,178)**

- The Acute over performance relates in the main to RWT. Having received Month 3 data the CCG has considered the level of performance reported and has reflected a level of over performance which it considers to be appropriate based on historic activity patterns.

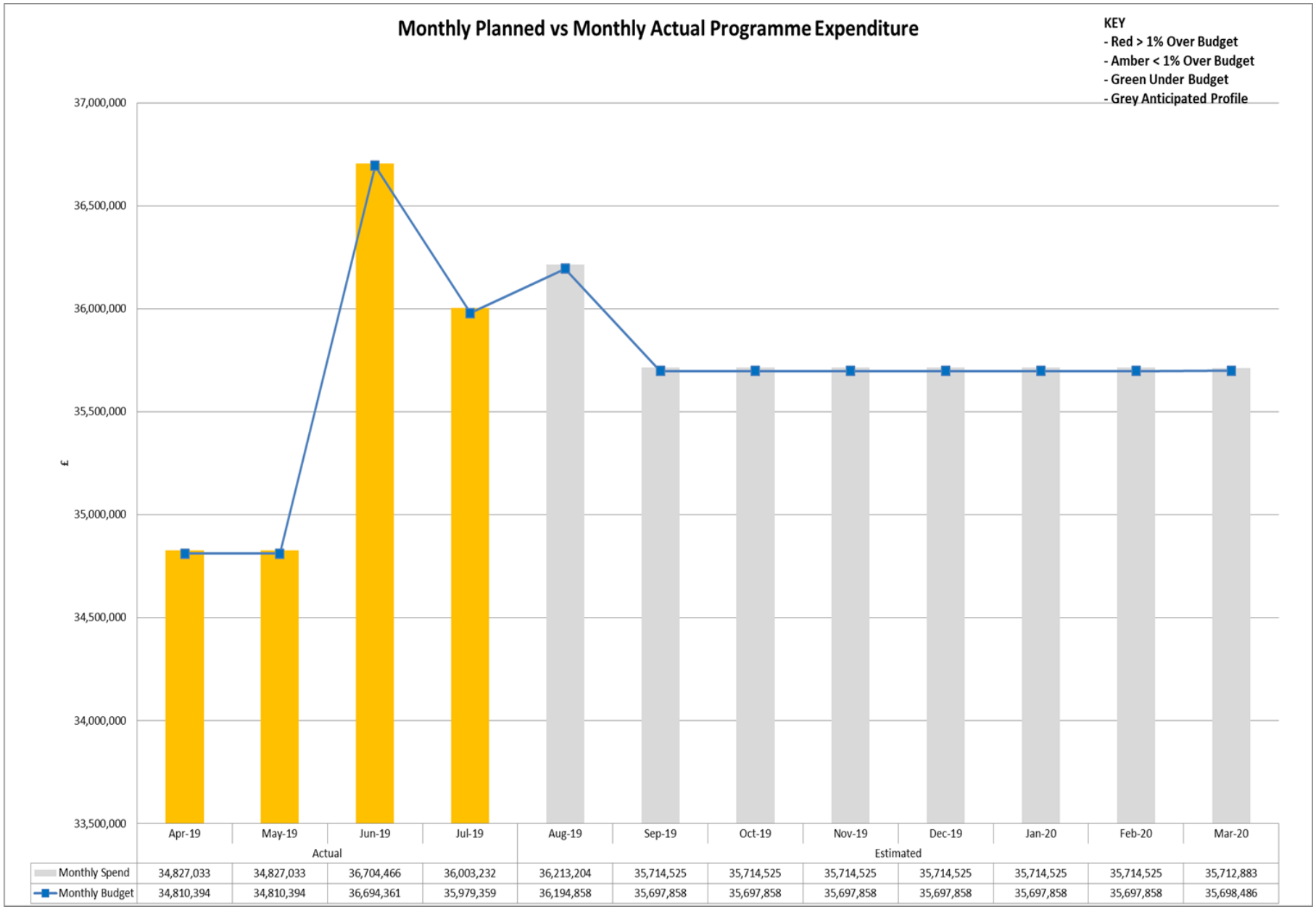
- The Mental Health over performance relates to the recognition of the recurrent impact of NCA activity.

- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, and the 1% reserve. For 20/21 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 1% recurrent surplus as shown below.

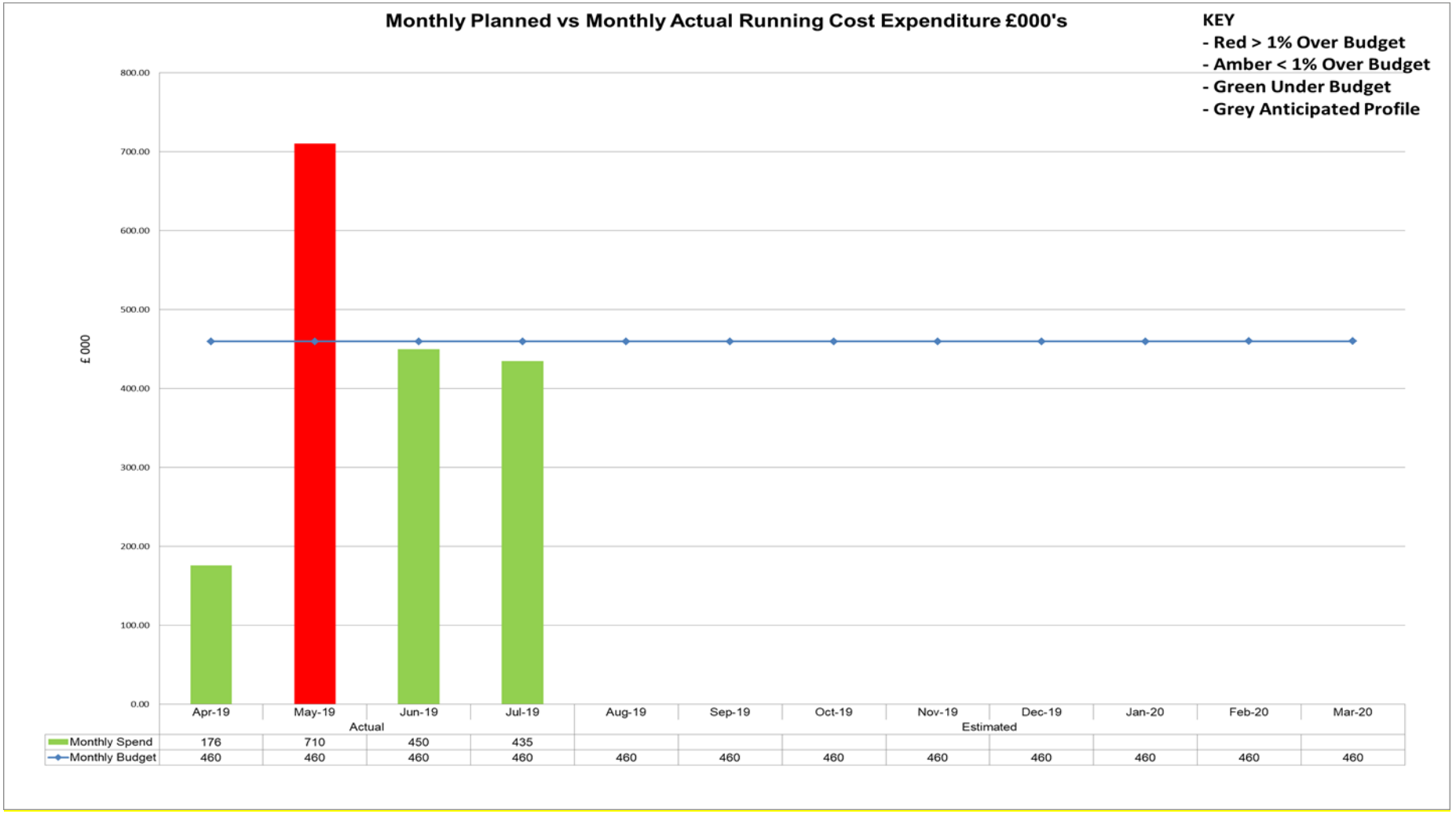
- The extract from the M4 non ISFE demonstrates the CCG achieved its plan, achieving 1.0% recurrent underlying surplus after adjusting for Co Commissioning

CCG UNDERLYING POSITION	Forecast Net Expenditure				Remove Non Recurrent Items					Part/Full Year Effects		2019/20 Underlying Position
	Plan	Actual	Variance	Variance	NR Allocations & Matched Expenditure	NR QIPP Benefit	Contingency	Other NR Spend / Income		QIPP	Other	
	£m	£m	£m	%	£m	£m	£m	£m		£m	£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	437.041				(10.650)							426.391
Acute Services	210.731	212.683	(1.952)	(0.9%)	(2.825)	1.110		(3.391)				207.577
Mental Health Services	42.238	42.381	(0.143)	(0.3%)	(1.818)	-		(0.270)				40.293
Community Health Services	45.628	45.595	0.033	0.1%	-	-		0.092				45.687
Continuing Care Services	16.006	15.973	0.033	0.2%	-	-		0.013				15.986
Primary Care Services	58.702	59.065	(0.363)	(0.6%)	(4.826)	0.500		(0.368)				54.371
Primary Care Co-Commissioning	38.145	38.145	-	0.0%	-	-	(0.191)	0.191				38.145
Other Programme Services	16.925	14.734	2.192	12.9%	(1.181)	1.540	(2.132)	1.861				14.822
Commissioning Services Total	428.375	428.575	(0.200)	(0.0%)	(10.650)	3.150	(2.323)	(1.872)		-	-	416.880
Running Costs	5.516	5.316	0.200	3.6%	-	-						5.316
TOTAL CCG NET EXPENDITURE	433.891	433.891	0.000	0.0%	(10.650)	3.150	(2.323)	(1.872)		-	-	422.196
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	0.000	0.0%					**Underlying Underspend / (Deficit)**			4.195
									% RRL			1.0 %



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Actual				Estimated							
Monthly Spend	34,827,033	34,827,033	36,704,466	36,003,232	36,213,204	35,714,525	35,714,525	35,714,525	35,714,525	35,714,525	35,714,525	35,712,883
Monthly Budget	34,810,394	34,810,394	36,694,361	35,979,359	36,194,858	35,697,858	35,697,858	35,697,858	35,697,858	35,697,858	35,697,858	35,698,486

- The graph details the monthly and cumulative budgeted and actual expenditure in 2019/20. The movement in spend between April and May is expected as there are missing accruals in the April position, as month 1 is not reported.



DELEGATED PRIMARY CARE

- The Delegated Primary Care allocation for 2019/20 is £38.145m. At M4 the CCG forecast outturn is £38.145m delivering a breakeven position.
- The 0.5% contingency and 1% reserve are uncommitted in line with the 2019/20 planning metrics under other GP Services.

- The table below shows the outturn for month 4:

	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	7,947	7,507	(440)	23,842	23,842	0		0	0
General Practice PMS	965	484	(481)	2,895	2,895	0		0	0
Other List Based Services APMS incl	510	783	273	1,531	1,531	0		0	0
Premises	835	798	(37)	2,505	2,505	0		0	0
Premises Other	22	28	6	65	65	0		0	0
Enhanced services Delegated	253	632	379	758	758	0		0	0
QOF	1,250	1,224	(26)	3,751	3,751	0		0	0
Other GP Services	742	1,260	518	2,226	2,226	0		0	0
Delegated Contingency reserve	64	0	(64)	191	191	0		0	0
Delegated Primary Care 1% reserve	127	0	(127)	381	381	0		0	0
Total	**12,715**	**12,715**	**0**	**38,145**	**38,145**	**0**		**0**	**0**

2019/20 forecast figures have been updated on quarter 2 list sizes to reflect Global Sum, Out of Hours and MPIG, Enhanced services, Locum cover, in year rent changes as well as the changes to the primary care networks .

The CCG continues to identify flexibilities within the Delegated budget and a paper will be taken to the Primary Care Commissioning Committee detailing flexibilities and agreed plans for expenditure to ensure the best possible use of resources.

2. QIPP

The key points to note are as follows:

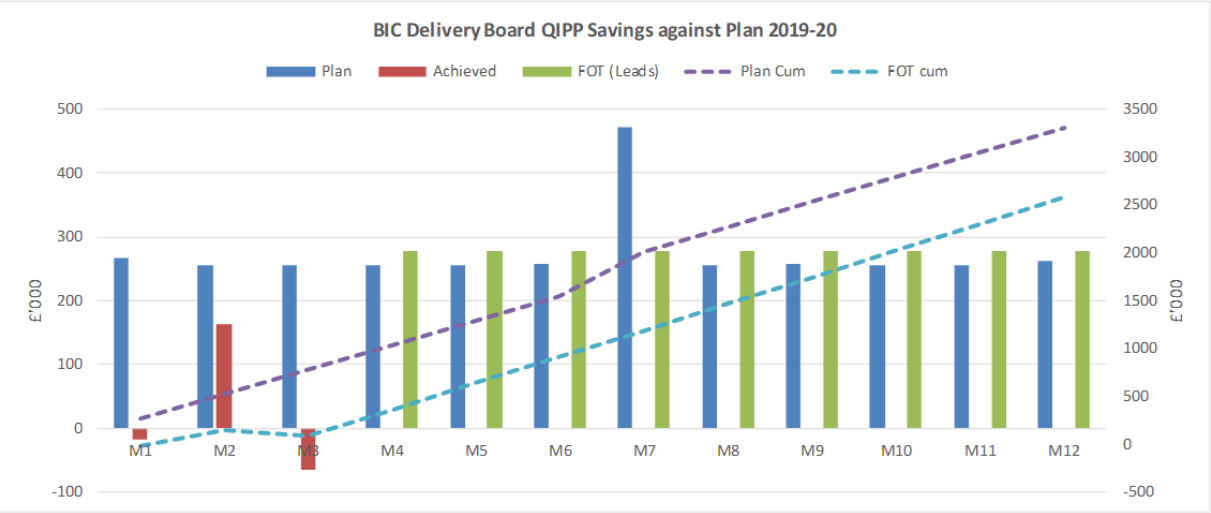
- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686m,(4.1%) the additional QIPP being identified at a high level as follows :

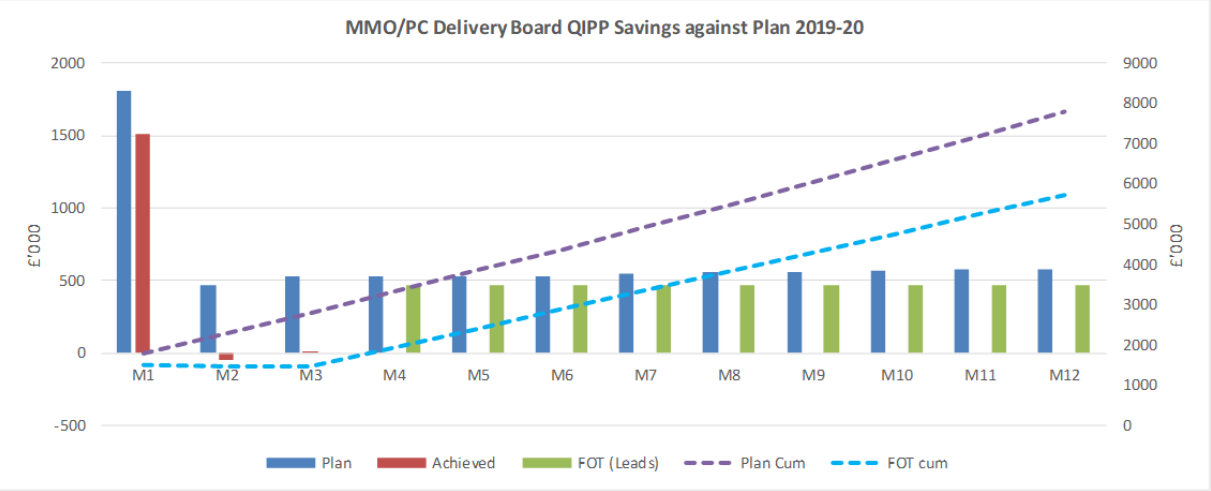
    - Prescribing £500k
    - Other Programme Services £1.54m
    - Acute service Independent/Commercial sector £1.1m

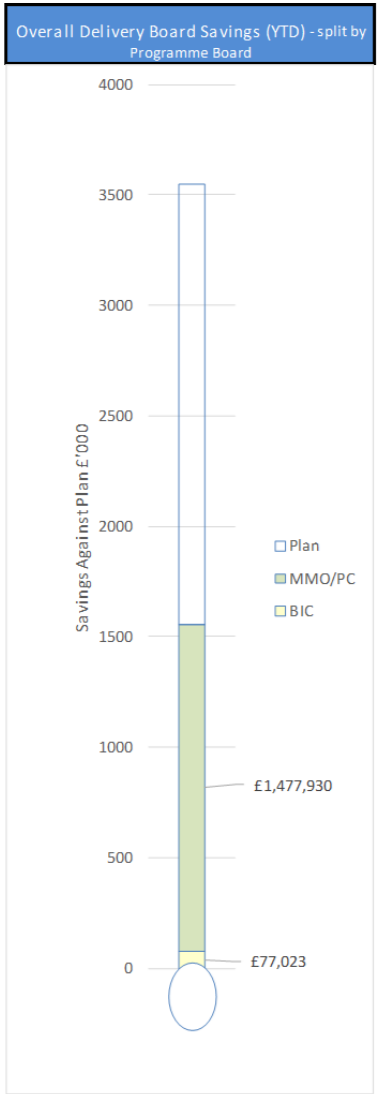
  The above categories represent the areas under higher levels of scrutiny by NHSEI.
- The plan assumes full delivery of QIPP on a recurrent basis (with the exception of the additional QIPP required to support the revised control total) as any non-recurrent QIPP will potentially be carried forward into future years.
- The CCG is formally reporting QIPP being delivered , as the CCG is achieving its financial metrics and is in a position to support any non recurrent slippage on QIPP through the deployment of reserves.
- Within BIC the key points are as follows:
    - At M3 QIPP delivery is behind the year to date plan and is unlikely to deliver the annual taget
    - The increase in QIPP target at in M7 reflects the decommissioning of Blakenhall
    - Work is ongoing in relation to QIPP scheme delivery related to acute spells. Such schemes have targetted specific HRGs. However, the montioring has been complicated as RWT review their coding practices. As a result activity is potentially being coded to different HRGs and the CCG appears to be underperforming against the original HRGs.
- Within MMO/PC the key points are as follows:
    - At M3 QIPP delivery is behind the year to date plan.
    - Prescribing has yet to report their QIPP position due to the timing of data received to support the monitoring of schemes. However ,Prescribing is confident its QIPP target will be delivered.

- The table below details the QIPP programme and the level of savings assigned to each Programme Board and form the basis of monitoring for 19/20.

QIPP Programme Delivery Board







Page 322

3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st July 2019 is shown below:

	31 July '19 £'000		30 June '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	3,000		2,319	**3**	681
Cash and Cash Equivalents	52		100	**4**	-48
	3,052		2,419		
Total Assets	**3,052**		**2,419**		
Current Liabilities					
Trade and Other Payables	-40,005		-37,332	**5**	-2,674
	-40,005		-37,332		
Total Assets less Current Liabilities	**-36,953**		**-34,913**		
TOTAL ASSETS EMPLOYED	**-36,953**		**-34,913**		
Financed by:					
TAXPAYERS EQUITY					
General Fund	36,953		34,913	**6**	2,040
TOTAL	**36,953**		**34,913**		

Key points to note from the SoFP are:

- The cash target for month 4 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**

Exception highlights were as follows;

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

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

This standard supports patients' right to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral. 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.

Wolverhampton CCG Position (June 19):

- WCCG 87.4%, England Commissioners 83.2%, STP 90.4%
- 92% WCCG patients started treatment within 21.2 weeks at any provider in England against the standard of 18 weeks (England was 23.8).
- There are no WCCG patients waiting 52+ weeks to start treatment.
- The CCG's performance is primarily affected by underperformance at RWT, achieving 87% (16,480 out of 19,006 patients) requiring an additional 1,006 patients to start treatment within 18 weeks of referral to achieve the national standard.
- The CCG has received a RAP proposal from RWT which the CCG Contracts Team have collated colleagues' comments and fed back to the Trust for further response.
- Recovery will be defined at speciality level and will support recovery of WCCG performance back to standard; this will be managed and assured via CRM/CQRM.
- Performance continues to be affected by ongoing increase in cancer referrals together with
- Specialities with the longest waiting times are Ophthalmology, Dermatology, Oral Surgery, Neurology and General Surgery.
- Any patients at week 45 are monitored individually by the COO.
- The Trust has no patients waiting over 52 weeks.

3.1.2. Urgent Care (EB5 - 4hr Waits, EBS7 - Ambulance Handovers, EBS5 - 12 Hr Trolley Breaches)

- The CCG's performance against this standard is assessed based on the validated performance for RWT:
- 89.9% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in July which has remained static from May.
- Performance remains challenged across the country with England at 86.5% and the Black Country STP achieved 86.8%.
- July nationally verified and published data has confirmed the following attendance splits for the Trust:
  - Type 1 (Major A&E): 12,201 (with 2,026 breaches) = 83.4%
  - Type 3 (Other A&E/Minor Injury Units): 8,440 (with 58 breaches) = 99.3%
  - Combined: 20,641 (with 2,084 breaches) = 89.9%
- The CCG continues to monitor performance and support programmes to improve performance at A&E Delivery Board, CQRM and CRM.
- 95% of all emergency admissions were admitted within 4 hours from decision to admit also above that of the Black Country (88.6%) and England (89.6%).
- Delayed Transfer of Care rates remain low at 2.89% for June indicating Trust is managing patient flow.
- The CCG is monitoring the impact of the Strategic Cell diverts on Delayed Transfers of Care (DToC) and delays in repatriations.
- Ambulance conveyances in to the Trust continue the upward trend and are under discussion at AEDB together with the triaging of patients from ED to the Urgent Care Centre.
- Trust is on track to provide Same Day Emergency Care (SDEC) in Type 1 Emergency Departments by September 19 in line with the national ambition.
- There were no breaches of the 12 hr standard in July.

3.1.3. Cancer – All Standards

- CCG analysis has demonstrated that the deterioration in performance is multi-faceted and relates in the main to: Diagnostic and robotic capacity, workforce capacity, late tertiary referrals and increasing referral activity specifically relating to urology and breast pathways. Royal Wolverhampton Trust is a tertiary cancer centre and historically is the preferred provider for local populations. The demand is in line with analysis of National Audit Office (NHS waiting times for elective and cancer treatment).

- ***2WW Breast Symptomatic specific issues and actions:***
  - 10% increase of breast referrals over the past 2 years.
  - The Trust has been running additional lists every Saturday since October.
  - The CCG are currently investigating the option of commissioning a Community Breast Pain Clinic together with the introduction of pain management prior to referral.
  - The Trust is working towards implementation of the 28 day faster diagnostic pathway for breast referrals – approach supported by NHSE/I.
  - A joint programme to relieve pressure on RWT waiting list commenced in July 2019. Targeted GPs across Wolverhampton, Cannock, SES & Seisdon CCG, Telford & Wrekin CCGs, Walsall and Dudley are being asked to discuss the alternative option of being referred to Walsall or Dudley, where waiting times are lower, with their patients at point of referral.

- ***All Cancer standards – issues and actions:***
  - Remedial action plan is in place and reviewed monthly with revised improvement trajectories agreed.
  - RAP anticipates return to 62 day performance by November 2019
  - Radiology and diagnostic capacity significantly challenged – despite some outsource activity.
  - Impact of delays on the 2WW cancer pathways (in particular Breast referrals) will start to affect performance against the 31 and 62 day standards.
  - Conversion rates remain in line with England rates and confirms appropriateness of referrals.
  - Complete redesign of Urology pathway; from the end of January 2019 the Trust have implemented the 28 day faster diagnosis pathway in Urology which has now demonstrated that patients reaching transrectal ultrasound guided (TRUS) biopsy stage waiting times are currently at 28 days in June from 52 days.
  - .

Cancer performance data for June 19

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	73.4%	70.4%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	3.8%	5.8%
EB8	31 Day (1st Treatment)	96%	84.4%	91.6%
EB9	31 Day (Surgery)	94%	72.5%	76.2%
EB10	31 Day (anti-cancer drug)	98%	98.1%	100.0%
EB11	31 Day (radiotherapy)	94%	95.8%	87.8%

Ref	Indicator	Standard	RWT	WCCG
EB12	62 Day (1st Treatment)	85%	55.7%	59%
EB13	62 Day (Screening)	90%	80.0%	73.3%
EB14	62 Day (Consultant Upgrade)	No Standard	72.0%	66.7%

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

3.2.1. Mental Health

3.2.2. EA3 - IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence).

- Performance is measured based on a quarterly performance however is monitored monthly. NHS England figures are based on a rolling quarter and confirm the April performance as 5.86% and above threshold of 4.75% for Q1-Q3.
- In order to achieve the increased threshold throughout the year, monthly monitoring will continue with focus on ensuring events are planned earlier in the year to ensure the achievement of the standard in 2019/20.

3.2.3. E.H.10: % of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment

- Difficulties experienced across the STP in age group of patients being able to attend routine appointments, further discussion is due to take place with BCPFT re options available to support access.
- Low numbers (18/20 on a rolling 12 month basis) affect performance against the national standard of 95%.

4. RISK and MITIGATION

The CCG was required to resubmit a plan which demonstrates £6.3m risk which currently is fully mitigated based on the assumption that the Black Country CCG Risk share agreement will be applied. The level of risk has been reduced in M4 to reflect the inclusion of costs within the main financial reporting.

The key risks are as follows:

- QIPP slippage £1.1m

- Over performance in Acute services £500k
- Mental Health overspend £500k
- Prescribing overspend £500k
- Other programme services including extension to control total £3.35m

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)	437.041																		
REVENUE RESOURCE LIMIT (CUMULATIVE)	447.069																		
Acute Services	210.731	212.683	(1.952)	(0.9%)	(0.500)	(1.000)				(1.500)	0.500			1.000					1.500
Mental Health Services	42.238	42.381	(0.143)	(0.3%)		(0.100)			(0.500)	(0.600)	0.500			0.100					0.600
Community Health Services	45.628	45.595	0.033	0.1%		-				-				-					-
Continuing Care Services	16.006	15.973	0.033	0.2%		-				-				-					-
Primary Care Services	58.702	59.065	(0.363)	(0.6%)		-		(0.500)		(0.500)	0.500			-					0.500
Primary Care Co-Commissioning	38.145	38.145	-	0.0%		-				-	0.633			-					0.633
Other Programme Services	16.925	14.734	2.192	12.9%		-			(3.350)	(3.350)				-	2.000	0.717			2.717
Commissioning Services Total	428.375	428.575	(0.200)	(0.0%)	(0.500)	(1.100)	-	(0.500)	(3.850)	(5.950)	2.133	-	-	1.100	2.000	0.717	-	-	5.950
Running Costs	5.516	5.316	0.200	3.6%		-				-				-					-
Unidentified QIPP						-				-				-					-
TOTAL CCG NET EXPENDITURE	433.891	433.891	0.000	0.0%	(0.500)	(1.100)	-	(0.500)	(3.850)	(5.950)	2.133	-	-	1.100	2.000	0.717	-	-	5.950
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	0.000	0.0%															
CUMULATIVE UNDERSPEND / (DEFICIT)	13.178	13.178	0.000	0.0%															

The key mitigations are as follows:

- Utilisation of Contingency
- Further extension to QIPP
- Delayed or reduce non recurrent spend
- Application of Black Country CCG Risk share arrangement.

In summary the CCG is reporting.

	£m Surplus(deficit)	
Most Likely	£13.178	No risks or mitigations, **achieves** control total
Best Case	£19.128	Control total and mitigations achieved, risks do not materialise **achieves** control total

Risk adjusted case	£13.178	Adjusted risks and mitigations occur. CCG **achieves** control total
Worst Case	£7.228	Adjusted risks and no mitigations occur. CCG **misses** revised control total

5. CONTRACT AND PROCUREMENT REPORT

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

6. RISK REPORT

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

7. PRIMARY CARE – FINANCE POSITION AS AT MONTH 3, JUNE 2019

The Committee received and noted this report for information which is considered at the Primary Care Commissioning Committee. It will be brought to this Committee on a quarterly basis.

8. OTHER RISK

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

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

9. RECOMMENDATIONS

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

Name: Lesley Sawrey

Job Title: Deputy CFO

Date: 27.8.19

Wolverhampton CCG Performance against the NHS Constitution Standards

Finance and Performance (F&P) 2019/20 - Wolverhampton CCG (06a)

Current Month: Jun-19

(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

19/20 Ref	Description	Data Level	Frequency	Period of Data	Year End Target / Threshold	Latest RAG	Compared to Previous Mth	Compared to Last 3 Rolling Mths	Year To Date (YTD)	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
EB3	Referral to Treatment (18 Wks)	CCG Provisional	Mth	Jun	92.0%	87.35%	↓	↓	88.38%													
		CCG Validated		Jun	92.0%	87.35%	↓	↓	88.38%													
		RWT		Jun	92.0%	85.90%	↓	↓	87.00%													
		Black Country STP		Jun	92.0%	90.38%	↓	↓	92.95%													
		National		Jun	92.0%	86.29%	↓	↓	86.54%													
EB4	Diagnostic Waits (6wks)	CCG Provisional	Mth	Jun	1.0%	0.68%	↑	↓	0.77%													
		CCG Validated		Jun	1.0%	0.89%	↑	↓	0.80%													
		RWT		Jun	1.0%	0.88%	↑	↓	0.79%													
		Black Country STP		Jun	1.0%	1.44%	↑	↑	1.74%													
		National		Jun	1.0%	3.76%	↑	↑	3.81%													
EB5	A&E (Waits Within 4hrs)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		No Data	95.0%	-																
		RWT		Jul	95.0%	89.88%	↑	↑	88.20%													
		Black Country STP		Jul	95.0%	86.78%	↑	↑	84.59%													
		National		Jul	95.0%	77.90%	↑	↓	79.65%													
EB6	Two Week Waits (2WW)	CCG Provisional	Mth	No Data	93.0%	-			-													
		CCG Validated		Jun	93.0%	70.04%	↓	↓	69.97%													
		RWT		Jun	93.0%	73.38%	↓	↑	72.13%													
		Black Country STP		Jun	93.0%	90.26%	↓	↑	89.35%													
		National		Jun	93.0%	90.06%	↓	↓	90.25%													
EB7	Two Week Waits (2WW) Breast Symptoms	CCG Provisional	Mth	No Data	93.0%	-			-													
		CCG Validated		Jun	93.0%	5.75%	↓	↓	6.40%													
		RWT		Jun	93.0%	3.82%	↑	↑	2.04%													
		Black Country STP		Jun	93.0%	73.44%	↑	↑	72.07%													
		National		Jun	93.0%	78.04%	↓	↑	77.46%													
EB8	31 Day Cancer Treatment	CCG Provisional	Mth	No Data	96.0%	-			-													
		CCG Validated		Jun	96.0%	91.59%	↑	↑	89.64%													
		RWT		Jun	96.0%	84.43%	↓	↓	86.24%													
		Black Country STP		Jun	96.0%	94.27%	↑	↑	93.96%													
		National		Jun	96.0%	95.99%	↑	↓	96.10%													
EB9	31 Day Cancer Treatment (Surgery)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		Jun	94.0%	76.19%	↓	↑	82.61%													
		RWT		Jun	94.0%	72.50%	↑	↑	72.45%													
		Black Country STP		Jun	94.0%	86.21%	↓	↓	89.53%													
		National		Jun	94.0%	91.23%	↓	↓	91.55%													
EB10	31 Day Cancer Treatment (anti cancer drug)	CCG Provisional	Mth	No Data	98.0%	-			-													
		CCG Validated		Jun	98.0%	100.00%	→	→	100.00%													
		RWT		Jun	98.0%	98.08%	↓	↓	99.32%													
		Black Country STP		Jun	98.0%	100.00%	↑	↑	98.97%													
		National		Jun	98.0%	99.25%	↓	↑	99.17%													
EB11	31 Day Cancer Treatment (Radiotherapy)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		Jun	94.0%	95.83%	↑	↑	87.83%													
		RWT		Jun	94.0%	94.85%	↑	↑	89.47%													
		Black Country STP		Jun	94.0%	96.03%	↑	↑	80.75%													
		National		Jun	94.0%	96.69%	↑	↑	96.56%													
EB12	62 Day Cancer Treatment 1st Definitive Treatment	CCG Provisional	Mth	No Data	85.2%	-			-													
		CCG Validated		Jun	85.2%	58.97%	↓	↓	65.10%													
		RWT		Jun	85.2%	55.69%	↓	↓	59.51%													
		Black Country STP		Jun	85.2%	75.21%	↓	↓	75.94%													
		National		Jun	85.2%	76.68%	↓	↓	77.85%													

Current performance is as published validated national data for Wolverhampton CCG unless indicated otherwise, i.e. only available at Trust level. Validated published CCG data is currently only available for April 19 for Mental Health Indicators.

19/20 Ref	Description	Data Level	Frequency	Period of Data	Year End Target / Threshold	Latest RAG	Compared to Previous Mth	Compared to Last 3 Rolling Mths	Year To Date (YTD)	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
EB13	62 Day Cancer Treatment (NHS Screening)	CCG Provisional	Mth	No Data	90.0%	-			-													
		CCG Validated		Jun	90.0%	80.00%	↑	↓	71.43%													
		RWT		Jun	90.0%	73.33%	↓	↓	77.69%													
		Black Country STP		Jun	90.0%	87.18%	↓	↓	90.63%													
		National		Jun	90.0%	85.10%	↓	↓	87.43%													
EB14	62 Day Cancer Treatment (Consultant Upgrade)	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		Jun	0.0%	72.00%	↑	↓	75.38%													
		RWT		Jun	0.0%	66.67%	↓	↓	73.51%													
		Black Country STP		Jun	0.0%	80.71%	↑	↓	80.92%													
		National		Jun	0.0%	81.42%	↓	↓	82.83%													
EB18	52 Week Waiters (RTT)	CCG Provisional	Mth	Jun	0	0	→	→	0													
		CCG Validated		Jun	0	0	→		0													
		RWT		May	0	0	→		0													
		Black Country STP		Jun	0	4	↑	↓	9													
		National		Jun	0	1117	↓	↓	3217													
EH1	IAPT Programme: Treated within 6 wks	CCG Provisional	Mth	No Data	75.0%	-																
		CCG Validated		Apr	75.0%	84.38%			84.38%													
		BCPFT		No Data	75.0%	-																
		Black Country STP		No Data	75.0%	-																
		National		No Data	75.0%	-																
EH2	IAPT Programme Referral to Treatment (18wks)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		Apr	95.0%	96.88%			96.88%													
		BCPFT		No Data	95.0%	-																
		Black Country STP		No Data	95.0%	-																
		National		No Data	95.0%	-																
EH4	EIP 1st Episode (within 2 wks)	CCG Provisional	Mth	No Data	57.1%	80.00%	↑	↓	76.92%													
		CCG Validated		Jun	57.1%	66.67%	→	↓	75.00%													
		BCPFT		Jun	57.1%	40.00%	↓	↓	53.33%													
		Black Country STP		Jun	57.1%	58.33%	↑	↑	51.35%													
		National		Jun	57.1%	76.54%	↓	↑	75.55%													
EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	CCG Provisional	Mth	No Data	0.0%	-																
		CCG Validated		Jul	0	0	↑	→	1													
		RWT		Jul	0	0	→	→	0													
		Black Country STP		Jul	0	0	→	→	0													
		National		No Data	0	-																
EAS5	Minimise rates of Clostridium Difficile	CCG Provisional	Mth	No Data	4 per Mth (48 Total)	-																
		CCG Validated		Jul	4 per Mth (48 Total)	3	↑	↓	13													
		RWT		Jul	48 Total - Seasonal Variation	1	↑	↓	7													
		Black Country STP		Jul	288 Total - Seasonal Variation	16	↑	↑	90													
		National		No Data	TBC	-																
EBS5	12 hr Trolley Waits	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		No Data	0	-																
		RWT		Jul	0	0	↑	↑	4													
		Black Country STP		No Data	0	-																
		National		No Data	0	-																
EBS6	No urgent operation should be cancelled for a second time	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		No Data	0	-																
		RWT		Jun	0	0	→	→	0													
		Black Country STP		No Data	0	-																
		National		No Data	0	-																

19/20 Ref	Description	Data Level	Frequency	Period of Data	Year End Target / Threshold	Latest RAG	Compared to Previous Mth	Compared to Last 3 Rolling Mths	Year To Date (YTD)	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
EBS3	CPA Follow Up within 7 days from Discharge	CCG Provisional	Qtr	No Data	95%	-																
		CCG Validated		Jun	95%	98.96%		↑	98.96%													
		BCPFT		Jun	95%	98.21%		↑	98.21%													
		Black Country STP		Jun	95%	97.30%		↑	97.30%													
		National		Jun	95%	95.05%		↓	95.05%													
EH10	CYP Eating Disorder (Urgent within 1 wk) - 12 Rolling Mths	CCG Provisional	Qtr	Jun	95%	100.00%			100.00%													
		CCG Validated		Jun	95%	100.00%			100.00%													
		BCPFT		Jun	95%	100.00%			100.00%													
		Black Country STP		Jun	95%	91.30%			91.30%													
		National		Jun	95%	77.67%			77.67%													
EH11	CYP Eating Disorder (Routine within 4 wks) - 12 Rolling Mths	CCG Provisional	Qtr	Jun	95%	90.00%			90.00%													
		CCG Validated		Jun	95%	90.00%			90.00%													
		BCPFT		Jun	95%	91.30%			91.30%													
		Black Country STP		Jun	95%	90.48%			90.48%													
		National		Jun	95%	83.43%			83.43%													
EH13	Physical Health Checks for People with a Severe Mental Illness	CCG Provisional	Qtr	No Data	60%	-																
		CCG Validated		Jun	60%	39.27%			39.27%													
		Primary Care		No Data	60%	-																
		Black Country STP		No Data	60%	-																
		National		No Data	60%	-																
EA3	IAPT Roll Out Access Rate	CCG Provisional	Mth	No Data	22%	-																
		CCG Validated		Apr	22% Full Yr (1.83% per mth)	1.75%	↓		1.75%													
		BCPFT		No Data	TBC	-																
		Black Country STP		No Data	TBC	-																
		National		No Data	TBC	-																

WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 17

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 30th July 2019**
Report of:	Tony Gallagher – Director of Finance
Contact:	Tony Gallagher – Director of Finance
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	£13.178m surplus	£13.178m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£443.955m	£430.777m	(£13.178m)	G
Revenue Administration Resource not exceeded	£5.516m	£5.346m	(£0.2m)	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£413k	£100k	(£313k)	G
Maximum closing cash balance %	1.25%	0.29%	(0.96%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£16.686m	£16.686m	Nil	G
Programme Cost *	£69,170k	£69,654k	£484k	G
Reserves *	£451k	£0k	(£451k)	G
Running Cost *	£919k	£886k	(£33k)	G

- The net effect of the three identified lines (*) is break even.
- Underlying recurrent surplus metric of 1% has been maintained.
- Programme Costs inclusive of reserves is showing a small overspend.
- Royal Wolverhampton Trust (RWT) M2 data requires further analysis.
- The CCG control total of £13.178m includes £3.15m of additional surplus as required by NHSEI.
- The CCG is reporting achieving its QIPP target of £16.686m.

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

	Annual Budget £'000	YTD Performance M03									
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)	In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o/(u)
Acute Services	210,663	52,666	53,249	582	1.1%	213,275	2,612	1.2%		2,412	200
Mental Health Services	40,747	10,161	10,504	343	3.4%	41,114	366	0.9%		367	(0)
Community Services	45,688	11,447	11,473	26	0.2%	45,714	26	0.1%		26	0
Continuing Care	16,006	4,001	3,919	(82)	(2.1%)	15,929	(77)	(0.5%)		(77)	0
Primary Care Services	57,968	14,492	14,340	(151)	(1.0%)	57,368	(600)	(1.0%)		(600)	0
Delegated Primary Care	37,573	9,393	9,536	143	1.5%	37,573	0	0.0%		0	0
Other Programme	13,912	3,478	3,337	(141)	(4.1%)	13,887	(26)	(0.2%)		(26)	0
Total Programme	**422,557**	**105,639**	**106,359**	**719**	**0.7%**	**424,859**	**2,302**	**0.5%**		**2,102**	**200**
Running Costs	5,516	1,379	1,336	(43)	(3.1%)	5,346	(170)	(3.1%)		30	(200)
Reserves	2,704	676	0	(676)	(100.0%)	572	(2,132)	(78.8%)		(2,132)	0
Total Mandate	**430,777**	**107,694**	**107,694**	**(0)**	(0.0%)	**430,777**	**0**	**0.0%**		**0**	**0**
Target Surplus	13,178	3,294	0	(3,294)	(100.0%)	0	(13,178)	(100.0%)		(13,178)	0
Total	**443,955**	**110,989**	**107,694**	**(3,294)**	(3.0%)	**430,777**	**(13,178)**	(3.0%)		**(13,178)**	**(13,178)**

- The Acute overperformance of £582k relates in the main to RWT. Having received Month 2 data the CCG has considered the level of performance reported and has reflected a level of over performance which it considers to be appropriate based on historic activity patterns.

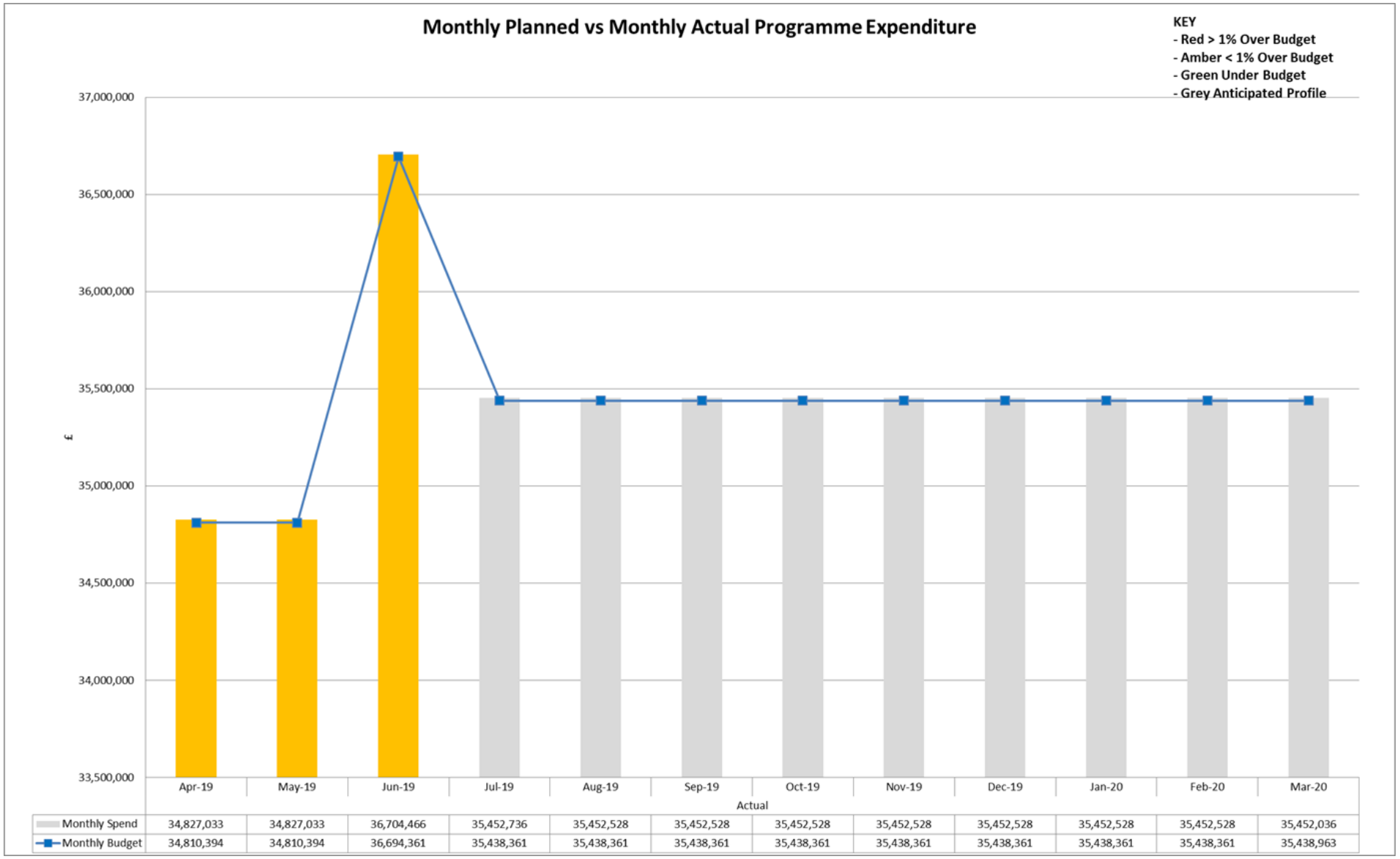
- The Mental Health over performance relates to the recognition of the recurrent impact of NCA activity.

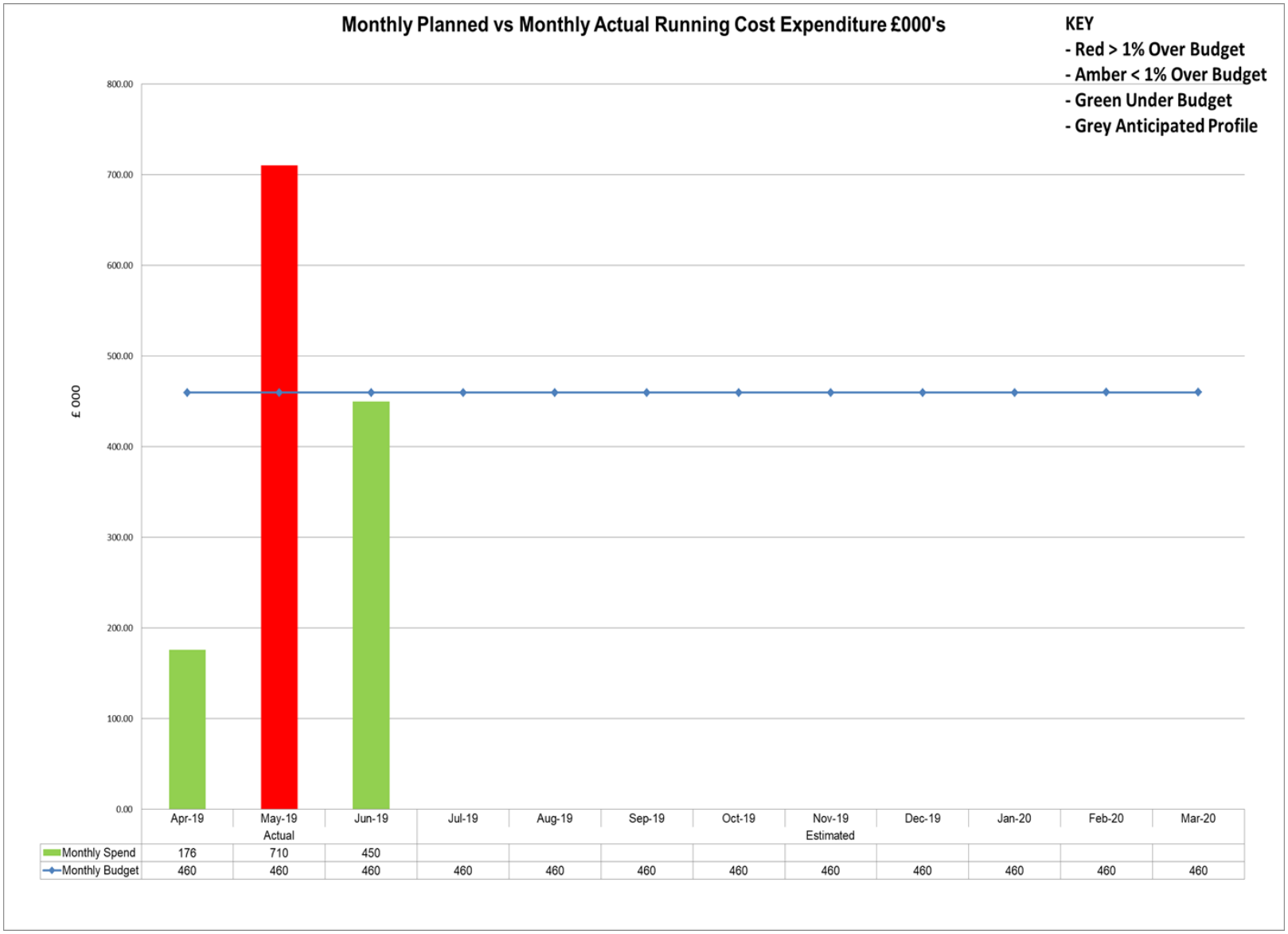
- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, and the 1% reserve. For 20/21 the CCG will need to reinstate the Contingency and 1% reserve which will be a first call on growth monies.

- 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 1% recurrent surplus as shown below.

- The extract from the M3 non ISFE demonstrates the CCG achieved its plan, achieving 1.0% recurrent underlying surplus after adjusting for Co Commissioning

CCG UNDERLYING POSITION	Forecast Net Expenditure				Remove Non Recurrent Items					Part/Full Year Effects		2019/20 Underlying Position
	Plan	Actual	Variance	Variance	NR Allocations & Matched Expenditure	NR QIPP Benefit	Contingency	Other NR Spend / Income		QIPP	Other	
	£m	£m	£m	%	£m	£m	£m	£m		£m	£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	433.927				(7.536)							426.391
Acute Services	210.663	213.275	(2.612)	(1.2%)	(2.851)	1.110		(2.073)				209.461
Mental Health Services	40.747	41.114	(0.366)	(0.9%)	(0.385)	-		(0.236)				40.493
Community Health Services	45.688	45.714	(0.026)	(0.1%)	-	-		(0.026)				45.688
Continuing Care Services	16.006	15.929	0.077	0.5%	-	-		(0.035)				15.894
Primary Care Services	57.968	57.368	0.600	1.0%	(4.027)	0.500		0.460				54.301
Primary Care Co-Commissioning	38.145	38.145	-	0.0%	-	-	(0.191)	0.191				38.145
Other Programme Services	16.044	13.887	2.158	13.4%	(0.300)	1.540	(2.132)	(0.060)				12.935
Commissioning Services Total	425.261	425.431	(0.170)	(0.0%)	(7.563)	3.150	(2.323)	(1.778)		-	-	416.917
Running Costs	5.516	5.346	0.170	3.1%	-	-						5.346
TOTAL CCG NET EXPENDITURE	430.777	430.777	(0.000)	(0.0%)	(7.563)	3.150	(2.323)	(1.778)		-	-	422.263
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	(0.000)	(0.0%)					Underlying Underspend / (Deficit)			4.128
									% RRL			1.0 %


Monthly Planned vs Monthly Actual Programme Expenditure
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
37,000,000
36,500,000
36,000,000
35,500,000
35,000,000
34,500,000
34,000,000
33,500,000
£
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20
Actual
Monthly Spend 34,827,033 34,827,033 36,704,466 35,452,736 35,452,528 35,452,528 35,452,528 35,452,528 35,452,528 35,452,528 35,452,528 35,452,036
Monthly Budget 34,810,394 34,810,394 36,694,361 35,438,361 35,438,361 35,438,361 35,438,361 35,438,361 35,438,361 35,438,361 35,438,361 35,438,963



- The graph details the monthly and cumulative budgeted and actual expenditure in 2019/20. The movement in spend between April and May is expected as there are missing accruals in the April position, as month 1 is not reported. This.

DELEGATED PRIMARY CARE

- The Delegated Primary Care allocation for 2019/20 as at M2 are £38.145m. At M3 the CCG forecast outturn is £38.145m delivering a breakeven position.
- The 0.5% contingency and 1% reserve are uncommitted in line with the 2019/20 planning metrics under other GP Services.

- The table below shows the outturn for month 3:

	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	5,960	5,644	(316)	23,842	23,842	0		0	0
General Practice PMS	724	363	(361)	2,895	2,895	0		0	0
Other List Based Services APMS incl	383	587	205	1,531	1,531	0		0	0
Premises	626	601	(25)	2,505	2,505	0		0	0
Premises Other	16	30	13	65	65	0		0	0
Enhanced services Delegated	189	432	243	758	758	0		0	0
QOF	938	918	(20)	3,751	3,751	0		0	0
Other GP Services	557	960	404	2,226	2,226	0		0	0
Delegated Contingency reserve	48	0	(48)	191	191	0		0	0
Delegated Primary Care 1% reserve	95	0	(95)	381	381	0		0	0
Total	**9,536**	**9,536**	**0**	**38,145**	**38,145**	**0**		**0**	**0**

2019/20 forecast figures have been updated on quarter 1 list sizes to reflect Global Sum, Out of Hours and MPIG, Enhanced services, Locum cover, in year rent changes as well as the changes to the primary care networks .

The CCG continues to identify flexibilities within the Delegated budget and a paper will be taken to the Primary Care Commissioning Committee detailing flexibilities and agreed plans for expenditure to ensure the best possible use of resources.

2. QIPP

The key points to note are as follows:

- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686m,(4.1%) the additional QIPP being identified at a high level as follows :

    - Prescribing £500k
    - Other Programme Services £1.54m
    - Acute service Independent/Commercial sector £1.1m

  The above categories represent the areas under higher levels of scrutiny by NHSEI.
- The plan assumes full delivery of QIPP on a recurrent basis (with the exception of the additional QIPP required to support the revised control total) as any non-recurrent QIPP will potentially be carried forward into future years.
- The CCG is reviewing and automating its QIPP reporting and as such monthly reporting will resume in M4. However, for M3 reporting has been taken from the PMO reports to Programme Boards.
- The table below detail the QIPP programme and the level of savings assigned to each scheme and will form the basis of monitoring for 19/20.

Project Details							Year to Date Position					
UI Ref	Boards	Work Stream • Acute • Mental Health • Community Health • Community Care • Primary care • Prescribing • Continuing Care • Other	Name	Data Source	TYPE	Lead	QIPP Annual Plan £	Planned Savings YTD	Actual Savings YTD	Total Savings Variance	Variance From Annual Plan And Total Cumulative Savings £	Savings of Total Plan achieved so far (%)
59	BIC	TBC	End of Life	BI	TF	Karen Evans	£ 650,000	£ 108,000	-£ 116,449	-£ 224,449	£ 766,449	-18%
113		TBC	Respiratory Right Care	BI	TF	Claire Morrissey	£ 240,000	£ 40,000	-£ 134,642	-£ 174,642	£ 374,642	-56%
86		TBC	Diabetes Right Care	BI	TF	Claire Morrissey	£ 125,000	£ 20,000	-£ 2,598	-£ 22,598	£ 127,598	-2%
42		TBC	Falls Service Redesign	BI	TF	Claire Morrissey	£ 200,000	£ 32,000	£ 107,506	£ 75,506	£ 92,494	54%
20		TBC	Peads Right Care	BI	TF	Maggs Courts	£ 593,000	£ 93,000	£ 82,509	-£ 10,491	£ 510,491	14%
162		Mental Health	Decommissioning Of Blakenhall Resource Centre / Grove	Lead	TF	Sarah Fellows	£ 216,000			£ -	£ 216,000	0%
21		TBC	Care Closer to Home	BI	TF	Andrea Smith	£ 1,015,000	£ 168,000	£ 155,731	-£ 12,269	£ 859,269	15%
93	MMO PC	Primary Care	Demand Management	BI	TF	Jo Reynolds	£ 178,000	£ 28,000	£ 103,870	£ 75,870	£ 74,130	58%
178		TBC	Glaucoma	BI	TF	Clare Barratt	£ 40,000	£ -	-£ 4,162	-£ 4,162	£ 44,162	-10%
151		Prescribing	Biosimilar Switch - Adalimumab & Rituximab	Lead	TX	Hemant Patel	£ 1,106,000	£ 100,000	£ 106,029	£ 6,029	£ 999,971	10%
127		Prescribing	Repeat Prescription	Lead	TF	Hemant Patel	£ 50,000	£ -	£ -	£ -	£ 50,000	0%
6 c		Prescribing	Low Clinical Value Drugs	Lead	TF	Hemant Patel	£ 60,000	£ 10,000	£ 4,671	-£ 5,329	£ 55,329	8%
108		Prescribing	Prescribing review Phase 2	Lead	TF	Hemant Patel	£ 100,000	£ 16,000	£ 8,312	-£ 7,688	£ 91,688	8%
6		Prescribing	General Prescribing Internal Efficiencies	Lead	TF	Hemant Patel	£ 1,350,000	£ 200,000	£ 246,434	£ 46,434	£ 1,103,566	18%
152		Prescribing	Biologics For RA	Lead	TX	Hemant Patel	£ 86,000	£ 14,000	£ -	-£ 14,000	£ 86,000	0%
118		Prescribing	Prescribing Right Care Diabetes	Lead	TF	Hemant Patel	£ 60,000	£ 10,000	£ 1,996	-£ 8,004	£ 58,004	3%
130		Prescribing	Prescribing Right Care Respiratory	Lead	TF	Hemant Patel	£ 147,000	£ 24,000	£ 824	-£ 23,176	£ 146,176	1%
149	TBC	TBC	Managing Growth	BI	TF	TBC	£ 1,226,000	£ 204,000	-£ 454,175	-£ 658,175	£ 1,680,175	-37%
179	TBC	TBC	A&E Impact of NEL QIPP	BI	TF	TBC	£ 243,000	£ 40,000	£ 24,628	-£ 15,372	£ 218,372	10%
140	MMO PC	TBC	Review of Stroke Therapy Line (Block)	TX	TX	Jeff Love	£ 98,000	£ 98,000	£ 98,000	£ -	£ -	100%
135	MMO PC	TBC	Contract Challenges POLCV	TX	TX	Sharon Sidhu & Vic Middlemiss	£ 500,000	£ 500,000	£ 500,000	£ -	£ -	100%
141	MMO PC	TBC	APMS Procurement	TX	TX	Gill Shelly	£ 735,000	£ 735,000	£ 735,000	£ -	£ -	100%
143	BIC	TBC	MSMG Budget Realignment	TX	TX	Maggs Courts	£ 20,000	£ 20,000	£ 20,000	£ -	£ -	100%
13	TBC	Other	Running Cost	TX	TF	Exec	£ 305,000	£ 305,000	£ 305,000	£ -	£ -	100%
142	TBC	Other	Risk/ Gain Share Benefit (RWT Aligned Incentive Benefit)	TX	TX	Exec	£ 1,000,000	£ 1,000,000	£ 1,000,000	£ -	£ -	100%
144	TBC	Other	WCS Budget Realignment	TX	TX	Exec	£ 35,000	£ 35,000	£ 35,000	£ -	£ -	100%
145	TBC	Other	CHC to Required Growth	TX	TX	Exec	£ 257,000	£ 257,000	£ 257,000	£ -	£ -	100%
146	TBC	Other	Excess Funding MH Contracts	TX	TX	Exec	£ 417,000	£ 417,000	£ 417,000	£ -	£ -	100%
147	TBC	Other	NCSO Realignment	TX	TX	Exec	£ 470,000	£ 470,000	£ 470,000	£ -	£ -	100%
148	TBC	Other	LD Realignment of Budgets	TX	TX	Exec	£ 896,000	£ 896,000	£ 896,000	£ -	£ -	100%
163	TBC	Other	UCC	TX	TX	Exec	£ 1,000,000	£ 1,000,000	£ 1,000,000	£ -	£ -	100%
177	TBC	Other	FNC To Required Growth	TX	TX	Exec	£ 118,000	£ 118,000	£ 118,000	£ -	£ -	100%
						Total	£ 13,536,000	£ 6,958,000	£ 5,981,484	-£ 976,516		-7%

3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 30th June 2019 is shown below:

STATEMENT OF FINANCIAL POSITION	As At 30th June 2019		
	30 June '19 £'000	31 May '19 £'000	Change In Month £'000
Non Current Assets			
Assets	0	0	0
Accumulated Depreciation	0	0	0
	0	0	
Current Assets			
Trade and Other Receivables	2,319	1,754	565
Cash and Cash Equivalents	100	338	-238
	2,419	2,092	
Total Assets	**2,419**	**2,092**	
Current Liabilities			
Trade and Other Payables	-37,332	-36,304	-1,028
	-37,332	-36,304	
Total Assets less Current Liabilities	**-34,913**	**-34,212**	
TOTAL ASSETS EMPLOYED	**-34,913**	**-34,212**	
Financed by:			
TAXPAYERS EQUITY			
General Fund	34,913	34,212	701
TOTAL	**34,913**	**34,212**	

Key points to note from the SoFP are:

- The cash target for month 3 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**

Exception highlights were as follows;

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

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

This standard supports patients' right to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral. 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.

Wolverhampton CCG Position (May 19):

- WCCG 88.5%, England Commissioners 84.0%, STP 91.1%/
- 92% WCCG patients started treatment within 20.4 weeks at any provider in England against the standard of 18 weeks (England was 24.7).
- There are no WCCG patients waiting 52+ weeks to start treatment.
- The CCG's performance is primarily affected by underperformance at RWT, University Hospitals Birmingham (UHB), University Hospitals of North Midlands (UHNM) and The Royal Orthopaedic Hospital (ROH); none of which were achieved the national standard at Trust level in May.
- Wolverhampton CCG achieved 88% at RWT requiring an additional 748 patients to achieve the national standard.
- Nuffield Health Wolverhampton achieved standard at 92.8% in May.

The Royal Wolverhampton NHS Trust Position (May 19):

- RWT 87.1%; England Providers 86.9% and STP 90.8%
- 92% patients started treatment within 21 weeks against the standard of 18 weeks.

- The CCG is awaiting a RAP proposal from RWT which is due early August, this will be defined at speciality level and will support recovery of WCCG performance back to standard, this will be managed and assured via CRM/CQRM.
- Performance has been affected in a significant rise in urgent referrals in to cancer 2 week wait taking clinical priority over routine appointments and using the same consultants & resources (in particular General Surgery, Urology, Skin) together with capacity issues.
- Specialities with the longest waiting times are Oral Surgery, Ophthalmology, Dermatology and General Surgery.
- Any patients at week 45 are monitored individually by the COO.
- The Trust have no patients waiting over 52 weeks.
- May has seen the highest ever RTT waiting list size at 39,305, however early unvalidated data is showing a reduction to circa 35k for June. The Trust is currently undertaking a data cleanse of the waiting list to ensure an accurate position.

3.1.2. Urgent Care (EB5 - 4hr Waits, EBS7 - Ambulance Handovers, EBS5 - 12 Hr Trolley Breaches)

- The CCG's performance against this standard is assessed based on the validated performance for RWT:
- 89.9% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in May which is an improvement on 86.4% in April.
- The Trust is ranked 36th out of 122 Trusts, 13 Trusts are part of the pilot for the new standards in UEC and are therefore not reporting against the 4 hr wait standard.
- Performance remains challenged across the country with England at 86.6% and the Black Country STP achieved 84.8%.
- May nationally verified and published data has confirmed the following attendance splits for the Trust:
  - Type 1 (Major A&E): 12,201 (with 2,026 breaches) = 83.4%
  - Type 3 (Other A&E/Minor Injury Units): 8,440 (with 58 breaches) = 99.3%
  - Combined: 20,641 (with 2,084 breaches) = 89.9%
- The CCG continues to monitor performance and support programmes to improve performance at A&E Delivery Board, CQRM and CRM.
- 96.3% of all emergency admissions were admitted within 4 hours from decision to admit also above that of the Black Country (89.7%) and England (88.8%).

- Delayed Transfer of Care rates remain low at 2.85% indicating Trust is managing patient flow.
- The CCG is monitoring the impact of the Strategic Cell diverts on Delayed Transfers of Care (DToC) and delays in repatriations.
- May saw a continuation in the upward trend in the number of ambulance conveyances into the Trust (compared with the same period last year) with an additional 300 (6.97%) during the month.
- Stroke ambulances accounted for 5.36% of all ambulances into the Trust during May 2019.
- NHS Long Term Plan milestones have been included in the 2019/20 A&E Delivery Board Programme Plan for oversight and assurance.
- Trust is on track to provide Same Day Emergency Care (SDEC) in Type 1 Emergency Departments by September 19 in line with the national ambition.
- The Trust reported two 12 hour decision to admit breaches in May; both breaches related to Mental Health patients. Themes from both RCAs showed main drivers to be; availability of Mental Health Beds in region, transport delays and delay in completion of Section papers by social worker once bed was located.

3.1.3. Cancer – All Standards

3.1.3.1. CCG analysis has demonstrated that the deterioration in performance is multi-faceted and relates in the main to: Diagnostic and robotic capacity, workforce capacity, late tertiary referrals and increasing referral activity specifically relating to urology and breast pathways. Royal Wolverhampton Trust is a tertiary cancer centre and historically is the preferred provider for local populations. The demand is in line with analysis of National Audit Office (NHS waiting times for elective and cancer treatment).

- ***2WW Breast Symptomatic specific issues and actions:***
  - 10% increase of breast referrals over the past 2 years.
  - The Trust has been running additional lists every Saturday since October.
  - The CCG are currently investigating the option of commissioning a Community Breast Pain Clinic together with the introduction of pain management prior to referral.
  - The Trust is working towards implementation of the 28 day faster diagnostic pathway for breast referrals – approach supported by NHSE/I.

- A joint programme to relieve pressure on RWT waiting list commenced in July 2019. Targeted Wolverhampton GPs have been asked to discuss the alternative option with their patients at point of referral of being referred to Walsall or Dudley where waiting times are lower.

- ***All Cancer standards – issues and actions:***
  - Remedial action plan is in place and reviewed monthly with revised improvement trajectories agreed.
  - RAP demonstrates return to 62 day performance by November 2019
  - Radiology and diagnostic capacity significantly challenged – despite some outsource activity.
  - Impact of delays on the 2WW cancer pathways (in particular Breast referrals) will start to affect performance against the 31 and 62 day standards.
  - Conversion rates remain in line with England rates and confirm appropriateness of referrals.
  - Complete redesign of Urology pathway; from the end of January 2019 the Trust have implemented the 28 day faster diagnosis pathway in Urology which has now demonstrated that patients reaching transrectal ultrasound guided (TRUS) biopsy stage waiting times are currently at 28 days in June from 52 days.

Cancer performance data for May 19

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	74.14%	72.75%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	0.55%	6.2%
EB8	31 Day (1st Treatment)	96%	87.61%	88.43%
EB9	31 Day (Surgery)	94%	65.52%	100.00%
EB10	31 Day (anti-cancer drug)	98%	100.00%	100.00%
EB11	31 Day (radiotherapy)	94%	88.55%	89.47%
EB12	62 Day (1st Treatment)	85%	68.45%	71.93%
EB13	62 Day (Screening)	90%	78.85%	68.75%
EB14	62 Day (Consultant Upgrade)	No Standard	77.02%	71.79%

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

3.2.1. Mental Health

Nationally validated data for Mental Health indicators has now been published for April 19 provisional data. There are currently no red rated indicators for the NHS Constitutional standards.

- ***IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) (EA3 – local reference: LQIA05).***
  - Performance is measured based on a quarterly performance however is monitored monthly. NHS England figures are based on a rolling quarter and confirms the April performance as 5.86% and above threshold.
  - The CCG's performance is in the main affected by the activity at the main provider The Black Country Partnership Foundation Trust (BCPFT), who has confirmed monthly performance under the 1.83% monthly threshold (22% full year) with May at 1.61%.
  - In order to achieve the increased threshold throughout the year, monthly monitoring will continue with focus on ensuring events are planned earlier in the year to ensure the achievement of the standard in 2019/20.

4. RISK and MITIGATION

The CCG was required to resubmit a plan which demonstrates £6.3m risk which currently is fully mitigated based on the assumption that the Black Country CCG Risk share arrangements will be applied.

CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)								
	Plan	Actual	Variance	Variance	Contract	QIPP	Performance Risks	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)	426.391																		
REVENUE RESOURCE LIMIT (CUMULATIVE)	436.419																		
Acute Services	207.848	208.049	(0.200)	(0.1%)	(0.750)	(1.000)				(1.750)	0.750			1.000					1.750
Mental Health Services	40.298	40.297	0.000	0.0%		(0.100)			(0.500)	(0.600)	0.500			0.100					0.600
Community Health Services	45.783	45.783	-	0.0%		-				-				-					-
Continuing Care Services	16.006	16.006	-	0.0%		-				-				-					-
Primary Care Services	53.901	53.901	-	0.0%		-		(0.500)		(0.500)	0.500			-					0.500
Primary Care Co-Commissioning	38.145	38.145	-	0.0%		-				-	0.526			-					0.526
Other Programme Services	15.744	15.744	-	0.0%		-			(3.350)	(3.350)				-	2.000	0.824			2.824
Commissioning Services Total	417.725	417.925	(0.200)	(0.0%)	(0.750)	(1.100)	-	(0.500)	(3.850)	(6.200)	2.276	-	-	1.100	2.000	0.824	-	-	6.200
Running Costs	5.516	5.316	0.200	3.6%		-				-				-					-
Unidentified QIPP						(0.100)				(0.100)				0.100					0.100
TOTAL CCG NET EXPENDITURE	423.241	423.241	(0.000)	(0.0%)	(0.750)	(1.200)	-	(0.500)	(3.850)	(6.300)	2.276	-	-	1.200	2.000	0.824	-	-	6.300
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	-	0.0%															
CUMULATIVE UNDERSPEND / (DEFICIT)	13.178	13.178	-	0.0%															

The key risk are as follows:

- QIPP slippage £1.1m
- Over performance in Acute services £750k
- Mental Health overspend £500k
- Prescribing overspend £500k
- Other programme services including extension to control total £3.35m

The key mitigations are as follows:

- Utilisation of Contingency
- Further extension to QIPP
- Delayed or reduce non recurrent spend

In summary the CCG is reporting.

	£m Surplus(deficit)	
Most Likely	£13.178	No risks or mitigations, **achieves** control total
Best Case	£19.478	Control total and mitigations achieved, risks do not materialise **achieves** control total
Risk adjusted case	£13.178	Adjusted risks and mitigations occur. CCG **achieves** control total
Worst Case	£6.878	Adjusted risks and no mitigations occur. CCG **misses** revised control total

5. Contract and Procurement Report

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

6. RISK REPORT

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

7. 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.

8. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **31.7.19**

Wolverhampton CCG Performance against the NHS Constitution Standards

		National Target	May 19 Performance	PERFORMANCE											
				J	J	A	S	O	N	D	J	F	M	A	M
	Referral to Treatment waiting times for non-urgent consultant-led treatment														
EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral.	92%	88.5%												
EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways.	0	0												
	Diagnostics														
EB4	Percentage of Service Users waiting 6 weeks or more from referral for a diagnostic test.	1%	0.9%												
	Cancelled Elective Operations (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. (RWT position).	0	0												
EBS6	No urgent operation should be cancelled for a second time. (RWT position).	0	0												
	A&E Waits														
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 (RWT position).	95%	89.9%												
EBS5	Trolley waits in A&E not longer than 12 hours (RWT position).	0	2												
	Cancer Waits - two week waits														

		National Target	May 19 Performance	PERFORMANCE											
				J	J	A	S	O	N	D	J	F	M	A	M
EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment.	93%	72.8%												
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%	6.2%												
	Cancer Waits - one month (31 days) waits														
EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	96%	88.4%												
EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery.	94%	100%												
EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen.	98%	100%												
EB11	Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy.	94%	89.5%												
	Cancer Waits - two month (62 days) waits														
EB12	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	85%	71.9%												
EB13	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a NHS Cancer Screening Service.	90%	68.8%												
EB12	Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	No National Target	68.8%												
	Health Care Acquired Infections														
EAS4	Zero tolerance Meticillin Resistant *Staphylococcus Aureus.*	0	0												
EAS5	Minimise rates of Clostridium difficile.	48	5 (ytd)												

		National Target	May 19 Performance	PERFORMANCE											
				J	J	A	S	O	N	D	J	F	M	A	M
	Mental Health														
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%													N/A
EH1	IAPT - Percentage of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral.	75%	84.4%												N/A
EH2	IAPT - Percentage of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral.	95%	96.9%												N/A
EA3	IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence). **(Rolling quarter ending April 19).*	22% FYE 4.75% Q1	5.86%*												N/A
EAS2	IAPT - Percentage of people who are moving to recovery of those who have completed treatment in the reporting period.	50%	54.9%												N/A
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.	56%	66.7%												N/A

Current performance is as published validated national data for Wolverhampton CCG unless indicated otherwise, i.e. only available at Trust level. Validated published CCG data is currently only available for April 19 for Mental Health Indicators.

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WOLVERHAMPTON CCG

GOVERNING BODY
10 August 2019

Agenda item 18

TITLE OF REPORT:	Summary – Wolverhampton Clinical Commissioning Group Audit and Governance Committee – 30 July 2019
AUTHOR(s) OF REPORT:	Peter Price – Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Director of Finance
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 WCCG Governing Body.
RECOMMENDATION:	• That the Governing Body **receive** and **note** the actions taken by the Audit and Governance Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	

1. BACKGROUND AND CURRENT SITUATION

1.1 Annual Audit Letter

External Audit gave a general update that the annual audit letter would go onto the CCG website and said that it was a positive letter providing appreciate assurance.

It reconfirmed that it gave an 'unqualified opinion' and that the External Audit Team had not had to use their statutory powers. The Committee accepted the report.

1.2 Internal Audit Progress Report

The progress report gave updates on each area and which quarter the delivery included in the plan. The areas identified were:

1. Corporate Governance – Equality and Diversity
2. Finance
3. Delegated Commissioning
4. Cybersecurity
5. Continuing Healthcare
6. Brexit Planning
7. Conflicts of Interest
8. Information Governance
9. HR/Restructuring
10. Audit Follow Up

Also included was a paper that had been requested by the Audit and Governance Committee around joint working when other organisations had merged. The Corporate Operations Officer also informed the Committee that this was also being discussed by the Transition Board and that the Transition Board Director had met with colleagues at Birmingham and Solihull. The Committee noted and accepted the report.

1.3 Internal Audit Charter

The Internal Audit Charter was presented to the Audit and Governance Committee for approval. The Charter outlines the purpose and scope, responsibilities of internal audit and CCG management responsibility. The changes that were requested last year had been added to the Internal Audit Charter. The Committee accepted and approved the report.

1.4 Final Internal Audit Report

The Finance Review focused on single tender waivers. It looked at processes, documentation and approval process. There were 2 medium and 1 low risk finding identified. Following recommendations, the CCG would be revising their waiver template and also providing staff training to ensure that going forward documentation was completed correctly. The Committee noted the report and would review recommendations at a future date.

1.5 Risk Reporting/Board Assurance Framework

The Corporate Operations Manager presented a report on the Risk Register and Board Assurance Framework to update the Committee since the last meeting.

As highlighted at the last meeting of the committee, the CCG's Operating Plan for 2019/20 set five priorities for the year ahead:-

1. Continue to commission high quality, safe healthcare services within our budget;
2. Focus on prevention and early treatment;
3. Ensure our services are cost effective and sustainable;
4. Align our clinical priorities, as appropriate, to the Black Country and West Birmingham STP/ICS;
5. Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them.

The Chair asked if a programme could be presented to the committee at the next meeting around deep dives for the rest of the year. The Committee noted the report and also noted the changes and actions taken against the risks in the risk register.

1.6 Review of Whistleblowing Policy

The Committee was given an update around the Whistleblowing Policy which was due for review next year. It would be picked up as a whole review of policies by HR.

There had been no instances of Whistleblowing reported and no instances of GPs approaching the CCG to use the Freedom to Speak Up Guardian.

1.7 Requirements of an Audit Committee as referenced in HFMA Document

The Committee were presented with a briefing paper summarising the role of the Committee and External Audi. It was advised that there was a positive relationship between the CCG and External Audit. The Committee noted the report.

1.8 Feedback to and from the Audit and Governance Committee

Mr Price advised that the CCG had been rated as 'Outstanding' for the fourth time in a row.

The Transition Board had discussed the recruitment for a Single Accountable Officer and the advert would go out shortly.

1.9 Losses and Compensation Payments – Quarter 4 2019/20
Update at next meeting.

1.10 Suspensions, Waiver and Breaches of SO/PFPS
There were 45 suspensions raised in quarter 1 of 2019/20. During this period there were 40 waivers and 46 non-healthcare invoices paid without a purchase order.

1.11 Receivable/Payable Greater than £10,000 and over 6 months
The Committee noted that as at June 2019, there were 5 receivables and 4 payable over £10,000 and greater than 6 months old.

1.12 Counter Fraud Progress Report
This paper was received for information.

2. CLINICAL VIEW

2.1. N/A

3. PATIENT AND PUBLIC VIEW

3.1. N/A

4. KEY RISKS AND MITIGATIONS

4.1. 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.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. N/A

Quality and Safety Implications

5.2. N/A

Equality Implications

5.3. N/A

Legal and Policy Implications

5.4. N/A

Other Implications

5.5. N/A.

Name	Tony Gallagher
Job Title	Director of Finance
Date:	27 August 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**	**24/05/19**

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WOLVERHAMPTON CCG

GOVERNING BODY
10 SEPTEMBER 2019

Agenda item 19

TITLE OF REPORT:	Summary – Remuneration Committee – 24 July 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 met to discuss matters relating to the Remuneration of the CCG's Senior Team.
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 27 July 2019.

2. ITEMS CONSIDERED BY THE COMMITTEE

2.1. Very Senior Manager Pay Arrangements

The committee discussed and have made recommendations to the Governing Body in respect of performance related pay for members of the CCG's Executive Team.

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. Not applicable.

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. There are no additional legal or policy implications arising from this report.

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:	August 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)	**Peter Price**	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
10 September 2019

Agenda item 20

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 2 July 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 2 July 2019
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	**Primary Care Operational Management Group Update** Patient feedback from the consultation on the proposed closure of the Wood Road branch surgery of Tettenhall Medical Practice continues to be gathered. **Primary Care Networks** The Committee approved the change of Clinical Director for the Royal Wolverhampton NHS Trust to Dr John Burrell.
RECOMMENDATION:	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Commissioning Committee works with clinical groups within Primary Care to transform delivery.

3. System effectiveness delivered within our financial envelope	Primary Care issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Commissioning Committee met on 2 July 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 – 2 July 2019

2.1 Primary Care Quality Report

2.1.1 The Primary Care Quality Assurance Co-ordinator (WCCG), Liz Corrigan, updated the Committee around primary care quality, providing an overview of quality improvement and activity in primary care. The report gave detail around a number of issues including the following:

- The Serious incident reported to NHS England's Practice Performer Intelligence Gathering Group (PPIGG) had been closed with no further action.
- The annual programme of Infection Prevention Audits were due to commence, schedule to be confirmed.
- Uptake of Friends and Family Test continued to outperform regional and national benchmarks.
- The programme of Collaborative Contract Review Visits for Wolverhampton practices was due to be completed by the end of July.
- The STP Practice Nurse Strategy approved by the Committee had been endorsed by the STP Clinical Leadership Group and was being considered by the other CCGs Primary Care Commissioning Committees.

2.2 Primary Care Operational Management Group Update

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

- Patient feedback from the consultation on the proposed closure of the Wood Road branch surgery of Tettenhall Medical Practice continued to be gathered.
- The planned IT system migration for Bilston Urban Village had been pushed back in agreement with the new providers.
- Estates work funded through the NHS England Estates and Technology Fund (ETTF) had been completed at Newbridge Surgery and work at East Park was almost complete. Discussion around the potential rationalisation of estate in the Oxley area was underway with the local GPs.

2.3 **Primary Care Networks (PCN) Update**

2.3.1 The Head of Primary Care (WCCG), Sarah Southall, presented a report which provided an update on the development of the PCNs, including a request from the Royal Wolverhampton NHS Trust (RWT) network for approval to change their designated Clinical Director.

2.3.2 The report also highlighted work by the Primary Care and Finance Teams to ensure that appropriate payments related to the new network Directed Enhanced Payments would be made in line with the requirements. These payments will include reimbursement for Clinical Director time and new roles such as Social Prescribing Link Workers and Clinical Pharmacists.

2.3.3 The report also updated the Committee around the offer available to PCNs, in line with a self-assessment of their maturity, for support with their development. A national prospectus provided eight modules across a range of issues that would support the development of PCNs.

2.3.4 The Committee approved the change of Clinical Director for the RWT PCN to Dr John Burrell.

2.4 **Primary Care Training Hub Proposal**

2.4.1 The Head of Primary Care (WCCG), Sarah Southall, advised the Committee that a proposal for the Primary Care Training Hub provision for Wolverhampton had been developed but that, due to commercial confidentiality, it would be discussed during the private part of the agenda.

2.5 **Quality Assured Spirometry Business Case (revised costs)**

2.5.1 The Strategic Transformation Manager (WCCG), Claire Morrissey, presented the report which advised the Committee that following discussion with Clinical Directors, the costs associated with the development of a Primary Care Spirometry Service had increased. The business case for the proposal had been revised and the Committee's attention was drawn to the revised costs which were now calculated to be £62,440 for 2019/20 and around £126,500 in future years.

2.5.2 Ms Morrissey also advised that each of the PCNs had been asked to develop an implementation plan for the service and that not all networks would be in a position to commence the service until quarter 4.

2.5.3 The Committee noted the revised costs for the service and that an update on the implementation of the service is provided in October 2019.

2.6 **Practice Resilience Funding**

2.6.1 The Head of Primary Care (WCCG), Sarah Southall, advised that the STP GP Forward View Programme Board received further funding to support practice resilience and had asked each CCG to consider how this might be used in each area. The Primary Care Operational Management Group was due to discuss potential funding requirements for Wolverhampton practices.

2.7 **Committee Meeting Frequency**

2.7.1 The Committee agreed to cancel the August 2019 meeting and consider whether a bi-monthly schedule of meetings would be possible going forward.

2.8 **Primary Care Commissioning Committee (Private) – 2 July 2019**

2.8.1 The Committee met in private to receive updates on the latest Local Medical Committee Meeting, the NHS Property Services Impact Report, the Primary Care Training Hub Proposal and Clinical Director Reimbursement.

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: 6 August 2019

REPORT SIGN-OFF CHECKLIST

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	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**	**06/08/19**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
10 September 2019

Agenda item 21

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 July and August 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: 2.1.2 **Rated Outstanding for fourth year running** 2.1.3 **Annual General Meeting – save the date** 4.1 **'What Matters to You?'**
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	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care

financial envelope	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 July and August 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 **GP and Pharmacy opening over August Bank holiday**
We have advertised our local GP and pharmacy opening over the August Bank holiday with a press release and on our website.
https://wolverhamptonccg.nhs.uk/primary-care/gp-extended-opening-hours

2.1.2 **Rated Outstanding for fourth year running**
In July we received an Outstanding rating from NHS England in its 2018/19 annual assessment of clinical commissioning groups. This is the highest possible rating by NHS England (NHSE), and we are the only CCG to be awarded this rating in the West Midlands.

This is the fourth consecutive year that the CCG has been recognised by NHSE as Outstanding. Only two other CCGs in the country have been rated as Outstanding for four years in a row, which puts us in the top 1.5% of best performing CCGs nationally during this period.

This year there were 24 CCGs rated as Outstanding out of 195 CCGs for 18/19.

We shared this good news via a press release and on our website and social media.

2.1.3 **Annual General Meeting – Save the date**
Preparations are well underway for our Annual General Meeting. To discuss financial year 18/19 and hear our plans and priorities for year 19/20, please join us on Wednesday 18 September 2019 at The Hayward Suite, Billy Wright Stand, The Molineux Stadium, WV1 4QR. The meeting starts at 12.30pm with a performance of our Flu Fighters story.

2.1.4 **Press Releases**
Press releases since the last meeting have included:

August 2019
- Number of people having free NHS Health Check soars
- Public invited to NHS Wolverhampton Clinical Commissioning Group's Annual General Meeting

- Year-8 boys in Wolverhampton given extra protection from cancer
- Get the right care this August Bank Holiday in Wolverhampton
- Help is at hand for young people awaiting exam results
- August Bank Holiday 2019 pharmacy opening in Wolverhampton

July 2109

- Tettenhall Medical Practice to extend branch surgery closure consultation
- School's out for summer! Be holiday ready!
- Holidaymakers urged to get the right care if illness strikes
- Wolverhampton CCG rated Outstanding by NHS England for the fourth year running
- Save a wasted journey to A&E and treat yourself at home for sprains and strains
- Measles warning for young adults attending summer festivals

2.2. Communication & Engagement with members and stakeholders

2.2.1 GP Bulletin

The GP bulletin is twice monthly and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

2.2.2 Practice Nurse Bulletin

The bulletin in August included the following:

- GPN strategy launch
- Primary Care Referral Guidelines – Paediatric Diabetes
- Public Health England Vaccine update
- Practice vacancies
- New Diabetes template and care plan
- The GPN single point
- 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 **'What Matters to You?'**
Residents in Wolverhampton were asked 'What Matters to You?' when it comes to local healthcare services during July.

The aim of the 'What Matters to You?' engagement roadshow was to give local residents the platform to join in with the National 'What Matter's to You?' conversation with regards to local healthcare services and what they would like to see more of in the future. WCCG took this opportunity to listen to local views and opinions and also talk about the different ways WCCG are commissioning health and care closer to home, online via Patient Access App and also to gauge how local people felt about health and social care working closer together and sharing patient records.

There were 11 public engagement events, which included six events at GP practices and five community events. The engagement roadshow launched on Tuesday 25 June 2019 and the last event was held on Saturday 20 July 2019. The online survey closed on Wednesday 31 July 2019. A total of 174 surveys were fully completed.

Recommendations and results from these engagement events will go to CCG Programme Boards and will then be published on our website in our You Said, You Did section.

4.2 **Have your say on proposed closure of GP branch surgery – Wood Road, Tettenhall Wood, Wolverhampton**
Wolverhampton CCG has asked Tettenhall Medical Practice to extend for one month its public consultation around the future of the branch surgery in Wood Road. The consultation will now close on Sunday 15 September.

The consultation was launched on Tuesday 7 May 2019 following a request from GPs at the Medical Practice to close the branch surgery. They told the CCG and patients that difficulties recruiting GPs to vacant posts meant they were unable to 'deliver the services we would like to from this branch'.

More than 830 patients and local people have already responded to the consultation and during July and August, the Practice encouraged more patients to complete the consultation survey. They will also hold a further drop-in event to ensure local people and patients have further opportunity to ask questions and air their concerns.

The CCG continues to support the Practice with the consultation. The consultation survey and all information about the consultation including events and the answers to frequently asked questions are available, both on the Lower Green Medical Centre website http://www.tettenhallmedicalpractice.nhs.uk/contact-us-3/ and on the CCG website at https://wolverhamptonccg.nhs.uk/contact-us/current-engagement-and-consultations/929-tettenhall-medical-practice-to-extend-branch-surgery-closure-consultation

4.3 PPG Chairs and Citizen Forum
PPG Chairs continue to meet in their four groups with support and attendance from CCG officers and lay member attendance when availability permits. Primary Care

Networks (PCN's) have been part of the discussions and as they are still developing work will continue to explore opportunities for engagement and participation.

Due to historical poor attendance from Citizen forum Representatives an e-mail was sent to the representatives to ask how they might prefer to receive information in the future now that the bi-monthly meeting had been suspended. In total three responses were received which demonstrates that there is some more work to do in terms of engaging with these groups.

5 LAY MEMBER MEETINGS – attended:

5.1 What Matters to You Survey – Bilston market
Primary Care Commissioning Committee
CCG Governing Body
CCG Governing Body Development
Quality and Safety Committee
Strategic communications
1:1 meetings with CCG Officers, Chair, Accountable Officer and HR officers
1:1 meeting with Patient representative
Local Medical Committee
Engagement Cycle
Joint Commissioning Committee
Transition Board
Medical Chambers Hub meeting

6. KEY RISKS AND MITIGATIONS

N/A

7 IMPACT ASSESSMENT

Financial and Resource Implications - None known

Quality and Safety Implications - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

Equality Implications - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

Legal and Policy Implications - N/A

Other Implications - N/A

Name: Sue McKie
Job Title: Lay Member for Patient and Public Involvement
Date: 29 August 2019

ATTACHED: none

RELEVANT BACKGROUND PAPERS
NHS Act 2006 (Section 242) – consultation and engagement
NHS Five Year Forward View – Engaging Local people
NHS Constitution 2016 – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)
NHS The General Practice Forward View (GP Forward View), April 2016
NHS Patient and Public Participation in Commissioning health and social care. 2017. PG Ref 06663
NHS Long Term Plan. 2019

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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	Details/ Name	**Date**
Clinical View	**n/a**	
Public / Patient View	**Sue McKie**	**29 August 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**	**29 August 2019**

Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
10 September 2019

Agenda item 22

TITLE OF REPORT:	NHS Workforce Race Equality Standard (WRES)
AUTHOR(s) OF REPORT:	David King, EIHR Manager
MANAGEMENT LEAD:	Sally Roberts
PURPOSE OF REPORT:	Report presents the CCG's annual WRES template for information for Governing Body.
ACTION REQUIRED:	☐ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The report demonstrates that the CCG is fully meeting its responsibilities with regard to the WRES. • Ethnicity is known for 97.4% of staff – a strong position • 27.4% of CCG staff identify as BME (increased from 25.3% in 2018) in comparison with a BME population of circa 14.5% identified in the 2011 census. Showing a CCG that is well reflective of the population it serves. • It is pleasing to note that in 201/19, BME people were proportionately represented amongst all board members and voting board members (an area where many Trusts have further work to do), they were underrepresented amongst executive board members compared to their level of representation in the workforce overall but it should be noted the CCG staff base is more diverse than the local population. • A WRES action plan will be developed to support continued work, with an exploration of the 3 issues identified in the staff survey.
RECOMMENDATION:	GB are asked to: • Note the contents of the report and progress made • Note that the CCG is meeting the expectations of NHS England with regard to the WRES.

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</u>

	<u>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. Intro

The NHS Workforce Race Equality Standard has been in place for a number of years and places obligations on both Commissioners and Providers of services. CCGs and Provider organisations are required to publish an annual date template showing outcomes for White and BME staff and develop action plans to address any issues that emerge. The CCG is also required to monitor and assure itself that those organisations providing services on its behalf have met their duties.

The CCG has published its templates annually since 2015 and thus the CCG's progress can be found.

https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018-19

2. WRES

The WRES technical guidance document and all other WRES resources are available via the following link. Further information can be found by following the link to the NHS England WRES webpage.

In addition the CCG requires those organisations providing services on its behalf to comply fully with the WRES – this is managed through the CCG contract management approach and the specific equality contractual requirements.

The 2019 report has been compiled and is included as an appendix to this paper and will be published on the CCG's website once agreed.

The report makes positive reading, illustrating that the CCG is performing well with regard to the WRES.

- The report showcases a CCG that is meeting its responsibilities, has good data and is reflective of the population it serves.
- Ethnicity is known for 97.4% of staff – a strong position
- 27.4% of CCG staff identify as BME (increased from 25.3% in 2018) in comparison with a BME population of circa 14.5% identified in the 2011 census. Showing a CCG that is well reflective of the population it serves.
- It is pleasing to note that In 2018/19, BME people were proportionately represented amongst all board members and voting board members (an area where many Trusts have further work to do), they were underrepresented amongst executive board members compared to their level of representation in the workforce overall but it should be noted the CCG staff base is more diverse than the local population.
- Within the staff survey a few points are worth noting, the percentage of staff who felt bullied / harassed by colleagues was % White = 17.3%, % BME = 7.7%. The 17% is a bit high, affected perhaps both by system change and that

those who chose to complete the survey may have been those who felt there was an issue. In terms of the WRES the BME percentage is great and reflects well on the CCG

- One stat that does not seem to match, relates to staff who responded to the survey, who felt that the CCG provides equal opportunities for career progression or promotion were split, % White = 96.2% % BME = 69.2%. This is quite a gap and will need to be explored further and will be by the WRES working group to identify what further actions are needed.
- Pleasingly the percentage feeling discriminated against by their manager is low (very low in comparison to other CCGs) ; % White = 7.7% % BME = 0.0% As a result it feels that there is either an inconsistency or a specific issue within the CCG that some respondents were affected by. The low percentage of staff feeling bullied and harassed by their manager reflects well on the CCG management, culture and values.

Included below is the relevant section of the CCG's 2011 Census demographic data.

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%**

It was also positive to note that the CCG has performed well with regard to metric 2, appointment from shortlisting. In 2017/18, 26.8% of White people were appointed from shortlisting, compared to 20.6% of BME people - this did not represent a statistically significant difference. Number of appointees overall: 22. For some organisations, a significant cap of over 20% exists for this metric.

The CCG will have for the first time submitted its raw WRES data to NHS England this year by the end of August 2019 as required.

3. Key actions on the WRES

The CCG will review its staff survey responses further to understand the feelings of staff completing and seek to increase the response rate next year. In the meantime the CCG Equality and HR team will continue to analyse other intelligence to ensure any remedial action is taken. Should any future surveys be undertaken across the

black country CCGs it is important that they support the collection of relevant data for the WRES.

4. Next steps

- The WRES working group will develop a WRES action plan for approval
- The WRES working group, formed with representatives from Governance, Equality and HR, will continue to meet during the year to and review the action plan and the progress made.

5. CLINICAL VIEW

6.1 None for this report.

6. PATIENT AND PUBLIC VIEW

6.2 None for this report.

7. KEY RISKS AND MITIGATIONS

7.2 Publication of WRES template is a requirement of NHS England.

8. IMPACT ASSESSMENT

Financial and Resource Implications

8.2 None for this report.

Quality and Safety Implications

8.3 The implications on Quality and Safety are intrinsic to the report.

Equality Implications

8.4 Equality implications are intrinsic to the report.

Legal and Policy Implications

9.5 Equality Objectives are part of the PSED requirement which is a statutory duty of the Equality Act 2010. Compliance with the PSED is a key requirement on the CCG legally and to provide NHS England with Assurance.

Other Implications

9.6 None

Name: David King
Job Title: EIHR Manager
Date:

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

REPORT SIGN-OFF CHECKLIST

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	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	

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Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2017)

Name of organisation	Date of report: month/year	
NHS Wolverhampton CCG	March	2019

Name and title of Board lead for the Workforce Race Equality Standard

Sally Roberts Chief Nurse

Name and contact details of lead manager compiling this report

David King EIHR Manager

Names of commissioners this report has been sent to (complete as applicable)

N / A

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

N / A

Unique URL link on which this Report and associated Action Plan will be found

https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018-19

This report has been signed off by on behalf of the Board on (insert name and date)

SMT August 2019

1. Background narrative

a. Any issues of completeness of data

Ethnicity was not known for 2.6% of the workforce of 116 employees at the end of March 2019 (excluding non-executive directors).

b. Any matters relating to reliability of comparisons with previous years

The CCG has updated its staff survey to ensure that all metrics can be reported upon.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

Workforce of 116 employees at the end of March 2019 (excluding non-executive directors). A further 15 non-executive directors were also listed.

b. Proportion of BME staff employed within this organisation at the date of the report

27.4% of the 113 employees of known ethnicity were listed as BME (excluding non-executive directors).

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

97.4% of the workforce of 116 employees at the end of March 2019 (excluding non-executive directors) self-reported their ethnicity.

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity

4. Workforce data

a. What period does the organisation's workforce data refer to?

Staff in post at March 2019
Disciplinary proceedings for the financial years 17/18 and 18/19
Recruitment and non-mandatory training during 18/19

5. Workforce Race Equality Indicators

For each of these four workforce indicators, compare the data for White and BME staff			
18/19	**17/18**	**Narrative**	**Action**
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.			
Total N refers to those of known ethnicity. OVERALL %BME Workforce: 27.4% BME; (Total N = 113) Ethnicity was not known for 3.1% of the workforce. The ethnicity breakdown of staff by pay band has been redacted due to the small numbers of staff within each pay band.	Total N refers to those of known ethnicity. OVERALL %BME Workforce: 25.3% BME; (Total N = 95) Ethnicity was not known for 3.1% of the workforce. The ethnicity breakdown of staff by pay band has been redacted due to the small numbers of staff within each pay band.	There were no statistically significant differences in the representation of BME staff by pay band compared to their level of representation in the workforce overall (excluding non-executive directors). This was the case at the end of March 2019 as well as at the end of March 2018. When the pay bands were aggregated, there was a trend for a higher percentage of BME staff in the lowest pay bands (Bands 4 and under), but this trend was not statistically significant. Please refer to the figures below. Total N refers to those of known ethnicity. 18/19 Workforce Overall: 27.4% BME; (Total N = 113) Bands 4 and under: REDACTED%; (Total N = 22) Bands 5 to 7: 25.0%; (Total N = 44) Bands 8A to 8B: REDACTED%; (Total N = 29) Bands 8C and over, VSM, and Medical: REDACTED%; (Total N = 18) 17/18 Workforce Overall: 25.3% BME; (Total N = 95) Bands 4 and under: REDACTED%; (Total N = 17) Bands 5 to 7: REDACTED%; (Total N = 41) Bands 8A to 8B: REDACTED%; (Total N = 27) Bands 8C and over, VSM, and Medical: REDACTED%; (Total N = 10)	

2. Relative likelihood of staff being appointed from shortlisting across all posts.			
Relative Likelihood = 1.07	Relative Likelihood = 1.30	In 18/19, 10.3% of White people were appointed from shortlisting, compared to 9.6% of BME people - this did not represent a statistically significant difference. Number of appointees overall: 15. In 17/18, 26.8% of White people were appointed from shortlisting, compared to 20.6% of BME people - this did not represent a statistically significant difference. Number of appointees overall: 22.	
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.			
Please refer to the narrative.	Please refer to the narrative.	There were fewer than 10 disciplinary proceedings in the 17/18 to 18/19 two-year window, and the 16/17 to 17/18 two-year window. Given the small numbers involved, little can be said about the pattern of disciplinary proceedings.	

4. Relative likelihood of staff accessing non-mandatory training and CPD.			
Not available	Relative Likelihood = 1.03	Information on the uptake of non-mandatory training was not available in 18/19. In 17/18, the likelihoods of White and BME staff accessing non-mandatory training were similar.	

National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.			
18/19	**17/18**	**Narrative**	**Action**
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.			
% White = 6.0% % BME = 8.3%	% White = Not available % BME = Not available	6.0% of White staff (3/50) and 8.3% of BME staff (1/12) who took part in the staff survey reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months; this did not represent a statistically significant difference.	

6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.			
% White = 17.3% % BME = 7.7%	% White = Not available % BME = Not available	17.3% of White staff (9/52) and 7.7% of BME staff (1/13) who took part in the staff survey reported experiencing harassment, bullying or abuse from other staff in the last 12 months; this did not represent a statistically significant difference.	The CCG will review the staff survey and seek to identify the underlying reasons for some staff to feel they are being bullied or harassed and thus what action is needed to address it.
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.			
% White = 96.2% % BME = 69.2%	% White = Not available % BME = Not available	96.2% of White staff (50/52) and 69.2% of BME staff (9/13) who took part in the staff survey felt that the CCG provides equal opportunities for career progression or promotion (excluding blank and "don't know" responses); this represented a statistically significant difference with BME staff less likely than White staff to feel that the CCG provides equal opportunities for career progression or promotion.	The CCG will look to further work to understand the underlying concerns of BME staff within the CCG.
8. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues			
% White = 7.7% % BME = 0.0%	% White = Not available % BME = Not available	7.7% of White staff (4/52) and 0.0% of BME staff (0/12) who took part in the staff survey reported experiencing discrimination from other staff in the last 12 months; this did not represent a statistically significant difference.	

Board representation indicator. For this indicator, compare the difference for White and BME staff			
18/19	**17/18**	**Narrative**	**Action**
9. Ethnicity profile of the Board's Executive, Non-executive, Voting, and Non-voting membership. Percentage difference between the organisations' Board membership and its overall workforce.			
Percentage differences: %BME total board - %BME overall workforce: +2.0% %BME voting board - %BME overall workforce: +2.0% %BME executive board - %BME overall workforce: -27.4%	Percentage differences: %BME total board - %BME overall workforce: -7.1% %BME voting board - %BME overall workforce: -7.1% %BME executive board - %BME overall workforce: -25.3%	In 18/19 and in 17/18, BME people were proportionately represented amongst all board members and voting board members, but were underrepresented amongst executive board members compared to their level of representation in the workforce overall. Ethnicity was not known for 10.5% of board members in 18/19 and for 8.3% of board members in 17/18.	

6. Are there any other factors or data which should be taken into consideration in assessing progress?

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

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NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 14th May 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Yvonne Higgins – Deputy Chief Nurse, WCCG

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

In attendance:
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG
Sukvinder Sandhar – Deputy Head of Medicines Optimisations, WCCG
Fiona Brennan – Designated Nurse Looked after Children, WCCG
Lorraine Millard – Designated Nurse Safeguarding Children, WCCG
Kassie Styche – Quality and Safety Officer, WCCG (Note Taker)

APOLOGIES:
Mike Hastings – Director of Operations, WCCG
Dr R Rajcholan – WCCG Board Member (Chair)
Sally Roberts – Chief Nurse, Director of Quality, WCCG
Ankush Mittal – Public Health, Wolverhampton Council
Steve Barlow – Public Health, Wolverhampton Council
Rachel Stone – Deputy Designated Nurse Safeguarding Children, WCCG
Annette Lawrence – Designated Lead Safeguarding Adults, WCCG
Hemant Patel – Head of Medicines Optimisations, WCCG
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG

QSC/19/045 Apologies and Introductions

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

QSC/19/046 Declarations of Interest

No declarations of interest.

QSC/19/047 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/047.1 Minutes from the meeting held on 9th April 2019 (Item 3.1)

Mr Oatridge stated that the minutes are very full and good minutes; however he feels that some discussions are missed and need to include more outcomes.

QSC/19/047.2 Action Log from meeting held on 9th April 2019 (Item 3.2)

QSC/19/026.5: Infection Prevention Service Update **-** To provide the catheter pilot data by the end of March 2019.

No report provided, for submission at June's meeting.

QSC/19/026.5: Infection Prevention Service Update **–** To include more data on catheters in the next service update report.

No report provided, for submission at June's meeting.

QSC/19/037.1: Quality Report: West Park Visit **-** To provide an update on an unannounced visit to West Park.

Visit is scheduled for 17th May 2019, update required in Junes Meeting.

QSC/19/039.1: Primary Care Report FFT **–** Mrs Roberts commented it would be useful to see the top five and bottom five practices.

Further changes made to the report.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/039.4: Draft Committee Annual Report – To send through to Mr McKenzie, the amendments i.e. names in the membership need removing.

Amendments made and report shared.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/048 Matters Arising

There were no matters arising noted.

QSC/19/049 Performance and Assurance Reports

QSC/19/049.1 Quality Report (Item 5.1)

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

Cancer - Overall cancer performance at RWT remains challenged.

A GP evening event took place recently to discuss the ongoing issues around Cancer performance. A panel from RWT responded to questions from the GPs and the dialogue was rich, however the attendance for this event was low. Notes and Key Action points will be collated and sent out shortly to the group.

Mrs McKie asked if any Practice Nurses had attended the event.

Ms Higgins stated that unfortunately there were no Practice Nurses at the Event but information would be cascaded to them.

There are still performance issues relating to the breast cancer pathway, all breast referrals now go through the “one-stop clinic appointment” whereby patients are seen by a consultant and have breast imaging, examination and fine needle aspiration performed on the same day. The wait for this pathway in March was 24 days against a 2 week standard but has deteriorated further at the time of reporting to 34 days.

Mrs McKie wanted clarification on whether the 28 days replaces the 2 week wait.

Ms Higgins confirmed this would be the performance measure from April 2020.

Mr Oatridge asked when the patients are likely to receive the results.

Ms Higgins responded that some of the results will be on the day of the test.

Mr Oatridge asked for assurance that we are working through all actions raised.

Ms Higgins was assured and stated that the figures for urology were improving and that the Cancer Patient Experience survey was positive.

Mrs McKie stated that the issues around cancer and waiting times will take time to see any improvement.

Mr Oatridge was encouraged by the progress but stated that the risk must remain red.

Ms Higgins stated that an STP Meeting had taken place on 1st May with NHSE/I to discuss the Black Country Cancer Performance and a set of system wide actions were identified.

Mortality – There is a lot of work happening with Mortality especially around coding and documentation; however there are still issues with Sepsis and Deteriorating Patients.

Ms Higgins informed the group that she recently attended RWT to walk the pathway for Deteriorating Patients and Sepsis, the Trust are using an electronic Sepsis Flag Tool but are not closing the loop and areas for improvement have been recognised.

The Trust has a Deteriorating Patients Recognition Group in place with the Head of Governance currently revising the Terms of Reference of request from the CCG.

There has been an increased staff capacity within the Critical Care Outreach team from 6 WTE to 12 WTE. There is a software issue at present with no capturing of the outcomes of the team; this issue is being addressed.

Ms Higgins stated that we are working well collaboratively in regards to Mortality however improvement in SHMI may take time.

Sepsis – Sepsis Nurses are now in post and a focused action plan has been developed to drive improvement. Ron Daniels, the National Lead for Sepsis, has visited the Trust to offer support and training. The sepsis CQUIN results for Q4 are awaited.

Maternity – Risk remains as green.

The Trust is working well with the Saving Babies Lives LMS agenda and are actively engaged.

External review from NHSI has taken place with positive feedback in relation to staff engagement; an action plan will go to CQRM to gain further clarification.

Mr Oatridge asked if staffing had improved and whether they have the correct numbers.

Ms Higgins replied that staffing has improved and the ratio of midwives to births is 1:28. She has been developing an LMS dashboard across the Black Country and RWT appear to have good outcomes.

Mr Oatridge requested an update on Walsall.

Ms Higgins responded that the capping has now been lifted.

Mrs McKie stated that she is aware that some women in the Shropshire area request to be seen at Wolverhampton which will have an impact on figures.

It was noted by the committee that the bookings at 12 weeks have increased and are the highest numbers for this year, it was agreed by the group that these figures are one to watch and trend lines to be included in the report for these figures.

BCP Workforce – Issues had previously been identified, however the workforce figures have improved with sickness on a downward trend, turnover rates have decreased and there is an improving picture.

Ms Higgins informed the group that a visit took place this month to Penn Hospital and overall it was a positive visit, however there will be further investigations into correlation between Safeguarding alerts and Incident reporting.

A re-visit to Penrose will take place on 14th May 2019 to look at leadership and progress against the action plan developed from the first visit.

Mrs Corrigan joined the meeting.

Probert Court – There are ongoing concerns which are being closely monitored by the Quality Nurse Advisor Team.

E Coli –The quality improvement project continues and we receive good collaboration across the system. The next meeting is scheduled for the end of May 2019.

Mr Parvez updated the group around a recent Endoscopy scoping Incident at RWT. Due to system and process issues there were 72 patients that were not sent for their routine endoscopy. It was highlighted that two patients came to harm with one patient that had passed away. This incident has been raised as a Serious Incident and assurance has been gained relating to actions taken following a recent table top meeting. The full report for this Serious Incident is due at the end of June 2019.

Mrs McKie asked if this was because of the way they were recording the data.

Mr Parvez added that this was down to system and human error issues and RWT are looking at governance processes going forward.

Mr Oatridge added a general point and wondered whether if patients were expecting to be called for something and this doesn't happen do they not contact the trust and chase them up.

Mr Parvez added that this incident came to light due to a patient contacting RWT and asking why they had not been called.

It was discussed between the group if the letters need to be changed to address this issue and give details of patients to contact us if they don't hear anything.

Mrs McKie added that this may be down to Ethnicity and was these figures looked at during the investigation of this incident.

Mr Parvez said this is something that he will feedback to the Trust.

Mr Price stated that the Never Events was still zero.

Ms Higgins responded that there had been one never event that had been retracted. Ms Higgins had met with Governance Team and the Trust did think that this incident met the criteria for a never event however the National Lead at NHSI did not agree and this was downgraded to a Serious Incident.

Mr Price stated this Quality Report was very comprehensive with month on month improvement.

Mr Oatridge replied that it was good to show the areas of risk within the report but would recommend that we have a top bar and bottom bar for the achievements to show where they started to where they are now.

QSC/19/049.2 Primary Care Report (Item 5.2)

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

Mr Oatridge commented that a lot of work has gone into the presentation of the report and it was much improved.

It was agreed in the meeting that starting next month the report will include rolling quarterly monitoring and concentrating on what has changed from the previous month.

ACTION: Mrs Corrigan

Mrs Corrigan highlighted the areas for concern within the report.

Serious Incidents in Primary Care – There have been two incidents recently within Primary Care.

One 'Near Miss' where a child was vaccinated two weeks too early, the incident was discussed with NHSI/E and PIIG. Mrs Corrigan was happy with how this has been managed and a full RCA has been completed.

Mr Oatridge questioned whether this this was correct dosage/immunisation and whether it was just down to incorrect dates.

Mrs Corrigan confirmed the correct immunisation was used and was just given two weeks early, there was no harm caused to the child.

Mrs McKie asked if all staff/practices are trained in how to undertake an RCA.

Mrs Corrigan confirmed they have received training and have ongoing support from the CCG. A standardised template is provided which the CCG review.

The second incident was a Patient with query DVT, unfortunately this patient passed away of pulmonary embolism. This incident was reported on STEIS and the full RCA was due this week however the practice required extra time to speak with the Practice Nurse involved in the care. This will be referred to PIIG.

Mrs McKie stated this this would have been very traumatic for the Nurse and asked what follow on support had been offered.

Mrs Corrigan replied that the Practice Nurse is receiving support from the practice, family and CCG have offered support.

Mrs McKie asked who is responsible for monitoring the action plan.

Mrs Corrigan replied that the action plan would be monitored within the Quality Team.

Mr Oatridge wanted clarification around the action plan and if this follows the staff member or the practice.

Mrs Corrigan responded that the action plan stays with the practice rather than the staff member. The NMC may follow this up but would only be where a major professional issue had been recognised. Lower level incidents would be expected to be included within a Nurses revalidation for learning.

Mrs McKie asked if this incident would need to be reported to NMC.

Mrs Corrigan stated that the correct process was followed and this was not needed to be reported, however will potentially be picked up through PIIG.

Training Hub – Training Hub work continues however there is a possible risk around the infrastructure of the Black Country and the re-procurement process. This is currently being reviewed by NHS England and looking at developing a Training Academy.

Ms Sandhar joined the meeting.

Mr Oatridge was interested to hear what types of training are offered to the GPs.

Mrs Corrigan replied that the training offers anything from Conflict Resolution to full training packages.

Ms Brennan and Ms Millard joined the meeting.

Mr Oatridge asked if the training hubs and training support will remain the same within the Primary Care Networks.

Mrs Corrigan confirmed that the training hub will remain the same.

Mr Price asked for further assurance around CQC inspection and ratings on page 67 of the report. He asked what assurances we have around inadequate practices.

Mrs Corrigan stated that the practice that was rated inadequate has now merged with a larger practice group and are working together. This offers increased leadership and infrastructure and more GPs to support improvements.

Mrs Corrigan left the meeting.

QSC/19/049.3 Safeguarding Adults, Children and Looked After Children Report (Item 5.3)

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

Ms Millard updated the group with key areas from the report.

SAR recently published with a robust action plan.

There are currently three Serious Case Reviews for children and work is ongoing with these.

There are currently two Table Top Reviews that are occurring for children that did not meet the threshold for a SCR, the learning for these will be collated and shared.

The CP-IS (Child Protection – Information Sharing) is now live at RWT and The Urgent Care Centre, however there is a delay with the system going live in Social Care.

The STP Working group is in its infancy but working very well, the terms of reference for this group have been produced and Mrs Roberts is kept informed regularly.

There are changes being made around the Safeguarding Board, the plan for the changes will be published in June 2019.

Mr Oatridge asked if there had been agreement to the changes.

Ms Higgins stated that there has been agreement and Mrs Roberts is confident with the changes.

Ms Millard stated that she is part of the Task and Finish Group and the feeling from that was positive.

Mr Oatridge wanted clarification around the transition period arrangements and when they would be in place.

Ms Millard said the decision had been made and will now be presented to the Board, the transition period will fall between September and December.

Mr Oatridge expressed his concerns around how this may pose a risk during the transition period.

Ms Higgins stated this can be reviewed and monitored from June.

Ms Millard informed the group that RWT failed to meet the trajectory for Level 3 Safeguarding Training at the end of March for Adults and Children. This has been discussed with RWT and extra training has been organised, this will be monitored.

Mr Oatridge recommended a report amendment, there is a lot of information within the report however feels it would benefit from having a key issues front sheet with summaries.

Action: Ms Millard and Mrs Brennan

Mrs Brennan informed the group of key areas for looked after children. She informed the group that the local demographics have now been included in the report on page 90. The figures have remained quite static, and finished the year on 44% Children placed in Wolverhampton and 66% Children placed out of Wolverhampton.

The Committee discussed the figures around Statutory Initial Health Assessments being out of date.

Mrs Brennan confirmed this was down to late requests from Local Authority.

Mr Price asked what the consequences are and if the Local Authority were held accountable.

Mrs Brennan stated that there are no huge implications with these and that they are usually completed only a few days over and targets are met.

Mr Strickland joined the meeting.

Mrs Brennan played a video to the Committee of the I Awards 2019.
https://youtu.be/YQTGv9TIDSA

The priorities moving forward as follows;

- Children placed here from other areas as work needs to be done around strengthening the oversight of children placed from outside of Wolverhampton.
- Private Children's Residential Homes as we recognise there is a number of Private Homes and we need to have assurance that the homes will be CQC registered.
- CAMHS referral when children are out of the City.

Mrs McKie requested the figures for unaccompanied minors.

Mrs Brennan responded that we have nine placed in Wolverhampton with three being in Foster Care and six at Royal Wolverhampton School. Mrs Brennan stated that these numbers were included in the figures within the report.

Mr Oatridge asked if there are any areas of vulnerability that she as worried about in relation to looked after children.

The Committee stated that this was a very good and positive report.

Mrs Brennan, Ms Millard and Ms Higgins left the meeting.

QSC/19/049.4 Medicines Optimisation Report (Item 5.4)

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

Electronic Discharge Audit - An annual audit was undertaken by the Prescribing Support Team to review the quality of Royal Wolverhampton NHS Trust hospital discharge summaries.

Overall, three out of seven audit standards were achieved. Name, dose and frequencies of drugs were consistently recorded. In contrast, duration was incorrectly stated or omitted in almost a quarter of cases. A total of 414 drugs were started, stopped or changed however reasons were stated on just 174. Of the 292 discharges where a new drug was started, no reason was given on more than two thirds of occasions which was very concerning.

Mrs McKie asked when this audit was completed.

Ms Sandhar stated this was an annual audit but the criteria had changed for this year's audit. Findings are that some figures have improved but others deteriorated since the implementation of the new system which has been addressed in this audit.

Mr Price asked if this report was a Clinical Audit and was the report presented at any other meeting.

Ms Sandhar was unsure where this sits and where the report gets shared but will find out further information and feedback to the group.

It was agreed with the Committee that this issue needs to be raised and may need escalating to Governing Body.

ACTION: Ms Sandhar

There is a National Project which is called STOMP (Stopping Over Medication of People) with a learning disability, autism or both, which is a positive project and having a positive impact. The next stage of this STP-wide project is to set up a multi-disciplinary working group to begin to explore the findings of the scoping exercise as well as the needs of these patients and to work together to develop a STP-wide plan.

There has been ongoing work from the Prescribing Support Team especially around the Prescribing Incentive Scheme which offers GP practices encouragement and reward to improve the quality, safety and cost effectiveness of prescribing. Successful implementation will deliver benefits in 2018/19 and subsequent years.

Mr Price asked from a Financial Point Of View, how much money had been invested.

Ms Sandhar replied that it has been calculated that financial benefits outweigh the investment.

Mr Oatridge stated that it was positive.

Mrs McKie replied in terms of Antibiotic Prescribing and asked if this was still happening and does it still need to be incentivised.

Ms Sandhar replied that it was so high on the National Agenda and targets get higher each year so feels the incentive scheme does need to stay, she added what they were doing in Wolverhampton does seem to be working well.

Ms Higgins rejoined the meeting and Ms Sandhar left the meeting.

QSC/19/049.5 Health and Safety Performance Report (Item 5.5)

Mr Parvez verbally updated the Committee on Health and Safety. The CCG has now received the report from the external company and are currently working through the action plan supplied by the outside Provider. A further meeting with the Provider has been arranged for Monday 20th May 2019: following this a full report will be submitted for June's Meeting.

ACTION: Mr Parvez

Mr McKenzie stated he had recently attended a presentation on Health and Safety at another committee where a useful checklist was shared. Mr McKenzie supplied Mr Parvez with a copy of the checklist to read and raise at the Provider Meeting on 20th May 2019.

QSC/19/049.6 Public Health Update (Item 5.6)

The above report was not submitted for this meeting and is required for June's Meeting.

ACTION: Dr Mittal and Mr Barlow

QSC/19/049.7 Annual Public Health Performance Report (Item 5.7)

The above report was not submitted for this meeting and is required for June's Meeting.

ACTION: Dr Mittal and Mr Barlow

QSC/19/050 Risk Register

Risk Review (Risks from Quality Report were discussed under agenda item 5.1)

Corporate Risk EPPR Support (CR05) – Work continues regionally, quarterly report is submitted to this Meeting.

Cancer – 62 and 401 Days (QS06) – Remains with high level score of 16.

Mortality (QS07) – Remains a high level risk with a score of 9 and ongoing.

Probert Court (QS08) – This risk has been reduced to a lower score of 8 following submission of this report, this continues to be monitored.

Maternity (QS05) – Remains a moderate score of 4.

Cancer – 2 Week Wait (QS09) – New Risk added to the register as a Very High level score of 16.

Transfer of GP Data within Flu Vaccination Contract – (QS10) – New Risk added to the register as a high level score of 9

QSC/19/051 Feedback from Associated Forums

QSC/19/051.1 Primary Care Operational Management Group (Item 7.1)

The Primary Care Operational Management Group minutes from 6th March 2019 were received for information/assurance.

QSC/19/051.2 NICE Group Minutes (Item 7.2)

The NICE Group Minutes from 27th March 2019 were received for information/ assurance.

QSC/19/052 Items for Escalation/Feedback to CCG Governing Body

- Data Discharge Audit (Medicines Management Report) - The Committee discussed whether the flagged issues around high figures for "no reasons for new drugs being started" need to be raised at Governing Body. An Action has been raised in regards to this audit and further update will be brought to June's meeting, it will then be decided if this needs to be considered to raise at Governing body.

QSC/19/053 Any Other Business

QSC/19/053.1 Mr Oatridge shared the amended copy of the Annual Quality and Safety Committee report and stated this needs to be agreed virtually/electronically as not quorate.

Mrs Styche to circulate for agreement, comments by Monday 20th May 2019, if no comments received the report will be taken as accurate.

ACTION: Mrs Styche

No recommendations to approve and no decisions to defer for June's Meeting.

QSC/19/054 **Date of Next Meeting:** Tuesday 11th June 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.29pm

Signed: …… **Date**: ……
Chair

NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 11th June 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sally Roberts – Chief Nurse, Director of Quality, WCCG
Marlene Lambeth – Patient Representative

In attendance:
Steve Barlow – Public Health, Wolverhampton Council
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Molly Henriques-Dillon - Quality Nurse Team Leader
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG
David King – Equality and Human Rights Manager
Katrina McCormick – Children's SEND Programme Officer
Matt Reid – Acting Head of Nursing - Corporate Support Services
Phil Strickland - Governance & Risk Coordinator, WCCG

APOLOGIES:
Mike Hastings – Director of Operations, WCCG
Sue McKie – Patient/Public Involvement – Lay Member
Ankush Mittal – Public Health, Wolverhampton Council
Jim Oatridge – Lay Member (Chair)
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Peter Price – Independent Member – Lay Member

QSC/19/055 Apologies and Introductions

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

QSC/19/056 Declarations of Interest

No declarations of interest.

QSC/19/057 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/057.1 Minutes from the meeting held on 14th May 2019 (Item 3.1)

The minutes from the last meeting were read and agreed as a true record.

QSC/19/057.2 Action Log from meeting held on 14th May 2019 (Item 3.2)

QSC/19/026.5: Infection Prevention Service Update - To provide the catheter pilot data by the end of March 2019 and to include more data on catheters in the next service update report.

There was an Infection Prevention update on the agenda under item 5.6.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/037.1: Quality Report: West Park - To provide an update on an unannounced visit to West Park. Visit due to take place on 17/05/19, update to be provided at June Meeting.

An update is to be provided in the quality report.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/049.6: Public Health Reports - Public Health update and Annual Public Health Performance Report to be submitted for June Meeting.

Reports were received and were on the agenda under items 5.9 and 5.10.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/049.5: Health and Safety – Mr Parvez to submit Report/Action Plan for Junes Meeting.

A report was received and was on the agenda under item 5.5.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/049.4: Medicines Management – E-Discharge Audit - To understand the process of closing the loop and to find out who the audit results are shared and who is accountable for the actions, feedback required in June Meeting.

Mrs Hough to gain progress update.

ACTION: Mrs Hough

QSC/19/049.2: Primary Care Report - Further changes to be made within the report, quarterly rolling data with just monthly key elements.

This action is ongoing and each month improvements are being made to the report.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/049.3: Safeguarding - Ms Higgins to look at raising a risk in regards to the transition of changes for Safeguarding Board.

Ms Higgins confirmed that she had spoken with the Safeguarding team with this and is in progress.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/053.1: Quality and Safety Committee Report (Annual) - KS to share the amended report with the group for virtual agreement by Monday 20th May.

Mrs Styche had spoken with Mrs Hough and the report had already been agreed but Mrs Hough sent it out and asked for comments to be forwarded to Mr McKenzie ahead of the Governing Body Meeting.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/058 Matters Arising

There were no matters arising noted.

QSC/19/059 Performance and Assurance Reports

QSC/19/059.1 Public Health Update (Item 5.9)

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

Mr Barlow advised the Committee that they were going to review the reports required. He added that there were two papers that had been presented to the Health Scrutiny Committee and he would send them to Mrs Hough to share with the Committee.

ACTION: Mr Barlow

NHS Healthchecks – These have been reformatted and are now provided through GP's; Wolverhampton were the worst performing and were in the top quartile in the last 12 months this has now improved. The offer is still there from Public Health for help, advice and support with audits etc.

Mrs Roberts asked Mr Barlow to share this with Sarah Southall's team again.

ACTION: Mr Barlow

Engagement with Families – This was the highest level since 2013.

Rough Sleepers in City – They have seen a reduction this year; the audits should be undertaken yearly but they are been conducted monthly. They have looked at additional services – homelessness etc.

Flu Fighters Campaign – Last year's campaign was a huge success; 28,000 comic booklet for schools were produced. Wolverhampton had the lowest uptake on children's vaccine before last year but an extra 1600 children were vaccinated. They are currently working on a second version of the booklet.

Mrs Roberts commented that the joined up approach was very successful.

Mrs Lambeth asked if the nasal spray was easier and if it helped the children.

Mr Barlow replied that yes it did help the children especially the ones with a needle phobia. This year's vaccine will contain pork gelatine. Religious leader's advice has been sought and it was believed that it is a better alternative.

Dr Rajcholan referred to page 214 of the papers and the 'Reduce Smoking Prevalence' section and asked if it was on EMIS.

Mr Barlow replied that yes it was on EMIS; they have to put in the code and it brings the template up and a print out of a self-help sheet with websites etc. If GPs need support on that, the team can go out to them.

Dr Rajcholan commented that it would be helpful for support.

Ms Higgins advised that her team was doing the first GP newsletter and added that they could put a link on that to guide GPs.

ACTION: Ms Higgins

Mrs Roberts referred to page 210 of the report and Children Receiving 2- 2.5 year old checks and noted that the numbers were below the target trajectory.

Mr Barlow stated that they are using health visitors, nurseries etc.

Mrs Roberts commented that this impacts upon school readiness. With regards to Population Health Management for school children she felt that they need to understand how we can support from a CCG perspective.

Mr Barlow advised that the comic books were aimed at five year olds and it was also used to encourage children to read as well as having the flu details in it.

Mrs Roberts advised that she had met with both John Denley and Ankush Mittal and she is going to work closely with Ankush Mittal as the CCG rep as well as the ICA work moving forward.

QSC/19/059.2 Annual Public Health Performance Report (Item 5.10)

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

QSC/19/059.3 Quality Report (Item 5.1)

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

Cancer (Red rated) – Performance on the two week wait (14 days) breast symptomatic pathway is now at 39 days; Harm reviews continue to be conducted for the 104 day plus pathway and the first harm in has been identified in the gynaecology pathway. A communication event has been held for GPs and although attendance was low, the evaluation and conversations were very positive.

Breast Performance – This was at 1.7/1.8% this week. An additional 30 slots have been allocated in an attempt to improve performance. Mrs Roberts has spoken to Diane Wake (Chief Executive at The Dudley Group NHS Foundation Trust) about the system supporting the Royal Wolverhampton Trust (RWT) cancer pathways. The STP is supporting this; there was a commissioning lead call yesterday and they were reviewing the referral rate per GP practice and mileage to other areas. RWT are scoping this there is a further meeting on Friday.

Mortality (Red rated) – There is a higher than expected SHMI in RWT; they have now recruited eight mortality reviewers who will help with standardisation of the mortality reviews.

Ms Higgins stated that a consistent theme within the mortality reviews remains recognition and response to the deteriorating patient. There is a Deteriorating Patients Recognition Group which the CCG now attend. The SHMI will now be produced monthly rather than quarterly; work continues with coding.

Mrs Roberts stated that they will keep this rated red for now.

Sepsis (Amber rated) –The sepsis CQUIN data has been received for quarter 4 and the ED performance for antibiotic administration has deteriorated; the Sepsis team are now working with ED. Ms Higgins advised that she had met with the team last week and it had been agreed at CQRM that there would be a spotlight session on sepsis and the deteriorating patient at the July meeting.

Mrs Roberts added that she had met with the Chief Nurse of RWT last week and she was assured that there is a collaborative focus on this area.

Maternity Capacity (Green rated) – The booking numbers remain low. C-Section rates are higher but an audit has been undertaken and assurance received.

Mrs Roberts asked the Committee if they would agree for this to be taken off as a risk and go back to business as usual.

The Committee **agreed** for this risk to be removed as a risk on the report.

BCP Workforce (Amber rated) – This was with regards to capacity and workforce; the workforce issue is improving. The quality team have undertaken two visits; one to Penn Hospital which is within report and Penrose (LD Provision). The Penrose visit identified some issues with leadership and staff not feeling supported with violence and aggression incidents and lack of training for autism; a report will come to the next meeting. Ms Higgins is meeting with the manager to discuss governance arrangements. They have had two more breaches since the report was written.

Mr Barlow left the meeting.

Probert Court (Red rated) – From 28th June 2019, Probert Court will cease to provide care. They are currently looking for robust step up and step down facilities across the city.

Mrs Roberts advised that the home is owned by Accord Housing. They are looking at three or four providers to assist with future developments. The procurement process is

going ahead.

Mrs Corrigan and Ms McCormick joined the meeting.

HCAI (Green rated) - E Coli is showing a positive picture; the system wide project seems to be impacting on performance.

The Committee was asked if they would agree for this to taken off as a risk on the report as the system wide group still meets.

The Committee **agreed** for this risk to be removed as a risk on the report.

West Park Safeguarding Incidents (Green rated) - Actions have taken place to rectify the concerns raised relating to Stroke Rehab. Ms Higgins advised that she would like agreement to step down the risk on the report.

The Committee **agreed** for this risk to be removed as a risk on the report.

Reduced CQC Rating of Wolverhampton Nursing Home (Amber rated) – Inadequate rating received from CQC mainly to do with safety element from Health and Safety.

QSC/19/059.4 Primary Care Report (Item 5.2)

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

Serious Incidents – There was a death that has been referred to PPIGG.

Quality Matters – There was an issue that had been referred to PPIGG.

Collaborative Contracting Visits – This will be completed by the end of Summer.

CQC – There are still two practices that were rated 'Requires Improvement'. One practice has merged with Health and Beyond (which was rated good) and the other is a VI practice.

Mrs Roberts asked if they were aware when CQC are going back to the practices.

Mrs Corrigan replied that they have been back and are still inadequate this has been since they have merged.

GP Newsletter – Kassie Styche is currently working on this.

Quality Matters – There is some positive referrals coming and trend analysis continues.

Mrs Corrigan advised that they are still getting BMA breaches but they are redirecting them.

Training Hub – This is now a STP action.

Mrs Roberts commented on the training hub and advised that they are going from each place to a STP footprint and proposals for an academy; there is a paper going to CLG next week to talk about the clinical academy. The hub for Black Country is in a much stronger position for funding from HEE.

Dr Rajcholan commented that the report on page 103 states that there is £22 million investment each year for three years, although it is not clear when this funding will be available.

Mrs Roberts advised that she had just come from an ICA meeting where the money was discussed and that paramedics training were discussed. They have agreed to pull

together an agreement as WMAS can recruit and grow paramedics.

Dr Rajcholan commented that the report also stated that there was a suggestion that there may be roughly one project manager, one administrator and one clinical educator per 300,000 of population and wondered if Wolverhampton would get one of each.

Mrs Roberts replied that this is being scoped in Wolverhampton.

Mrs Corrigan left the meeting.

QSC/19/059.5 SEND Update (Item 5.3)

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

Increase in Special School Places – There has been an increase in the number of children and young people school places from September 2018.

Review of Local Offer – A review is being undertaken and is at draft recommendations stage and is likely to recommend key actions in relation to the certain areas of activity mainly governance, communications, local offer, engagement, workforce development, systems and processes, joint commissioning and transition. The review has provided clarify on what is needed now.

CCG SEND Action Plan – This area of work is based on the self-assessment diagnostic checklist and six key domains against which the CCG will be measured as part of the inspection process by CQC. Significant progress has been made in relation to the leadership and governance domain with a strengthened CCG SEND governance structure now in place.

Engagement – In terms of engagement, the CCG have recently commissioned the children and young people forum 'Changing our Lives' to undertake co-production work in relation to progressing personal health budgets and around quality of health standards for children and young people in SEND.

Mr King joined the meeting.

Clinical View – Clinical view of SEND is provided via the role of DMO and close working relationships with providers.

Patient and Public View – The SEND programme of work routinely engages with parents/carers and children and young people with SEND in various streams of work.

Dr Rajcholan asked if all children in special schools have a 'Personal Health Budget'.

Ms McCormick replied that yes they do. The CCG are piloting the Personal Health Budget choices site which should help. Young children have got their views on what they need to make their lives easier.

Mr Reid joined the meeting.

Key Risks and Mitigations:

- **Data Gaps**: A sub-group is now in place linking in Council with a dashboard. JNCA will be completed by the end of July; the CCG has inputted into this.
- **Out of Date Service Specification**: These are currently being updated and a service plan is in place now.
- **DMO Capacity Risk**: this is being reviewed.
- **Standard Operating Procedures**: These still need to be agreed for out of city children and equipment. These are being progressed.
- **LA Increase in Statutory Assessment Meeting Panels** – These pose a health capacity risk. These are currently being considered via the SEND Health Steering Group.
- **LA SEND Hub** – Parents can view this when they like; however there are some

IG issues for RWT.

- **CAMHS** – This is routinely flagged as an area for improvement in SEND inspections.

Mrs Roberts advised that this will be presented at Governing Body next week and it is important that the Committee are aware that we are awaiting the inspection. A lot progress has occurred in the last 12 months and we will highlight to the Governing Body issues and progress.

Ms McCormick left the meeting.

QSC/19/059.4 Equality and Diversity Report (Item 5.4)

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

CCG – The template is delivering; it is where it should be for the CCG. This is the first year that CCGs have got to submit anything to NHSE. This will need to be published in July 2019.

Providers/Non-NHS Providers – With regard to WRES; Compton has provided their action plan. A report has been published on WRES.

Royal Wolverhampton Trust – Mr King has spoken to their HR director about the EDS2 and advised them that their website had not been updated. It is not a serious problem. Mr King will continue to monitor as well as for Black Country Partnership Foundation Trust.

Ms Higgins asked Mr King if this has been escalated to RWT.

Mr King advised that he had spoken with them; he offered to forward the summary to Ms Higgins. He added that providers are not sure what they have to present and when.

Mrs Roberts advised that the CCG WRES was going to SME

Dr Rajcholan asked what blue stood for in the RAG rating.

Mr King replied that the actions are due but are new actions and added that both providers are aware of them.

Mrs Roberts thanked Mr King for a comprehensive report.

Mr King left the meeting.

QSC/19/059.5 Health and Safety Performance Report (Item 5.5)

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

Mrs Roberts advised that the report shows compliance of the CCG for the health and safety of their staff. The CCG have got a third party company to oversee this and they have visited the CCG offices and undertaken a full inspection on 29th March 2019. They produced an action plan. Mr Parvez and the team have taken on the action plan and since then a lot of work has been undertaken. This work is shown on the subsequent action plan and has got some quarterly actions on it; she added that it has worked really well.

Mr Strickland joined the meeting.

QSC/19/059.6 Infection Prevention Service Update (Item 5.6)

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

Care Home Activity – There have been six outbreaks of influenza A and one diarrhoea

and vomiting case in January. There were 5 outbreaks of influenza A and 1 diarrhoea and vomiting case in February. There was 1 outbreak of influenza A and 2 diarrhoea and vomiting case in March. Advice and support given by Infection Prevention Team and treatment prescribed by RIT.

GP Audit Results – 18 practices were audited; 11 of them have seen improvements in their overall score from the previous year. Themes of non-compliance were mainly environmental issues; window blinds, fabric notice boards, carpeted areas, hand wash basins and waste bins and wooden impermeable furniture.

Mrs Roberts enquired as to whether the trust has strong arrangements to feed back into the CCG for Primary Care.

Mr Reid replied that his link here is Mrs Corrigan.

Mrs Roberts asked if the trust closes the loop on these issues.

Ms Higgins commented on the themes that are seen by the CCG staff e.g. sinks, bins and sharps etc. and she knows they used to be sent to Vanessa Whatley but she said she would check that this will be sent to Mr Reid now.

ACTION: Ms Higgins

Surveillance Results – **C *Diff*** (end 18/19) - The CCG had 41 attributable C *Diff* cases against a trajectory of 70 with the trust having 31 attributable C *Diff* cases against the trajectory of 34. There were a total of 48 cases for the CCG and 40 for the trust in total and they have raised issues with definitions of cases.

MRSA - As of 2nd June 2019 there were 6 cases for the trust and 8 cases for the CCG. This will be a challenge this year.

Gram Negative Bacteraemia – A City wide approach to reduce gram negative bacteraemia, the action plan consists of three themes; prescribing, hydration/Every Contact Counts and catheter management. Many of the patients had no contact with the hospital.

Ms Higgins commented that work is also taking place around oral hygiene with the care homes.

E. coli – The figures increased in May; the trust will continue with the workstream.

Mrs Roberts commented on the 18/19 figures and asked what happened around October/November time to have such an increase.

Ms Higgins stated that this was when the work started.

Ms Henriques-Dillon asked if they were from the care homes.

Mr Reid replied that yes they would be patients going through ED with UTIs. He stared further engagement with District Nurses was required; they have now identified a nurse to support continence nursing.

Mrs Roberts advised that community services which is being linked in with this.

Mr Reid advised that as part of the Infection Prevention Strategy they will be working on reducing catheter usage.

Ms Henriques-Dillon commented on section 4.1 of the report 'Key risks and mitigation'
There is a risk that Wolverhampton will not retain its excellent reputation for the prevention of infection without the sustained input in to care homes. Mitigation: The Quality Team at the CCG have taken on the nursing home audits but there is still a gap with Residential homes – Public health is engaged.

Ms Henriques-Dillon advised that she had accompanied someone from the team to do some audits a while ago in two different care homes and is still awaiting the trust to share the data.

Mr Reid will action this.

ACTION: Mr Reid

Mr Reid left the meeting.

QSC/19/059.7 Deteriorating Patient (Item 5.7)

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

Ms Higgins presented this paper and advised that the final version of the FREED document is within the report; it has been confirmed at the Frailty and End of Life meetings and will also go through STP CLG.

Mrs Roberts advised that a Wolverhampton GP (Gill Pickavance) provided some feedback on how well it was received.

Dr Rajcholan commented on the FREED booklet and noted that it was used as a pilot around Nursing Homes in Walsall and Wolverhampton and wondered whether it was to be distributed to residential homes as well.

Ms Higgins replied that yes it will be rolled out. She added that the 'Stop and Watch Early Warning Tool' is really helpful and they might need to remove the NEWS2 detail as Residential homes don't do observations. Some staff from some of the Residential Homes have attended training.

Ms Henriques-Dillon added that this will also involve families.

Ms Higgins stated that it is going down really well.

Mrs Roberts advised that for Residential Homes to do it well it will need resources.

Dr Rajcholan queried the WMAS call out.

Ms Higgins replied that there was an initial increase in call outs while staff were becoming aware of change in response to deterioration. The increase in preferred place of care is also looking positive.

Dr Rajcholan commented that this dovetails when patients come out of New Cross and there is a DNACPR in place discharge notes are not noting the DNACPR.

Ms Higgins advised that they have spoken to Director of Nursing about scoping the RESPECT paperwork.

Mrs Roberts added that the City wide Mortality Improvement Group agreed the RESPECT paperwork in principal and it has been put onto the ICA End of Life Group agenda.

Ms Higgins advised that the FREED document will link with the RESPECT paperwork.

QSC/19/059.8 Quality Assurance in Care Home Report (Item 5.8)

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

Serious Incidents – Overall the serious incidents are decreasing.

Pressure Ulcers (Category 3 and 4) - 83% of Nursing Homes have had no category 3 or 4 pressure ulcers.

Ms Higgins advised that with regards to the STP work, robust reporting has been noted at QSG.

Falls – The number of falls is declining; training on falls prevention has been delivered and 495 care home staff has now been trained across the year.

Mrs Roberts asked if we have a benchmark for falls and asked of the four falls reported in quarter 4 how many patients did this equate to.

Ms Henriques-Dillon commented that there are a thousand patients with four patients suffering a fall.

Ms Higgins stated that they could use acute numbers as a benchmark.

Ms Henriques-Dillon agreed and suggested that they could also use benchmarking for Pressure Ulcers too. She added that with regards to Serious Incidents; more homes had more than one Serious Incident.

A&E Attendances – The number of A&E attendances is also decreasing and the gap between attendance and admissions are better. Falls, chest infection and sudden onset confusion are the biggest category for admissions.

RITs Team – The use of the RITs team is static at the moment.

WMAS Data – There appears to be an increase on call outs and conveyances across all homes not just nursing homes.

Mrs Roberts wondered if this information could be split with Nursing Homes.

Ms Henriques-Dillon advised that there are more people dying in their Preferred Place of Care.

Safety Thermometer – The monthly average harm free care percentage for participating care homes continues to be high at 96.05% above the national target of 94.3%.

CQC Ratings – There is one home that has been rated 'inadequate' in quarter 4.

Dr Rajcholan commented on the harm free care and that there were eight nursing homes listed.

Ms Henriques-Dillon replied that there were seven Nursing Homes and Arden Manor is a care home.

Infection Prevention – Some homes have been closed because of outbreaks; the team want to undertake more Hand Hygiene audits.

Mrs Roberts commented that it is really helpful for us to breakdown and correlate outbreak data. She added that the CCG have got good mitigation and some triangulation data. Also, with regards to page 4 of the report for RITs etc. it shows some breakdown and triangulation.

Ms Henriques-Dillon advised that the end of the SPACE project evaluation report has been published highlighting that 100% of Nursing Homes were utilising safety crosses, that there were positive trends in harm reduction (falls, pressure injuries Category 3 and 4, urinary tract infections, significant reduction in ambulance conveyance). There is a SPACE conference in a few weeks' time in July.

Ms Henriques-Dillon left the meeting.

QSC/19/060 Risk Review

QSC/19/060.1 Risk Register (Item 6.1)

No new risks for committee this month; are awaiting Safeguarding risk; Mr Strickland will chase.

ACTION: Mr Strickland

Committee Risks:

Mortality - SHMI (QS07) – There was a typo on the risk register for this the latest update date should read April 19.

Maternity Capacity and Demand (QS05) – It was agreed that this could be stepped down.

Probert Court (QS08) – This could probably be stepped down next month.

QSC/19/061 Feedback from Associated Forums

QSC/19/061.1 Governing Body (Item 7.1)

The Governing Body minutes from 9th April 2019 were received for information/assurance.

QSC/19/061.2 Commissioning Committee (Item 7.2)

The Commissioning Committee minutes from 28th March 2019 and 25th April 2019 were received for information/assurance.

QSC/19/061.3 Primary Care Operational Management Group (Item 7.3)

The Primary Care Operational Management Group minutes from 12th April 2019 were received for information/assurance.

QSC/19/061.4 Area Prescribing Committee (Item 7.4)

The Area Prescribing Committee minutes from 19th March 2019 were received for information/assurance.

QSC/19/061.5 Finance and Performance Report (Item 7.5)

The Finance and Performance Report was received for information/assurance.

QSC/19/062 Items for Escalation/Feedback to CCG Governing Body

- Cancer outcome diverts – next time
- SEND – to development committee next time.

QSC/19/063 Date of Next Meeting: Tuesday 9th July 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12:45pm

Signed: …… **Date**: ……
Chair

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NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 9th July 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Mike Hastings – Director of Operations, WCCG
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG

Lay Members:
Jim Oatridge – Lay Member (Deputy Chair)

Patient Members:
Marlene Lambeth – Patient Representative

In attendance:
Maxine Danks - Head of Individual Care, WCCG
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG
Kelly Huckvale – Information Governance Officer, Arden and GEM CSU
Annette Lawrence – Designated Lead Safeguarding Adults, WCCG
Peter McKenzie – Corporate Operations Manager, WCCG
Lorraine Millard – Designated Nurse Safeguarding Children, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG
Lesley Thorpe – Primary Care Macmillan Nurse Facilitator, WCCG

APOLOGIES:
Steve Barlow – Public Health, Wolverhampton Council
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Sue McKie – Patient/Public Involvement – Lay Member
Ankush Mittal – Public Health, Wolverhampton Council
Peter Price – Independent Member – Lay Member
Sally Roberts – Chief Nurse, Director of Quality, WCCG

QSC/19/064 Apologies and Introductions

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

QSC/19/065 Declarations of Interest

No declarations of interest.

QSC/19/066 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/066.1 Minutes from the meeting held on 11th June 2019 (Item 3.1)

The minutes from the last meeting were read and agreed as a true record.

QSC/19/066.2 Action Log from meeting held on 11th June 2019 (Item 3.2)

QSC/19/059.1 - Public Health Update**:** To forward the two papers that had been presented to the Health Scrutiny Committee to Mrs Hough to share with the Committee.

Mr Barlow had sent his apologies to the meeting but had sent an update prior to the meeting. One of the papers was already in last month's pack 'The Vision for Public Health 2030' paper under agenda item 5.10 and the other was tabled at the meeting and Mrs Hough advised that she would send the electronic copy to the Committee members.

ACTION: Mrs Hough

QSC/19/059.1 - NHS Healthchecks**:** The offer from Public Health for help advice/support with audits remains. Mrs Roberts asked Mr Barlow to share this with Sarah Southall's team.

Mr Barlow had advised that he had e-mailed Sarah Southall's team and offered support.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/059.1 - EMIS**:** Smoking cessation link on EMIS and if GPs need support, the team can go out to them – to put the link on the first GP newsletter to help the GPs.

The newsletter had been completed and was distributed to GPs on 2nd July 2019.

Dr Rajcholan advised that she couldn't access the link at her surgery but could access it from other surgeries.

Mr Hastings offered to follow this up with Mrs Lisa Holder.

ACTION: Mr Hastings

QSC/19/059.6 - Infection Prevention Service Update**:** Ms Higgins commented on the themes that are seen by the CCG staff e.g. sinks, bins and sharps etc. and she knows they used to be sent to Vanessa Whatley but she said she would check that this will be sent to Mr Reid now.

The IP audits are received by the CCG to enable themes to be identified.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/059.6 - IP Audit Data**:** To follow up - Ms Henriques-Dillon had accompanied someone from the IP team to do some audits a while ago in two different care homes and is still awaiting the trust to share the data.

Mr Reid advised prior to the meeting that one care home audit was forwarded as per request. The second audit – IP shadowed and full audit was not completed, therefore no report was compiled/available.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/060.1 - Risk Register**:** To chase Safeguarding risk.

This is now on the risk register.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/067 Matters Arising

There were no matters arising noted.

QSC/19/068 Performance and Assurance Reports

QSC/19/068.1 Quality Annual Report (Item 5.1)

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

Ms Higgins advised that the team had reviewed previous annual reports but had tried a new template which now shows a synopsis of the team achievements and added that it was open for comments and feedback.

Dr Rajcholan stated that it was commendable on how it was presented; it showed clear direction and identified priorities going forward.

Mr Oatridge commented that it was a splendid report; which was easy to read and engages the reader. The report does not talk about what hasn't been achieved. Also it may be enhanced if it included the governance framework for CCG within it.

Ms Higgins replied that Mr Oatridge's comments and suggestions were very helpful and added that it is only at draft stage.

Ms Lawrence and Ms Millard joined the meeting.

QSC/19/068.2 Safeguarding Annual Report (Item 5.2)

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

Ms Millard advised that the report highlighted key points taken from the quarterly reports over the last 12 months, which are included as appendices to this report. It was noted that a new template had been used for this year's annual report. Positive feedback was received from the committee regarding the new format

Mr Oatridge asked if he could make a general comment which was he felt the report could look more balanced if it showed things that weren't achieved as well as the things that were achieved. He added that the report would benefit from a governance overlay showing the reporting into this Committee and the Governing Body and would identify the challenging and reporting elements.

Ms Millard stated that there are two governance structures, one for the CCG and one for the Wolverhampton Safeguarding Boards/Partnership. The report outlines and provides narrative relating to WCCG's Statutory Safeguarding responsibilities.

Ms Higgins stated that the team will review the governance structure.

QSC/19/068.3 Child Death Changes and Wolverhampton Safeguarding Arrangements (Item 5.12)

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

Ms Millard advised that the new Safeguarding arrangements have got to be embedded by September 2019 and added that Mrs Roberts is now the new chair of both Adults and Children MASA going forward for the first year**.**

Ms Lawrence and Ms Millard left the meeting.

QSC/19/068.4 Quality Report (Item 5.3)

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

Cancer (Red rated) – With regards to the issue around the two week wait breast symptomatic patients are being offered alternative hospitals within a two mile radius.

Mr Hastings added that they had looked at the distance from the GP practice to New Cross Hospital, Wolverhampton and then within two miles for other hospitals and patients could go to the Manor Hospital, Walsall or Russells Hall Hospital, Dudley.

Ms Higgins stated that GPs are being informed of waiting times.

Dr Rajcholan commented that the determining factor from GP practice is within two miles and asked if GP practices have been informed.

Mr Oatridge queried if it was still with patient choices as well as the waiting times.

Mr Hastings replied yes it was around patient choice and they will look for the first actual appointment; RWT were at 50 days for two week wait as of last week.

Ms Higgins advised that they are still continuing with the harm review process. RTT performance has declined; the CCG has asked for a remedial action plan outlining how performance will be improved and speciality level detail.

Mortality (Red rated) – Going forward the SHMI is going to be reported on a monthly basis rather than quarterly. There are a high number of CQC mortality outlier alerts; a new one has been received for COPD, the trust is working on a response.

Sepsis (Amber rated) – The trust now have a dashboard supported by the new e-sepsis flagging system. The CCG have walked the pathway and Ms Higgins now sits on the Deteriorating Patient Group. The trust is really embracing the work. At the next CQRM (RWT) the trust will be presenting spotlight sessions on Mortality and Sepsis, so we can see further progress and gain assurance.

BCP Workforce (Amber rated) – Workforce remains the same; there are system wide concerns. Penrose visit detail came to the last Committee meeting. The TCP lead also met with the trust last week. Ms Higgins advised that she has seen improvement from last October to now.

Suicide Data – The number of actual suicides have increased for Sandwell and Wolves; there were 10 in 2017, 16 in 2018 and 13 in 2019 with a further five attempted suicides; a further detailed analysis is been undertaken to look specifically at Wolverhampton data and identify themes and trends.

Dr Rajcholan wondered if there was a particular group e.g. PTSD.

Mr Parvez replied that there was nothing highlighted on STEIS; the theme showed that it was mainly men over 50 years old; Sandwell appear to have more suicides so collaborative work continues.

Ms Higgins commented that Liverpool has a zero suicide initiative and they have been asked to present at the STP Mental Health group.

She added that there were concerns around the Duty of Candour process following a recent visit and further assurance has been requested.

Data in relation to 12 hour breaches in RWT with regards to Mental Health patients and within the Black Country has been received. Walsall had one 12 hour breach; RWT have had eight 12 hour breaches relating to Mental Health patients.

Mr Hastings advised that some people came in from MERIT group yesterday and they had mentioned about their bed availability system and wondered if RWT were using. He added that it is in the style of a dashboard and when Mr Hastings was shown the system it said that it was last updated within the last 8-10 minutes. This showed all information across the MERIT trusts across the country.

Mr Parvez suggested that if we could get the link then RWT can advise whether they use it and he asked Mr Hastings for the link to share it with RWT.

ACTION: Mr Hastings

Probert Court (Red rated) – The Home has now actually closed and have removed the risk.

Mr Oatridge asked if this was a full home closure and asked if all patients had been moved.

Ms Higgins replied that they have been moved as it was only a step down facility.

Dr Rajcholan asked when the procurement process was taking place for a replacement.

Ms Higgins replied that there were two providers interested; Eversleigh was one and

there was another new one.

Reduced CQC Rating of Wolverhampton Nursing Home (Amber rated) – This was due to an inadequate Nursing Home and relates to the Health and Safety elements.

Cancer – The trust are not on track with this; the CCG have had a revised remedial action plan and they are predicting a return by February 2020.

Ms Higgins stated that they have left the original prediction in red but has shown the new date in green.

Ms Higgins advised that she had spoken with CQC last week as RWT are awaiting a CQC visit; they are undertaking focus groups in July at West Park with a potential visit at the end of July/August.

QSC/19/068.5 Primary Care Report (Item 5.4)

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

Mrs Corrigan had provided apologies ahead of the meeting and Ms Higgins asked for any questions/comments but advised that work is ongoing around the hub.

Mr Oatridge stated that the report format was very good.

QSC/19/068.6 Cancer and End of Life Update (Item 5.5)

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

Ms Higgins advised that Mrs Thorpe had sent her apologies and added that this was a new report as Mrs Thorpe's workstream. Mrs Thorpe is doing some really good work and her next report will identify priorities going forward. Mrs Thorpe has been instrumental in developing the harm review process and she also conducts peer review and patient engagement work. She has arranged training events and has been part of the red bag implementation as the swan boxes; she has also been working on the Verification of Death policy to help improve quality. Ms Higgins asked the Committee if there was anything they would like to see in the report going forward.

Mr Hastings wondered what was happening with the End of Life EPACS system.

Ms Higgins replied that she had recently had a discussion with the Deputy Chief Nurse (Ms Whatley) at RWT and she was going to speak with IT about how they can move forward with EPACS; she had recognised a barrier.

Mr Hastings advised that he would speak with Ms Whatley

ACTION: Mr Hastings

Dr Rajcholan asked if there was help from IM&T to come and speak with GPs.

Mr Hastings replied that the idea is for it to be fully integrated and the last he heard there were seven practices that were running a pilot.

Dr Rajcholan added that some practices are not confident in using the system and would value some support.

Ms Huckvale joined the meeting.

QSC/19/068.7 Information Governance Report - Quarter 1 (Item 5.6)

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

There was 248 pieces of activity undertaken in quarter 1; they were awaiting the release

of the toolkit but this has now happened.

Workplan – This is on the agenda for ratification.

IG Handbook – Last year they revised the policies and therefore the handbook is now more succinct.

Compliance Spot Checks – These have been undertaken; there was nothing to note so no concerns.

DSP Toolkit – This has now been released.

Priorities for Quarter 2 – IAO/IAA annual risk reviews commencing in August.

IG Incidents – There has been one near miss reported within quarter 1. This related to an e-mail where a recipient from a Care Home under investigation was unintentionally copied into an email which was confidential. Staff continue to raise concerns.

Caldicott Guardian Log Work Remit 2019/2020 - Five DPIAs have been submitted to the IG team for review and comment. Four were regarding CCG commissioning services and the other one was a High Intensity User Project. They have gone back with comments and are working on a data sharing agreement.

Subject Access Requests – There was one request for information during 1st April 2019 – 2nd July 2019. This related to CHC records of deceased patient and will be handled under the Access to Health Records Act and Mr McKenzie will be responding to this request.

General Practice Information Governance Service – There has not been much contact; however, the same practice has contacted the service twice in the first quarter and a DPIA has been completed on behalf of all practices.

QSC/19/068.8 Information Governance Handbook (Item 5.7)

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

The latest handbook has been drafted on policies that were approved last year and Mr McKenzie was happy with the content.

The Role of the Data Protection Officer (DPO) – The Committee has to authorise or accept DPO.

Ms Huckvale stated that as far as she was aware some practices have purchased their own.

Dr Rajcholan commented that she had not received any feedback.

Ms Huckvale advised her to speak with Mr McKenzie.

The Committee **approved** the Information Governance Handbook.

QSC/19/068.9 Information Governance Workplan 2019/2020 (Item 5.8)

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

Updated Changes – The timeframe column has been amended.

Information Asset Register – This was completed September - December last year and has been bought forward to be conducted in August/September this year.

IT Related DSPT Assertions – This row has been added towards the bottom of the workplan and that there will be regular meetings with the provider; just need to agree

timescales.

Mr Hastings referred back to the Handbook with regards to practices if they have any issues with their smart cards it should say they need to contact RWT.

Dr Rajcholan stated that there is a presumption that they have to contact RWT.

Mr Hastings added that it would be helpful to point people towards the help desk.

Ms Huckvale left the meeting and Mr Strickland and Mr McKenzie joined the meeting.

QSC/19/068.10 FOI Report (Item 5.9)

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

Freedom of Information Requests (April – June 2019) – There have been 62 FOI requests which is about average. The CCG has responded to 52 of the 62 requests received of which 51 were replied to within the deadline; we requested an extension of the other one and the remaining 10 are still within the deadline. These requests come in from all people; students, media, MPs etc.

Ms Danks joined the meeting.

Subject of Requests – During this quarter, requests for information have covered the formation of Primary Care Networks (PCN) whereby the CCG were asked how many PCNs had and how many were rejected. The CCG responded within 20 days and this information was in the public domain. There have also been some Personal Health Budget queries. This is all in line with what is happening and there was nothing of concern.

Mr Oatridge asked if there was anybody dissatisfied with the responses.

Mr McKenzie replied that no there wasn't, he added that sometimes they get somebody come back for further information. However, some have unrealistic queries and if we don't hold the information we let them know.

DPO for Practices – Dr Rajcholan asked Mr McKenzie if there was an update on this.

Mr McKenzie replied that he will chase.

ACTION: Mr McKenzie

Mr McKenzie and Ms Higgins left the meeting.

QSC/19/068.11 Quality Assurance in CHC Report (Item 5.10)

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

Key Issues:

The ICT have noted a reduction in the number of inappropriate referrals for consideration against the criteria for NHS funded care. This is following the change in process for completion of the initial screening checklist. The team are now going out themselves to review the patients. They have agreed to fund a three month period of care to review their needs.

Fast Track – This is now being scrutinised with the District Nurses; Ms Danks still has some concerns and has been raised with the End of Life workstream.

Personal Health Budget – The CCG met the target last year and looking at comparative data, the CCG are in the middle.

Ms Higgins joined the meeting.

Paperless – All files are in the process of being scanned and the team are being stopped making new files. They are moving across to a web based system which is also being used across the Black Country. It will hopefully be live in September, and will give a snapshot of patients. This will also help to identify workload etc.

Quality Premium – The CCG are meeting the Quality Premium target required of CHC; which requires 80% of full CHC assessments to be completed within 28 day timescale and less than 15% of CHC full assessments to be completed in an acute setting.

CCGs – The team are working with other CCGs for commissioning; there was an event last week and it was noted that Birmingham are also now doing the same as the CCGs within the Black Country. Birmingham were historically higher priced but all are aligned going forward.

Appeals – There are only eight outstanding at the moment; which is a low number in comparison to other areas.

Dr Rajcholan stated that it was a good comprehensive report thanked Ms Danks and asked about the recruitment of a RMN.

Ms Danks replied that it was a Registered Mental Health Nurse as the one who had been in post has left the CCG due to personal reasons.

Mr Hastings asked about IT system and whether it had been checked out with IT Department at RWT.

Ms Danks replied that the IT Department are liaising with the company.

Ms Danks left the meeting.

QSC/19/068.12 Quarterly CQUIN Update (Item 5.11)

The above report was not available to be circulated to the Committee before the meeting.

It was decided that this report would be presented at the next meeting.

QSC/19/069 Risk Review

QSC/19/069.1 Risk Register (Item 6.1)

Committee Risks:

Cancer 62 and 104 Day Cancer Pathways (QS06) – This had been picked up on the Quality Report.

Breast Cancer 2 week wait (QS09) – To provide an update next month.

Probert Court – The Nursing Home is now closed. It was **agreed** that this could be **removed** off the Risk Register.

SEND Risk – A query was raised as to whether it was best for this risk to be on this Committees Risk Register or the Commissioning Committee.

Ms Higgins replied that there are two issues with the SEND Risk; one is funding which should be commissioning and the other is regarding being ready for review which should be this Committee.

EPRR - Mr Hastings stated that they need to look at EPRR again especially with the impending EU exit being pushed to October. It is felt that costs will be a lot higher e.g.

warehousing will be more expensive, this needs to be reviewed.

Mr Strickland advised that he would pick this up with Tally Kalea.

Mr Hastings stated that core standards have come through for EPRR.

RTT - Ms Higgins enquired whether there was a risk relating to RTT.

Mr Hastings queried from which perspective as the value of RTT should go to F&P or the Quality side of it.

Ms Higgins replied that she thought it was a similar risk to mortality.

Mr Hastings stated that he would look at the data with Mrs Moon.

ACTION: Mr Hastings

Workforce - Mr Oatridge queried as to whether there was a corporate risk around workforce generally e.g. lack of nurses; pensions for GPs etc.

Mr Strickland commented that this is picked up at Primary Care Commissioning Committee.

Mr Oatridge commented that there may be a bubble effect with work flows in and felt that there should be a risk around workforce etc.

Mr Strickland stated that there could potentially be two risks.

Mr Hastings asked Mr Strickland to have a look and recommend what is best.

ACTION: Mr Strickland

Mr Oatridge advised that he thought it should be a corporate risk.

Mr Strickland advised that he would speak with Mr McKenzie.

Maternity Capacity and Demand (QS05) – It was **agreed** that this risk could be **closed**.

Mr Strickland left the meeting.

QSC/19/070 Feedback from Associated Forums

QSC/19/070.1 Health and Wellbeing Board (Item 7.1)

The Health and Wellbeing Board minutes from 10th April 2019 were received for information/assurance.

QSC/19/070.2 Commissioning Committee (Item 7.2)

The Commissioning Committee minutes from 30th May 2019 were received for information/assurance.

QSC/19/070.3 Primary Care Operational Management Group (Item 7.3)

The Primary Care Operational Management Group minutes from 17th May 2019 were received for information/assurance.

QSC/19/070.4 NICE Group (Item 7.4)

The NICE Group minutes from 15th May 2019 were received for information/assurance.

QSC/19/071 Items for Escalation/Feedback to CCG Governing Body

- MASA and Child Death changes

QSC/19/072 Any Other Business

Australian Flu - Mr Hastings advised that there is an outbreak of Australian Flu at the moment and the UK usually follows the trend of these cases which was peaking in June so we would normally see effects in August/September and wondered if there were any preparations for this.

Ms Higgins replied that yes the flu group is looking into this. This has been discussed at CQRM with regards to getting vaccinations earlier; there is a CQUIN and it will be added to the GP Primary Care Newsletter.

Mr Hastings wondered if it would be covered with the trivalent vaccinations.

Ms Higgins replied that she but didn't know the strain; they have seen a rise in numbers in Australia but they are not dependency as yet. However, this has been sent out to Primary Care and they are working on flu preparation.

Mr Oatridge asked if the practices would need to do anything different.

Mr Hastings commented that PHE had not made the vaccinations available yet and queried as who the PHE representative was as it needs to be raised at the next Health Protection Forum and added that it was normally himself or Mr Kalea that goes from the CCG.

Ms Higgins asked if Mr Hastings wanted someone from Quality to attend and asked Mr Hastings to share the dates to see if someone could go. She advised that Mrs Corrigan also does monthly calls about screening/vaccinations etc.

ACTION: Mr Hastings

QSC/19/073 **Date of Next Meeting:** Tuesday 13th August 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Apologies received from Ms Higgins and Dr Rajcholan.

Meeting closed at 12:15pm

Signed: …… **Date**: ……
Chair

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 25th June 2019
Science Park, Wolverhampton

Present:

Dr M Asghar	Governing Body GP
Dr D Bush	Governing Body GP, Finance and Performance Lead
Mr T Gallagher	Director of Finance
Mr M Hastings	Director of Operations
Mr L Trigg	Independent Committee Member (Chair)
Mr S Marshall	Director of Strategy and Transformation (part meeting)

In attendance

Mr P McKenzie	Corporate Operations Manager
Mrs L Sawrey	Deputy Chief Finance Officer
Mr P Strickland	Governance and Risk Coordinator (part meeting)
Mrs H Pidoux	Business Operations Support Manager

1. Apologies

Apologies were submitted by Mr Green and Mr Middlemiss

2. Declarations of Interest

FP.379 Dr Bush declared an interest in an item contained in the Contract and Procurement report regarding Probert Court as his GP surgery provided a service to this provider. This was noted.

3. Minutes of the last meetings held on 30th April 2019

FP.380 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.381 Item 144 (FP.361) – CYP receiving treatment from NHS funded community services – it was queried whether the submission from the Trust was just for the Trust – Mr Hastings to follow up and confirm.

Mr Strickland joined the meeting

Item 146 – Risk relating to stranded costs associated with the Community Dermatology Service procurement will be added to the Committee Risk

Register – details included in Contract and Procurement Report. Confirmation of costs still awaited from RWT. Mr Strickland to discuss with Mr Middlemiss and an update to be provided for the next meeting.

5. Matters Arising from the minutes of the meeting held on 30th April 2019

FP.382 There were no matters arising to discuss from the last meeting.

6. Review of the Risk Register

FP.383 Committee Risks

FP11 System pressures A&E performance and FP04 Increased activity at RWT were both noted as high risks.

FP08 NHS Property Services Charges 2017/19 &2018/19 – Mr Hastings stated that NHS Property Services had reported that PS practices owed a substantial amount of money to the CCG relating to facilities management charges. This will go to Primary Care Commissioning Committee to agree a repayment process.

Mr Gallagher proposed that the risk register should be reviewed where appropriate to reflect the 2019/20 assessment. Mr Gallagher agreed to review the risks he was responsible for and to discuss the others with the responsible Executive. Mr Gallagher and Mr Strickland would then revise the risk register for the next meeting.

Resolved: The Committee;

- Noted the contents of the report and the actions being undertaken
- Risks to be reviewed and potentially restated in line with Month 2 reporting

Mr Strickland left the meeting

7. Finance Report

FP.384 Mrs Sawrey and Mr Gallagher introduced the report relating to Month 2 May 2019;

- Financial metrics are being met. Underspend from last year; £42k, had been brought forward.
- Extension to control total has been required due to NHSE directive, following an overall review of the regional financial position. Wolverhampton CCG has been requested to increase its in year surplus by £3.15m with a consequent increase in the CCG's QIPP target from £13.536m to £16.686m. As the CCG has been requested to contribute a disproportionate share within the Black Country (£3.15m of the £8.4m) the Black Country Risk Share agreement will be enacted to provide additional mitigation. The agreement needs to be revised as it does not currently include Sandwell and West Birmingham CCG. The Committee

will be kept updated and a proposed agreement brought for consideration as required.

- RWT SLAM reporting required additional scrutiny and challenge
- Breakeven reported due to limited monitoring data being received. Since report was written Month 2 data had been received.
- The pure positions reported at M1 were £1.7m over committed under National Tariff and £681k over following the application of the Aligned Incentive Scheme (AIS). The CCG had raised several queries which may have a significant impact on the M1 position.
- M1 QIPP delivery was not reported as activity data was currently not reconciled or cleansed.
- Issues had occurred with the drawdown of cash as cash remained at the end of the month. Actions are being taken to ensure that invoices are cleared to enable the more effective management of the cash drawn down.

Resolved: The Committee;

- Noted the contents of the report.

8. Contract and Procurement Report

FP.385 Mr Gallagher reported, on behalf of Mr Middlemiss, the following key points;

Royal Wolverhampton NHS Trust (RWT)

- The April 2019 financial position showed an over performance of £700k
- CQUIN schemes had been agreed with RWT and performance will be monitored against these
- The clinical audit schedule for 2019 had been proposed to the Trust to include; A&E triage, Admissions Avoidance, POLCV, Special Educational Needs Assessment, MSK pathways and referrals for suspected Glaucoma. The aim of the audit programme is to provide the CCG with assurance that commissioned services are functioning effectively as per the agreed contract/specifications.
- Dermatology – The Trust had assured the CCG that work is underway on workforce alignment. The Trust had still not provided any information on stranded costs.
- Phoenix Walk In Centre – this service is provided by the Trust which the CCG pays towards. In line with NHSE Guidance how this is provided has to change by December 2019. The Walk in Centre must either close or transfer to an Urgent Treatment Centre. A report evaluating options and recommending a way forward is to go to Private Commissioning Committee for consideration.

Black Country Partnership Foundation Trust (BCPFT)

- Improving Access to Psychological Therapies (IAPT) target - this had not been achieved for Month 1 and the CCG had requested a plan from the Trust that shows what actions are being undertaken to ensure performance improves. The CCG had invested significant

funding in the contract to support achievement of the target and had confirmed with the provider that a contract performance notice would be issued in Month 2 if the target is not met.

- Data Quality Improvement Plan (DQIP) – the CCG had asked the Trust to engage in working together to identify Personal Health Budgets, in collaboration with Sandwell and West Birmingham CCG.

Nuffield

- Contractual issues – Agreement had been reached on 2019/20 contract values for all associate commissioners to the contract and Contract Particulars had been signed off.

  A Quality Assurance visit had been scheduled for July and a Procedures of Low Clinical Value (PoLCV) Commissioning Policy Audit in August. The latter is important for ensuring adherence to the service specifications commissioned by the CCG and to ensure spend stays within plan.

Vocare

- CQC had rated the service provided by Vocare as Good overall. It was noted that this service was previously rated as Required Improvement by CQC during their visit in November 2018. An unannounced quality assurance visit was carried out by the CCG in April. No immediate risks or concerns were identified during the unannounced visit.

WMAS- Non-Emergency Patient Transport Service (NEPT)

- The Governing Body had agreed a 6 month extension to the contract to allow a re-procurement to be undertaken. This was to be considered at the private meeting of the Commissioning Committee.

Accord Housing Association Limited – Probert Court

- As terms could not be agreed with Accord for an extension of this contract, the service will end on 30th June 2019. The CCG is changing the model of provision and aims to commission several providers to provide the service.

Acorns Children's Hospice

- The CCG has been informed that Acorns is terminating the hospice at home service and considering closing its hospice in Walsall where commissioned inpatient and outreach services are delivered. A Black Country approach is being considered and an impact assessment will be completed and updates provided for the Committee.

Resolved: The Committee

- Noted the updates given and actions undertaken.

9. Monthly Performance Report

FP. 386 Mr Hastings introduced the report which focused on the CCG's performance against the NHS Constitutional Standards. The following key points were discussed and noted;

- A&E performance – this continues to be a challenging area both regionally and nationally. RWT performance is better than other Trusts in the area, however, performance fluctuates.

- Referral to Treatment (RTT) – monitoring will now take place against year end performance (March 2019)

- Cancer 2 week wait Breast Symptomatic – referrals continue to increase and the Trust is putting on additional clinics, however the current wait in Woverhampton is 38 days (target is 14 days). Dudley and Walsall are both achieving the target. A significant amount of work is being undertaken to tackle this from a system perspective. Providers, commissioners, Cancer Alliance and NHS Midlands are involved and it had been agreed to initiate a referral diversion service. Practices which are located near to the Dudley/Walsall borders will be giving the option of referring patients to the local acute provider in those areas if patients would prefer. It was noted that this is labour intensive with daily liaison with the practices and monitoring of performance The success of this is dependent on a number of variables and it will be closely monitored to ensure RWT performance is improving and performance is not impacted adversely in the other areas.

Resolved: The Committee noted the update given.

10. Scheme of Delegations

FP.387 Mr McKenzie presented a report for consideration in relation to the operational delegations to the Director of Finance, Mr Gallagher, following the implementation of the CCG's joint appointment of the Chief Finance Officer, Mr Green, with Sandwell and West Birmingham CCG.

It was agreed that the Committee would recommend to the Governing Body that the Director of Finance be given delegated authority to act on behalf of the Chief Finance Officer in the exercise of his authority set out in the areas of the CCG's Detailed Scheme of Delegation and to provide comments on Urgent Actions taken on behalf of the Governing Body by the Chair and Accountable Officer in line with Standing Order 3.8. This delegated authority is to be exercised when the Chief Finance Officer is unavailable to support operational efficiency.

Resolved: The Committee agreed to recommend the proposed operational delegation arrangements to the Governing Body.

11. Excess Treatment Costs

FP.388 Mr McKenzie presented a report on activity undertaken in Quarter 4 of 2018/19 related to Excess Treatment Costs associated with research undertaken by the Local Clinical Research Network (LCRN) on behalf of Wolverhampton CCG which is the lead CCG for the West Midlands Region.

It was explained that the model developed involved the LCRM managing arrangements on a day to day basis using funding top-sliced from CCG allocations on a per capita basis. Confirmation was given that this is not a financial risk for the CCG as the money is top sliced prior to the CCGs receiving their allocations. Responsibility for this lies with NHSE including auditing and this is how the process is managed nationally.

Resolved: The Committee

- noted the contents of report
- took assurance that the LCRM is acting in line with the agreed model and delegation from the West Midlands CCGs.

12. Additions/updates to Risk Register

FP.389 There were no additions or up dates for the risk register.

13. Any other Business

FP.390 There were no items to discuss under any other business.

12. Date and time of next meeting

FP.391 Tuesday 30th July 2019 at 2.00pm, 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 30th July 2019
Science Park, Wolverhampton

Present:

Dr M Asghar	Governing Body GP (part meeting)
Dr D Bush	Governing Body GP, Finance and Performance Lead
Mr T Gallagher	Director of Finance
Mr J Green	Chief Finance Officer
Mr M Hastings	Director of Operations
Mr V Middlemiss	Head of Contracting and Procurement
Mr L Trigg	Independent Committee Member (Chair)

In attendance

Mr P McKenzie	Corporate Operations Manager
Mrs L Sawrey	Deputy Chief Finance Officer
Mrs H Pidoux	Business Operations Support Manager
Miss N Underhill	Observer, university student

1. Apologies

Apologies were submitted by Mr Marshall.

2. Declarations of Interest

FP.392 There were no declarations of interest.

3. Minutes of the last meetings held on 25th June 2019

FP.393 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.394 Item 144 (FP.361) – CYP receiving treatment from NHS funded community services – it was queried whether the submission from the Trust was just for the Trust – Mr Hastings to follow up and email answer.

Item 146 (FP.376) – Risk relating to stranded costs associated with the Community Dermatology Service procurement will be added to the Committee Risk Register – RWT had submitted revised information on stranded costs and the level sought had reduced and is not at a scale that

puts the procurement at risk. The CCG and RWT's Directors of Finance (DoFs) had met and agreed the principles for the stranded costs and would meet again to agree the final figure. Following this a report will be brought to the Committee for consideration. A decision can then be made as to whether this needs to be included on the risk register.

Item 147 (FP.383) – Risk Register – moderate risks to be restarted in line with Month 2 reporting – this had been completed action closed.

5. Matters Arising from the minutes of the meeting held on 25th June 2019

FP.395 There were no matters arising to discuss from the last meeting.

6. Review of the Risk Register

FP.396 Mr McKenzie reported that the risk registers had been reviewed by Mr Gallagher and Mr Strickland following discussion at the last meeting. Updates were given as follows;

Corporate Risks

CR18 – Failure to deliver long term financial strategy - the level of risk had been raised to reflect the requirement to, in line with national guidance, produced a revised long term financial plan for 2019/20 and the narrative had been updated accordingly.

Committee Risks

FP02 - Loss of Key Staff and Business Continuity – this risk had been reduced and the narrative updated.

Resolved: The Committee;

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

7. Monthly Performance Report

FP.397 Mr Hastings introduced the report and the following key points were discussed and noted;

- Referral to Treatment (RTT) – performance continues to be below standard. The CCG is working closely with the Trust and is awaiting a RAP proposal from the Trust with definition at a speciality level to support recovery of performance back to standard.

  It was queried why the England Commissioners figure (84.0%) was different to the England Providers figure (86.9%). It was felt that this could be due to cross border patients; however, this would be confirmed.

- Urgent care – pressure continues in the system.

- Cancer – there are capacity issues across all standards with 2 week wait Breast Symptomatic the most concerning. The waiting time at RWT had ceased rising and is now consistent. The backlog is also starting to clear. Following the introduction of a joint programme to relieve pressure on RWT by targeted Wolverhampton GPs asked to consider referring to Walsall or Dudley, where the waiting times are lower, a decrease in referrals to RWT by those practices had been seen. It was agreed to bring a report to the next meeting for consideration. It was clarified that the impact on the local providers is monitored to ensure the target is not breached due to addition referrals to them by the Wolverhampton practices.

  Discussion is due to take place with the Cancer Alliance to gain agreement to look at capacity and demand across the Black Country in identified specialities.

Resolved: The Committee

- noted the update given.
- Clarification of England Commissioner and Provider figures to be sought
- Report on the impact of the joint programme to reduce pressure on RWT with targeted practices to be shared at the next meeting.

8. Finance Report

FP.398 Mrs Sawrey introduced the report relating to Month 3, June 2019;

- Financial metrics are being met.
- Extension to control total to £13.178 includes £3.15m of additional surplus as required by NHSEI. A review of QIPP schemes was being undertaken to ensure that the increase in the control total is covered by additional QIPP and to identify slippage in schemes. This is non-recurrent and is covered within risk/mitigation in year
- RWT SLAM Month 2 data required continued further analysis
- Breakeven reported due to limited monitoring data being received.
- M2 data is indicating overperformance at RWT with a significant overspend. A meeting between the CCG and RWT's DoFs and their deputies had taken place to work towards a joint understanding of the forecast position. These meetings are to take place monthly and the Finance and Activity subgroup is to be reintroduced to meet between the DoFs meetings.
- Mental Health NCAs continued to be an area of concern as the level of expenditure and patient complexity was increasing. Many of the patients were receiving observations resulting in higher

than normal daily rates. The levels of NCAs are volatile as is the type and cost of care required and received.

A number of patients had been discharged from Specialised Commissioning beds into WCCG commissioned beds. There had been and continued to be a number of discharges and there was an expectation that requests for joint funding packages with WCC for patients discharged into community packages will be forthcoming which are being quantified and would add to cost pressure. This was being managed by the Finance and Contracting teams.

The Committee considered the CCG/RWT Risk/Gain Share Model for 2019 and the variation to plan for the CCG due to the current over performance in unplanned activity. It was noted that significant movement would impact on the risk/gain share agreement for 2019/20.

Resolved: The Committee;

- Noted the contents of the report.

9. Contract and Procurement Report

FP.399 Mr Middlemiss presented the following key points;

Royal Wolverhampton NHS Trust (RWT)

- Maternity Cap – previously a cap had been introduced by RWT on the number of births it could safely manage. The Trust achieved the aim of keeping this number below 5000 births in 2018/19. The cap has not been formally lifted; however the Trust will continue to monitor the situation and will look to accept a limited number of cases from adjacent areas in 2019/20.
- Phoenix Walk In Centre – The Governing Body had supported the expansion of this service to an Urgent Care Centre. The CCG will write to RWT confirming agreement to the business case. This will include a confirmed financial quantum for 2019/20 and beyond, specific reporting requirements and details on how information will be included in the Service Level Agreement Monitoring (SLAM).

Black Country Partnership Foundation Trust (BCPFT)

Performance and Quality Issues

- Improving Access to Psychological Therapies (IAPT) target - the Trust had underperformed in Month 1 and 2 and had submitted a Remedial Action Plan which showed continued underperformance until Month 5. The CCG had issued a Contract Performance Notice as this was unacceptable. The 3 key areas of concern were accommodation, reporting and recruitment. Further details and assurance are required from the provider. It was reported that the local Primary Care

Networks are keen to have IAPT staff in surgeries as it is beneficial to the patients. Work is continuing to source suitable locations.

Other contractual issues

- Decommissioning of Wellbeing Service – the CCG is decommissioning the service and transitioning it into Complex Care due to concerns with the service not being consultant led and unacceptably long waiting lists.

  The target timeline for this change is proposed as December 2019 and an implementation plan is expected from the Trust by September 2019.

Other Contracts

Accord Housing Association Limited – Probert Court

From 30th June 2019 the contract with Accord for services at Probert Court had ended and been replaced by two alternative nursing homes, Eversleigh and Primrose Hill. The CCG's CHC and Quality Teams were supporting with implementing the service and ensuring the quality standards expected by the CCG are met.

Resolved: The Committee

- Noted the updates given and actions undertaken.

12. Additions/updates to Risk Register

FP.400 There were no additions or up dates for the risk register.

13. Any other Business

FP.401 There were no items to discuss under any other business.

12. Date and time of next meeting

FP.402 Tuesday 27th August 2019 at 2.00pm, CCG Main Meeting Room

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 2 July 2019 at 2.00pm
PA125 Stephenson Room, Technology Centre, Wolverhampton Science Park WV10 9RU

MEMBERS ~

Wolverhampton CCG ~

Name	Position	Present
Sue McKie	Chair (voting)	Yes
Les Trigg	Lay Member (Vice Chair) (voting)	Yes
Steven Marshall	Director of Strategy & Transformation (voting)	Yes
Sally Roberts	Chief Nurse & Director of Quality (voting)	No
Dr Salma Reehana	Clinical Chair of the Governing Body (non-voting)	No
Dr David Bush	Locality Chair / GP (non-voting)	No
Dr Manjit Kainth	Locality Chair / GP (non-voting)	No

NHS England ~

Bal Dhami	Senior Contracts Manager – Primary Care, NHSE	Yes

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
John Denley	Director of Public Health	No
Dr B Mehta	Wolverhampton LMC	No
Jeff Blankley	Chair of Wolverhampton LPC	No

In attendance ~

Helen Hibbs	Chief Officer (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Co-ordinator	Yes
Mike Hastings	Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Claire Morrissey	Strategic Transformation Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Awa Jallow	Work Experience Student (Observer)	Yes

Welcome and Introductions

WPCC530 The Chair welcomed attendees to the meeting and introduced Awa Jallow who was shadowing Ms Corrigan as part of her work experience placement with the CCG.

Apologies

WPCC531 Apologies were received from Sally Roberts, John Denley and Dr Ankush Mittal (who was due to attend on John Denley's behalf), Jeff Blankley and Drs Bush, Reehana and Mehta.

Declarations of Interest

WPCC532 The Chair declared that she had an interest in items relating to Primary Care in her role with the Child Death Overview Panel for Walsall and Wolverhampton. As this did not constitute a Conflict of Interest, she remained in the meeting.

Minutes of the Meeting held on the 4th June 2019

WPCC533 The minutes of the meeting held on 4 June 2019 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from Previous Minutes

WPCC534 There were no matters arising from the previous minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC535 **Action 37 (Minute No: WPCC525) – Wolverhampton Primary Care Strategy update**
An update to be provided to committee in Sept (as Aug meeting cancelled)

Action 38 (Minute No: WPCC526) – STP Primary Care Strategy Update
An update had been provided to committee members. Further update due at Sept meeting.

Action 39 (Minute No: WPCC481) – Tettenhall Medical Practice – Wood Road Branch Closure
This had been transferred from the Private meeting and an update was due to be provided at the meeting in September.

RESOLVED: That the above was noted.

Primary Care Update Reports:

Primary Care Quality Report

WPCC536 Ms Corrigan presented the report, highlighting the following key points:-

- The Serious incident reported to NHS England's Practice Performer Intelligence Gathering Group (PPIGG) had been closed with no further action.
- Four issues raised through Quality Matters were being referred to PPIGG but no significant action was anticipated.
- The annual programme of Infection Prevention Audits was due to commence, further details, including exact dates, were awaited.
- Uptake of Friends and Family Test (FFT) continued to outperform regional and national benchmarks.
- The programme of collaborative contracting visits to practices was due to be completed by the end of July.
- The STP Practice Nurse strategy approved by the committee had been endorsed by the STP Clinical Leadership Group and was being considered by the other CCGs' Primary Care Commissioning Committees.

In response to a query around the timescale for approval of the Practice Nurse strategy, Ms Corrigan confirmed that, following agreement at the STP clinical leadership group, the other CCGs were developing timescales for approval to allow consultation with appropriate stakeholders, including local medical councils.

RESOLVED: That the report and highlights above were noted.

Ms Corrigan and Ms Jallow left the meeting.

Primary Care Operational Management Group Update

WPCC537 Mr Hastings presented the report, highlighting the following key areas of discussion at the June meeting of the group:-

- Patient feedback from the consultation on the proposed closure of the Wood Road branch surgery of Tettenhall Medical Practice continued to be gathered. The local MP had arranged a public meeting at which the CCG would be represented.
- The planned IT system migration for Bilston Urban Village had been pushed back in agreement with the new providers.
- Estates work funded through the NHS England Estates and Technology Fund (ETTF) had been completed at Newbridge Surgery and work at East Park was almost complete. Discussions around potential rationalisation of estate in the Oxley area was underway with the local GPs.

RESOLVED: That the update was noted.

Primary Care Networks Update

WPCC538 Ms Southall presented the report, which provided an update on the development of Primary Care Networks (PCNs), including a request from the Royal Wolverhampton Trust network for approval to change their designated clinical director.

The report highlighted work by the Primary Care and Finance teams to ensure that appropriate payments related to the new network Directed Enhanced Service (DES) would be made in line with requirements. These payments included reimbursement for Clinical Director time and new roles including Social Prescribing Link Workers and Clinical Pharmacists. The PCNs had agreed that provision for Social Prescribing should link in with the existing service provided by Wolverhampton Voluntary Sector Council and a Service Level Agreement was being developed to support this.

In response to questions in relation to social prescribing, Ms Southall confirmed that the funding available was to employ link workers for each PCN in addition to those employed through the existing service. She highlighted that the long term plan would require additional link workers to be in place in future years and the PCNs were working with the Voluntary Sector Council to understand how this would be implemented in a complementary way to existing provision.

The report also highlighted the offer available to PCNs, in line with a self-assessment of their maturity, for support with their development. A national prospectus provided eight modules across a range of issues that would support the development of mature PCNs. In response to a question, Ms Southall confirmed that PCNs would have flexibility in which modules they took up, based on the needs identified through the maturity matrix self-assessment. The CCG's Primary Care Group Managers were working with PCNs to identify areas where they would benefit from the development offer available. In response to further questions, she also confirmed that PCNs were working to understand their population health needs to identify service requirements and that, in line with on-going assurance processes and measures identified in the NHS Long Term Plan implementation Framework, measures of success would continue to be developed.

The Chair highlighted the importance of continued patient engagement as PCNs matured and it was noted that PCNs were being supported in meeting their responsibilities in these areas. In response to a question around the identification of risks associated with the development of PCNs, Ms Southall confirmed that, as networks matured and the STP and CCG Primary Care priorities crystallised, risks would be identified and assessed.

The Committee were informed that, when the Royal Wolverhampton

Trust PCN had submitted their network application they had not completed the process of identifying a substantive Clinical Director and had named Dr Julian Parkes as an interim Clinical Director. Following the conclusion of the process, Dr John Burrell was now nominated as the Clinical Director and the committee were asked to approve this change.

RESOLVED:

1) **That approval be given to the change of Clinical Director for the Royal Wolverhampton Trust Primary Care Network to Dr John Burrell.**
2) **That the update was noted.**

Primary Care Training Hub Proposal

WPCC539 Ms Southall advised the committee that a proposal for the Primary Care Training Hub provision for Wolverhampton had been developed but that, due to commercial confidentiality, would be discussed during the private part of the agenda.

Quality Assured Spirometry Business Case (revised costs)

WPCC540 Ms Morrissey presented the report, which advised the committee that, following discussion with Clinical Directors, the costs associated with the development of a Primary Care Spirometry service had increased. The Business case for the proposal had been revised and the committee's attention was drawn to the revised costs which were now calculated to be £62,440 for 2019/20 and around £126,500 in future years.

Ms Morrissey also advised that each of the Primary Care Networks (PCNs) had been asked to develop an implementation plan for the service and that not all networks would be in a position to commence the service until Quarter 4. In response to a question about the activity and costing levels outlined in the report, she highlighted that they were projections, there was likely to be an element of season variation and that data suggested current patient registers did not match with expected prevalence. It was noted that, whilst this meant that the cost for Spirometry could therefore be higher, investment in earlier diagnosis would lead to savings through preventative measures across the broader pathway. In response to a further question about arrangements in the Royal Wolverhampton Trust PCN, it was confirmed that discussions continued with all PCNs to develop their implementation plan.

The Chair raised a query in relation to the uptake of training for practice nurses and Ms Southall confirmed that one date had been cancelled as, whilst practices were working on their implementation plan, they needed to clarify their workforce requirements as a number of nurses had already been trained. The committee asked that an update on the implementation of the service be provided in October 2019.

RESOLVED:

1) **That the revised costs for the Quality Assured Spirometry Service in Primary Care be noted.**
2) **That an update on the implementation of the service be provided in October 2019.**

Any Other Business

WPCC541 **Practice Resilience Funding**

Ms Southall advised that the STP GP Forward View programme board received funding to support practice resilience and had asked each CCG to consider how this might be used in each area. The Operational Management Group was due to discuss potential funding requirements for Wolverhampton and a proposal would be circulated for virtual approval by the committee prior to its next meeting.

Committee Meeting Frequency

The Committee agreed to cancel the August 2019 meeting and consider whether a Bi-monthly programme of meetings would be possible.

Date of Next Meeting

WPCC542 **Tuesday 3 September at 1.30pm 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 27th June 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	No

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	No

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Sally Roberts	Chief Nurse & Director of Quality	No
Andrew Wolverson	Head of Service People - Commissioning - WCC	No

In Attendance ~

Alison Lake	PA	Yes
Vic Middlemiss	Head of Contracting & Procurement	No
Philip Strickland	Governance & Risk Coordinator	Yes
Hemant Patel	Head of Medicines Optimisation	Yes
Alicia Wood	Commissioning Manager - WCC	Yes

Apologies for absence
Dr Gulati, Sally Roberts, Vic Middlemiss and Andrew Wolverson

Declarations of Interest
CCM807 None.

Minutes
CCM808 The minutes of the last Committee meeting, which took place on 30th May 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM809 None

Committee Action Points

CCM810 None to review.

RESOLVED: That the above is noted

Repeat Prescription Management Project in General Practice

CCM811 The Committee was presented with a report to discuss the findings of a repeat prescription audit and a plan to reduce waste and minimise variation between primary care practices by means of planned management programme to medicines optimisation.

RESOLVED: That the above is noted and the plan was approved.

Contracting Update

CCM812 The Committee was presented with a report update for the period June 2019.

Royal Wolverhampton NHS Trust

Performance Targets

Contract Performance

The CCG financial position for April 2019 shows an over performance of £700K, an analysis is being carried out to establish the cause. The outcome is based solely on one month of data and a more robust activity pattern will emerge throughout the financial year.

Diagnostics – the Trust continues to see a high numbers of referred patients into Radiology. The department is working closely with the Cardiac ? cardiologyto fully utilise current capacity.Additional capacity has been made available for April and May (2019) to ensure target is maintained.

Referral to Treatment – Target for April 2019 was missed. The Trust has moved to an electronic referral system however, due to technical issues the Trust has put in place a manual system to ensure information for each patient is entered onto the system on a daily basis.

Cancer Targets –

RWT continues to predict failure of the following indicators:

- 2 week wait,
- 31 Day Sub-surgery target
- 62 Day Screening
- 62 Day wait for first treatment.

The Trust has seen a steady rise in Breast referrals over a short period of time; that being an average of 84 per week to an average of 105 per week (19.75% growth). Whilst additional capacity has been made available, performance is now at its lowest ever position, with only 3.77% of patients being seen within 2 weeks for breast symptomatic.

A pilot has been agreed for Urology with the introduction of a new referral form and pathway. This will run for a 6 month period with Wolverhampton GPs.

Other Contractual Issues

Dermatology

Meetings with RWT are focused on mobilisation and transitions of the service. Further discussions with the Trust are ongoing.

Phoenix Walk in Centre

The contract between RWT and the CCG has been finalised and signed. Discussions continue around CQUIN which remains to be agreed.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

Improving Access to IAPT

The Trust has underperformed in April and May 2019 and not met the IAPT target. The CCG has requested a plan of action to aid the Trust in recovery of performance.

Data Quality Improvement Plan (DQIP)

The CCG has requested a project plan with milestones for the implementation of Graphnet to ensure progression. Meetings will be taking place and the Trust will be asked to work collaboratively to identify Personal Health Budgets with Sandwell and West Birmingham CCG.

Other contracts

Accord Housing Association Ltd – Probert Court

Contract terms have not been reached between the CCG and Accord; therefore the contract will end 31 June 2019. Arrangements are currently underway to wind down the service and other providers are currently being sourced to take up this service.

Acorn Children's Hospice

The CCG has received correspondence from Acorn stating their intentions to terminate the hospice at home service and the hospice in Walsall.

Patients are currently being consulted and work is underway to assess the impact of the closure and determine alternative prevision.

RESOLVED – The Committee noted the updates and actions being undertaken.

Review of Risk

CCM813 The Committee was presented with the current corporate risks and noted that there were no changes but needed updating.

A new addition to the register is –

CC15 – Monitoring of cost concerns after transfer of the Dermatology service.

CC14 – Monitoring to continue on the Acute Dermatology provision.

RESOLVED – That the above has been noted and agreement given to add additional risks linked to dermatology to the risk register and to monitor the new risk.

Any Other Business

There were no items raised under any other business.

Date, Time and Venue of Next Meeting

Thursday 25 July 2019 at 1pm in the CCG Meeting Room 1

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 25th July 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	No
Tony Gallagher	Director of Finance	Yes
Sally Roberts	Chief Nurse & Director of Quality	No
Andrew Wolverson	Head of Service People - Commissioning - WCC	No

In Attendance ~

Helen Pidoux	Business Operations Support Team Manager	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Philip Strickland	Governance & Risk Coordinator	Yes (part)
Yvonne Higgins	Deputy Chief Nurse	Yes

Apologies for absence

Apologies were received from Steven Marshall and Sally Roberts

Declarations of Interest

CCM814 There were no declarations of interest.

Minutes

CCM815 The minutes of the last Committee meeting, which took place on 27th June 2019 were agreed as a true and accurate record with the following to be amended;

- Vic Middlemiss was not in attendance at the meeting
- Cancer targets paragraph to be updated as it duplicated the Referral to Treatment information.

RESOLVED: That the above is noted. Vic Middlemiss to update cancer targets paragraph.

Post meeting note: minutes update to read;

Cancer Targets –

RWT continues to predict failure of the following indicators:

- 2 week wait,
- 31 Day Sub-surgery target
- 62 Day Screening
- 62 Day wait for first treatment.

The Trust has seen a steady rise in Breast referrals over a short period of time; that being an average of 84 per week to an average of 105 per week (19.75% growth). Whilst additional capacity has been made available, performance is now at its lowest ever position, with only 3.77% of patients being seen within 2 weeks for breast symptomatic.

A pilot has been agreed for Urology with the introduction of a new referral form and pathway. This will run for a 6 month period with Wolverhampton GPs.

Matters Arising

CCM816 There were no matters arising

Committee Action Points

CCM817 There were no current actions to review.

Contracting Update

CCM818 The Committee was presented with a n update for the period July 2019.

Royal Wolverhampton NHS Trust

Performance Targets

The financial position showed an over performance of £1.1m. This is significant and analysis is being undertaken to understand the causes. It was highlighted that it is based on only two month's data and a more robust position will be known as activity patterns become more established during the financial year.

A meeting is to take place between the Directors of Finance from the CCG and RWT to gain a joint understanding of the likely forecast position which will be included in the report submitted to the Finance and Performance Committee.

The impact of over the border patient flows was discussed. It was confirmed that the figures in the report relate to Wolverhampton patients only.

Contract Performance

Referral to Treatment (RTT) - the further deterioration of performance is compounded by increased activity to achieve cancer targets. A Remedial Action Plan (RAP) is awaited from the Trust to provide speciality specific details of the

corrective action being taken.

Other Contractual Issues

Dermatology – Further information on stranded costs had been received from RWT and this is to be discussed by the Directors of Finance from the CCG and RWT with an update brought to the Committee.

Phoenix Walk In Centre – The CCG's Governing Body had supported the proposal for the expansion of the Walk In Centre to an Urgent Care Centre.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

Improving Access to IAPT
The CCG had issued a Contract Performance Notice due to continued underperformance. Close monitoring will continue as part of the Remedial Action Plan. Work is continuing to source suitable locations to resolve accommodation issues.

Other contracts

Accord Housing Association Ltd – Probert Court
This contract had ended and been replaced by two alternative nursing homes from 1st July 2019. The Continuing Care Team is working with the homes to implement a uniform way of working to meet the quality standards expected by the CCG, including streamlining the pathway from RWT.

RESOLVED – The Committee noted the updates and actions being undertaken.

Review of Risk

CCM819 The Committee was presented with the current corporate risks and noted that there were no changes.

There was a new addition to the Committee level risk register –

CC16 – Well-being service BCPFT – the impact of not recommissioning the service and a merger with complex care – discussions are on-going with the service and an update will be brought to the Committee as appropriate.

RESOLVED – That the above has been noted

Any Other Business

CCM820 Proposed branch practice closure (Wood Road) – it was noted that the consultation period had been extended to 30th August 2019. Clarification was given this will be dealt with by the CCG's Primary Care Commissioning Committee (PCCC). This is

included on the risk register of both the PCCC and Primary Care Operational Management Group.

Date, Time and Venue of Next Meeting

Thursday 29th August 2019 at 1pm in the CCG Meeting Room 1

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 21 May 2019 commencing at 11.00am
In JISC 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	PA to Chief Officer and Chair of Governing Body, WCCG (minute taker)

In Attendance:

Mr J Green	Chief Finance Officer, Sandwell and West Birmingham CCG and WCCG
Dr H Hibbs	Accountable Officer, WCCG
Mr A Kay	Head of Financial Resources, WCCG
Mr J McLarnon	Manager, External Audit, Grant Thornton
Dr S Reehana	Chair of the Governing Body, WCCG
Mr M Stocks	Partner, External Audit, Grant Thornton
Ms J Watson	Senior Manager, PWC

Apologies for attendance:

AGC/19/45 Apologies were received from Ms Breadon and Mr Gallagher

Declarations of Interest

AGC/19/46 There were no declarations of interest.

Minutes of the last meeting held on 23 April 2019

AGC/19/47 The minutes of the last meeting were agreed as a true record with the below amendments:

Under AGC/19/26 under Item 147 on page to the word ‘which’ to be replaced with ‘when’.

Under AGC/19/38 that the action allocated to Mr Oatridge ‘That Mr

Oatridge gave a verbal update around cyber security to the Governing Body members' was taken off the action log as this would be picked up under the work undertaken by Mr McKenzie.

Matters arising (not on resolution log)

AGC/19/48 There were no matters arising.

Resolution Log

AGC/19/49 The resolution log was discussed as follows;

- Item 149 – (AGC/19/15) - Counter Fraud Progress Report - Ms Putwa to speak with Mr Mohan if any further information could be shared with the Committee regarding the live investigation that was currently taking place and a timetable for when this information could be received by the Governing Body – Update will be given when possible.
- Item 150 – (AGC/19/16) - Draft Counter Fraud Plan – Ms Putwa to speak to Mr Mohan about the fact that there were no proactive exercises mentioned in the workplan – Workplan 2019/20 was updated to add the Fraud Risk Group involvement and also updated the additional work to be carried out within the Standard 3.2. A final and amended version of the CF Workplan 2019/20 was shared with the CFO.
- Item 153 – (AGC/19/28) - External Audit Progress Report - More granular information would be provided in the final report around testing measures – This had been provided in the report. Closed.
- Item 154 – (AGC/19/30) - Cyber Security - Mr McKenzie to bring back a report of the organisations performance against the 10 cyber risks once completed – To be discussed at July 2019 Audit and Governance Meeting.
- Item 155 – (AGC/19/31) - Delegated Commissioning Final Report – Internal Audit to provide further information in respect of the medium risk identified around incomplete deadlines for practice visits and the testing used – On agenda.
- Item 156 – (AGC/19/32) - Risk Management Report - Staff reminded to look at their relevant risk registers and update them – This had been followed up and staff training was being arranged. Closed.
- Item 157 – (AGC/19/33) - Draft Internal Audit Plan for 2019/2020 - Mr McKenzie to add a line in the Board Assurance Framework to show which audit function was sending assurance around certain areas – to be discussed at July Audit and Governance Committee Meeting.
- Item 158 – (AGC/19/36) - Draft Governance Statement – The final draft would be presented at the next Audit and Governance Committee Meeting – On agenda.
- Item 159 – (AGC/19/37a) - Draft Committee Annual Report – Mr McKenzie to show actions against the effectiveness review to the annual report – On agenda.
- Item 159 – (AGC/19/37b) - Draft Committee Annual Report – Miss Patel to include this to the July Audit and Governance Committee

agenda – On agenda.

- Item 161 – (AGC/19/38) - Draft Final Account and their Preparation - Mr Kay and Mr Green were asked to look at the wording on page 14 of the document with regard to the sentence 'The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared'. – Update. Closed.
- Item 162 – (AGC/19/39b) - Draft Final Account and their Preparation - Mr Kay to provide further explanation around whyld be given around why there had been an increase in expenditure from 23 in 2017/2018 to 382 in 2018/2019 with regards to Other Professional Fees under Operating Expenses – This was due to there being a new subjective code which meant that mapping was different so the interpreting fees had now been added to the professional fees amount. Closed.

Final 2019/20 Internal Audit Plan

AGC/19/50 Ms Watson advised that the Final 2019/20 Internal Audit Plan now included days allocated to HR/Restructuring as discussed at the previous Audit and Governance Committee meeting.

It was confirmed that the sentence on page 7 of the report ' We ask Management and the Audit and Governance Committee to confirm that they accept this risk and are confident that assurance, where needed, is being provided from other sources' was a standard statement issued in reports.

The Committee also felt that it would be beneficial for there to be a KPI around the proportion of audits completed through the year. This would allow better measuring of deadlines by quarter. Dr Hibbs agreed that this would be a good idea but there should be a caveat that if things couldn't be completed for example if it wasn't the correct time to do so that deadline could be changed. Ms Watson said that this could be monitored by both Internal Audit and the Executive Team.

RESOLUTION: The Committee:

- Accepted the plan for future work.
- Internal Audit to add a KPI around the proportion of audits completed through the year.

Internal Audit Report: Data Protection Act 2018

AGC/19/51 Ms Watson presented a report on Internal Audit Report on the CCG's arrangements in respect of the Data Protection Act 2018. There had been one medium risk finding around 'Monitoring performance of the CSU' and one low risk 'Operating effectiveness'.

It was a very positive report and the Chair thanked Mr McKenzie and his team for their hard work around data protection.

RESOLUTION: The Committee:

- Noted and accepted the report.

Internal Audit Annual Report 2018/19 (which includes the Head of Internal Audit Opinion)

AGC/19/52 A draft Audit Opinion had been given at the last meeting as 'generally satisfactory with some improvements required' pending the completion of internal audit work for the year.

The Internal Audit team confirmed that, following the completion of audit work this had now been changed to 'satisfactory', the highest rating of assurance provided. Although there were medium risks identified, the internal audit team had seen evidence that the CCG were actively working to manage and mitigate risks. It was noted that a rating of satisfactory was rarely given and the CCG was commended on this.

Ms Watson advised that there was the potential that risks would increase for the CCG as they started to work and potentially merge with other organisations. The Committee asked if the Internal Audit team could provide a paper on learning experiences around this from other areas which they would like to share with the Black Country Transition Board.

The Committee reiterated that they understood the risks associated with potential mergers but accepted that the CCGs would retain statutory responsibilities that would need to be met.

RESOLUTION: The Committee:

- Noted and accepted the report.
- Internal Audit to provide a paper on learning experiences from merged organisations and risks to be shared with the Black Country Transition Board.

External Audit and the report to those charged with governance

AGC/19/53 The External Audit Team issued the CCG with an 'unqualified opinion' on the Financial Statements.

As highlighted in previous reports, the External Auditors had examined the potential value for money risks around cancer and mortality performance at Royal Wolverhampton Trust (RWT) and concluded that the CCG was doing all it could do drive change at RWT in these areas.

The report was very positive and External Audit thanked the finance team for their assistance.

The Committee thanked Mr Gallagher, Mr Kay and the finance team for their hard work.

RESOLUTION: The Committee:

- Noted the report.

Management Representation Letter

AGC/19/54 Mr Trigg highlighted that some of the wording in the Management Representation Letter was not necessarily proportionate for Governing Body Members, particularly for those without technical financial expertise who would be signing this off.

It noted that the wording reflected nationally defined expectation and it was agreed that future management representation letters would be circulated in advance of sign off meetings in order for Governing Body Members to discuss and raise any questions about the content of the letter.

RESOLUTION: The Committee:

- Noted the report.
- Management Representation Letters to be issued in advance for Governing Body Review in the future.

CCG Annual Report, Final Accounts and their Preparation

AGC/19/55 Mr Kay presented the final accounts with the changes that had been made. This was as below:

- Page 92 – 1.51 – 'Leases' section deleted as they are not material.
- Page 94 – 1.17.1 – A line re 'Financial Assets at Amortised cost' taken out as not relevant.
- Page 95 – noted re 'Foreign Currency' and 'Research and Development' taken out as not appropriate.
- Page 97 – Note 4 - figures amended to show no decimal places.
- Page 99 – Note 4.5 - Pension note replaced by new version from NHSE.
- Page 103 – Note 17.3 – Impact of IFRS 9, figures realigned as they were showing against the wrong column headings and figures included on ' Financial Assets measured at amortised cost' (previously missing).
- Page 105 – Note 23.1 – Figures included on line 'financial liabilities measured at amortised cost' (previously missing)
- Page 107 – Note 30 – Irrelevant columns taken out.
- Page 108 – Note 33.1.1 and 33.1.2 replaced 'low exposure' to 'no exposure'
- Page 110 – Pooled Budget now shows only CCG expenditure
- Page 111 – Walsall CCG related parts payment amended.

The overall position of the CCG was still showing as a 42k surplus.

RESOLUTION: The Committee:

- Approved the changes made and the Chair would recommend the signing off of the accounts at the Governing Body Meeting.

Final Governance Statement

AGC/19/56 The Head of Internal Audit Opinion had now been added to the report.

RESOLUTION: The Committee:

- Noted the report.

Committee Annual Report

AGC/19/57 The additional wording on section 3 on committee effectiveness had been added following the discussion at the last meeting. The report would be presented to the Governing Body as confirmation that the committee had met its terms of reference.

RESOLUTION: The Committee:

- Noted and accepted the report.

Feedback to and from the Audit and Governance Committee

AGC/19/58 The main point highlighted was the ongoing discussions at the Transition Board about the changes that would be occurring.

Dr Hibbs informed the Committee that there was an event that she would be attending where Simon Stevens would be talking about ICS and single commissioning.

RESOLUTION: The Committee:

- Noted the update

Losses and Compensation Payments – Quarter 4 2019/20

AGC/19/58 As previously noted at a previous committee there was only one loss to be reported regarding a stolen laptop in a house burglary.

RESOLUTION: The Committee:

- Noted the report.

Suspension, Waiver and Breaches of SO/PFPS

AGC/19/59 Mr Kay noted the below in quarter 4 of 2018/19:

- During quarter 4 of 2018/19 there were 18 invoices in breach of PFPs (3.08% of all invoices paid);

- 22 waivers were raised during quarter 4 (48 in the year);
- 57 non-healthcare invoices were paid without a purchase order being raised during quarters 4 (151 in the year).

RESOLUTION: The Committee:

- Noted the report.

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

AGC/19/60 The Committee noted that as at March 2019 there were:

- There was one invoice greater than 10k and over 6 months old.
- 6 purchase ledger invoices greater than £10k and over 6 months old.

Mr Oatridge asked about the invoice for Wolverhampton City Council dated 17 January 2018 which had still not been dealt with. Mr Kay advised that he would look into this and feedback at the next meeting.

RESOLUTION: The Committee:

- Noted the above.
- Mr Kay to look into the resolution of outstanding invoices.

A&G CSU Service Auditor Report (for CCG CFOs and Deputies)

AGC/19/61 This paper was received for information

RESOLUTION: The Committee:

- Noted the report

ES ISAE 3402 Report

AGC/19/62 This paper was received for information

RESOLUTION: The Committee:

- Noted the report

Any Other Business

AGC/19/63 There were no items to discuss under Any Other Business.

Date and time of next meeting

AGC/19/64 Tuesday 30 July 2019 at 11am at Wolverhampton Science Park

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Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 9th May 2019

Members:
Dr Salma Reehana – Chair, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Paul Maubach – Accountable Officer, Dudley CCG and Walsall CCG
Dr Anand Rischie – Chair, Walsall CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG and Wolverhampton CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Chief Finance Officer, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG
Julie Jasper – Lay Member, Sandwell & West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Laura Broster – Director of Communications and Public Insight, Dudley CCG

In Attendance:
Alastair McIntyre – Portfolio Director, Black Country & West Birmingham STP
Charlotte Harris – Note Taker, Black Country & West Birmingham STP
Deborah Rossi – Transition Director, Black Country & West Birmingham CCGs
Jonathan Fellows – Independent Chair, Black Country & West Birmingham STP
Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG
Steven Marshall – Director of Strategy and Transformation, Wolverhampton CCG
Vic Middlemiss – Head of Contract and Procurement, Wolverhampton CCG

Apologies:
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 There were no declarations of interest.

1.4 The minutes of the meeting held on the 11th April 2019 were agreed as an accurate record.

1.5 The action log was reviewed and actions confirmed as delivered or others taken within the agenda.

1.6 Actions 141, 142, 147, 148 and 149 were closed. In regards to action 147, a report will be submitted to the July JCC meeting.

1.7 In regards to action 140, there is a planning session scheduled for the STP on 07 June 2019. It was agreed there would need to be a session before for commissioners to discuss the models under consideration in the four areas. David Frith, Strategy Unit, is completing a paper on the similarities and differences between the models. It was agreed another date for this

discussion will be sought. It was noted on 23 May 2019, there is a West Midlands "Thinktank" which can allow the members to be cited on what is being done by the Strategy Unit.

1.8 Action 146 was deferred.

2. CCG TRANSITION BOARD

2.1 The Terms of Reference has been amended and sent to Governing Bodies for approval. The chairing arrangements have been agreed. The next meeting is to discuss the draft options appraisal report. There will be an agenda item for the JCC Executive Development Session on the 23 May 2019 regarding a single commissioning voice.

3. CLINICAL LEADERSHIP GROUP (CLG) UPDATE

3.1 Prof Nick Harding updated members on ongoing discussions from the CLG. At the April meeting there was an update from Sarah Shingler and Timothy Horsburgh on the Children and Young People workstream. There was a review of the model hospital date analysis. A cancer update will be a standing agenda item due to the current performance issue. There was a focus on breast cancer and 2 Week Wait performance at Wolverhampton. The value of the clinical senate and clinical networks were discussed at the meeting with an action for Prof Nick Harding and Dr Helen Hibbs to write to Dale Bywater setting out the STP views – the JCC noted that this has been done. Prof Nick Harding gave an update on progress with the challenged services work and that Jonathan Odum is now leading on this.

4. FORMALLY DELEGATED AREAS

4.1 Transforming Care Partnership

4.1.1 Steven Marshall gave an update in Dr Helen Hibbs's absence. There was a discussion on the total numbers and there has been a reduction in beds. There is still pressure to reduce bed numbers. There is still a challenge around admissions. It was agreed it would be beneficial to understand the Black Country Partnership FT community model and how this is being clinically led. It was agreed they would be invited to attend the next JCC meeting.

4.1.2 Laura Broster informed the meeting that the engagement phase (for the community model) is closing on 23 May 2019 for public comments. The Operations group will then be doing a review in June. It was agreed this needs to be total review not just a focus on the engagement aspect.

Action: A presentation from the Black Country Partnership FT community model for Transforming Care Partnership to occur at the June JCC meeting.

Dr Anand Rischie entered the meeting.

4.2 Mental Health

4.2.1 Reporting has moved to a bi monthly cycle. There was no update this month.

4.3 CHC Care Home Procurement – Highly Complex Care – Proposal

4.3.1 Vic Middlemiss discussed the procurement update on CHC complex care. There has been significant progress. It was noted the project group, with representatives from all four CCGs, had discussed and considered various procurement options with Any Qualified Provider (AQP) being the preferred option. This is currently being used for Core CHC. A paper which outlines all risks and benefits of all of the options was available. A comprehensive Service Specification is being developed. There will be a market and engagement event in early June.

4.3.2 It was proposed that Wolverhampton CCG assume the role of the host commissioner. Wolverhampton CCG Governing Body would sign off the procurement documentation and behalf of the other CCGs. Wolverhampton CCG would be designated as lead contracting authority, with the other CCGs names as associates. It was proposed each of the CCGs remain responsible for payment to providers as determined by individual patients and their registered GPs.

4.3.3 It was agreed the Service Specification would need to be tested against existing strategic priorities. There should be a minimum criteria required for Care Homes such as with IT. This could be developed into a generic specification for CHC and Care Home placements. There is a risk regarding there being less provision than originally available by moving to AQP which could impact on the continuity of care. The CHC Complex Care spend for 2018/19 will need to be reviewed and it would be beneficial to have the 2019/20 forecast. Vic Middlemiss informed that the matrix to collect the information is being expanded to include more granularity. There is a need to ensure there is a common detailed cohort of patients for the Black Country. The risk of stability of the provider market will need to be monitored and recorded on a risk register.

4.3.4 It was agreed a paper would be presented to the four CCG Governing Bodies recommending delegated authority to the JCC regarding CHC Care Home Procurement.

Vic Middlemiss left the meeting.

5. RISK REGISTER

5.1 The issue of limited delegated authority was discussed and the impact on moving at pace. It was agreed this can be discussed at the Transition Board.

5.2 Peter McKenzie will be a single point of contact for Governance and will ensure that a representative from one of the four CCGs will be in attendance at each JCC (and Transition Board) going forward.

6. MATTERS OF COMMON INTEREST

6.1 **Place Based Update – Sandwell & West Birmingham**

6.1.1 Andy Williams discussed the care alliance arrangements and the progress that has been made. For West Birmingham, the Birmingham Health and Well Being board have rejected the outcomes framework.

6.1.2 The second phase of the boundary consultation has closed. It was noted the timeframe and logistics will need to be taken into account. The intentions of the regulators is unclear.

Steven Marshall left the meeting.
Peter McKenzie entered the meeting.

6.2 **Performance and Assurance Return**

6.2.1 The performance data for each STP will now be available monthly, provided by NHS England and NHS Improvement (NHSE/I).

6.2.2 NHSE/I have yet to confirm the reporting arrangements for tracking Transformation Assurance. In the meantime we will proceed as last year until any alternate process is agreed.

6.2.3 The Bronze Pack will be circulated for information. It was suggested RightCare and Get It Right First Time (GIRFT) information could also be presented.

6.3 **Midland Metropolitan Hospital (MMH)**

6.3.1 This is business as usual. The hospital will open in 2022. An operational plan for commissioning is being developed. There may be an adjustment of sites but this is not formalised and is subject to consultation.

Alastair McIntyre left the meeting.

6.4 **Staff Survey Results (all CCGs)**

6.4.1 The CCGs are conscious of the increased levels of uncertainty of staff regarding their future. There will be continued transparency to try to reduce this.

7. FEEDBACK FROM GOVERNING BODIES

7.1 No update was given.

8. UPDATE FROM STP

8.1 There is a workshop on MMH on 31 May 2019.

8.2. There is Board to Board with Birmingham and Solihull STP on 12 June 2019.

8.3 There is a review of the governance of the STP regarding the representation of Primary Care Networks (PCN) and Non-Executives. The proposed PCN leaders have indicated they would like four seats; one seat to represent each place.

9. ITEMS FOR INFORMATION

9.1 There were no items raised.

10. ANY OTHER BUSINESS

10.1 There were no items raised.

11. DATE OF NEXT MEETING

Thursday 13 June, 09:00-10:30, Meeting Room 1, 2R, Kingston House, 438-450 High Street, West Bromwich, B70 9LD

JCC Action Log

No.	Date	Action	Lead	Deadline	Status Update
140	14th Mar 2019	CCGs to meet and discuss the models under consideration in the four places and look at how these build to a sustainable ICS and ensure sustainability when trying to establish acute collaboration.	Alastair McIntyre Matthew Hartland	31st May 2019	
143	14th Mar 2019	Dr Helen Hibbs to take forward an exercise to map all current Specialised Services, understand which services could be delegated and identify the risks from the direction of travel for Specialised Services. Dr Helen Hibbs also to discuss Specialised Services with Alison Tonge.	Dr Helen Hibbs	End of July 2019	Meeting arranged to discuss Specialised Services for 18 June 2019
146	11th Apr 2019	Dr Helen Hibbs to share the West Midlands Quality Review Service workforce review information with JCC members	Dr Helen Hibbs	9th May 2019	

150	9th May 2019	A presentation from the Black Country Partnership FT community model for Transforming Care Partnership to occur at the June JCC meeting.	Dr Helen Hibbs	9th May 2019	**Completed**

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Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 9th June 2019

Members:
Dr Salma Reehana – Chair, Wolverhampton CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Paul Maubach – Accountable Officer, Dudley CCG and Walsall CCG
Dr Anand Rischie – Chair, Walsall CCG
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG and Wolverhampton CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Chief Finance Officer, Walsall CCG
Helen Mosley – Lay Member, Dudley CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Laura Broster – Director of Communications and Public Insight

In Attendance:
Alastair McIntyre – Portfolio Director, Black Country & West Birmingham STP
Charlotte Harris – Note Taker, Black Country & West Birmingham STP
David Frith – Black Country Academy Proposal, Strategy Unit
Deborah Rossi – Transition Director, Black Country & West Birmingham CCGs
Jonathan Fellows – Independent Chair, Black Country & West Birmingham STP
Peter McKenzie – Corporate Operations Manager, Wolverhampton CCG
Sharon Liggins – Interim Chief Operating Officer, Sandwell & West Birmingham CCG
Suzanne Brady – TCP Community Model, Black Country Partnership Foundation Trust

Apologies:
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Julie Jasper – Lay Member, Sandwell & West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC

1. INTRODUCTION

1.1 Welcome and introductions as above. Dr Anand Rischie chaired the meeting until the arrival of Dr Salma Reehana.

1.2 Apologies noted as above.

1.3 Jim Oatridge declared an interest in regards to item 11.1 as he is a Governor for the University.

1.4 The minutes of the meeting held on the 11th April 2019 were agreed as an accurate record.

1.5 The action log was reviewed and actions confirmed as delivered or others taken within the agenda.

1.6 In regards to action 140 this was confirmed to be in regards to a strategic conversation regarding financial flows. It was agreed the deadline would be revised to 31 August 2019 and a discussion on what is needed would occur.

1.7 In regards to action 146, this was closed as the CSU are completing a workforce review.

1.8 Action 150 was closed.

Alastair McIntyre, Paul Maubach and Dr Salma Reehana entered the meeting.

2. CCG TRANSITION BOARD

2.1 There have been discussions on the 3 phase workplan. There has been the recommendation for a single Accountable Officer for the CCGs. There will be a Remuneration Committee (Rem Comm) in common on 18 June 2019. There will a decision in the July Governing Body meetings. They are reviewing the timetable for Governing Body phasing of future steps for a single commissioning voice. There will be monthly communications to employees.

3. CLINICAL LEADERSHIP GROUP (CLG) UPDATE

3.1 Dr Anand Rischie updated members on ongoing discussions from the CLG. At the May meeting there was a discussion on Vulnerable Services which Dr Jonathan Odum is leading.

3.2 Dr Helen Hibbs noted the concerns regarding 2 Week Wait Breast Cancer, particularly with Royal Wolverhampton Trust. A Cancer Board across the Black Country and West Birmingham is being established. A message will be sent out from Royal Wolverhampton Trust to partners regarding referrers considering other providers during this period.

Helen Mosley entered the meeting.

4. SUBACROMIAL DECOMPRESSION

4.1 Laura Broster presented a report on *Commissioning Policy: Subacromial Decompression*. The JCC was asked to approve the process, including funding for continuing support from Arden and GEM CSU, and to consider whether a request should be made to CCG Governing Bodies to delegate authority to approve policies on these procedures to the JCC.

4.2 It was agreed there is good evidence base work however, the JCC does not have delegated authority to agree the recommendations from the paper. This will need to go to the Governing Body meetings. There is a STP/CCG Policy group that is reviewing harmonising policies.

Actions:
A paper to be developed for the Governing Bodies regarding the recommendations from the Subacromial Decompression paper for the process to be approved, including funding for continuing support from Arden and GEM CSU, and to consider whether to delegate authority to approve policies on these procedures to the JCC.
The STP/CCG Policy Group to develop a paper on what process they are doing and cross boundary decision making, for example with Birmingham and Solihull STP.
The STP/CCG Policy Group to develop scenario work in regards to Policies of Limited Clinical Value.

Sharon Liggins left the meeting.

5. FORMALLY DELEGATED AREAS

5.1 **Transforming Care Partnership – Black Country Partnership FT Community Model**

5.1.1 Dr Helen Hibbs discussed the Panorama programme that was broadcasted last week in regards to abuse of vulnerable people. There are regular reviews now being carried out by case managers.

Sharon Liggins re-entered the meeting.

5.1.2 Suzanne Brady discussed the Black Country Partnership Foundation Trust Community Model. The current barriers include recruitment to posts outstanding and challenges with a new process. Lesson learned include the impact of pace, focus on cultural work, and the most admissions coming from the transition cohort.

5.1.3 There has been public consultation on the bed model and potential closures. The next steps include the operation group reviewing and making recommendations.

5.1.4 Paul Maubach requested information on the full cohort of patients, what services are interacting with one another, and to map health outcomes status of the patients. It was also requested to map patients that are accessing the service out of area, and those that are changing their GPs to access the service. Dr Helen Hibbs agreed to review the current data available.

Action: Dr Helen Hibbs to review the current data available on Transforming Care Partnership to review whether an understanding of, the full cohort of patients, what services are interacting with one another, the health outcomes status of the patients, what patients are accessing the service out of area, and those that are changing their GPs to access the service, can be gained.

5.2 **Mental Health**

5.2.1 Dr Helen Hibbs presented the report on *STP Mental Health Workstream update "Once Commissioner" Programme*. There are new leads for the projects on Personality Disorder.

6. RISK REGISTER

6.1 BC009 has been updated.

6.2 BC005 and BC008 will be closed.

7. MATTERS OF COMMON INTEREST

7.1 **Place Based Commissioning Update – Walsall**

7.1.1 Dr Anand Rischie gave an update on the Walsall Together programme. Seven Primary Care Networks (PCNs) have been established. Walsall Healthcare Trust will take the lead. The CCG will remain an observer on the board until there is further clarity on finances.

7.1.2 Dr Helen Hibbs noted there are 32 PCNs within the Black Country and West Birmingham STP. A representative from each place will need to be identified. Alastair McIntyre is reviewing the governance for the STP.

7.1.3 Thanks were given to Dr Helen Hibbs for writing out to the Black Country and West Birmingham STP GPs.

7.2 **Performance and Assurance Return**

7.2.1 Alastair McIntyre presented the Performance report that went to the May STP Health Partnership Board.

7.2.2 It was agreed this item would be discussed earlier in the agenda at the next meeting for a more detailed discussion. It was requested there be specific discussions on Urgent and Emergency Care due to the focus from regulators on A&E performance. The draft for the Urgent and Emergency Care Transformation Plan will presented to the group for information.

Actions:
A detailed discussion on Performance and Assurance, with a focus on Urgent and Emergency Care and Cancer, to occur at the July JCC.
The Urgent and Emergency Care Transformation Plan that is being submitted on 05 July 2019 to be presented at the July JCC.

8. FEEDBACK FROM GOVERNING BODIES

7.1 No update was given.

9. UPDATE FROM STP

8.1 Jonathan Fellows notified there had been a Board to Board with Birmingham and Solihull STP on 12 June 2019. There were discussions and presentations on Midland Metropolitan Hospital and commissioning.

8.2 There are four categories for the ICS matrix; (1) Emerging, (2) Developing, (3) Maturing, (4) Thriving. It is believed the STP is between *Developing* and *Maturing*.

8.3 There will be a report at the next STP Board regarding the four capital schemes.

10. ITEMS FOR INFORMATION

10.1 Bronze Packs

10.1.1 Lucy Heath, RightCare, will be supporting workstream leads with work around the Bronze Packs.

David Frith entered the meeting.

11. ANY OTHER BUSINESS

11.1 Black Country Academy Proposal

11.1.1 David Frith and Paul Maubach presented on an *Outline Proposal for a Black Country ICS Academy*. This is to build intelligence, learning and collaboration. The recommendation was to approve in principle the concept of a Black Country Academy as a focus for system learning, innovation and improvement, determine the optimal scope and define any further work required, with internal and/or external partners to advance the academy concept as a potential component within the STP's Long Term Plan.

11.1.2 It was agreed that engagement with the University is important. There is a need to connect with the Local Workforce Action Board and Health Education England to ensure there is no duplication of work. It was requested to mindful of branding to ensure West Birmingham is included.

11.2 Chair of July JCC

11.2.1 It was confirmed that Prof Nick Harding will be chairing the JCC in absence of Dr Salma Reehana.

12. DATE OF NEXT MEETING

Thursday 11 July, 09:00-10:30, T051, Board Room, Dudley CCG, Brierley Hill Health & Social Care Centre, Venture Way, Brierley Hill, DY5 1RU

JCC Action Log

No.	Date	Action	Lead	Deadline	Status Update
140	14th Mar 2019	CCGs to meet and discuss the models under consideration in the four places and look at how these build to a sustainable ICS and ensure sustainability when trying to establish acute collaboration.	Alastair McIntyre Matthew Hartland	31st May 2019	14/06/2019 – Revised deadline to 31st August 2019
143	14th Mar 2019	Dr Helen Hibbs to take forward an exercise to map all current Specialised Services, understand which services could be delegated and identify the risks from the direction of travel for Specialised Services. Dr Helen Hibbs also to discuss Specialised Services with Alison Tonge.	Dr Helen Hibbs	End of July 2019	A meeting has been arranged to discuss Specialised Services for 18th June 2019
151	13th June 2019	A paper to be developed for the Governing Bodies regarding the recommendations from the Subacromial Decompression paper for the process to be approved, including funding for continuing support from Arden and GEM CSU, and to consider whether to delegate authority to approve policies on these procedures to the JCC.	Dr Salma Reehana	11th July 2019	
152	13th June 2019	The STP/CCG Policy Group to develop a paper on what process they are doing and cross boundary decision making, for example with Birmingham and Solihull STP.	STP/CCG Policy Group	11th July 2019	
153	13th June 2019	The STP/CCG Policy Group to develop scenario work in regards to Policies of Limited Clinical Value.	STP/CCG Policy Group	11th July 2019	
154	13th June 2019	Dr Helen Hibbs to review the current data available on Transforming Care Partnership to review whether an understanding of, the full cohort of patients, what services are interacting with one another, the health outcomes status of the patients, what patients are accessing the service out of area, and those that are changing their GPs to access the service, can be gained.	Dr Helen Hibbs	8th August 2019	
155	13th June 2019	A detailed discussion on Performance and Assurance, with a focus on Urgent and Emergency Care and Cancer, to occur at the July JCC.	Alastair McIntyre	11th July 2019	
156	13th June	The Urgent and Emergency Care Transformation Plan that is being	Alastair McIntyre	11th July 2019	

No.	Date	Action	Lead	Deadline	Status Update
	2019	submitted on 05 July 2019 to be presented at the July JCC.			

Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 11 July 2019

Members:
Nick Harding (acting Chair), Chair Sandwell and West Birmingham CCG
Helen Hibbs – Accountable Officer, Wolverhampton CCG
Mike Abel, Lay Member, Walsall CCG
Julie Jasper, Lay Member, Sandwell and West Birmingham CCG
Helen Moseley, Lay Member Dudley CCG
Laura Broster, Director of Communications, Dudley CCG
Matt Hartland, Chief Finance and Operating Officer, Dudley CCG
Anand Rishcie, Chair, Walsall CCG
James Green, Chief Finance Office, Sandwell and West Birmingham CCG
Paul Maubach, Accountable Officer, Dudley CCG and Walsall CCG
Ian Sykes GP in Sandwell and Chair elect Sandwell and West Birmingham CCG

In Attendance:
Alastair McIntyre, Portfolio Director, Black Country and West Birmingham STP
Sharon Liggins (for Andy Williams), Chief Operating Officer, Sandwell and West Birmingham CCG
Sharon Sidhu, National Diabetes Prevention Programme lead, Wolverhampton CCG
Jonathan Fellows, Chair, Black Country and West Birmingham STP
Peter McKenzie, Corporate Operations Manager, Wolverhampton CCG
Helen Ward (by phone item 4.4 only), Clinical Workstream lead, Respiratory group
Emma Smith, Governance lead, Dudley CCG

Apologies:
Andy Williams, Accountable Officer, Sandwell and West Birmingham CCG
David Hegarty, Chair, Dudley CCG
Les Trigg, Lay Member Wolverhampton CCG
Peter Price, Lay Member Wolverhampton CCG
Salma Reehana, Chair Wolverhampton CCG
Deborah Rossi, CCG Transition Director

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 There were no declarations of interest declared.

1.4 There minutes of the 13 June 219 were agreed as an accurate record.

1.5 The action log was reviewed and actions confirmed as delivered or others taken within the agenda.

1.6 Actions 140; 154 were not due.

1.7 Action 151 there was no update and this was rolled forward to next meeting

1.8 Actions 140; 143; 152; 155 were on the agenda.

1.9 Action 156 a draft of the plan was still being worked on. This wold be submitted as draft to NHS E tomorrow 12 July 2019 and feedback received. A final Plan was to be submitted by 2 August 2019. It was agreed that the draft plan would be circulated for information.

Action: Alastair McIntyre

2. CCG TRANSITION BOARD

2.1 The Transition Board was due to meet after the Joint Commissioning Committee Meeting.

3. CLINICAL LEADERSHIP GROUP (CLG) UPDATE

3.1 An update on the June CLG meeting noting that meeting had discussed; the West Midlands Stroke Review, work on Sustainable Services, medicines management, Maternity, actions plans were in place for the evidence in the 'Bronze WSOA' packs, the challenges in improving cancer performance. The meeting had received a draft proposal about the creation of a Black Country Academy and that the System has been successful in bidding (as one of 7 national sites) as a frailty collaborative.

3.2 JCC also noted that there was to be a CLG progress stocktake at next meeting.

3.3 JCC noted that there has been 3 expressions of interest from staff to be released at cost to their employer from black country providers and interviews were to be held on 22 July 2019. It was hoped that there would be some positive outcome and this would give some management support to CLG priority work streams.

4. PERFORMANCE AND TRANSFORMATION

4.1 The JCC requested more time to discuss performance on UEC and Cancer and in particular what could be done to improve performance in both these areas.

4.1.1 The Committee gave consideration to performance across the system, in particular the challenges faced in the areas of Cancer and Urgent Care. The main issues for performance in cancer are breast cancer 2 week waits, where at Royal Wolverhampton people were not being seen in a timely way. The committee were pleased to hear that a robust plan is now in place to address this and recognised the psychological impact of waiting for such a diagnosis. There is now ongoing, timely communication to GPs to share the waiting time information from providers. This will be used to encourage shared decision making and enable patient choice. It is hoped that this will see a movement of referrals from Royal Wolverhampton Trust to Walsall and Dudley. This could impact on the waiting times at Walsall and Dudley but this will be closely monitored. Royal Wolverhampton Trust have now also recruited to one of the posts that they had vacant which should impact on their ability to see more patients and ease the waiting times further. This level of collaboration by our acute providers is positive. Diane Wake, STP Cancer lead is looking to establish a Black Country Cancer Board to look at the other system issues relating to this key area.

4.1.2 For urgent and emergency care, there has been a moderate improvement in achievement of the 4hr standard. Across the Black Country we are currently at 82% (April 19) against a target of 95%. The committee were concerned about the fatigue in the system and the momentum required to make a real improvement shift in this area, particularly with a continued increase in the number of people going into our ED departments. This is a complex issue, however we can see that change is possible, as demonstrated by the improvements to ambulance conveyances by WMAS. The Committee agreed that work to reach agreement on the fundamental root causes is required before we can mobilise the

system into response mode. In the Urgent and Emergency Care Plan being written for the STP we are identifying areas of best practice which need to be spread across the system.

4.1.3 JCC Noted the paper on Cancer and the system support agreement reached to support recovery at RWT. It was noted that RWT had recruited one interventional radiologist.

4.1.4 GPs were being given daily information to enable them to make appropriate decisions with their patients about referrals taking into account accurate waiting times for treatment. Patient choice has been a key factor in the recovery plan and whilst challenging, there was now a plan for improvement and the BCWB system was seeing improved performance already. There was however a long way to go to recovery to the constitutional standard.

Actions: Alastair McIntyre to talk to Andy Williams/Rachel Ellis about establishing a BCWB UEC Board– to review provide System oversight and understand root cause of performance and enable sharing of solutions/best practice and ensure robust approach to flu planning.

4.2 **Specialised Commissioning**

4.2.1 JCC noted that NHS Midlands is establishing a collaborative specialist commissioning forum. This will meet bi monthly. Alison Tonge, Director of Commissioning has also written to the STP to offer a rep from the Commissioning Directorate to attend STO board. The STP will take up that offer**.**

4.2.2 NHS Midlands is also developing a Regional Services Strategy for the whole portfolio.

4.2.3 The work on specialised commissioning continues, with consideration of delegation of budgets to Integrated Care Systems, when they are up and running, is being considered. These are likely to be services that are stable and not contentious and areas such as specialist renal and cardiac care. There will be a full national process on this but the JCC are keeping a watch on it and are engaged to influence where we can.

Action: CAMHS T4 update next time under Mental Health update.

Action: To keep Spec Comm as a standing item on the agenda.

4.3 **CCG Policy Harmonisation Group**

4.3.1 Sharon Sidhu presented a paper updating the group on the work underway to harmonise policies for PoLV across four CCGs and the challenges where there were cross boundary issues for Staffordshire and Birmingham

4.3.2 JCC noted that the group was established last year with the aim of trying to bring more consistency to policy positions, this was requested by providers who were struggling with these differences. The Group is also looking at how we align to neighbouring areas such as Birmingham and Solihull (BSOL). JCC recognised the excellent process in BSOL and that the Black Country policy group is trying to manage a number of factors, not least the national work to establish policies for evidence based interventions. There has been some difference in the adoption of these policies and with more guidance to come from a national perspective. The JCC was keen to agree a process for these to be accepted or otherwise. There was agreement to stop any further local policy development until we have clear indication of what will feature in the national developments.

4.3.3 The Committee agreed that the Black Country Policy Group should have more robust clinical engagement and representation and we agreed that a proposal will be submitted to our

Governing Bodies to recommend that we adopt as a key principle, a policy position where we seek to harmonise these policies across the Black Country and West Birmingham.

Action: Sharon Sidhu to draft proposal for submission to each CCG Governing Body to recommend as a key principle policy position, that we seek to harmonise these policies across the Black Country and West Birmingham.

Action: Agreed that BCWB would join the existing SWB and BSOL group and look to greater involvement of Clinicians

4.4 Respiratory Black Country STP Group Queries (Helen Ward - Chair of the Black Country and West Birmingham Respiratory Group dialled on)

4.4.1 The JCC Received a paper seeking system working to improve delivery of:

- STP coordination of training as better value than dispersed model pilot to standardise COPD guidance and inhaler training was successful but need funding to roll out prior to winter across the STP request to upskill 500 staff at scale and pace in breathlessness management Clinical leadership and coordination of respiratory training across the STP to deliver.

4.4.2 Helen was thanked for the paper, this was clearly something that will produce better outcomes for patients and was in line with expectations of the Long Term Plan and as such was an area we should prioritise for prevention.

Action: A revised paper to each CCG's Governing Body to seek investment. James Green/Matt Hartland to support and paper to go to next CCG Governing Bodies for approval.

4.5 **Place Based Commissioning Update – Sandwell and West Birmingham**

4.5.1 Sharon Liggins updated the group that the two alliances in Sandwell and also West Birmingham are undertaking work on identifying priorities and will take to GB in September in members, governance etc.

5. FORMALLY DELGATED AREAS

5.1 **Transforming Care Partnership**

5.1.1 Review of governance structure to be fit for future through to April 2020.TCP is Intensive support and forensic teams with each place responsible for community support decision on community beds to be made at TCP board next week and fuller report to GBs in due course bid for £500k non recurrent Transformation funding – comes with caveats and contingent on delivery of trajectory.

5.2 **Mental Health**

5.2.1 Updates to be given BiMonthly going forward.

6. RISK REGISTER

6.1 Peter McKenzie – no copy of Risk Register this month – need to add in risks around spec comm. Needs further development in context of role of committee going forward under one Accountable Officer.

7. FEEDBACK FROM GOVERNING BODIES

7.1 No update was given.

8. UPDATE FROM STP

8.1

- Online self-assessment tool will give baseline for development support to rewach ICS coronation before 31 March 2021.
- Wolverhampton and Walsall HT set up group to look at Clinical and back office collaboration.
- 5 year STP plan being developed.
- 4 large capital schemes - £79m granted – may not now be sufficient to support all 4 and Walsall ED configuration is crucial to MMH case and build time is tight to support effective MMH opening.
- Request to all provides to reduce capital spend in year. – Directors of Finace trying to reach agreement – very difficult decisions and need agreement by Monday.

9. ITEMS FOR INFORMATION

8.1 No items to discuss under this agenda item .

10. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

10.1 **Chair of August JCC**

10.1.1 It was confirmed that Ian Sykes will be chairing the JCC in absence of Dr Salma Reehana.

11. DATE OF NEXT MEETING

Thursday 8 August 2019, 09:00-10:30, Board Room, Walsall CCG, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL

JCC Action Log

No.	Date	Action	Lead	Deadline	Status Update
140	14th Mar 2019	CCGs to meet and discuss the models under consideration in the four places and look at how these build to a sustainable ICS and ensure sustainability when trying to establish acute collaboration.	Alastair McIntyre Matthew Hartland	31st May 2019	14/06/2019 – Revised deadline to 31st August 2019
151	13th June 2019	A paper to be developed for the Governing Bodies regarding the recommendations from the Subacromial Decompression paper for the process to be approved, including funding for continuing support from Arden and GEM CSU, and to consider whether to delegate authority to approve policies on these procedures to the JCC.	Dr Salma Reehana	11th July 2019	Action Closed
152	13th June 2019	The STP/CCG Policy Group to develop a paper on what process they are doing and cross boundary decision making, for	STP/CCG Policy Group	11th July 2019	On agenda

No.	Date	Action	Lead	Deadline	Status Update
		example with Birmingham and Solihull STP.			
153	13th June 2019	The STP/CCG Policy Group to develop scenario work in regards to Policies of Limited Clinical Value.	STP/CCG Policy Group	11th July 2019	On agenda
154	13th June 2019	Dr Helen Hibbs to review the current data available on Transforming Care Partnership to review whether an understanding of, the full cohort of patients, what services are interacting with one another, the health outcomes status of the patients, what patients are accessing the service out of area, and those that are changing their GPs to access the service, can be gained.	Dr Helen Hibbs	8th August 2019	
155	13th June 2019	A detailed discussion on Performance and Assurance, with a focus on Urgent and Emergency Care and Cancer, to occur at the July JCC.	Alastair McIntyre	11th July 2019	On agenda
156	13th June 2019	The Urgent and Emergency Care Transformation Plan that is being submitted on 05 July 2019 to be presented at the July JCC.	Alastair McIntyre	11th July 2019	A draft of the plan was still being worked on. This wold be submitted as draft to NHS E tomorrow 12th July and feedback received. A final Plan was to be submitted by 2nd August. It was agreed that the draft plan would be circulated for information.
157	11 July 2019	Alastair McIntyre to talk to Andy Williams/Rachel Ellis about establishing a BCWB UEC Board– to review provide System oversight and understand root cause of performance and enable sharing of solutions/best practice and ensure robust approach to flu planning.	Alastair McIntyre	8 August 2019	
158	11 July 2019	CAMHS T4 update next time under Mental Health update.	Steven Marshall	8 August 2019	
159	11 July 2019	To keep Spec Comm as standing item on the agenda.	Admin	8 August 2019	Completed and closed
160	11 July 2019	Sharon Sidhu to draft proposal for submission to each CCG Governing Body to recommend as a key principle policy	Sharon Sidhu	8 August 2019	Update to be given after AO appointment

No.	Date	Action	Lead	Deadline	Status Update
		position, that we seek to harmonise these policies across the Black Country and West Birmingham.			on 25 September 2019
161	11 July 2019	Agreed that BCWB would join the existing SWB and BSOL group and look to greater involvement of Clinicians.	Sharon Sidhu	8 August 2019	Update to be given after AO appointment on 25 September 2019
162	11 July 2019	A revised paper to each CCG GBs to seek investment and for approval.	James Green/Matt Hartland	8 August 2019	

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