NHS
Wolverhampton
Clinical Commissioning Group

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

A G E N D A

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		21	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 11 February 2020		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 10 September 2019
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Ms S McKie welcomed Dr S Reehana back to the Governing Body and stated she will be chairing the meeting today.

Attendees ~ Ms S McKie **Clinical**	 Chair
Dr M Asghar	Board Member
Dr R Gulati	Board Member
Dr M Kainth	Board Member
Dr S Reehana	Board Member
Management	
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 Ali	Senior HR Business Partner
Ms K Evans	Solutions and Development Manager (part)
Ms K Garbutt	Business Operations Officer
Ms S Liggins	Interim Chief Operating Officer - Sandwell (part)
Mr P McKenzie	Corporate Operations Manager
Ms J Salter Scott	Head of Engagement and Communications – Sandwell (part)
Ms A Smith	Head of Integrated Commissioning (part)

Apologies for absence

Apologies were received from Dr R Rajcholan, Mr T Gallagher, Mr D Watts, Mr J Denley and Dr A Mittal.

Declarations of Interest

WCCG.2442 All Governing Members declared an interest in agenda item 8 – Outline Case for Change and agenda item 9 – Communications and Engagement Plan.

RESOLVED: That the above is noted.

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

WCCG.2443 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group (WCCG) Governing Body meetings held on the 9 July 2019 be approved as a correct record. However, Dr S Reehana pointed out her apologies were not noted.

Matters arising from the Minutes

WCCG.2444 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2445 There were no Committee Actions

RESOLVED: That the above is noted.

Chief Officer Report

WCCG.2446 Dr H Hibbs presented the report she pointed out that The Black Country and West Birmingham Sustainability Transformation Plan (STP) is working to deliver both the Strategic Planning Tool (combined finance, activity and workforce plan) for STP and the STP narrative 5 year plan.

The long term draft narrative plan is currently with all organisations to contribute to and some public and patient engagement events are taking place in September to listen to the public and respond to the long term plan. This will be presented to Health Watch in October and will be brought back to the Governing Body in November.

Mr J Oatridge and Ms S Roberts arrived

Ms S McKie asked how we are publishing the engagement event. Dr Hibbs confirmed this is being carried out locally and this will on the back of Wolverhampton's Annual General Meeting.

The STP Stocktake meeting took place on the 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.

RESOLVED: That the above is noted.

Governing Body Vacancy

WCCG.2447 Mr P McKenzie stated that as Dr Julian Parkes has resigned from his position on the Governing Body following his retirement as a GP this has created 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.

Ms McKie asked what happens if we do not fill the vacancy. Mr McKenzie confirmed that this will then remain vacant.

Ms S Liggins and Ms J Salter Scott arrived

RESOLVED: That the vacant position on the Governing Body is filled by a by-election for a GP from the vertically integrated practices.

Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration – Outline Case for Change

WCCG.2448 Ms Sharon Liggins and Ms Jayne Salter Scott introduced themselves to the Governing Body. Ms Liggins referred to the report which sets out the options considered by the Black Country and West Birmingham Joint Commissioning Committee and the Transition Board. 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. She pointed out Appendix 2 which outlines the timelines.

Dr Hibbs pointed out one of the assumptions within the paper regarding running costs needing to reduce. There is a significant risk regarding the costs of transition with one off professional fees likely to be incurred.

Mr Marshall stated partners may now support the merger of CCGs. However there is an increased risk relating to working with Local Authorities as there are very different funding agreements with social care in place across the four CCGs. There are many items to explore. Ms Liggins stated all the CCGs would agree with this. She added the options need to be explored and the Transition Board will manage this process.

Mr Oatridge supported Dr Hibbs' points. A significant amount of work needs to be undertaken and sufficient resources need to be available. Ms Liggins stated the programme team is scheduled to attend the next Transition Board. There is a big costing exercise to be carried out.

Mr P Price enquired about the financial implications. Dr Hibbs referred to the Birmingham merger and they had to take 20% out. Their expenses did go up in the first year. Mr Green added there will be non-recurrent costs incurred through the process. In the longer term it will deliver savings

Mr Marshall referred to the timeframe of the application of May 2020 which is very tight. What happens if we miss this deadline. Ms Liggins agreed it is tight. Dr Reehana added this is not a very easy decision there may be slippages on time.

Ms S Roberts stated that after the Accountable Officer appointment a refresh of the Terms and Conditions of the Transition Board is needed.

Mr L Trigg pointed out that the report reads in several places that it is a foregone conclusion that a merger of the 4 CCGs will take place. Dr Hibbs stated that this is one of the likely outcomes but cannot be taken as a foregone conclusion.

Ms Liggins stated the whole process including pre-scoping and consultation outcomes will come back to the Governing Body in November 2019 and February 2020.

Mr Marshall asked if we have a plan B if the GPs do not support this. Dr Hibbs stated the Integrated Care System (ICS) requires a single commissioning voice.

RESOLVED: That the Governing Body approved the next stage, the listening stage with the caveats – care is required with the language within the reports in the future and the Transition Board Terms of Reference will need to be reviewed.

Ms K Evans and Ms A Smith arrived

Black Country and West Birmingham Clinical Commissioning Groups Merger or Continued Collaboration – Communications and Engagement Plan

WCCG.2449 Ms J Salter Scott presented the report. She stated the plan details the steps we will take to ensure stakeholders have the opportunity to influence our proposals for a strategic commissioner. There are draft key messages which we hope to use in the listening exercise during October. The question we are hoping to explore with stakeholders is "if we move to a single CCG what would good look like".

Ms Salter Scott added that the feedback will be collated and presented in November. In terms of the approach and process it is a listening exercise not a formal consultation. It is really important that we continue to work with Human Resources and with our colleagues in Primary Care. It is also important all GPs have their views. She pointed out that Appendix 2 will be updated in the future. What is missing from the presentation is the telling of a story and this will be adjusted regarding the journey we are on.

Mr Trigg asked who will be managing the accountability. Ms Salter Scott stated that this has gone to the Transition Board and assumed the resource will be split across all 4 CCGs. Dr Hibbs stated it would be shared across the 4 CCGs. Dr Reehana pointed out that Health Education West Midlands which involves GP trainees is missing from the stakeholders map. Mr P McKenzie referred to item 7 Member Practice Engagement and the importance for each individual vote within each CCG.

Mr Oatridge referred to the Stakeholder map and pointed out that our neighbours Shropshire are missing. It was agreed that they would be added. He also stated that our staff can be patients also and duality needs to be recognised.

Mr Trigg added he has a real issue as the report is heavily loaded in one direction it needs to be open and transparent. This was supported. Dr D Bush added on page 60 it should read in point 3 "whether we should merge". A discussion took place and Ms Salter Scott confirmed that the slides do need to be looked at. We have the opportunity to change this now. Ms Liggins confirmed that the Governing Body views will be taken back to the Communications and Engagement lead and work will be carried out on the issues.

Ms S Liggins and Ms J Salter Scott left

RESOLVED: That the Governing Body endorsed the Communications and Engagement Plan and give approval to seek views of stakeholders using the key messages in appendix 4 of the plan.

Community Model for Learning Disabilities in the Black Country

WCCG.2450 Ms S Roberts presented the report which is to make a recommendation to the Governing Body on the future of assessment and treatment beds and the associated community services. 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.

RESOLVED:
(a) That the Governing Body supported the new model of care.
(b) That the Governing Body supported the recommendation on the future bed base for assessment and treatment beds, with any no longer required being closed.

Integrated Care Alliance (ICA) Progress

WCCG.2451 Ms K Evans stated this report provides key highlights, risk and issues across the programme. This has been ongoing for 18 months to 2 years and there is a robust governance structure in place. She pointed out that each of the clinical sub groups has agreed a plan which they are working towards delivering. The plans are detailed in the report on pages 198 – 201.

RESOLVED: That the Governing Body noted the work being undertaken within the Wolverhampton Integrated Care Alliance.

Better Care Fund (BCF) Quarterly report

WCCG.2452 Ms A Smith presented the report which informs the Governing Body on the work being undertaken within the Better Care Fund Programme. She pointed out that we continue to meet the Delayed Transfers of Care ambition.

There is a reduction of non-elective admissions that are aligned to some of the schemes within the BCF Programme. Ms Smith reported a number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of June which is slightly higher than in the previous year.

Work continues on identifying suitable accommodation for the South East Adult Community Care (Co-Location of Community Neighbourhood teams). Space has been identified at Bilston Health Centre and floor plans are currently being drawn up.

Ms Smith referred to the table on page 233 outlining the Pooled Budget. She pointed out that the planning template has not been distributed as she is still waiting for some further details. Once received this will be distributed to the Governing Body.

A lot of cross over work is being carried out and there is a proposal to bring 2 programmes of work together. Dr Hibbs supported the proposal. She thanked Andrea Smith for her work. Mr S Marshall added the agreement from the Local Authority has been submitted to the Programme Board and they support the proposal.

RESOLVED: That the above Governing Body supported the recommendations of the merging of the programmes.

Sustainability Transformation Plan (STP) Planning

WCCG.2453 Dr Hibbs referred to the presentation which gives some priorities. The main priorities are on page 248 ensuring our local health and care system is fit for the future. Public views are shaping our plan and during April and May, each local Healthwatch across the Black Country and Birmingham engaged with the public and the key themes are highlighted on page 251.

Mr J Oatridge commented that within the plan it did not include how we manage the estate. Dr Hibbs confirmed this would be useful and this can be included within the plan.

RESOLVED: That the above is noted

Dr Asghar arrived

Board Assurance Framework and Risk Register

WCCG.2454 Mr McKenzie presented the report. The report has been updated following the Governing Body's review of the organisation's strategic objectives in May 2019. He referred to the risks on the framework highlighted in red. He pointed out the deep dive has been delayed in Primary Care.

Mr M Hastings reassured the Governing Body that the planning relating to Brexit for March has been carried over and he will be attending an event in Leicester next week.

RESOLVED: That the above is noted

Commissioning Committee

WCCG.2455 Dr M Kainth presented the July/August reports highlighting that 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.

The Committee endorsed providing additional funding in respect of the Fixed Term investment for Autism Spectrum Disorder and Investing in Speech and Language Therapy. The Committee reviewed the service specification for Trauma and Abuse Counselling which was agreed in principle. The Committee also reviewed and agreed the Eating Disorder Service Specification.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2456 Ms Roberts presented the report she pointed out the key points. Cancer performance remains significantly challenged, with further deterioration of all cancer targets except 31 days sub-treatment surgery and anti-cancer drug. This is being monitored on a weekly basis. Dr R Gulati expressed concern relating to referrals for patients from Royal Wolverhampton Hospital Trust (RWT) to Walsall and Dudley Hospitals which could cause pressure. Ms Roberts confirmed this is being monitored on a daily basis. Dr Hibbs stated this is a major concern, however RWT have recruited additional staff. Mr Hastings added the number of patients is minimal and the numbers are known. Dr M Kainth asked what Dudley are doing that we are not. Dr Hibbs stated patient's preference to go to Wolverhampton has increased and RWT have lost some key members of staff.

Mortality indicators for Standarised Hospital Mortality Index (SHMI) remain above national expected rates. In light of improving performances the Quality and Safety Committee made the decision to reduce the risk rating for mortality.

Ms Roberts pointed out that the Care Quality Commissioning (CQC) has carried out unannounced visits in August at RWT.

Due to failures in the Well Led and Safe domains identified at a recent Care Quality Commissioning (CQC) inspection, a Wolverhampton Nursing home is expected to receive a reduced CQC rating.

Lotus Clinical Services came to Wolverhampton Clinical Commissioning Group's (WCCG) 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.

Ms Roberts mentioned a new booklet in respect of the flu vaccinations for children will be coming out soon.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2457 Mr J Green presented the reports. He focused on the report for August. He referred to the finance position table on page 315 indicating the year to date position against key financial performance indicators which are all rated green.

The Delegated Primary Care allocation for 2019/20 is £38.145m. At month 4 the CCG forecast outturn is delivering a breakeven position. On page 320 of the report this shows some underspends. This has been discussed at the Primary Care Commissioning Committee and resources are available against the plans being developed.

Mr Green referred to the Quality, Innovation Productivity and Prevention (QIPP) key points on page 321.

He pointed out performance and the main areas. Referral to Treatment time - 92% of WCCG patients started treatment within 21.2 weeks at any provider in England against the standard of 18 weeks. There are no patients waiting 52 plus weeks to start treatment.

Mr Green referred to 4. Risk and Mitigation. The CCG was requested 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 month 4 to reflect the inclusion of costs within the main financial reporting.

RESOLVED: That the above is noted.

Audit and Governance Committee

WCCG.2458 Mr P Price presented the report. He pointed out that the Audit and Governance Committee had received a paper around joint working when other organisations had merged.

RESOLVED: That the above is noted

Remuneration Committee

WCCG.2459 Mr P Price stated the report was for information.

RESOLVED: That the above is noted.

Primary Care Commissioning Committee

WCCG.2460 Ms S McKie referred to the report and highlighted that patient feedback from the consultation on the proposed closure of the Wood Road branch surgery of Tettenhall Medical Practice continues to be gathered.

The Committee approved the change of Clinical Director for the Royal Wovlerhampton NHS Trust to Dr John Burrell.

She pointed out the Quality Assured Spirometry Business Case revised costs. 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 £62440 for 2019/20 and around £126500 in future years.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2461 Ms S McKie referred to the report. She pointed out the Annual General Meeting is taking place on Wednesday 18 September 2019. The Hub meetings are still taking place and she will try to attend when she can. There are still concerns around communication with the Citizens Forum representatives and more work is needed regarding this.

RESOLVED: That the above is noted.

Workforce Race Equality Standard (WRES)

WCCG.2462 RESOLVED: That the report is noted.

Minutes of the Quality and Safety Committee

WCCG.2463 RESOLVED: That the above minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2464 RESOLVED: That the above minutes are noted

Minutes of the Primary Care Commissioning Committee

WCCG.2465 RESOLVED: That the above minutes are noted

Minutes of the Commissioning Committee

WCCG.2466 RESOLVED: That the above minutes are noted

Minutes of the Audit and Governance Committee

WCCG.2467 RESOLVED: That the above minutes are noted

Black Country and West Birmingham Joint Commissioning Committee Minutes

WCCG.2468 RESOLVED: That the above minutes are noted

Any Other Business

WCCG.2469 Dr Reehana thanked Ms S McKie for acting as Chair at the Governing Body meetings.

RESOLVED: That the above is noted.

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

WCCG.2470 There were no public or press present at the meeting.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2471 The Board noted that the next meeting was due to be held on **Tuesday 12 November 2019** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 3.00 pm

Chair..……..

Date ……

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
12 November 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 AO Recruitment

2.1.1 Following the recruitment process held on the 25 September 2019, Mr Paul Maubach has been selected as the the Accountable Officer for the Black Country and West Birmingham CCGs. We are currently reviewing the arrangements for the transition of Accountability for Wolverhampton CCG.

2.2 Listening Exercise

2.2.1 At the last Governing Body there was agreement to proceed with a listening exercise to seek the views of key stakeholders in relation to the future of the Black Country and West Birmingham CCGs.

2.2.2 Throughout October there have been events in each CCG area to listen to staff, member practices, public representatives and other stakeholders. The events have offered an opportunity to explain the local and national context in which change is being considered. There was detail on the options that have been considered and what the case for change might be for a move towards a single CCG. There was also detail on what some of the challenges might be to a single CCG before moving on to ask people to consider the following with regard to future CCG arrangements:

- What do you value from the current CCGs?
- What would good look like to you in terms of future CCG arrangements?
- Do you have any concerns in terms of future CCG arrangements?
- How might these concerns be resolved?
- What questions would you want answered before you could make a decision?

2.2.3 The feedback will prove invaluable in determining what the next steps should be and to inform a decision on whether we move to a formal consultation. The themes from these sessions is currently being analysed and will be presented to the Transition Board meeting on the 14 November 2019.

2.3 Clinical Leadership Group

2.3.1 The Black Country & West Birmingham STP Clinical Leadership Group (CLG) was established in September 2018.

The CLG meets monthly and has representation from all organisation across the STP at a clinical level.

2.3.2 The three main functions of the group are to:

- Define the clinical agenda
- Provide clinical input to the workstreams and to be a critical friend
- Provide a clinically led arrangement through the emerging STP/ICS landscape.
- The group supports the 12 Clinical Strategy Priority areas

2.3.3 Cancer:

- The CLG cancer work stream is supporting a clinically led system response to current 2WW Breast Cancer performance issues. Following the implementation of the diversion pathway for 2WW breast cancer pathway performance has improved significantly. The number of cases within the backlog has reduced and the wait time for appointments has reduced.
- An NHSI led West Midlands Urology Project Group has been established to manage the Specialised Commissioning Specification for Urology Cancer surgery. All four acute providers are part of the Black Country UAN. RWT and WHT have well established links between urology teams which are planned to be formalised. Dudley has established links with RWT. Sandwell and West Birmingham links currently with University Hospital of Birmingham.
- The West Midlands Urology Project Group is considering the creation of provider alliances to serve the West Midlands (Birmingham and Solihull, Black Country, Hereford and Worcestershire, Coventry and Warwickshire, Shropshire and Staffordshire). Some specialist work will only be undertaken in one or two centres.

2.3.4 Urgent and Emergency Care

Sepsis /recognition of the deteriorating patient:

- Clinical focus of this work stream is deterioration and sepsis pathways at the front door.
- QI approach to improve SEPSIS recognition is in place in all four Trusts but requires standardisation
- The Principles of QI and how to endorse throughout the system, including at trust, community and independent sector will be explored and supported by the STP Academy and the Clinical Leadership Group .
- A working group is reviewing the use of NEWS2 in the community and primary care settings. Roll out of the FREED booklet will support this work stream.
- NEWS2 and antibiotic resistance to be discussed at the Medicines Management and Pharmacy workstream.

2.4 **Long Term Plan for the STP**

2.4.1 The Black Country and West Birmingham Strategic Plan is currently being developed by all Partners. We have worked with local Healthwatch organisations to understand the views of local people and we have produced a draft plan. We hope to finalise this plan over the next few weeks ready for publication. In addition a summary document, plan on a page and a website will be produced for patients and the public to access from early December 2019.

2.5 **GPN Strategy Launch**

2.5.1 The General Practice Nurse Strategy has been developed at a time of significant change both nationally and locally across the Black Country. General Practice Nurse (GPN) is a role that is unique because as a profession it works across the whole age span with patients and the public to optimise the health of the practice population within the community, provides health advice and promotion and manages acute events. The recent announcement of a Primary Care Network contract as part of the initiatives within the NHS Long term Plan offers a fantastic opportunity for the role of GPN to flourish and grow even further, the advancement of new roles to Primary care is even more exciting and we look forward as a nursing community to working collaboratively for the benefit of our local population.

2.5.2 The aim of the Black Country General Practice Nurse strategy is to define our values for all our nurses, fellow professionals, patient's carers and the public we serve. This is provided via an overarching strategy document and an additional suite of documents to support:

- Induction of new staff
- Preceptorship
- Competencies
- Skills and education
- Clinical supervision
- Retention

2.5.3 The purpose of the strategy is to provide nurses and managers with a means to benchmark skills and knowledge, offer a clear entry and progression pathway into Primary Care for nurses at all levels and outline support mechanisms for all staff throughout their nursing journey.

2.5.4 This strategy was co-designed and developed with GPNs, practice managers, GPs and LMC representatives, lead nurses across the patch, and had input from patients and carers as well as from colleagues in higher education and NHS England.

2.5.5 Following the completion and approval of the GPN Strategy a Black Country-wide launch event was held. A total of 83 people attended the event, including practice nurses, HCAs, Nursing Associates, student nurses and colleagues from across the four Black Country CCGs, NHS England, Health Education England and our local Training Hub. A marketplace event was also held that had representatives from local apprenticeship providers, universities, Personalised Care team, Training Hub and the HEE Return to Practice Team. Speakers included local nurse and GP leads, HEE colleagues, NHS England lead and GPN Digital Nurse Champions, we also held a plenary session with GPN colleagues. The event is currently being evaluated and this will be presented in November.

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:	**31 October 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**	**31/10/19**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 NOVEMBER 2019

Agenda item 7

TITLE OF REPORT:	**Application to Vary the CCG Constitution**
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	To ask the Governing Body to authorise an application to vary the CCG's constitution to adopt the new NHS England model constitution format
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• NHS England issued new guidance for CCGs on the contents of constitutions (the model constitution) in 2018. • This guidance sets out the core requirements for the constitution and gives greater flexibility for CCGs to make changes to elements of the governance framework outside of the NHS England process for changing the constitution. • A draft of the new constitution and supporting Governance Handbook have been produced for inclusion in an application to NHS England to vary the constitution.
RECOMMENDATION:	That the Governing Body approve the draft constitution for inclusion in an application to NHS England to vary the constitution.
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> There is a statutory requirement for the CCG to have an up to date, published constitution. Making an application for a review will ensure that the CCG will have a constitution that reflects the

	latest guidance and operating approach.

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG's constitution is its primary Governance document, setting out how it makes decisions. NHS England issued new guidance for CCGs in the form of a model constitution in 2018, setting out the core requirements for inclusion and suggesting that other elements (including terms of reference for committees etc.) should be managed separately from the Constitution in a Governance Handbook published on the CCG's website.

1.2. In order to adopt the new model constitution the CCG will need to make an application to NHS England who are responsible for agreeing changes to CCG constitutions. The procedure for making these variations is set out in statutory guidance stating that an application for a change should detail the proposed changes and make an assessment of the impact of these changes.

2. NHS ENGLAND MODEL CONSTITUTION

2.1. Historically, the CCG's constitution has followed the format of the model constitution issued by NHS England to support the authorisation process for CCGs in 2013. This includes a full suite of appendices, including the CCG's standing orders, Scheme of Reservation and Delegation and terms of reference for committees. This means that in order to make changes to any of these documents, an application needed to be made to NHS England to vary the Constitution.

2.2. In 2018 NHS England issued a new version of the Model Constitution for CCGs. This aimed to streamline the document to the core components and give greater flexibilities to CCGs to make minor changes to governance structures (e.g. Terms of Reference for Committees, Operational Scheme of Delegation) without seeking NHS England Approval. The revised format of the constitution includes:-

- **The Constitution** – including the legal status of the constitution, the CCG's area, Membership matters and the outline arrangements for exercising the functions of the CCG
- **Appendix 1 –** Glossary of Terms
- **Appendix 2 –** Statutory Committee Terms of Reference (Audit and Governance, Remuneration and Primary Care Committees)
- **Appendix 3 –** Standing Orders (rules for appointing Governing Body Members, meeting arrangements)

- **Appendix 4 –** Delegated Financial Authority Limits

2.3. The guidance suggests that, following the adoption of the new constitution format, CCGs should produce a Governance Handbook which will include the elements from the existing document such as the Scheme of Reservation and Delegation, other Committee Terms of Reference and detailed financial and conflict of interest policies. This should be published on the CCG website, but will not be subject to NHS England review when changes are proposed.

3. DRAFT CONSTITUTION

3.1. A draft of the CCG's Constitution in line with the new formatting requirements has been and a Governance Handbook has been produced. This has mostly involved taking the current constitution and its provisions and inserting it into the new model but there have been a number of minor changes made at the same time. Due to the difference in structure, it is not possible to produce tracked changes indicating the amendments so the table below gives details of the changes made:-

Constitution Section	Amendment Made	Details
Appendix 3 – Standing Orders	2.2.6, 2.2.8, 2.2.13 Appointment process for Lay Member, Practice Manager, Secondary Care Consultant	These individuals are eligible to serve two terms of office. The new wording clarifies that, at the end of their first term, the Governing Body will determine whether to re-appoint them for a second term.
	3.3 Petitions	Change to state the Chair will decide whether to include a petition received on the agenda for the Governing Body. Previous version required all petitions to be included on the agenda (which might not be appropriate)
	3.6.2 Quorum	Provision to allow 'virtual attendance' in exceptional circumstances pre-agreed by the Chair.
	3.12.3 Public Attendance	Amendment to clarify that Member meetings are not held in public
	3.12.4 Public questions	Additional paragraph to reference CCG's procedure for managing public questions
	4.2.1 Terms of Reference	Provision to include Committee Terms of Reference in Governance Handbook
Scheme of Reservation and Delegation (not included in constitution but detail for information)	Inclusion of 'policy areas'	Formatting change to align Scheme with the other Black Country and West Birmingham CCGs to support future collaboration
	Ungrouping of various responsibilities into separate items in table	
	Remuneration Committee arrangements	Clarification of responsibilities in line with NHS England legal advice that decisions about remuneration are a legislative function

Constitution Section	Amendment Made	Details
		of the Governing Body (on the advice of the Remuneration Committee)
	Approval of Risk Management arrangements	Role of Audit and Governance Committee in line with revised risk management arrangements

3.2. Applications for variation of the constitution must be authorised by the CCG Membership and the proposal to make this application was raised and agreed at the Members meeting on 2 October 2019. All Practices were subsequently emailed a copy of the proposed new constitution and details of the proposed changes along with an opportunity to raise any queries. No direct feedback has been received.

3.3. In line with NHS England Guidance, the new constitution includes a provision to speed up the process of making future minor changes by only requiring Membership approval of 'substantive' proposals for changes. Following feedback at the Members meeting the table below aims to provide an initial guide of what would deemed to be substantive and non-substantive. This is not designed to provide a comprehensive definition but working guidance. In addition, the provision in the constitution also allows for two or more elected Governing Body Members to refer any proposed changes to the Membership for decision if they consider a change proposed by the Accountable Officer deemed to be substantive has been wrongly defined.

Substantive Changes	Non-Substantive Change
• Changes to the CCG name or area • Changes to the composition of the Governing Body • Changes to the powers reserved to the members • Changes to Member's rights or arrangements for members meetings	• Corrections of typographical errors etc. • Changes to wording to reflect changes in legislation or new guidance • Changes to the list of Member practices following mergers etc. • Changes to list of Joint arrangements following agreement

4. NEXT STEPS

4.1. If the Governing Body gives authority to proceed, an application to vary the constitution will be made to NHS England. This will, in line with the statutory guidance, include an impact assessment and outline the CCG's approach to seeking member and other stakeholder views. NHS England aims to respond to applications within eight weeks.

4.2. The other Black Country and West Birmingham CCGs are also in the process of adopting or have adopted the new model constitution format. This means that all four CCGs will be able to work from the same position as work to align governance structures continues. In particular, it will be possible to undertake any work to amend the terms of reference for non-statutory committees to support collective working approaches without going through the NHS England constitutional review process.

5. CLINICAL VIEW

5.1. All GP Member practices have been provided with an opportunity to comment on the proposed changes. No specific feedback has been received.

6. PATIENT AND PUBLIC VIEW

6.1. As the proposed changes to the constitution are administrative in order to comply with the latest guidance, it has not been deemed necessary to specifically seek patient and public views on these changes.

7. KEY RISKS AND MITIGATIONS

7.1. There is a risk that the CCG's constitution will be out of date and not fit for purpose if it is not structured in line with the latest guidance. Adopting the new model will mitigate this risk.

8. IMPACT ASSESSMENT

Financial and Resource Implications

8.1. There are no specific financial or resource implications associated with this report.

Quality and Safety Implications

8.2. There are no specific Quality and Safety implications associated with this report.

Equality Implications

8.3. There are no specific equality implications associated with this report.

Legal and Policy Implications

8.4. The CCG is required by legislation to have a constitution that complies with guidance produced by NHS England on the content and format. The new draft constitution is in line with this guidance and an application to vary the constitution will be submitted in line with the procedure set out in NHS England's guidance on CCG Constitutions.

Other Implications

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

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

ATTACHED:

Draft Constitution

RELEVANT BACKGROUND PAPERS

NHS England Model Constitution and Guidance
NHS England Procedure for Clinical Commissioning Groups to apply for constitution change merger or dissolution

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	GP Members Meeting & Email	**October 2019**
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	October 2019
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**	**29/10/19**

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NHS Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
November 2019

Agenda item 8

TITLE OF REPORT:	Primary Care Strategy (V1.5 Final)
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To share with Governing Body the revised final agreed Primary Care Strategy for Wolverhampton following approval by Primary Care Commissioning Committee in October 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• The CCG Primary Care Strategy was initially approved by Governing Body in 2016. Implementation has been reported routinely via Milestone Review Board to confirm the extent to which progress has taken place, raising exceptions where necessary. • Significant progress has been made to implement the strategy and national guidance (General Practice Forward View) however in response to further national guidance including the NHS Long Term Plan earlier in 2019 the strategy has been reviewed and reproduced to reflect national and local development requirements. • This report provides an overview of the priorities captured in the 2019 strategy.
RECOMMENDATION:	1. The board should note that Primary Care Commissioning Committee have been kept sighted on the process of engaging the public, findings from audits undertaken in primary care and progress made to realise the objectives in the initial strategy. 2. The revised strategy has been agreed in principle by Primary Care Commissioning Committee in October 2019. 3. Governing Body should confirm their endorsement of the decision to approve the 2019 strategy noting that Primary Care Commissioning Committee will be kept sighted on progress being made to achieve the delivery objectives detailed in Appendix 1.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of services we commission. 2 Reducing health inequalities in Wolverhampton. 3 System effectiveness delivered within our financial envelope.

Enclosure: Primary Care Strategy (V1.5 Final)

1. BACKGROUND AND CURRENT SITUATION

1.1. The initial Primary Care Strategy approved by Governing Body in 2016 began implementation whilst co-commissioning with NHS England was in place for Primary Medical Services. Since 2017 Wolverhampton CCG has been fully delegated allowing primary medical services to be commissioned by the CCG with member practices resulting in further progress to implement the strategy.

1.2. Earlier in 2019 further planning guidance and the NHS Long Term Plan were published, and this coupled with the extent of implementation of the 2016 strategy prompted a review of the Wolverhampton Primary Care Strategy.

2. PRIMARY CARE STRATEGY

2.1 A series of aspirations set out in the 2016 strategy had been notably achieved and recognition of the improve state of general practice in the City is one that has been met favourably by the Primary Care Commissioning Committee, recognising that there is still further improvement to be made.

2.2 The revised strategy focuses on those further improvements including the development of new models of care in which patients get more options, better support and effective joined up care, at the right time in the right care setting and will be able to take more control of their own physical and mental health and wellbeing.

2.3 The long term plan describes the changes needed to health care services including the introduction and development of a number of new roles and how digital solutions will support patients in new and different ways when accessing primary medical services giving patients an all-round better experience of care.

2.4 The strategy defines a clear vision to commission the right healthcare services for our population recognising the health challenges relating to deprivation and how reducing inequalities through working collaboratively with health and social care partners to realise the vision.

2.5 Priorities for developing primary care include setting up primary care networks, population health management, improving access in general practice, full implementation of the primary care network enhanced service over the remainder of this and the coming two years and active involvement in the development of the integrated care system.

2.6 The implementation plan details how opportunities to embrace workforce challenges being faced in primary care, the availability of suitable estate to provide improved services from within neighbourhoods and the need for improved digital access to primary care are all key features within the work programme that will seek to enable successful delivery of the strategy.

3. CLINICAL VIEW

3.1. The latest iteration of the strategy has been developed with clinical input from both General Practitioners and nursing representatives within the CCG including the CCGs Chief Nurse.

4. PATIENT AND PUBLIC VIEW

4.1. In the summer an engagement event was held with members of the public providing the opportunity for patients and carers to consider the progress made since 2016 and recognise where further development should take place in response to the NHS Long Term Plan. A series of questions were posed to practices and have since been discussed over recent months at network level, those discussions continue allowing engagement to be meaningful and relevant to neighbourhood need and national expectations.

4.2. The CCGs Governing Body lay member for Patient and Public Involvement has been sighted on the development of the strategy and the views of the public and the ongoing communications and engagement arrangements that are detailed within the strategy.

5. KEY RISKS AND MITIGATIONS

There are two risks already recorded on the CCGs Risk Register that inform the Board Assurance Framework. Risks associated with workforce and digital are most prominent and subject to a number of actions that are actively taking place to mitigate both areas.

6. IMPACT ASSESSMENT

6.1 Financial and Resource Implications

Implications associated with finance and resources are detailed in local budget setting at the beginning of each financial year and subject to periodic review at Primary Care Commissioning Committee. Resource requirements associated with digital and workforce have been set aside based on a combination of national and local allocations.

6.2 Quality and Safety Implications

The strategy seeks to sustain high standards of patient safety and clinical effectiveness. The national quality outcomes framework and local framework for primary care will be used as the vehicle for improving and sustaining care quality and there is commitment for continued investment to enable improvement.

6.3 Equality Implications

The existing Equality Impact Assessment will be reviewed in the coming months, any changes required with be shared with the responsible committee for further consideration and approval.

6.4 Legal and Policy Implications

None identified at this stage.

Name: Sarah Southall
Job Title: Head of Primary Care
Date: 28 October 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	**S Reehana**	
Public/ Patient View	**S McKie**	
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**S Marshall**	**31.10.19**

NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Strategy 2019 - 2021

October 2019

Version 1.5.1 FINAL

Contents

1.0 Introduction

The first primary care strategy was published by Wolverhampton CCG in 2016, in anticipation of being fully authorised to commission Primary Care (General Practice) in March of the following year. The strategy laid out a series of aspirations:-

- The over-arching outcomes following the implementation of the Primary Care Strategy
- Our plans for a fundamental shift to treating more people in a community setting (as part of the Right Care, Right Place, Right Time overall CCG strategy)
- How General practice will operate at greater scale, underpinned by network alliance; non-clinical support between and amongst practices; GP IT; workforce and estates
- The influence that General Practice hold as the gateway to commissioned activity in Wolverhampton (Practices as Commissioners)
- How Procurement and Contacting for new services will be deployed in the emerging and forming GP networks.

In pursuing this strategy, much progress has been made and this revised document provides us with the opportunity to consider progress made and the next steps in recognition of national policy changes and in particular the NHS Long Term Plan that advocates Primary Care being the bedrock on which all other services should be built.

2.0 Context

2.1 The National Directives and Plans

The NHS Long Term plan, released in early 2019, sets out the new vision for the NHS for the next ten years. This vision, seeks to develop New Models of Care in which patients get more options, better support and effective joined-up care, at the right time, in the optimal care setting. This way, care will be more pro-active, and people will be able to take more control of their own physical and mental health and wellbeing.

The Long-term Plan describes what changes need to be made by all healthcare services such as the development of new job roles and how digital solutions such as Apps will support patients to access care in new and different ways, to give patients an all-round better experience of care

There are 5 major changes identified which build on the aspirations outlined in the GP Five Year Forward View (2016).These are:

2.2 Local - Wolverhampton

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

In order to achieve this, we have five priorities for the coming year:

- continue to commission high quality, safe healthcare services within our budget;
- focus on prevention and early treatment;
- ensure our services are cost effective and sustainable;
- align our clinical priorities, as appropriate, to the Black Country and West Birmingham STP/ICS;
- Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services wrapped around them

For Wolverhampton CCG, this means focusing on maintaining work currently underway in key priority areas, both locally and regionally, as well as supporting planned transitions to an Integrated Care System (ICS) and integrated care provision for the four 'places' of the Black County and West Birmingham Sustainability and Transformation Partnership (BCWB STP) – Wolverhampton, Walsall, Dudley and Sandwell and West Birmingham. This focus will enable us to align the CCG with the ICS as it develops, transitioning to the local, regional and national healthcare system set out in the NHS's Long-Term Plan (LTP).

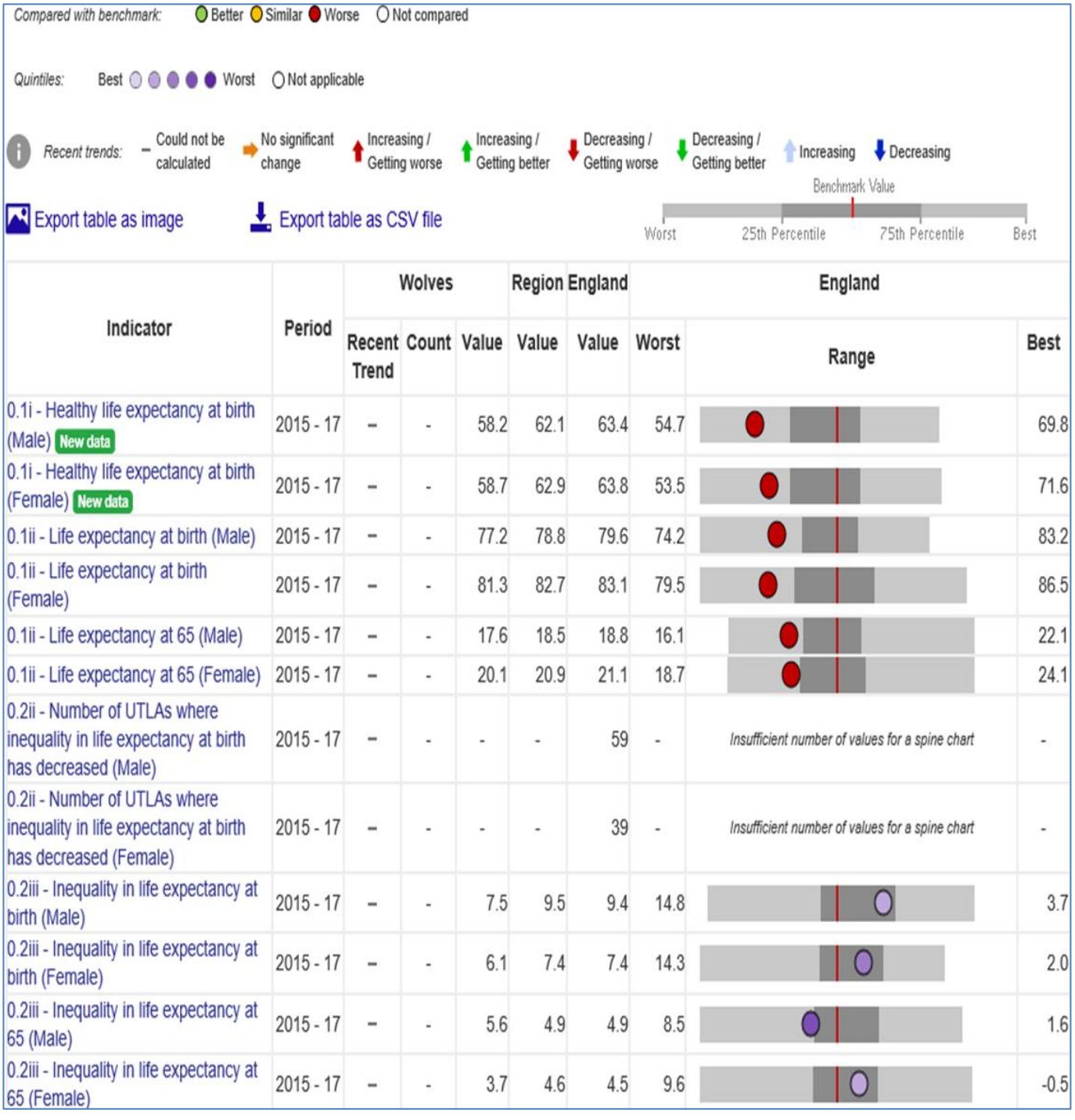
The City of Wolverhampton's population has been growing in recent years, and now stands at in excess of 290,000 in April 2019.

The city is ethnically diverse, with 35.5% of residents in 2011 being of BAME (Black and Minority Ethnic) heritage. Furthermore, 16.4% of the population in 2011 were not born in the UK. Many religions are followed, and the city has the second-highest proportion of Sikh residents in the country. A fifth of the population is disabled, similar to the English average using Experian's Mosaic classification system (updated in early 2016) provides the following profile. The largest proportion of households in the city are the 'Family Basics' group (18,585 or 17.8%) who are described as "families with limited resources who have to budget to make ends meet". The second most common household type is Transient Renters (15,798 or 15.2%), households comprised of "single people privately renting low cost homes for the short term". The third most common household is Modest Traditions (13,188 or 12.7%), who are "mature homeowners of value homes enjoying stable lifestyles".

3.0 Challenges

Wolverhampton has a number of health challenges relating deprivation including childhood obesity, child poverty, infant mortality (higher than the England average but improving) but with fewer secondary school age pupils having tried/smoking. Further details can be found in the city's Joint Health & Wellbeing Strategy 2018-23.

Through adopting a collaborative approach between the CCG, Public Health and our practice groups NHS Health Checks are at the highest rate they've ever been in the city having been one of the worst performing CCGs/Local Authorities in England in 2016/17.



Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
0.1i - Healthy life expectancy at birth (Male) New data	2015 - 17	–	-	58.2	62.1	63.4	54.7		69.8
0.1i - Healthy life expectancy at birth (Female) New data	2015 - 17	–	-	58.7	62.9	63.8	53.5		71.6
0.1ii - Life expectancy at birth (Male)	2015 - 17	–	-	77.2	78.8	79.6	74.2		83.2
0.1ii - Life expectancy at birth (Female)	2015 - 17	–	-	81.3	82.7	83.1	79.5		86.5
0.1ii - Life expectancy at 65 (Male)	2015 - 17	–	-	17.6	18.5	18.8	16.1		22.1
0.1ii - Life expectancy at 65 (Female)	2015 - 17	–	-	20.1	20.9	21.1	18.7		24.1
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male)	2015 - 17	–	-	-	-	59	-	*Insufficient number of values for a spine chart*	-
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female)	2015 - 17	–	-	-	-	39	-	*Insufficient number of values for a spine chart*	-
0.2iii - Inequality in life expectancy at birth (Male)	2015 - 17	–	-	7.5	9.5	9.4	14.8		3.7
0.2iii - Inequality in life expectancy at birth (Female)	2015 - 17	–	-	6.1	7.4	7.4	14.3		2.0
0.2iii - Inequality in life expectancy at 65 (Male)	2015 - 17	–	-	5.6	4.9	4.9	8.5		1.6
0.2iii - Inequality in life expectancy at 65 (Female)	2015 - 17	–	-	3.7	4.6	4.5	9.6		-0.5

We know that Primary Care plays an important role in improving the health of local populations, but we also recognise that changing how patients receive care will be a collective responsibility with patients not just the responsibility of Primary Care Networks and the Practitioners that work within them. We have to continue to develop and implement a programme of at scale initiatives.

We are introducing a genuine parity of esteem through transformation of services, policy change and societal attitude.

Responding to the NHS 10-year Plan's focus on Mental Health we are creating a system where patients have easier access to services:-

- early diagnosis and prevention
- have smoother transition from child to adult mental health services
- grow stronger, and early links with education
- ensure that primary care is supported to help but does not become the default for every patients
- make sure that all patients in crisis have support 24/7
- can access same day emergency and can get help to prevent suicide when they feel this is the only option left to them.

3.1 Reduce Inequalities

Improvements in life expectancy are a key success indicator and focus for all the partners within Wolverhampton. To achieve these, the council and public-sector partners will be working together to transform health outcomes across the city. Public Health will support and provide external advice to partners beyond the NHS and social care in taking a place-based approach.

Key to extending the reach of public health will be a primary care service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

Although the City of Wolverhampton is younger than the English average, it still has challenges from an aging population, and by 2041 is projcted that 60,935 residents will be aged 65+, which is a rise of 42%.

In response to the future challenges which all services will experience the City of Wolverhampton has a Health and Wellbeing programme, which we fully support and are a key partner in developing and delivering. The Joint Health and Wellbeing Strategy 2018-2023 has created three overarching priorities are thematically grouped as follows:-

Growing Well	• **Priority 1 Early Years - s**upporting patents to be active in their child's development • **Priority 2 Children and young people's mental wellbeing and resilience-** Working to improve children and young people's mental health
Living Well	• **Priority 3 Workforce- s**upporting people to stay healthy throughout their working lives, and helping people stay in work when they experience health problems (mental or physical). Develop, attract and retain high quality staff to ensure a health and social care workforce equipped for the future. • **Priority 4 City Centre** – Improving the city centre e.g. transport links that enable walking and cycling, reducing rough sleeping and tackling problems associated with alcohol misuse and public safety. • **Priority 5 Embedding prevention across the system** – Enabling people to live longer and healthier lives by helping them change their lifestyle and improving the environment in which they live.
Ageing Well	• **Priority 6 Integrated Care; frailty and End of Life** – Health partners working together more effectively, in particular, for people who are frail or at the end of life. • **Priority 7 Dementia Friendly City** – Working together to enable the City to be Dementia Friendly for people living with Dementia and their families.

3.2 What we have achieved so far

We are piloting initiatives, chosen as part of our previous strategy with the aim of both improving general primary care services and supporting a shift of care into the community.

Over the last 2 years Primary Care services have put in place:-

- Practices actively engaging to afford more resilience at practice level leading to improved patient care.
- Improved access to Primary Care providing additional appointments through introducing hubs in the community with appointments available until 8 pm weekdays plus weekends and bank holidays.
- More services available at weekends including dedicated nurse appointments, pharmacy reviews, phlebotomy and other specialist clinics available for patients to access.
- Primary care counselling service for patients to access in a timely manner closer to home and without referral to mental health services.
- A Special Access Service for patients who have been excluded from General Practice lists as a result of violent or aggressive behaviour.
- A local Quality Outcomes Framework (QOF+) focussing on the prevention and treatment of conditions including diabetes, obesity, alcohol, hypothyroidism, COPD and Asthma and also included in the scheme are physical health checks for patients recorded on learning disability or serious mental illness register(s) and finally an initiative to improve bowel cancer screening.
- Supporting patients to be treated at home or in a nursing home when previously they would have been treated in a hospital
- Increased palliative care services available to those who wish to die in their place of choice
- Improvements in the health and social care of people with Long Term Conditions including:
- Diabetes, CVD (AF diagnosis, warfarin treatment and NOACs, hypertension, heart failure and stroke, cardiac rehab following MI) and COPD
- Improved the health and social care of people living with frailty by providing targeted interventions
- A strong emphasis on putting the patient at the centre of our planning and encouraging primary care to work together to achieve improved population-based health and well-being

3.3 Our Vision for Primary Care

Supporting the continued improvement and development of Primary Care in Wolverhampton is one of our main priorities over the next 2 years which we will achieve through implementing this strategy.

This strategy is intended to reflect our ambitious programme of system-wide, large-scale change and recognises the importance of primary care as the foundation of our entire health system.

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

However, it's important to recognise there will be a continued focus on general practice services and will not directly cover other primary care services such as dentistry and ophthalmology. This reflects the fact that the CCG's membership is comprised of general practitioners and the CCG's responsibility to ensure the continuous improvement of primary medical services. These other services are still being commissioned by NHS England however, how these change in response to the 10 Year Plan, and changes to any plans will be undertaken in due course.

1. **Priorities for Developing Primary Care**
   - Setting up Primary Care Networks
   - Population health management
   - Improving access in general practice
   - Mature Primary Care Networks through implementation of the Network Directly Enhanced Service
   - Active involvement in the development of the Integrated Care System

2. **Our Clinical Priorities for Primary Care**
   - Frailty
   - Children and Young People
   - End of Life Care
   - Mental Health

3. **NHS Long Term Plan**
   - Boost out of hospital care
   - Reduce pressure on emergency hospital services
   - Control over your own health and more personalised care
   - Digitally enabled primary and outpatient care
   - Focus on population health – moving to Integrated Care Systems everywhere

The Long-Term Plan has committed to increase available funding for community and primary care. We will use this additional funding on improving our services e.g. developing our Primary Care Networks is fundamental to the success of this strategy.

Supporting the continued improvement and development of Primary Care is a key ambition for Wolverhampton CCG, reflected in our work programmes however introducing reforms to Primary Care will not occur over night and will bring with them both structural and operational challenges.

4.0 Opportunities

4.1 Primary Care Networks

In Wolverhampton we have worked with General Practice to put the foundations in place for practices working as networks. A primary care network (PCN) consists of groups of general practices working together across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. These networks provide care for populations between 30 – 50k patients. There is a greater opportunity for GP practices to provide a wider range of services situated closer to the patient's residence.

In operating in such a way, network of practices will be in a position provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, 'First Contact Physiotherapy, extended

access and social prescribing. Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

These networks will be the footprint around which integrated community-based teams and community and mental health services will develop. Networks will use data to assess the needs of the local population and identify people who would benefit from targeted, proactive support.

Although the GP practice will be part of a wider network of practices, they will still retain their unique identity and relationship with their own patients and continue to provide local services to their patients.

Since national guidance was published in March 2019, the CCG have worked closely with practice groups to formalise working arrangements as Primary Care Networks. In May 2019 the CCG approved 6 applications from groups of practices which contractually formalises their working relationships via the Network 'Directly Enhanced Service' (DES).

It is expected that these 6 primary care networks will strengthen and develop their services based on population health need. There are four overarching Programme areas that national directives are steering local deployment.

PCN Development
All six networks will be supported by the CCG to mature in a timely manner to the CCGs acknowledges the challenges of competing priorities PCNs will face All PCN will be required to identify, from available data, their population health needs and prepare a full DES Network Agreement in June that addresses each of the following:-

Schedule 1 – Network Specifics
Schedule 2 – Additional Terms
Schedule 3 - Activities
Schedule 4 – Financial Arrangements
Schedule 5 - Workforce
Schedule 6 – Insolvency Events
Schedule 7 – Arrangements with organisations outside the network

Network agreements will be regularly updated to reflect the maturity and the changes that arise in the implementation phase. The Network DES recognises that practice remain independent and there may be occasions when a practice may leave or join a network. These changes will be proposed to the CCG Commissioning Committee to ensure that the requirements of the Network DES (specification and guidance) have been met prior to any change.

By the end of 2019/20 there will be new national service specifications attached to the Network DES to be enacted in 2020/21 the DES will continue to be developed over subsequent years as part of the 5 year deal for GPs.

The speed of collaboration will be critical to the maturity and effectiveness of each of our networks in Wolverhampton. This has been a core component of the 5 year strategy in the Wolverhampton Clinical Strategy and practices are now well placed to develop at pace. The CCG has been and will continue to be committed to supporting and encouraging PCN development along with other stakeholders and partners and strive to

achieve better services for patients. The PCN situation for Wolverhampton is hlighlighted in the table below

Name	Composition
Wolverhampton North Network	7 practices | 52,584 patients
Unity East Network	8 practices | 32,867 patients
Wolverhampton South East Network	7 practices | 56,933 patients
Royal Wolverhampton Trust Network	8 practices | 55,516 patients
Unity West Network	5 practices | 38,197 patients
Wolverhampton Total Health	6 practices | 56,321 patients

A copy of our networks composition can be found in Appendix 2.

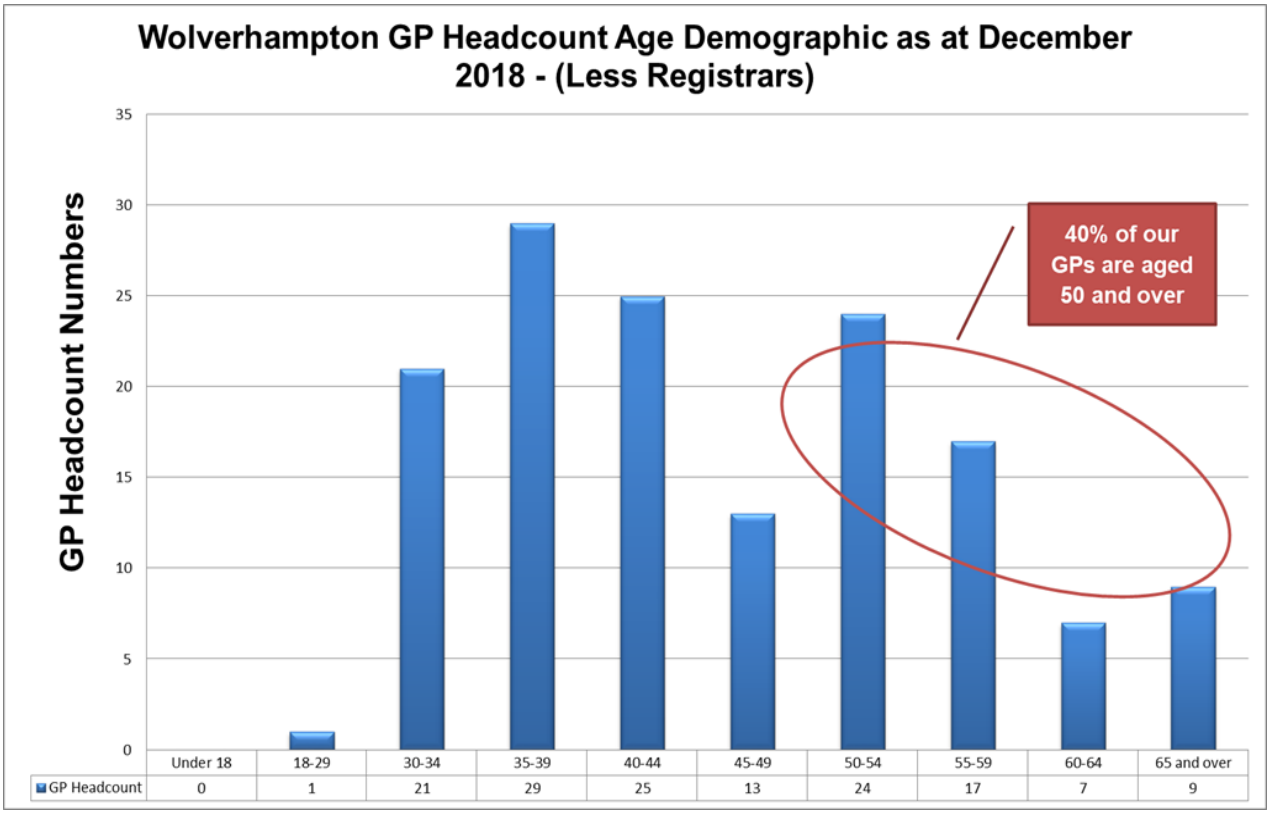
4.2 Workforce

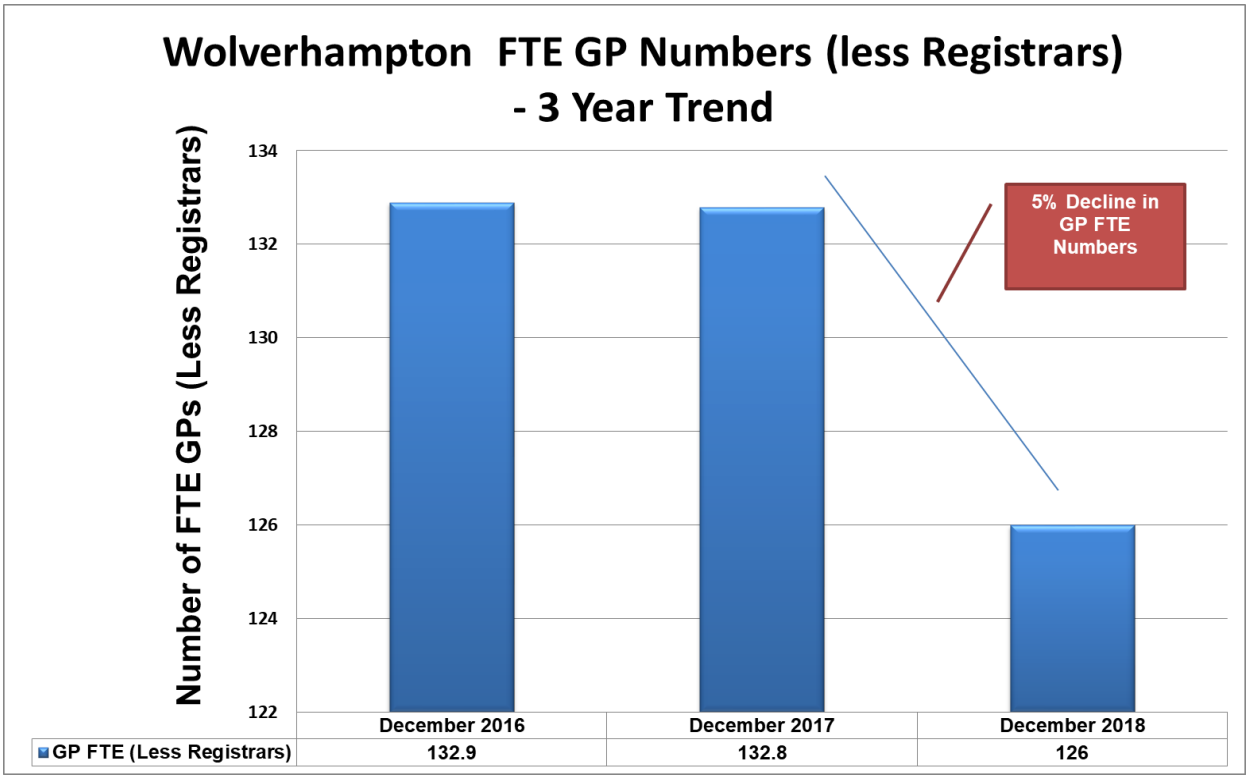
The increase in demand General Practitioners face has been a significant cause for concern due to the number of GPs either leaving the profession or newly qualified Doctors not wanting to enter the Primary Care.

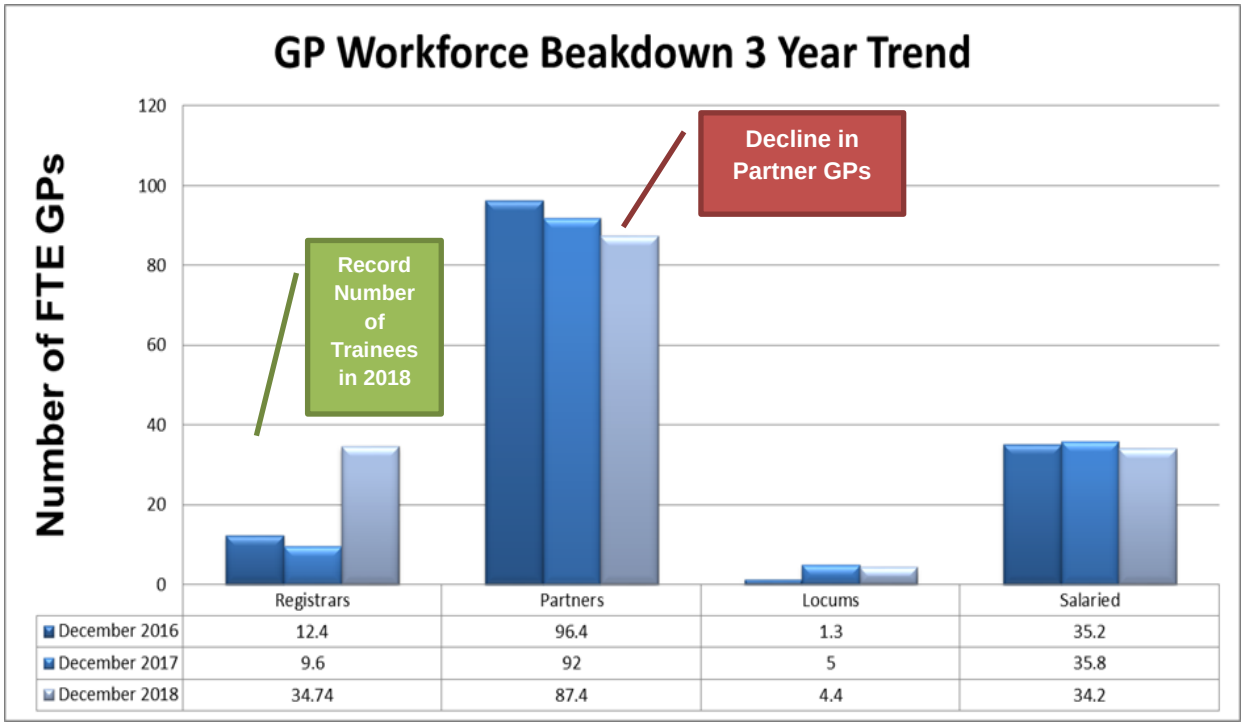
In addition, there are added complexities with the aging workforce profile of GPs. This has been recognised through the partnership work between the Black Country and NHS England and Intensive Support Site funding has allowed the greater interaction and co-design of a series of initiatives to attract and retain GPs in the Black Country. In Wolverhampton we are establishing stronger links with our training practices and Training Programme Directors to support GP Trainees to complete their training and find substantive employment in the area.

The CCG does recognise also the importance of close working with GPs to ensure we achieve a sensible flow of GPs both at early, mid and late career – the objective being to keep GPs in the profession in order to sustain an even distribution across the age profile.

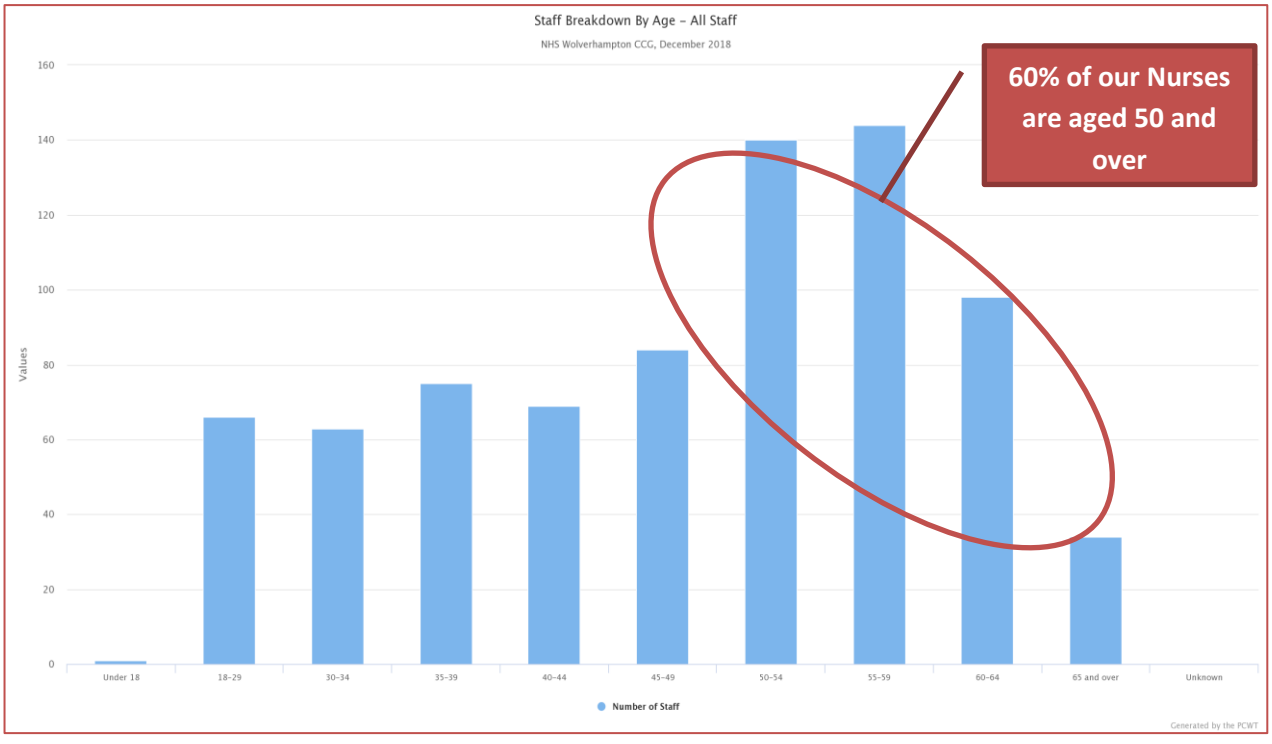
There are a number of GP workforce retention initiatives that are actively promoted and being accessed by Wolverhampton GPs affording mentoring, networking and portfolio careers and also access to expert advice on career planning and other support for GPs who wish to return to practice and want to be part of our membership.


Wolverhampton GP Headcount Age Demographic as at December 2018 - (Less Registrars)
GP Headcount Numbers
35
30
25
20
15
10
5
0
40% of our GPs are aged 50 and over
Under 18
18-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65 and over
GP Headcount
0
1
21
29
25
13
24
17
7
9


Wolverhampton FTE GP Numbers (less Registrars) - 3 Year Trend
Number of FTE GPs (Less Registrars)
134
132
130
128
126
124
122
5% Decline in GP FTE Numbers
December 2016
December 2017
December 2018
GP FTE (Less Registrars)
132.9
132.8
126



Similarly, the practice nurses age profile emphasises the importance of working with practices to develop and promote general practice nursing as a career for the future. A high proportion of practice nurses are nearing retirement. Through our local engagement with the workforce and educational providers, a suite of retention projects will be co-designed to improve practice nurse retention. Improved rates of student placements have begun to be realised however, more work needs to be done to develop and strengthen our workforce. The STP General Practice Nurse Strategy is also due to be launched in September 2019.



There will be an expansion of nursing and other undergraduate training places and there will be an increase in international recruitment. There will also be an increase in the number of volunteers.

4.3 Estates

Our estates plans have been developed in response to the national and local drivers for change and by building on our progress to date, we will continue to develop a fit for purpose estate and support management system to:-

- Improve the capability and capacity for Primary Care provision to address population growth and demographic change
- Support and enable the delivery of clinical strategies and new models of care
- Deliver better service integration, improvements in service efficiency and better outcomes for our residents
- Improve the effective utilisation of the estate
- Increase efficiencies and ensure value for money both from our existing estate and from any investments in estate developments
- Improve the quality, flexibility and condition of the estate
- Reduce risk and improve service resilience at local and system levels
- Rationalise and dispose of surplus or unfit estate.

Our estates team will, through our governance systems and continuing stakeholder engagement, ensure that the plans remain as live documents and will be updated to reflect emerging new models of care, changing need and funding resources.

There is close collaboration between the estates function, primary care commissioners and the locality planning infrastructure. The Local Estates Forum and other planning forums ensure close collaboration with the wider health and care stakeholders. The estate strategy will continue to be service led and will enable us to achieve clinical and service aims and plans.

The CCG will maintain a focus on the efficient management and utilisation of and value for money from the existing estate. There are many alternatives available other than new or extended buildings.

4.4 Digital

The Long-Term Plan clearly articulated the need for improved access for patients, including patients having better access to their health care records. This will be implemented through an integrated online triage solution, accessible via the NHS Patient Access app and also directly through the patient access portal on the GP Practices websites. Improving patient choice will further be expanded through the deployment of an online Video Consultation solution. Patients will have the option of choosing the type of consultation they receive and this will also support patients who struggle to access services directly at the practice.

The development of the Insight Shared Care Record will allow clinicians access to patients' full records as they move between healthcare professionals.

The 111 service will be able to book patients directly into GP appointments at practices with Wolverhampton.

Through the HSCN programme the CCG is installing a brand-new network infrastructure replacing the old broadband N3 lines with scale able IPVPN lines that will allow the network to expand with the requirements of the organisation moving forward.

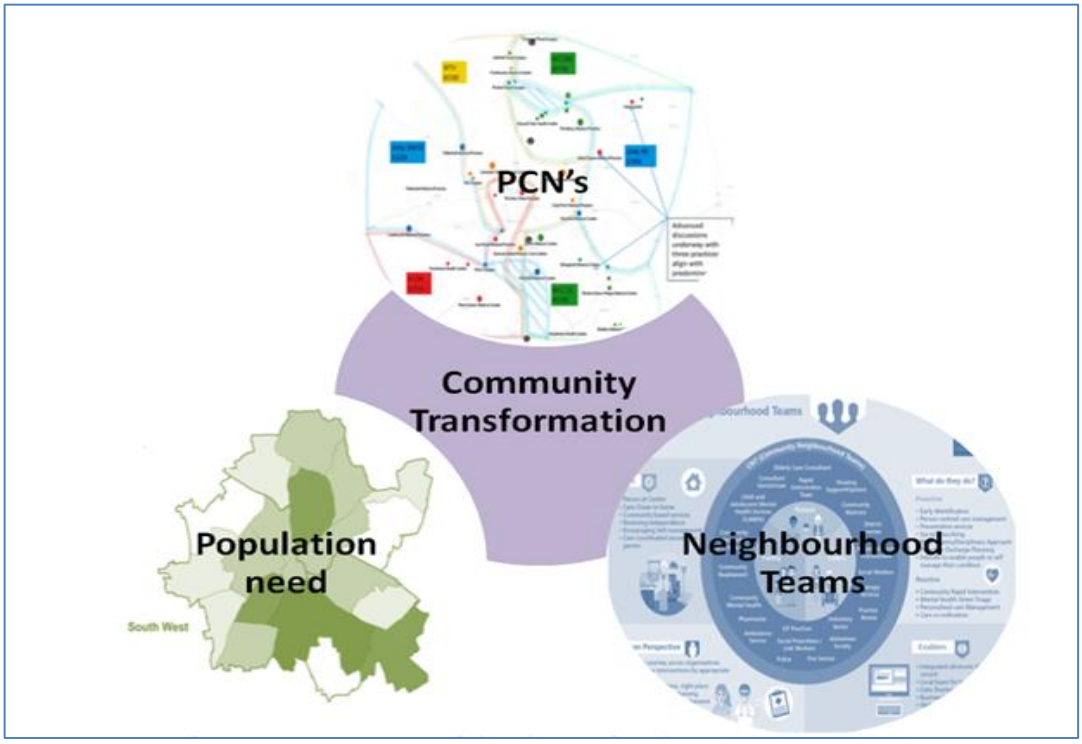
4.5 Inter-dependencies with the NHS Long Term Plan

4.5.1 Boost out of hospital care and move to greater collaborative working between Primary and Community Health Services

Wolverhampton is committed to continuing and building upon the work already achieved in developing system wide health and care integration with a strong focus on care closer to home but going forward, with a much stronger emphasis on 'wrapping' this integration around Primary Care. The NHS Long Term plan investment into developing Primary Care Networks supports the journey that Wolverhampton has already been already embarked on. A key shift over the life of this strategy, supported by Wolverhampton's Integrated Care Alliance will bring into place, will see:-

- A transformed Community Services supporting PCNs in Wolverhampton that will offer:-

  - Improvements in care for patients at the end of life, and the need to reduce the numbers of patients dying in an acute bed where this is unavoidable
  - Increased capacity within community services and admission avoidance initiatives
  - Aligned care provision with population need
  - Integrated locality hubs to maximise joint working opportunities with system partners including Adult Social Care, Housing, Mental Health and the Voluntary Sector (one of which has been fully operational since December 2018)
  - Flexible, viable and sustainable community services now and in the future
  - The further professional development of community nursing services to provide care which matches patients needs

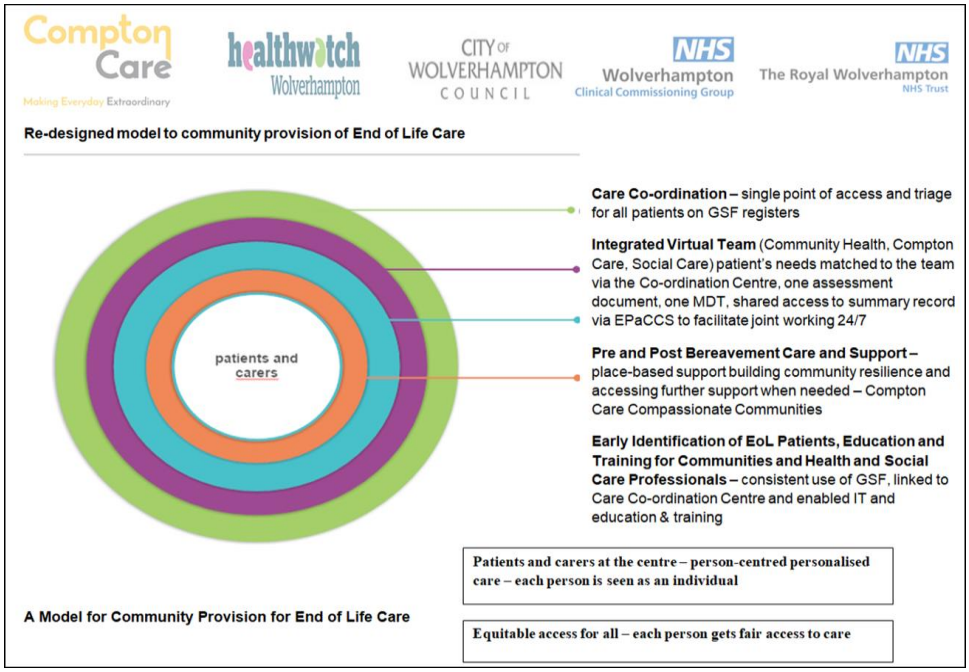


- Fully integrated, structured, Community Multi-Disciplinary Team (MDT) approaches that will enable each Primary Care Network to access social care, voluntary sector, housing, mental health and community health skills, knowledge and expertise. This will prevent patient escalating into acute care where possible and work with patients

who have been accessing acute services but who can be better supported closer to home and in their communities. For the population of Wolverhampton, this means more integrated, person centred care. The MDT approach is already in progress with over 50% of practices across the city active now and plans in place for the remainder to go live during 2019/2020.

- Each practice will benefit from ongoing development of the Rapid Intervention Team to enable more patients to be triaged and treated in their own homes.

- A new model for community based end of life care



- We will work with our PCN's to help them identify priorities for their development and gain access to the support offers that become available, including organisational development that will support the ongoing integration of Community bases services with PCNs
- The introduction of healthy ageing coordinators at a PCN level working across the system to reduce/delay the progression of frailty

4.5.2 Reduction in pressure on emergency hospital services

Wolverhampton will continue to actively promote primary and community-focused alternatives to hospital for unplanned care. There has already been substantial resources and pathways designed to prevent hospital attendance for those at risk of unnecessary hospitalisation. We will continue to improve and develop:

- Improved access to out of core GP hours over and above the General Medical Services contract.

- Integrated MDTs in primary care for patients identified requiring a multi-disciplinary approach to assure the appropriate care at home in the community and away from urgent/emergency care where appropriate. Primary Care MDT co-ordination, will make use of personalised care plan and a shared care record across Health, Social Care and Mental Health providers.

- Additional primary care sessions during bank holidays.
- Urgent Treatment Centres (UTC) to more appropriately manage primary care patients who attend the acute site.
- Integrated NHS 111 with the UTC to allow direct booking of primary care appointments as an alternative to emergency department attendance.
- A Primary Care in-reach approach to support care for residents in care homes as part of the wider development of multi-disciplinary team working enabling patients to be treated in their usual place of residence without the need for them to be conveyed to hospital.

4.5.3 More control over your own health and more personalised care when you need it

Personalised care is one of the five major practical changes to the NHS that will take place over the next five years, as set out in the NHS Long-Term Plan. Primary care and PCNs are well place to support individuals to manage their own personal health and care.

Primary care will play a pivotal role in this in a number of ways:

- Implementing social prescribing within PCNs
- Expanding on good practice models such as health coaching and programmes such as Make Every Contact Count.
- Introducing Shared Decision Making (SDM) with patients.
- Ensuring that patients have personalised care plans where appropriate concentrating on “what matters to me”.
- Ensuring a co-ordinated, multi-disciplinary approach to managing personalisation at a “universal” and “targeted” level

We have adopted an approach to delivering the personalisation agenda based on 6 nationally recognised evidence-based components. These include:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including the legal rights to choose.
- Social prescribing and community-based support.
- Supported self-management.
- Personal health budgets and Integrated personal budget

Going forward our aim is that we:

1. Progress Policing and Community Safety Partnerships (PCSP)/ health coaching training programme across the entire STP.
2. Deliver two strategic co-production events for people across the STP so they are aware of the work we are undertaking to support them in managing their own health and well-being.
3. Strengthen peer support offers by using outputs from peer support mapping and commission facilitation training for groups through the four local Community and Voluntary Services.
4. Engage with commissioners over strategic direction and ensure contracts support on-going personalisation.
5. Plan and deliver a training programme for health coaching and personalised care support through the year.
6. Explore PHBs for high intensity users and integrated personal budgets for children and young people with Education Health and Care (EHC) plans.

4.5.4 Digitally enabled primary and outpatient care will become main stream

Effective digital solutions should be the norm rather than the exception. Our digital infrastructure will support patients to use digital solutions to access information on their conditions, make bookings into their local GP practice (and soon PCNs), place orders for repeat prescriptions and understand their health needs through online digital support for example, smoking cessation and weight management.

We will seek to align national and local priorities at scale to support improved clinical outcomes. For example, having virtual MDT consultations with both primary and secondary care health professionals so that care can be jointly planned for the patient.

Digital is a key enabler for improvement and in turn, aligned to the NHS Triple Aim. Wolverhampton forms part of an STP Digital Workstream which will realise the opportunity to align organisational priorities for digital with the overarching objectives for primary care as detailed within both the STP Clinical and Primary Care strategies.

Specific work to be undertaken over the life of this Strategy is as follows:-

- **On-Line Consultation** - consulting with patients using technology including email, skype, text and telephone. Wolverhampton Practices are expanding on their online consultation facilities to enable functionality to be made available to all practices over the life of this Strategy and twin tracking this technical work with proactive on-site marketing and engagement for GP practices and patients in order to maximise the uptake and opportunity

- **NHS App** - NHS App will continue to be a national platform providing people with a 'front door' into a range of online health and care services. Wolverhampton is committed to promoting and ensuring digitally enabled services are interoperable with the NHS App. It is already proving to be an important platform in enabling the public fast and reliable access to i.a. NHS 111, practice appointment booking, renewal of prescriptions and viewing of GP medical records. The NHS App will further evolve through seamless integration with the smartest and most effective applications, tools and services on the market. Wolverhampton will:-

    - Ensure that all practices in our area have GP Online Services access technically enabled within their system Ensure all practices have reviewed their GP Online services settings to ensure they are appropriate for patient use
    - Ensure all relevant staff are briefed on the NHS App rollout and requirements for supporting patients
    - Review 111 Online provision to ensure appropriate for potential increased usage/activity from exposure within the NHS App

- **Extended Access NHS 111 Direct Booking**
  Wolverhampton will work with Practices and Providers to ensure full coverage by September 2019. This work enables 111 to have access to directly book appointments into locally provided extended access hubs.

- **A Black Country and West Birmingham wide interoperability platform** aimed at data sharing across a wider footprint of providers is underway. Through a Walsall and Wolverhampton collaboration, a project is in delivery implementing a repository based shared care platform. This will lead to introduction of a wider shared care record and identification. Ensuring information captured within clinical care settings is appropriately and securely shared will not only enhance care but also provide management information to support secondary usage such as commissioning and public health activities.

- **Working with partners, patients and providers to develop and promote digital solutions for patients and staff** that enable:-
  - Access to more self-management/help tools such as Apps and videos that support the management of Long Term Conditions such as Asthma and Diabetes
  - Access to digital networks/groups for patients and staff to enable peer support and information sharing
  - Maximising the use of digital media to promote the local area as a great place to live and work to help attract and retaining staff in Primary Care

4.5.5 We will increasingly focus on population health – moving to Integrated Care Systems everywhere

Our Local place-based Integrated Care Alliances (ICA) is being developed and implemented in support of the clinical strategy. This is an emerging vehicle for bringing together health and care services for our populations

We have committed to use all the enablers we have at our disposal to make integration a reality:-

- We will use our commissioning strategy as a lever for change. We recognise the unique opportunities this allows, and the innovative approaches that will support this strategy.
- Through our introduction of PCNs we will be able to support local decisions on how services are provided and support network and neighbourhood-based delivery models.
- Through our approach to place-based care we will promote integration and joint working with local authority and social care colleagues. Joint working and where appropriate joint appointments will be encouraged.
- We will undertake system transformation across all partners to re-enforce a one system principle,. Made up from primary, community and intermediate care teams this will increase the capacity and responsiveness of our services to those who need it.

5.0 Primary Care Services

We have supported the new deal for General Practice, the new Contract (2019) and funding arrangements which include:-

- Network DES funding is predicated on practices confirming their willingness to collaborate and work together as a network (not necessarily merging existing contracts) whilst maintaining their independence. The network application process concluded in May 2019 and 6 networks have been approved for the city. Funding will flow to the Network's nominated provider as set out within the respective Network Agreement.
- Individual practices who have signed up to the Network DES will receive an additional payment for engagement with the Primary Care Network Scheme. This is the only funding that is paid directly to practices for participation in the DES.
- In support of the DES NHS England will invest in a number of new roles, importantly the introduction of a Clinical Director in each network and a proportion of funding for this role on a basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This will be provided on a sliding scale based on network size and will rise in subsequent years.
- Funding for new roles including Social Prescribing Links Workers (100%) and other professionals including Clinical Pharmacists, Physicians Associates, First Contact Practitioners and Paramedics (75% contribution).

New roles will be introduced over a 3 year period and will be key to networks maturity and will equip them with the workforce they need to tackle population health needs that can be met in the community.

5.1 Finance

Financial planning for Primary Medical Services spanning the next 5 years forms part of the CCGs overall financial plan. The plan includes allocations for the Network Contract DES (£1.50 per registered patient) intended to support the day-to-day operation of the network and Practice Engagement Payment (£1.76 per registered patient).

The following table shows the financial breakdown for primary care funds based on the new GP contract payments and other allocations that have been confirmed for the GP Five Year Forward View (GPFV):

Descriptor	Source	Value	Payee
Network DES	CCG Discretionary	£1.50 per patient	Network
Practice Engagement Payment	CCG Delegated	£1.76 per patient	Practice
Improving Access Fund	NHS England	£6 per patient	CCGs
GPFV (Resilience, Retention, Admin & Clerical, Online Consultation, Practice Nursing)	NHS England	19/20 £1,167 20/21 £1,274	STP (Wolverhampton CCG) - [Plan in place]
GFPV Achieving Sustainable GP Workforce Targeted Retention (Four Pillars)	NHS England	19/20 £127k	STP (Wolverhampton CCG) - [Plan in place]
GPFV First 5s	NHS England	19/20 £50k	STP (Wolverhampton CCG) - [Plan in place]
Social Prescribing 100% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x 3	Per Network
Clinical Pharmacist(s) 70% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x	Per Network
Clinical Director Funding 0.25/1day per week	NHS England	19/20 £0.51 per patient 20/21 £0.57 per patient	Network
First Contact Practitioner (70%)	NHS England	20/21 x 1 21/22 x 2	Network
Physicians Associate (70%)	NHS England	20/21 x 1 21/22 x 2	

5.2 Directed Enhanced Services

One of the most critical parts of developing our Primary Care Network is how funding will be allocated. The main mechanism is through an agreement called a Directed Enhanced Services (DES), also being referred to as the 'Primary Care Network Contract'. The DES details how the funding will be allocated by services and the diagram below highlights which ones we are focusing on and what we need to consider implementing this effectively.

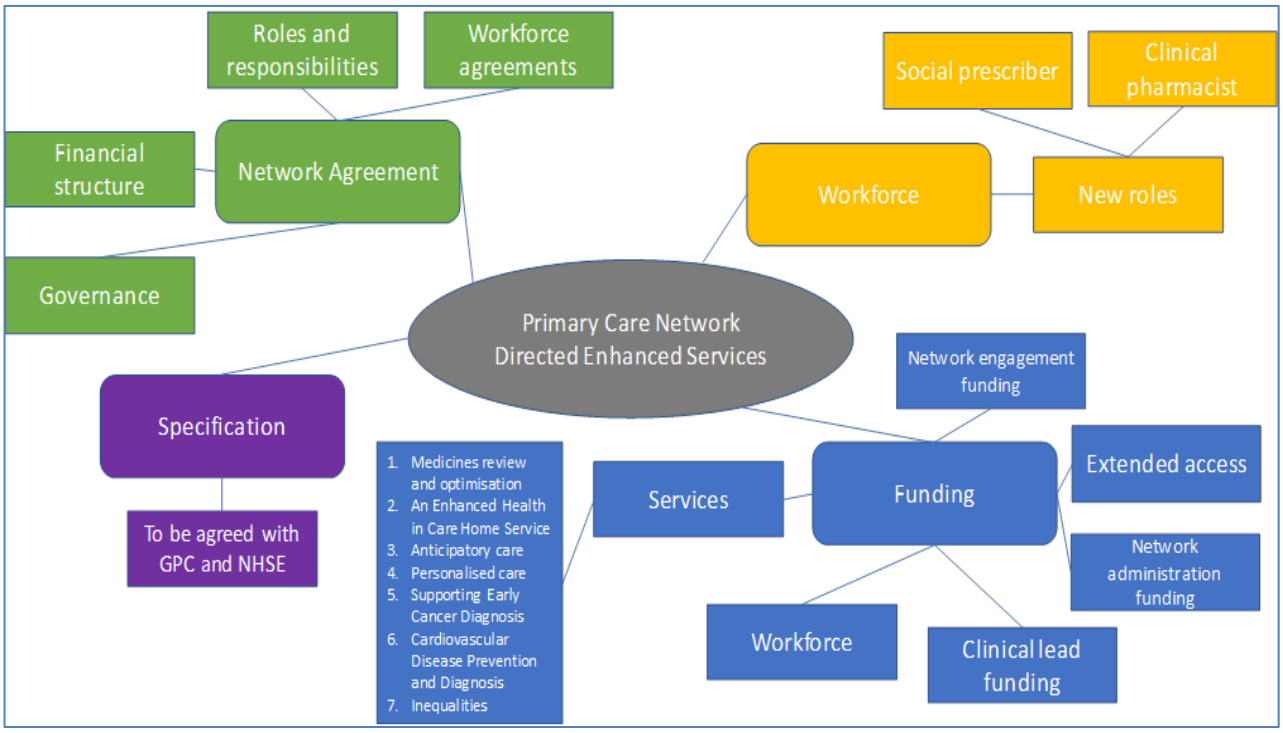
Having agreed, signed off contracts for services and the new way of working begun, the networks will have a good level of financial security. This security means that the networks can focus on formation and the delivery of front-line patient care without having to worry about current funding streams.

Other DES Specifications that the CCG actively encourage practices to participate in are as follows:-

- Learning Disability Health Checks
- Minor Surgery
- Vaccination Programmes (Shingles Catch Up, Pertussis, Meningococcal Freshers, Seasonal Influenza & Pneumococcal Polysaccharide Vaccination Programme 2019/20)
- Extended Access (till July 2019)

Practices are required to 'sign up' to these direct with NHS England and collaborative monitoring takes place in year with the CCG. NHS England may alter/vary their offer in years beyond 2019/20.

Public Health also commission services from General Practice, primarily NHS Health Checks.



5.3 Quality Outcomes Framework (National)

NHS England commission a national framework for general medical services contract holders in England. This is a voluntary scheme comprising of a collection of clinical and public health indicators organised by disease or intervention categories and have been selected representing care that is principally the responsibility of general practice and there is good evidence of health benefits that are likely to result from improved care provided in primary care.

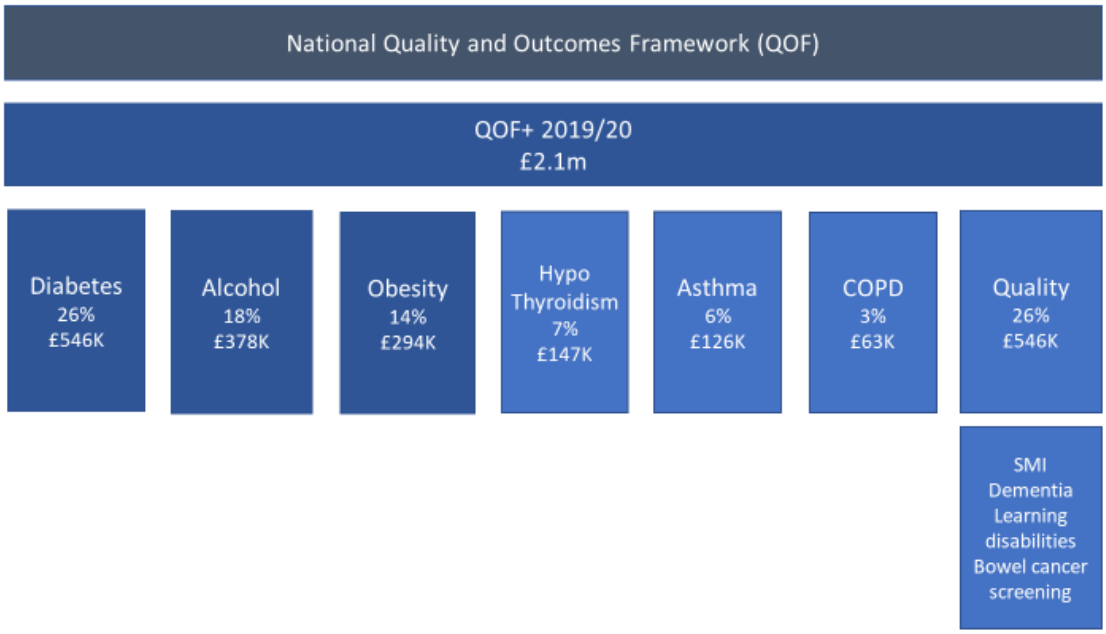
There are a number of clinical domains including atrial fibrillation, heart failure and hypertension and dementia and mental health. Nationally In 2019 more indicators will be added to some domains including diabetes, blood pressure control and cervical screening. A new quality improvement domain (QI) that focuses on prescribing safety and end of life care have also been introduced but the QI domain is likely to be subject to change year on year.

5.4 Quality Outcomes Framework (QOF+ Local)

Locally, the CCG introduced QOF+ in 2018/19 with particular focus on prevention of deterioration and/or ill health. The scheme was designed in conjunction with GPs from within the membership and designed to complement work already taking place in QOF whilst tackling areas of concern in the city.

The initial priorities including diabetes, alcohol and obesity and comprised of 19 indicators for practices to work towards the scheme has been developed further in 2019/20 and spans other priorities including COPD, Asthma, Hypothyroidism and a small compliment of quality requirements.

There are now 34 indicators and the value of the scheme has increased to £2.1 m in 2019/20.



5.5 Local Enhanced Services

The CCG invests additional local funding based on population health needs, these are of course prioritised to ensure

- QOF+
- Minor Surgery (Networks)
- Improving Access
- Minor Injury
- Basket of Services

All practices are actively encouraged to participate at practice and/or network level affording patients localised care delivery, closer to home.

5.6 Our Approach to Integration

The Long-Term Plan states that by 2021 Integrated Care Systems (ICSs) will cover the whole country.

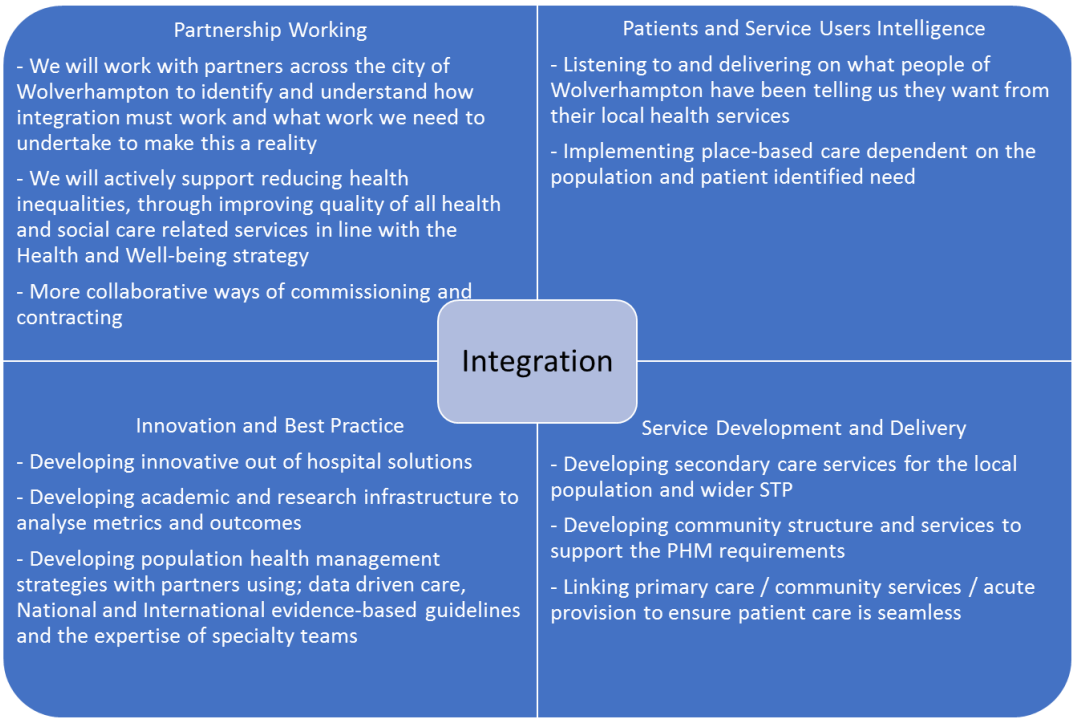
Nationally there has been the development of a new integration framework. We are a committed partner within the Black Country and are supporting the development and adoption of this new Integrated Care approach has been created to ensure that all associated organisations:

- Are committed to working in partnership in the best way possible to support our service users, carers and their families
- Support the development of integrated care for more specialist services
- Listen and co-produce services with our service users and stakeholders
- Play a pro-active role in developing the Wolverhampton Integrated Care Approach.

We also recognise that integration is an important enabler within Primary Care Networks and our aims for delivering integrated care within Wolverhampton can be split into the following areas:

- Partnership Working
- Patients & Service User Intelligence
- Innovation & Best Practice
- Service Development & Delivery

The illustration below provides more detail about how integration will be achieved for each component.



As part of the integration plan, the CCG will support the development of Multi-Speciality Community Provider and Primary and Acute Care Systems which will deliver new ways of delivering more integrated services in primary care and community settings.

Clinicians have identified a range of clinical priorities with the overall objective of improving experiences of care for patients first and foremost whilst also improving the way in which primary and secondary care professionals work seamlessly to improve care for their patients.

We are continuing to Integrate systems by ensuring we place Primary Care at the centre of the patient's pathway and work with, for example Local Authorities and the third sector taking advantage of their experience and knowledge for example contributing and signing up to key frameworks such as the Social Care Green Paper.

To help us to continue to meet our aspirations will draw on a number of key support functions to help deliver on the above. These include workforce development, contract management, IT and estates. By doing this we will ensure that any new service development or pathway changes are robust and that the needs of the patients and the staff will be met.

We use data and population health analysis to understand the needs of our patients. Through this we have targeted our resources into long-term conditions such as diabetes, alcohol abuse, obesity and cancer screening (QOF+). We are also redesigning key pathways, developing new roles and improving the way in which care is delivered we aim to strengthen all our primary care services, which will in turn help us to improve the health of patients and to continue to deliver an improved and consistent level of service.

6.0 Work Streams and Delivery Programme

In order to deliver the priorities detailed in this strategy a comprehensive programme of work has been developed to enable the CCG to meet the challenges and opportunities - our aims and aspirations outlined within this strategy. The over-arching work programme, which will be delivered over the next 2 years, has been developed from; conversations with patients on their experiences, from clinicians on where they know patient care can be improved, from internal teams, from data and information that is constantly reviewed as well as national priorities. A summary of the improvements that will be realised over the next 2 years are summarised in Appendix 1.

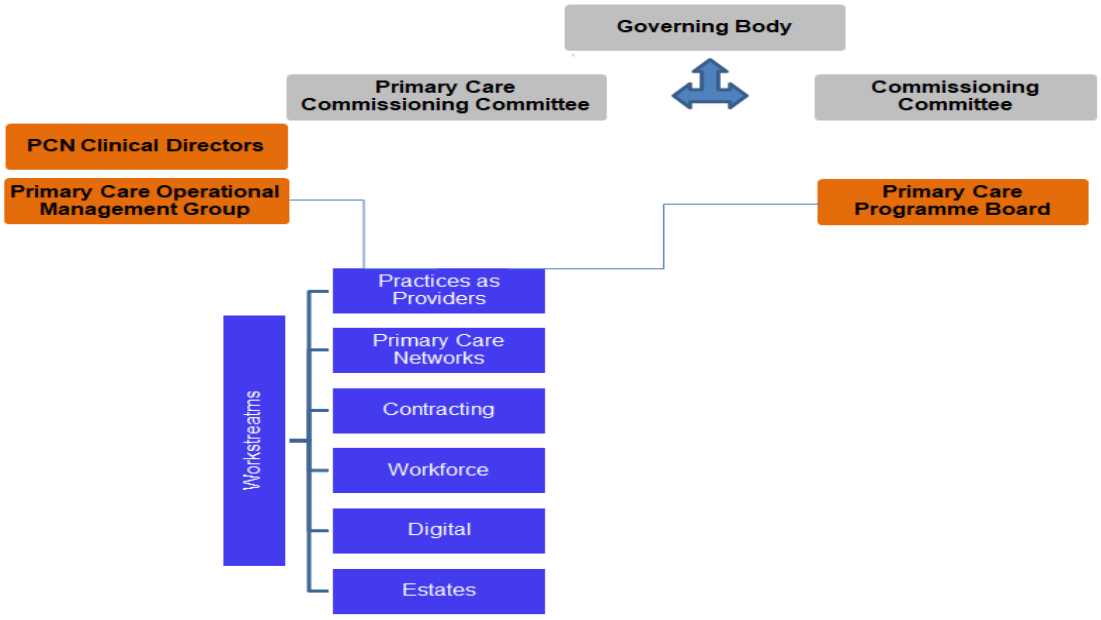
6.1 Our Delivery Programme

The changes within Primary Care are happening at a pace not seen before within the NHS. Formation of Networks, introduction of new Primary Care roles for staff such as the Physicians Associate, changes to contracts and new contracting and funding flows all make the need for good, robust governance and therefore accountability vital.

Being able to continually demonstrate that we consider these changes in Primary Care and the impacts on patients, individuals and our organisation is of paramount importance. This focus on accountability helps to keep the organisation transparent and ensure that the services it commissions are safe and deliver quality that all would expect in the 21st Century.

We do this through our clinical and non-clinical advocates as part of our Board and sub-committees. At the forefront of this is our commitment to ensuring we really 'hear' our patients and the experiences of care they had received by our services. Our engagement processes must therefore be robust and effective to reflect this.

As a CCG we have implemented the below accountability structure so that we are able to demonstrate to all stakeholders how we make decisions and how we hold ourselves to those decisions. This also aids us to have oversight on service changes and understand what the impact on our populations will be.



This structure also supports us with effective communication and information sharing between and across all stakeholders.

6.2 Measuring and Monitoring Quality in Primary Care

The Primary Care Contract Review process will be a significant influence in the measurement of practice and network quality to ensure our Primary Medical Services Contracts (GMS, PMS and APMS) are robust and are delivering the outcomes they said they would. We have implemented an on-going programme of contract monitoring and review visits this enables us to make declarations to NHS England with confidence.

The responsible committee will be regularly updated on practice and network performance using data and assurance measures that will demonstrate if networks are maturing in line with national guidance. There are a wide variety of indicators used to measure how well practices and networks are achieving and those in need of support.

As this strategy shows, the aim is to increase the support to patients, within primary and community settings so they are better equipped to manage their own health needs.

Our focus on areas such as diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support and online therapies for common mental health problems will, in part, help to achieve this and also social prescribing, as part of the Network requirements to further support care being delivered in the community and closer to patients' homes. Social prescribers are included in both our workforce plans and Network structures.

6.3 Communication, Engagement and Participation

We recognise that robust engagement processes and procedures will be essential to ensuring we meet our operational priorities. We remain committed to engaging with local people and communities in a meaningful way that enables us to understand their needs and improve their experience of care.

Over the past 12 months we have worked across Wolverhampton to strengthen our communication and engagement processes. This is enabling us to involve local people in Wolverhampton-wide service change. Our commissioning intentions are based partially

on what we have heard from our community. There are a plethora of ongoing engagement sessions that take place across the city, some disease specific others more generic.

Engagement sessions held during the summer of 2019 regarding Primary Care services have confirmed what patients would like to see:-

- Easy access to urgent GP services 24 hours a day 7 days a week – different individuals wanting this provided in different ways, but the key themes were urgent and preferably with a GP who has access to information about their health problems
- Less urgent access to as wide a range of services as possible close to home available at their own or another practice within the Primary Care Network. This would also include specific types of clinic including diabetes, respiratory etc.
- Variety of health professionals in primary care for minor ailments, provided they had the training required and were able to make easy onward referrals to the GP or other services. Patients with multiple long term conditions were more hesitant to see alternative health professionals as they thought it was important that the health professional understood their history and they valued consistent, face to face care.

Groups felt that they needed further education to understand the solutions being investigated and what this would mean in practice. They also felt that if results were made available electronically they may need support to understand them and it may not be suitable to make all results available online. Concerns were raised regarding data security and the level of information being made available between care groups and professionals it was felt that more detailed information could be shared face to face in MDT meetings and any information sharing between groups and professionals must meet data security requirements.

This illustration was prepared based on one of a number of engagement events that took place over the summer 2019 and helped to capture the thoughts and views of patients and the public.

We are continuing to engage locally about both health and social care services delivered locally, and across the Black Country footprint. We will build on the collective work we have undertaken with partners so that we continue to play our part in delivering integrated care by place and across the Black Country. In this way, we will ensure Wolverhampton residents have a role in the developing health and care landscape and that their voices are heard.

We will continue to use the outcomes from engagement events and forthcoming events to help shape how we integrate our services and deliver first class care.

We will continue to draw on a range of two-way communication channels and engagement techniques to reach and listen to our target groups, including:

- Regular stakeholder mapping – to refine our understanding of the communities we need to engagement with
- Outreach activity such as events and roadshows
- Press and public relations including regular content for print and broadcast media, where appropriate
- Social media
- Newsletters and other communications collateral
- Surveys and formal consultations

The Primary Care Team have a series of engagement activities scheduled for 2019 and also plan to extend into 2021 these briefly comprise of the following areas of importance although this is not an exhaustive list:-

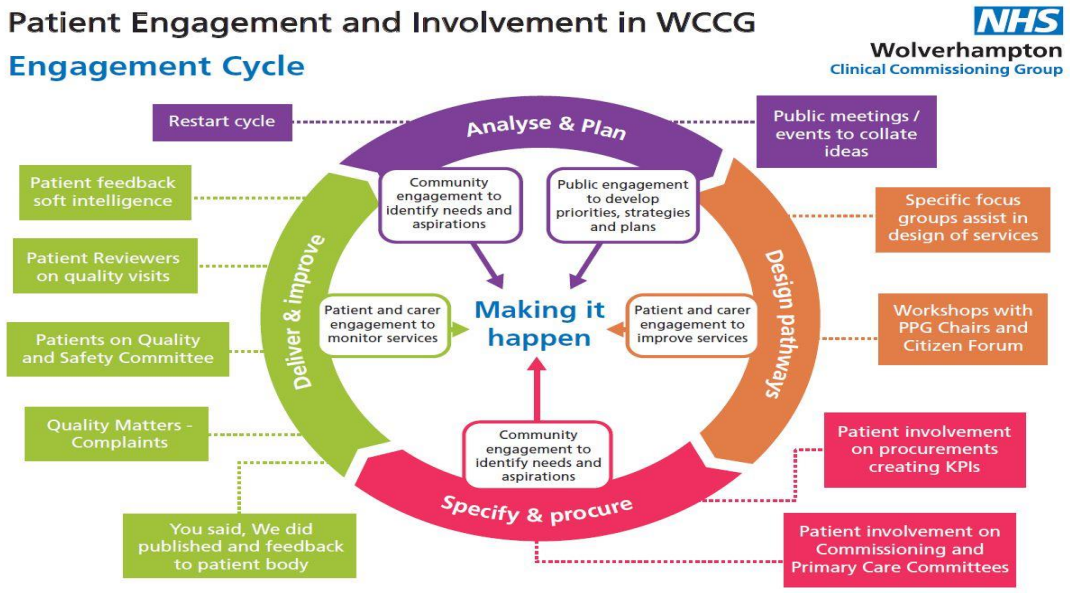
- Frailty & OTs in general practice
- End of Life Care
- Paediatric Pathways
- Primary Care Network Development
- Different Consultation Types & New Roles in General Practice
- Redesign of Wound Care Services

Engaging with and involving our CCG colleagues will have additional focus over the coming year as we understand the implications of the Long-Term Plan for the future of clinical commissioning groups. We know that colleagues welcome regular staff briefings, which are led by our Accountable Officer. Our staff have the opportunity to engage with the Executive Team on their floor walks or take time for a brief chat 'Coffee with the Chair' which is held monthly.

Engagement

with the

community in line with the CCGs Engagement Strategy will continue. Primary Care is one of a number of influencing factors that forms the basis for both the engagement and commissioning cycles.



6.4 Implementing the Strategy and Monitoring our Progress

There are many priorities identified in this strategy. In order for the priorities to be worked through sufficiently they will all be captured in the CCGs Work Programmes, many firmly rooted within the Primary Care Team. There are six task and finish groups that have defined work programmes to manage the workload in a prioritised and co-ordinated way. The activities arising from the individual work programmes will be routinely reviewed by the responsible executive(s) and committees in order for timely assurance to be provided to the CCGs Governing Body. Periodic reports will be provided for the entire programme to the Milestone Review Board. A robust programme management office approach has been adopted to ensure that delivery & non-achievement are actively captured and reported.

The assurance reporting provided to Milestone Review Board (quarterly) is intended to provide a balanced view of delivery (and non-delivery) across all priorities from each respective task and finish group.

Following approval by the responsible Committee, Primary Care Commissioning Committee there will be a series of activities that take place to ensure the strategy reaches a range of stakeholders as defined in the diagram below:-

Engagement events will be taking place on an ongoing basis based on the CCGs Commissioning Intentions, Primary Care Network activities and other associated CCG engagement priorities with both staff and the local community to ensure that the work programmes understood and the benefits are being realised to meet the needs of our community.

6.5 Conclusion

Primary care is now more important than ever and despite the challenges faced and significant pressure and constrained resources local people have access to comprehensive and universal healthcare which is free at the point of need. This is testament to our hardworking, committed staff in practices who try to provide the very best care they can.

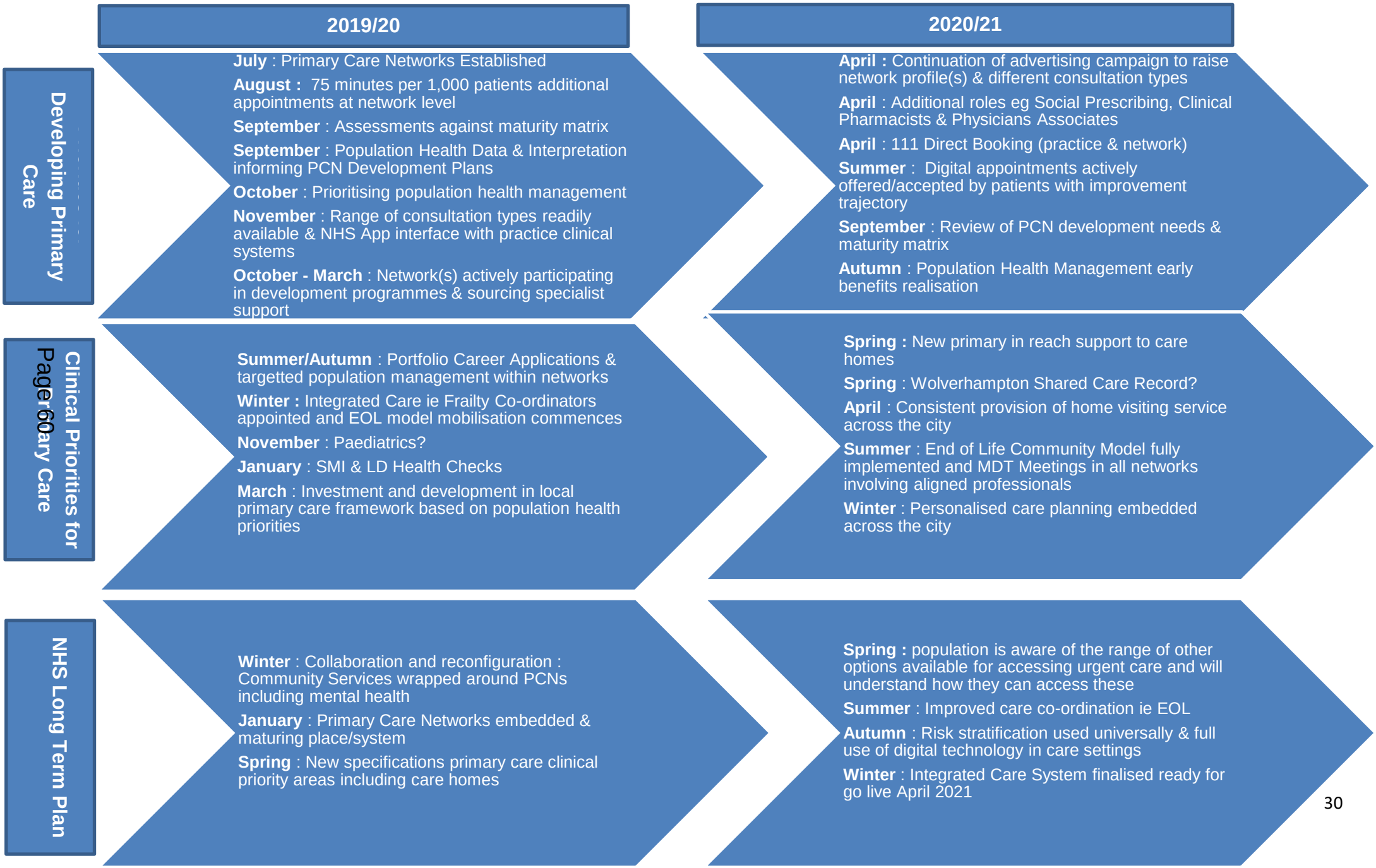
This strategy and the Black Country STP Primary Care Strategy (2019) define an improvement journey for the exceptional healthcare our population deserves and that everyone can access. We believe that we should develop a true partnership between the users of our service, their carers, our public and our primary care providers, to strive to achieve better health care.

We know that primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping people recover from episodes of ill health and injury. Through growing new workforce roles, introducing new primary care models and utilising digital and estate solutions, we will change how we deliver care to our population.

However, there are significant challenges being faced by primary care, in particular general practice. We need to radically rethink primary care if we are to deliver sustainability beyond the current decade. This is due to the increase in workload with the uncertainty of future workforce and the need to manage increasing numbers of people with multiple and complex health needs.

Our vision for primary care in Wolverhampton is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources. The deliverability of the strategy is twinned with the commitments defined in the STP Long Term Plan and Primary Care Strategy that pave the way for system transformation over the next 5 years although reliant on the foundations within this strategy to achieve those longer term objectives. All of these documents are designed to give us the best chance to make care accessible for patients and ensure as far as possible that the developments and service improvements are delivered to the highest standards possible with the resource we have available to us.

Appendix 1
Primary Care - High Level Delivery Plan



Appendix 2
Primary Care Networks Composition – Wolverhampton

Unity East Network	
• Ashmore Park Health Centre	• Dr Fowler- Oxley Surgery
• I H Medical Bilston Health Centre	• Mayfield Medical Centre
• Poplars Medical Practice	• Primrose Lane
• Probert Road Surgery	• The Bilston Family Practice

Unity West Network	
• Castlecroft Medical Practice	• Dr Whitehouse- The Surgery
• Pennfields Health Centre (IH)	• Penn Surgery
• Tettenhall Medical Practice	

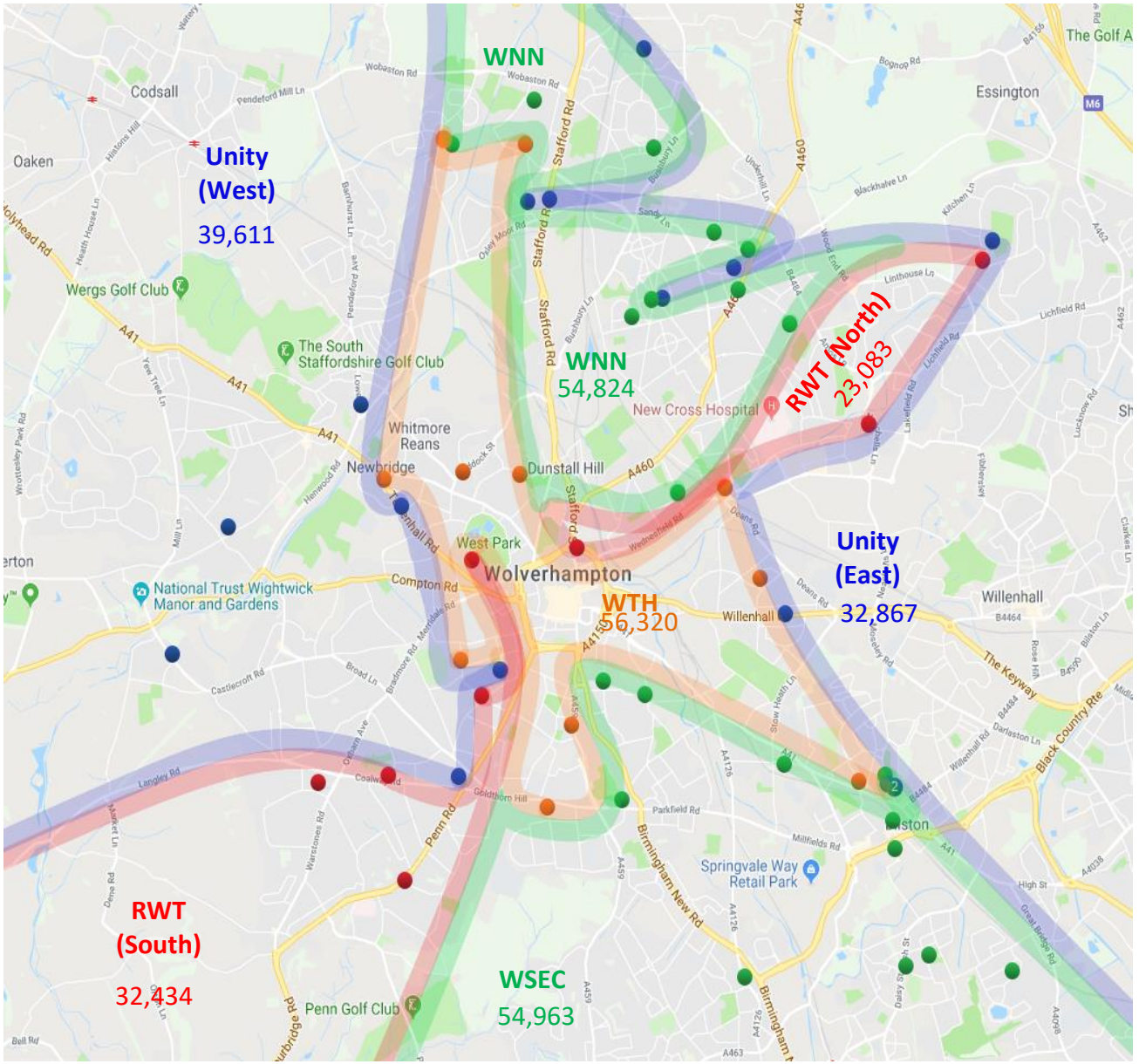
Wolverhampton Total Health	
• Duncan Street	• East Park Medical Practice
• Fordhouses Medical Practice	• Newbridge Surgery
• Tudor Medical Centre & Branches	• Whitmore Reans Health Centre (& Branches)

Wolverhampton North Network	
• Ashfield Road Surgery	• Cannock Road Medical Practice
• Beats Grove Surgery	• MGS Medical Practice
• Forestbury Medical Practice	• Showell Park Health & Walk-in-Centre
• The Surgery, Woden Road	

Wolverhampton South East Collaborative	
• Bilston Health Centre	• Bilston Urban Village Medical Centre
• Ettingshall Medical Centre	• Hill Street Surgery
• Health and Beyond	
• Parkfields	

RWT PCN	
• Alfred Squire Medical Practice	• Coalway Road Surgery
• Lea Road Medical Practice	• Penn Manor Medical Centre
• The Surgery, Wednesfield	• Thornley Street Surgery
• Warstones Health Centre	• West Park Surgery

Unity East Network	Dr K Krishan
Unity West Network	Dr K Ahmed
Wolverhampton Total Health	Dr G Pickavance
Wolverhampton North Network	Dr S Rafiq
Wolverhampton South East	Dr R Mohindroo
RWT PCN	Dr J Burrell



GLOSSARY OF ABBREVIATIONS

Abbreviation	
CCG	Clinical Commissioning Group
CD	Clinical Director
EOL	End of Life
IT	Information Technology
MDT	Multi Disciplinary Team
OT	Occupational Therapist
PCN	Primary Care Network
PPG	Patient Participation Group
RWT	Royal Wolverhampton Trust
STP	Sustainable Transformation Partnership

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
Tuesday 12 November 2019

Agenda item 9

Title of Report:	**Emergency Preparedness, Resilience and Response (EPRR)**
Report of:	Mike Hastings, Accountable Emergency Officer (AEO) & Senior Responsible Officer (SRO)
Contact:	Tally Kalea, Commissioning Operations Manager (COM)
Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	The purpose of the report is to assure the Governing Body on the EPRR and EU Exit status in WCCG. The CCG is currently meeting all requirements for EPRR for both local and regional assurance.
Public or Private:	Public
Relevance to CCG Priority:	Planning
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG is both resilient and compliant in line with statutory and regulatory requirements
• **Domain 4:** Planning (Long Term and Short Term)	The CCG has a suite of plans in place to enable it to respond to a full range of incidents, both internal and external.

BACKGROUND AND CURRENT SITUATION

1.1. Whilst the NHS England EPRR Framework specifically details roles and responsibilities. Wolverhampton CCG (WCCG) also has a requirement to be compliant with the NHS England EPRR Core Standards and submit an annual self-assessment to NHS England.

1.2. The Core Standards submission requirement was met for WCCG and a rating of 'Substantially compliant' has been approved by NHSE. A copy of the submission can be found in the Appendices (Appendix 1)

1.3. WCCG also has a duty to prepare for the pending EU Exit. Following guidance from the EU Exit national team, sit reps weekly were asked to be submitted in late spring detailing the organisations preparedness. WCCG had no issues reported back.

1. MAIN BODY OF REPORT

1.1. Wolverhampton CCG has worked closely with local Providers on 'No-Deal' Scenario and sought assurances within primary care should there be a no deal exit. Further details can be found in the Appendices (Appendix 2).

1.2. In line with ongoing planning and reporting mechanisms a work plan for the year has been agreed and will be carried out over the next twelve months. (Appendix 3)

1.3. The organisations EU Exit Senior Responsible officer (SRO) has regularly attended Regional conferences and webinars. Information has been filtered down to the Operational Task Team and wider communications have been sent out where necessary.

1.4. WCCG continues to update all plans in accordance with the national guidance received from NHSE and the EU Exit team; these include robust Business Continuity Plans, Major Incident Response Plans and Departmental Service Level Plans. The robustness of these plans was tested during the 2019 summer heatwave.

1.5. WCCG has also sought regular assurance from the Local Authority and the Trust to ensure local plans are in place within their relevant organisations in preparedness for EU Exit. Further meetings will take place in the build up to 31st October 2019.

2. RISKS AND IMPLICATIONS

Key Risks

2.1. At present WCCG is well placed in terms of its level of preparedness and planning and continues to make progress in this area.

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

Financial and Resource Implications

2.3. The Business Continuity process will confirm the critical areas of WCCG business and ensure that such activities are able to continue, despite and throughout any disruption or incident.

Quality and Safety Implications

2.4. Based on the 2018/19 EPRR Core standards self-assessment WCCG maintains its "substantially compliant" assessment and has identified the areas for progression in the work programme to be presented at the November 2019 Governing Body Meeting.

Legal and Policy Implications

2.5. Whilst WCCG remains well placed in terms of both regulatory and statutory requirements the continued development of EPRR needs to be maintained to ensure on-going preparedness and compliance.

3. RECOMMENDATIONS

- That the Governing Body **Receive** and **Note** the contents of this report

Name: **Tally Kalea**
Job Title: **Commissioning Operations Manager**
Date: **29th October 2019**

ATTACHED:

EPRR Core Standards (Appendix 1)

Detailed EU Exit Assurance (Appendix 2)

EPRR Timeline/Workplan 19/20 (Appendix 3)

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**	
Medicines Management Implications discussed with Medicines Management 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**	
Signed off by Report Owner (Must be completed)	**T Kalea**	**01/10/2019**

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Emergency Preparedness, Resilience and Response (EPRR) Timeline 19/20

September/October 2019	Potential EU Exit planning Update Governing Body on EPRR Submission outcome
December 2019	Update BC policy Update GB on core standards result
January 2020	Potential exercise date (?)
February 2020	Update Governing body and Quality and safety commitee on EPPR
March 2020	TNA for EPRR staff/Arrange training
May 2020	Update BC plans
June 2020	Update MIRP/ Core standards submission

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Appendix 3 – Detailed EU Exit assurance

The following statements have been taken from NHS England and Improvement's EU Exit team for assurance purposes

- Make sure your EU Exit team is in place. This should include:

- Advising your Board that the EU exit response is being stood up for leaving the EU on 31 October
    - Wolverhampton CCG (WCCG) has updated the relevant boards and SMT around Brexit scenarios.

- Having an EU Exit SRO in place, with supporting EU Exit team, and full management and oversight of the organisation's Single Point Of Contact (SPOC) email for EU exit communications
    - WCCG have the above in place. Mike Hastings being SRO and the performance inbox being the SPOC

- Having relevant subject matter experts available for critical areas including supply/ procurement, pharmacy, logistics, estates and facilities, workforce, data
    - WCCG has strong links with all areas mentioned. Meds management, Quality Team and the Estates Team are regularly updating the EU Exit lead.

- Reinstating on-call arrangements, and ensuring on-call directors understand what is required of them and the escalation routes for problems
    - WCCG has a robust on-call system in place and staffs are fully trained on arrangements

- Ensure your business continuity plans are up-to-date and tested, including winter and flu plans
    - All major plans have been updated and Business Continuity were approved during EPRR core standards 2019

- Make sure you are engaged with local system preparations around EU exit through Local Health Resilience Partnerships and Local Resilience Forums, and have agreed to link with partner agencies including local authority, CCG and provider colleagues to collaboratively manage and address issues.
    - WCCG actively participates with LHRP and LRF as well as local providers and Local Authority

- Re-familiarise your teams with details of the EU exit operational guidance from 21 December 2018 bearing in mind some aspects of this may have been supplemented with further information (see link below) or may be updated in the coming weeks
    - WCCG SRO attended National Workshop and further information will be sent once summaried.

- Revisit your organisation's contract and supplier assurance process including 'walk the floor' checks, to include smaller and/or niche local suppliers not covered by national assurance exercises (this applies to both CCGs and providers)
    - WCCG will seek assurance from all suppliers and contracts in the approach to 31st October

- Ensure you communicate with healthcare professionals and patients using the available information on the GOV.UK, NHS England and Improvement websites and NHS Choices.
    - Regular communications have gone out to all parties. These will continue where necessary

Please select type of organisation: **Clinical Commissioning Group**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	0	2
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	9	0	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	5	3	2	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	0	0	0	0
Total	43	38	3	2

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	14	14	1	0
Long Term adaptation planning	5	5	0	0
Total	19	19	1	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG & remaining columns in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG & remaining columns in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Clinical Commissioning Group	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Director of Operations - Mike Hastings/ Non Executive Director - Les Trigg/ EPRR Lead - Tally Kalea	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR policy is being drafted, final version will need to be approved at board level	Non compliant	Completed draft to be reviewed by Sandwell &West Birmingham EPRR lead and further approval will be abtained from Governing Body	Mike Hastings/Tally Kalea	3 months	
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	EPRR updates are verbally given at Operations Meetings. Minutes and reports of Governing Body and Quality and Safety Committee are attached.	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Work Programme attached	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Chart structure attached.EPRR policy is being drafted, final version will need to be approved at board level.	Fully compliant				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR policy is being drafted, final version will need to be approved at board level	Non compliant	Completed draft to be reviewed by Sandwell &West Birmingham EPRR lead and further approval will be abtained from Governing Body	Mike Hastings/Tally Kalea	3 months	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Risk team have risk assessement docuements and process in place and wil be used if necessary	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Through Commissioning Operatiosn Team escalted to board level where required	Fully compliant				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	collaborative group meeting with Partner trust and LA take place but not minuted. EU EXIT group has been formed and have met Quarterly	Fully compliant				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	MIRP	Fully compliant				
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	MIRP	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave plan updated 2019	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Within Cold Weather Plan	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Previously attended working group in accordance with providers. Work closely with LA on flu planning. WCCG has its own Pan Flu Plan - to be updated in Q3 2019	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Previously attended working group in accordance with providers. Work closely with Trust and LA on infecious desease control	Fully compliant				

18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	MIRP	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	As part of CCG BC plans	Fully compliant				
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	On call rota is mainatined with operations team	Fully compliant				
25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	No critical incidents have taken place. Director on-call refresher training is due in 2020. previously deleivered by NHSE in 2017. CCG in house and OOO rota attached within documents	Fully compliant				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff		Partially compliant	TNA required for all staff- this will be followed up with a schedule of training for necessary staff	Mike Hastings/Tally Kalea	12 month plan	suppoert from NHSE collegaues may be required
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Regional Comms exercise took place in July - CCG was fully active in the process where required - schedule attached in submission folder	Fully compliant				
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Key on call staff staff have had on call training (email attached in subm	Fully compliant				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Process attached. Testing and lessons learned are still required.	Partially compliant	Testing of ICC is required and lessons learned need identifying and sharing	Mike Hastings/Tally Kalea	12 month plan	
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Via shared drive, hard copy in ICC	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	BC plans have been updated early 2019	Fully compliant				
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records	documented in MIRP action cards in attached. Re-training is required for previous staff and for new staff who ae interested. This will be addressed in the TNA as part of the work programme.	Fully compliant				
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	documented in MIRP action cards in attached. No exercising has taken place therefore testing has not been completed	Partially compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Comms Policy - reviewed 2019	Fully compliant				
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Comms Policy - reviewed 2019	Fully compliant				
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Comms Policy - reviewed 2019	Fully compliant				
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings	attached in submission	Fully compliant				
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	attached in submission	Fully compliant				

42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Agreement in place with Trust for mutual aid. Email agreement in place. Document in progress	Fully compliant				
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Contained within MIRP	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity policy in place to be reviewed in Q4 2019	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business continutity policy attached and Business continuty plans atatched supports this	Fully compliant				
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Contained within BC Plans	Fully compliant				
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Held electronically on shared CCG Drive	Fully compliant				
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Contained within BC plans	Fully compliant				
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Contained within BC policy and BC Plans attached	Fully compliant				
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Contained within BC policy and BC Plans	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Contained within BC policy and BC Plans	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Contained within BC policy and BC Plans	Fully compliant				

Ref	Domain	Standard	Detail	Clinical Commissioning Group	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather											
Domain: Severe Weather Response											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	Contained within Heatwave plan	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Cooling units and relaxed office atire in place	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Management aware of advice/guidance to offer to staff. Busines continuity arragements made if necessary	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)		The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	CCG communicates with Providers to ensure patient care is supported during any disruption	Fully compliant				
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	CCG communicates with Providers to ensure patient care is supported during any disruption	Fully compliant				
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	Tennancy agreement	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	Weather warnigsare received and considered within the Operations teama nd information is cascaded to staff where necessary	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	in line with LA arrangements	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	in line with LA arrangements	Fully compliant				
10	Severe Weather response	Warning and informi	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Comms in place via Email and visual screen messages VIA 'Jayex' Solution	Fully compliant				

11	Severe Weather response	Flood response	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	in line with LA arrangements	Fully compliant				
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Risks recorded within Risk teams logs	Fully compliant				
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Verbal agreement in place	Partially compliant	Verbal agreemeent in place - documentation needs to be completed and approved	Mike Hastings/Tally Kalea	6-9 months	
14	Severe Weather response	Exercising	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	CCG works with Wolverhampton Science Park to ensure building and occupants are aware of testing procedures and that lessons learned are shared	Fully compliant				
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	CCG works with Wolverhampton Science Park to ensure building and occupants are aware of testing procedures and that lessons learned are shared	Fully compliant				
Domain: long term adaptation planning												
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions		Fully compliant				
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	In line with tennancy agreement and regular meetings with landlord	Fully compliant				
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	In line with tennancy agreement and regular meetings with landlord	Fully compliant				
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	in line with LA arrangements	Fully compliant				
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	In line with tennancy agreement and regular meetings with landlord	Fully compliant				

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR policy is being drafted, final version will need to be approved at board level	Partially compliant	Completed draft to be reviewed by Sandwell &West Birmingham EPRR lead and further approval will be abtained from Governing Body	Mike Hastings/Tally Kalea	3 months	
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy sta	EPRR policy is being drafted, final version will need to be approved at board level	Partially compliant				
26	Training and exercis	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff		Partially compliant	TNA required for all staff- this will be followed up with a schedule of training for necessary staff	Mike Hastings/Tally Kalea	12 month plan	suppoert from NHSE collegaues may be required
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Process attached. Testing and lessons learned are still required.	Partially compliant	Testing of ICC is required and lessons learned need identifying and sharing	Mike Hastings/Tally Kalea	12 month plan	

34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	documented in MIRP action cards in attached. No exercising has taken place therefore testing has not been completed	Non compliant				
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Verbal agreement in place	Partially compliant	Verbal agreemeent in place - documentation needs to be completed and approved	Mike Hastings/Tally Kalea	6-9 months	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 November 2019

Agenda item 10

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

2. ITEMS DISCUSSED – SEPTEMBER 2019

2.1 Devolvement of Mental Health NCA's Budget to BCPFT

The committee considered and approved a proposal to devolve management of the budget for non-contracted activity for out of area mental health patients to Black Country Partnership Trust. This will operate in shadow form for six months and should support the Trust in delivering transformation initiatives to enable this budget to be spent more effectively and locally. The committee have asked for an update before the end of the shadow running period.

Action - The Governing Body notes the updates provided

2.2 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

- The committee were advised that a Recovery Action Plan had been agreed for Referral to Treatment targets. This would be closely monitored.
- Work with colleagues in Primary Care to divert referrals relating to Breast Cancer was beginning to have a positive impact at the trust. The consequent impact on performance at Dudley and Walsall Trusts was being monitored.
- The Community Dermatology service was moving to mobilisation. A potential issue with commissioning arrangements in Staffordshire was being monitored.

Black Country Partnership Foundation Trust (BCPFT)

- An update was provided on work to support IAPT provision in GP surgeries. It was expected that this provision would be in place by the end of September 2019.
- The Trust had responded to audit findings relating to their compliance with duty of candour requirements and invited the CCG to review their progress.

Action - The Governing Body notes the updates provided

2.3 Review of Risks

The Committee received an update of the risk register highlighting the current risks. The committee were advised that the risk relating to the Emotional Wellbeing service had been updated, potential risks associated with the new arrangements for non-contract spend for mental health patients and community dermatology would be reviewed for potential addition to the risk register at the next meeting.

Action - The Governing Body notes the updates provided

2.4 Items which should not routinely be prescribed in Primary Care

The Committee received a report outlining NHS England guidance that had been issued in relation to medicines of limited clinical value. It was proposed and agreed that the CCG supports the implementation of the guidance with a local communications and engagement exercise.

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: **26 September 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 November 2019

Agenda item 10

TITLE OF REPORT:	**Commissioning Committee – October 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 October 2019
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RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
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 October 2019 meeting.

2. MAIN BODY OF REPORT – October 2019

2.1 Children & Young People Continuing Care Funding Decisions

The Committee was presented with a report for approval to implement a Resource Allocation System (RAS) which will ensure equality for allocated funding to children and young people in need of continuing care in alignment with their clinical needs.

The Committee noted the contents and gave approval for the system

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

2.2 Social Worker in ED

The Committee were presented with a report for approval to support a12 month pilot post for a social care worker to carry out holistic assessments of frailty patients and carers, this post will support the preparation for the winter pressures with a view to reducing and preventing avoidable admissions.

The Committee noted the contents and gave approval with a request for an impact analysis assessment approach to be presented at the November 2019 committee.

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

2.3 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

Activity/ Performance

The Committee was updated on the overview and key contractual areas for October 2019.

Contract Performance

- Referral to Treatment – performance in this service continues to deteriorate by 1% below the agreed trajectory. A Remedial Action Plan (RAP) has been agreed. The Trust continues to focus on reducing the backlog using all available capacity available.

- Cancer – the performance of the 62 day referral treatment has deteriorated further. The CCG continues to monitor and work closely with RWT through the Cancer Recovery Action Plan.

- Dermatology – mobilisation of the service continues, procurement phase has now completed and awarded to Circle Integrated Care. The Trust has stated that no staff will be TUPEd to the new service. As a consequence the service will now not commence fully until 1 March 2020.

- Phoenix Walk In Centre – Following approval to change the operating model to an Urgent Treatment Centre (in line with national guidelines), the Trust has stated that the minimum data requirements will not be made available. This is being further challenged by the contracting team.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

- Improving Access to IAPT – An update of Q1 data shows underachievement in Month 1 only. Recent data has shown, monitoring of outstanding actions to be completed is in place and performance is on track.

Nuffield

Contractual Issues

The CCG carried out an audit to assess compliance with POLCV Policy and MSK Care pathways in September 2019. The outcome have been discussed and share with Nuffield.

The CCG Quality team also carried out a Quality Assurance Visit which went well with all Duty of Candour applied correctly.

Urgent Care/Ambulance/ Patient Transport

Non-Emergency Patient Transport Service (NEPTS)

The moderation stage of the re-procurement has been completed and the outcome will be presented at the Wolverhampton and Dudley CCG Governing bodies in October 2019.

111 Service

The provider for this service will transfer to West Midlands Ambulance Service on the 5 November 2019. It is hoped this will reduce Category 2 and 3 callouts by using the WMAS Clinical Assessment Service. Monitoring will be carried out to assess the impact of this service during the winter months.

Other contracts

- Termination of Pregnancy Service– The contract with the new provider will commence on 1 January 2020. Mobilisation meetings are already underway between the commissioner and the new provider for this service.

- Assisted Conception Service – Invites for tender for re-procurement of this service are due to be issued on 17 October 2019.

The Committee noted the contents of the update

Action - The Governing Body notes the updates provided

2.4 Review of Risks

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

The Committee noted the update report

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: **31th October 2019**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY MEETING
Tuesday 12 November 2019

Agenda item 11

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). July/August 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 - Significant improvements have been achieved since the implementation of the revised diversion initiative for the breast 2 week wait pathway. The number of cases within the backlog has significantly reduced and the wait for appointment times decreased. Daily monitoring of waiting times for this pathway across providers involved continues. A return to 28 day one stop clinic time performance is expected by November 2019. An additional mega breast clinic has also been established and commenced in September 2019. • Referral to treatment time incomplete pathway performance has not achieved the 92% target and is deteriorating. This KPI was highlighted as an area of concern to QSC in October. This may impact on the quality and safety of care provided to patients. No patients have currently waited over 52 weeks; however, performance against the 95% standard dropped to 84.5% in August. A recovery action plan has been received by the CCG and, following clinical challenge, has been amended and now accepted. The recovery plan, and associated trajectory, identifies specific speciality l actions to drive improvement. The focus is to reduce backlog where possible and ensure all available capacity is used effectively.

	Assurance has been gained that a process for identifying any harm associated with the delay is being implemented; this will include CCG clinician participation. • Mortality - The number of deaths has decreased when compared to last month, along with the SHMI which currently stands1.1547; however the crude mortality rate has risen slightly. The mortality outlier for COPD has been completed and submitted to CQC. Key learning was identified in relation to improving knowledge and awareness of NIV criteria at emergency portals and in non-specialist wards and antibiotic prescribing for bronchiectasis. A continuous Quality Improvement project has commenced to review the pathway for EOL care in and out of hospital. This has commenced in the renal directorate, with a focus on identifying preferred place of death. The bereavement nurse is now in post and will commence improving the process for including families/relatives in mortality reviews. Methods for triangulation of outcomes of lessons learnt from clinical audits, serious incident learning and other governance processes with outcomes of SJRs continues to be explored to ensure maximum learning and to allow quality improvement initiatives to be developed. A themed spotlight session on mortality, sepsis and recognition and response to deteriorating patients was presented by the Trust at 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 has been undertaken by the CCG. The review highlighted numbers have decreased within Wolverhampton but increased in Sandwell and West Birmingham. Key themes from the review include around 40% of patients had a history of alcohol or drug misuse. More than

	90% of patients had a history of previous self-harm or suicide attempts reported for all these incidents. 55% of these patients made more than 1 attempt of suicide or self-harm. 70% of patients were known or were referred to 5 or more mental health services. The findings will be shared with BCPFT and recommendations identified. • Further analysis continues in relation to the regional comparison of 12-hour breach data in relation to mental health patients. A system wide meeting with independent providers has taken place to identify how processes for out of hours bed provision can be improved. A demonstration of a system wide bed management database is being organised to support this. • Two Nursing Homes are currently rated "Inadequate" by CQC. Robust action plans are in place. The homes are being supported by the CCG's QNA and City Council QACO teams and improvements have been seen. • In July 2019 Quality and safeguarding annual reports were received by the committee outlining achievements for last year. Safeguarding adults, children and children and young people in care report was received by the committee to provide assurance that the designated professionals continue to maintain an oversight of the quality and safety matters of safeguarding and CYPiC and are working collaboratively with partner agencies to address issues as they are identified. Public health updates were received by the committee and WCCG is working closely with public health to receive a monthly report of key indicators. • In August 2019, a review of the SEND health element has been completed and was received by the committee. The SEND health review has identified key recommendations and these will be agreed by the SEND steering group. • In addition assurance and an update was received by committee relating to Primary Care, End of Life, Medicine optimisation report, Equality and diversity, Health and Safety performance, Compton Care Quality Visit, BCPFT DOC Assurance Visit, BCPFT Serious Incident Suicide Deep Dive.
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. 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, were included. 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:** • Significant improvements have been achieved since the implementation of the revised diversion initiative	

Key issue	Comments	RAG
	for the breast 2 week wait pathway. The number of cases within the backlog has significantly reduced and the wait for appointment times decreased. Daily monitoring of waiting times for this pathway across providers involved continues. A return to 28 day one stop clinic time performance is expected by November 2019. • An additional mega breast clinic has also been established and commenced in September 2019. • For July, 16 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. 10 of the patients related to tertiary referrals, 3 of these were received before day 40 of the pathway and 6 were received on or after day 62 of the patient pathway.	
Referral to treatment time incomplete pathway performance has not achieved the 92% target and is deteriorating. This may impact on the quality and safety of care provided to patients.	An additional performance risk which may impact on quality of patient care has been identified in relation to referral to treatment time. No patients have currently waited over 52 weeks; however, performance against the 95% standard has dropped to 84.5% in August. **Risk Mitigation** • A recovery action plan has been received by the CCG and, following clinical challenge, has been amended and now accepted. • The recovery plan and associated trajectory identifies specific departmental actions to drive improvement. The focus is to reduce backlog where possible and ensure all available capacity is used effectively. • Assurance has been gained that a process for identifying any harm associated with the delay is being implemented, this will include CCG participation.	
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 1.1547, which is lower than previously reported. 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	

Key issue	Comments	RAG
	CQRM's, Trust and system wide mortality improvement groups and attendance at the mortality review group. **Risk Mitigation:** • The number of deaths has decreased when compared to last month, along with the SHMI, however the crude mortality rate has risen slightly. • The mortality outlier for COPD has been completed and submitted to CQC. Key learning was identified in relation to continuing to work with nursing homes to identify incidence of inappropriate transfer and areas of improvement, improving knowledge and awareness of NIV criteria at emergency portals and in non-specialist wards and antibiotic prescribing for bronchiectasis. • A continuous Quality Improvement project has commenced to review the pathway for EOL care in and out of hospital. This has commenced in the renal directorate, with a focus on identifying preferred place of death. • The bereavement nurse is now in post and will commence improving the process for including families/relatives in mortality reviews • Methods for triangulation of outcomes of lessons learnt from clinical audits, serious incident learning and other governance processes with outcomes of SJRs continues to be explored to ensure maximum learning and to allow quality improvement initiatives to be developed.	
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:** • Improvements with sepsis pathways within the ED have been sustained. A key focus for the sepsis team is now to improve performance within in patient areas and other emergency portals. • Following the update of the electronic observation system to include sepsis screening and NEWS2, data relating to performing observations within a timely manner has been challenged. This is partly attributable to data capture changes however this also correlates with increased serious incidents reported in relation to sub optimal care of the deteriorating patient. The CCG has requested an improvement plan outlining clear actions for improvement and a trajectory for when improvements are expected. • The CCG has supported a review of the Critical Care Outreach Team within the Trust and key actions have been identified to strengthen the service.	
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.	

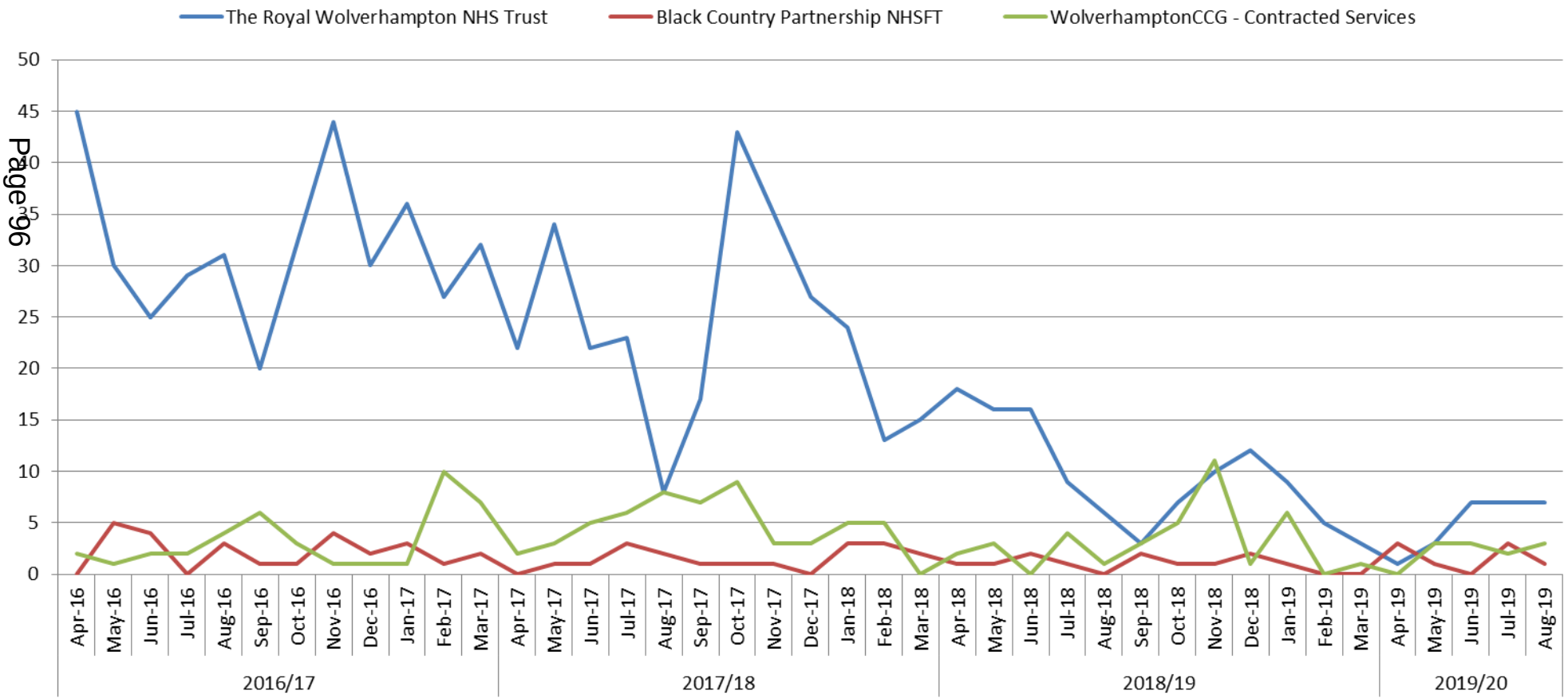
Key issue	Comments	RAG
	Risk Mitigation: • A themed review of suicide SIs has been conducted. Key themes from the review include around 40% of patients had a history of alcohol or drug misuse. More than 90% of patients had a history of previous self-harm or suicide attempts reported for all these incidents. 55% of these patients made more than 1 attempt of suicide or self-harm. 70% of patients were known or were referred to 5 or more mental health services. The finding will be shared with BCP and recommendations identified. • A further meeting with independent providers has taken place to identify how processes for out of hour's bed provision can be improved. A demonstration of a system wide bed management database is being organised to support this. • Workforce data remains static. • The CCG continue to work with the provider to strengthen reporting processes. A further revised report template will be presented to November CQRM. The aim of the revisions is to enable the CCG to gain further assurance in relation to core services and key quality indicators.	
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. • Joint quality visit by LA & CCG quality completed • No new quality or safeguarding concerns reported	
Some emerging concerns regarding nursing home being unable to deliver to the Step Down Contract	Should the nursing home be unable to deliver to the Step Down contract, this could have an impact on flow across the system. Care Home manager and staff are accessing training and development opportunities offered by the CCG. A "Walk in my Shoes" visit was conducted to increase understanding and improved communication across Providers. Quality Improvement programme of work agreed between providers facilitated by the designated QNA. **Risk Mitigation** • QNA continues to provide intensive support within the home. • Joint visit with CWC quality assurance officer being planned.	

Key issue	Comments	RAG
	• Manager accessing support via managers meetings and development opportunities. • Key actions identified following the “Walk in my Shoes” event are progressing	

2. PATIENT SAFETY

2.1 Serious Incidents

Chart 1: Serious Incidents Reported by Month



In total, 11 Serious Incidents (SIs) were reported in August 2019. Of these 7 related to RWT, 1 to BCPFT and 3 to WCCG.

Chart 2: Serious Incident Types Reported August 2019

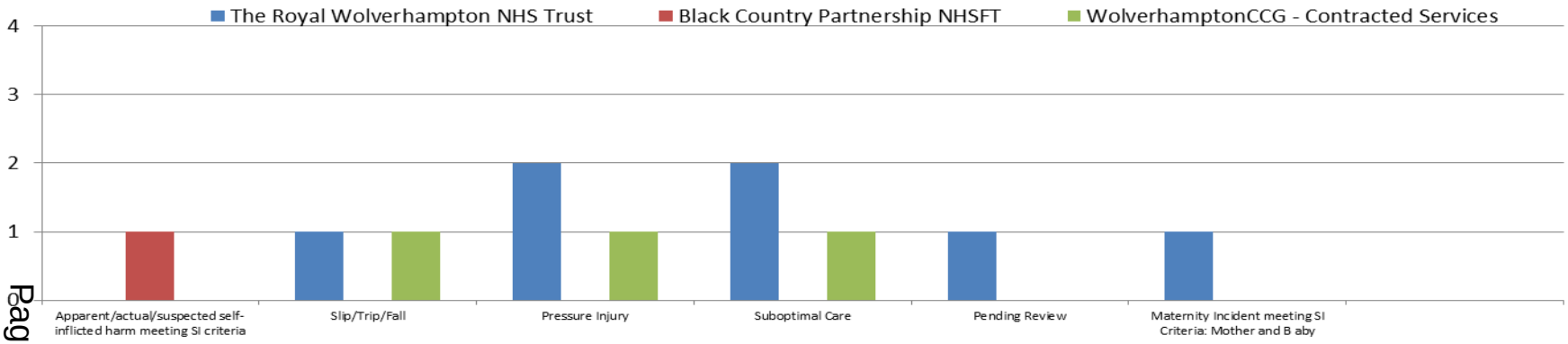


Chart 2 shows the breakdown of serious incident types reported by each provider for August 2019. Initial data for September is identifying an increase in SIs reported under the delayed diagnosis category by RWT. Further analysis will be undertaken and reported at QSC in November.

2.3 Never Events

Table 1: Reported Never Events

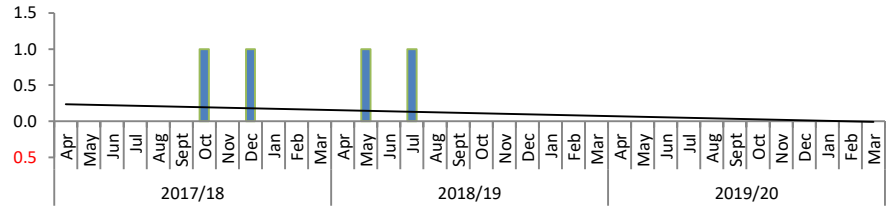
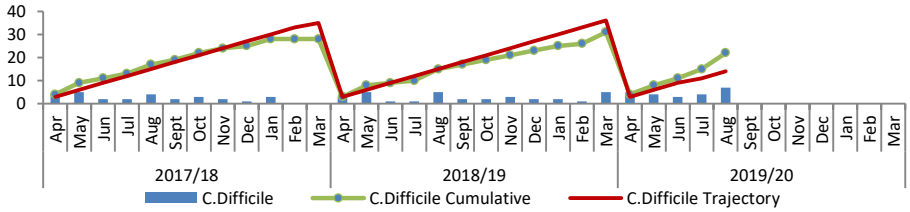
	Yr. 16-19	Yr. 17-19	Yr. 18-19	April 19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Yr. to date
Royal Wolverhampton	**5**	**4**	**4**	0	0	1	0	0								1
Black Country Partnership	**0**	**0**	**0**	0	0	0	0	0								0
Other providers	**0**	**1**	**0**	0	0	0	0	0								0

Total Reported	**5**	**5**	**4**	0	0	1	0	0							1

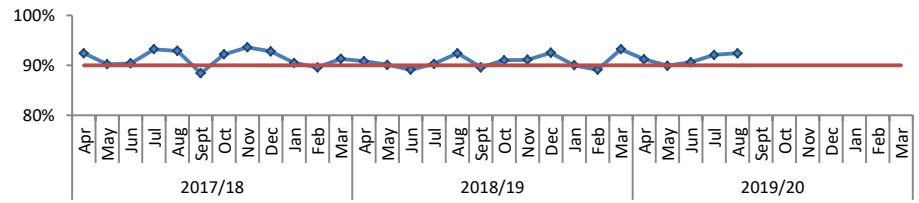
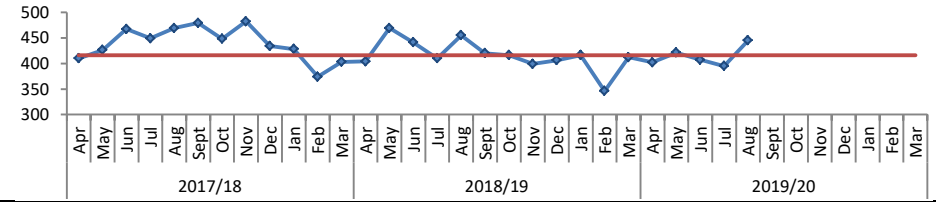
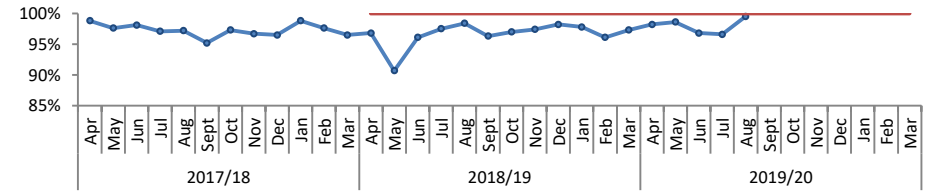
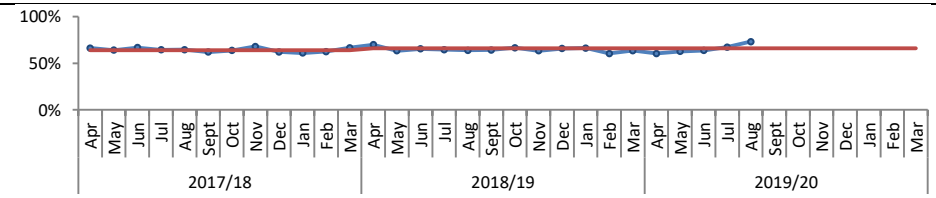
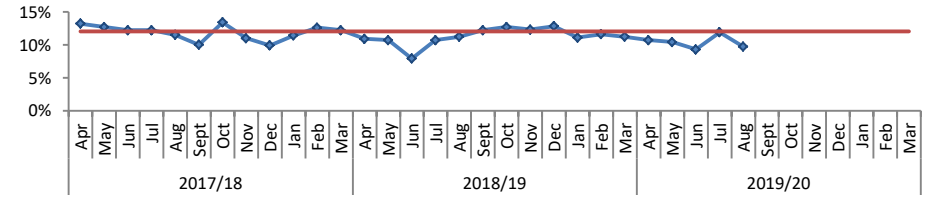
No new never events reported for this period.

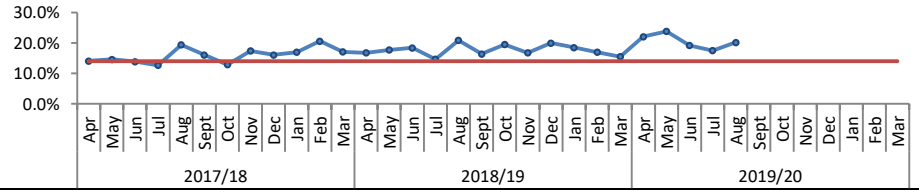
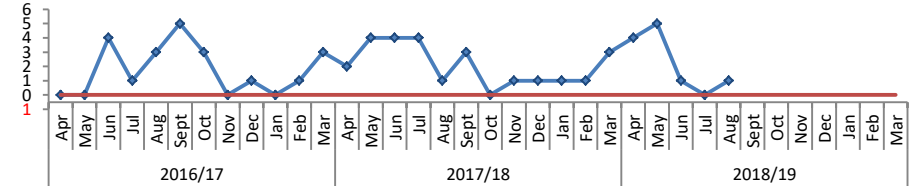
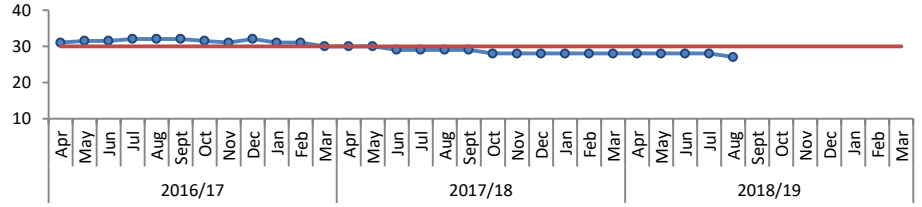
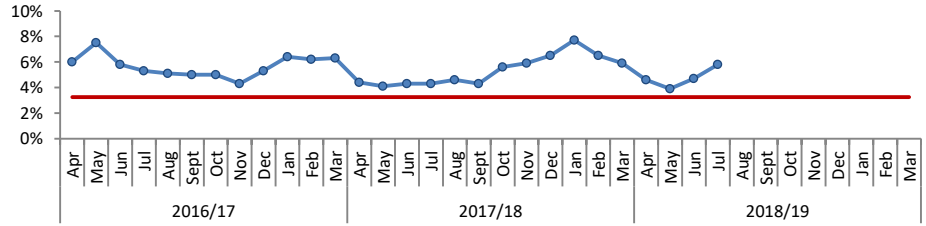
3. ROYAL WOLVERHAMPTON HOSPITAL TRUST

3.1 Infection Prevention

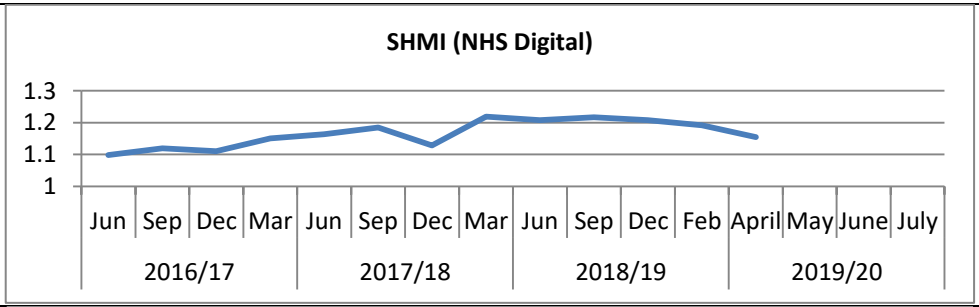
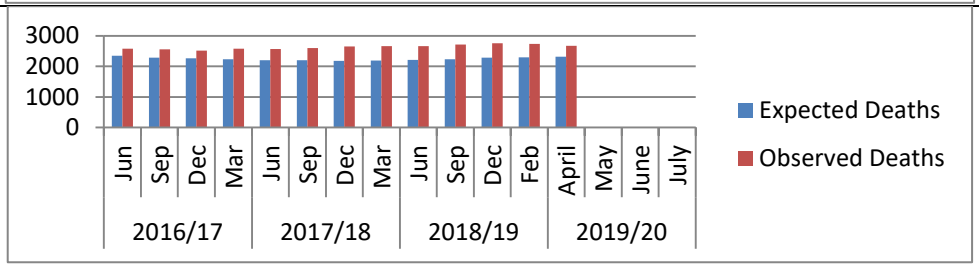
Measure	Trend	Target	Assurance/Analysis
MRSA		**0**	No new MRSA cases reported in August 2019.
C. Diff		**<35**	The Trust reported seven cases in August 2019. The cumulative figure for 2019/20 is 22 and slightly above trajectory. A deep dive into all C-diff cases reported since April will be conducted by the trust to identify any trends to inform improvement. 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

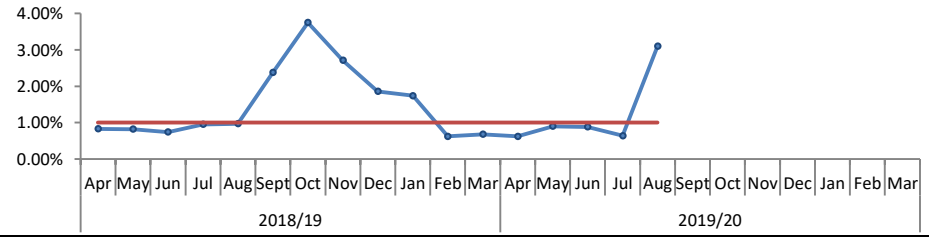
Measure	Trend	Target	Assurance/Analysis
Bookings at 12+6 weeks		>90%	Bookings at 12+6 weeks were 92.4% in August (92.1% July).
Number of Deliveries (mothers delivered)		<416	Number of mothers delivered increased in August to 445, up from 395 in July.
One to One care in established labour		100%	Number of mothers delivered increased in August to 445, up from 395 in July.
Breastfeeding (initiated within 48 hours)		>=66%	August showed a further increase to 73.2% from 66% in July. Analysis has identified that this is as a direct result of improvements in continuity of carer, particularly with multiple births.
C-Section – Elective (Births)		<12%	The rate for elective C-Sections decreased to 9.7% in August and remains within target.

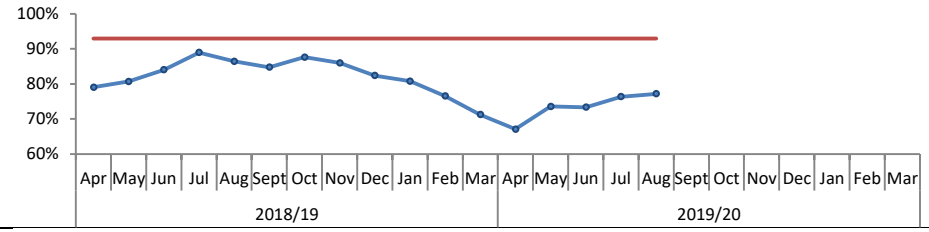
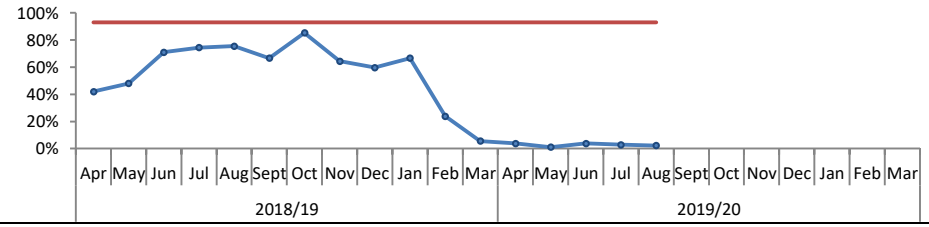
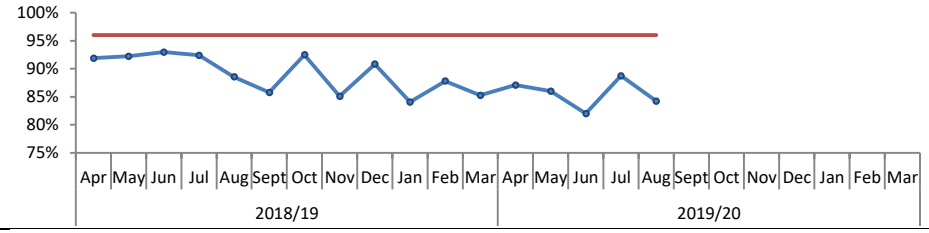
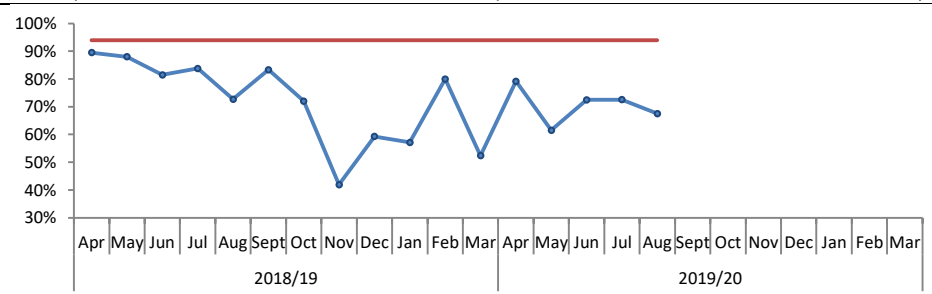
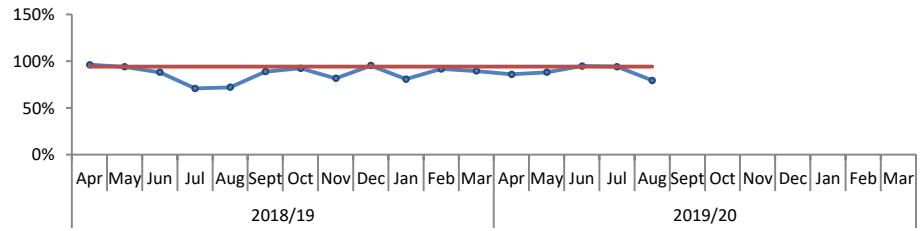
Measure	Trend	Target	Assurance/Analysis
C-Section – Emergency (Births)		<14%	Emergency C-section case rate has seen an increase to 20.2% in August and remains above target.
Admission of full term babies to Neonatal Unit		0	One baby was admitted to neonatal unit during August 2019.
Midwife to Birth Ratio (Worked)		<=30	The Midwife to birth ratio currently stands at 1:27 which is within national standards.
Maternity – Sickness Absence		<3.25%	Despite a downward trend at the beginning of the year, Maternity sickness showed a further increase in July to 5.8%, up from 4.7% in June. (Reported one month behind).

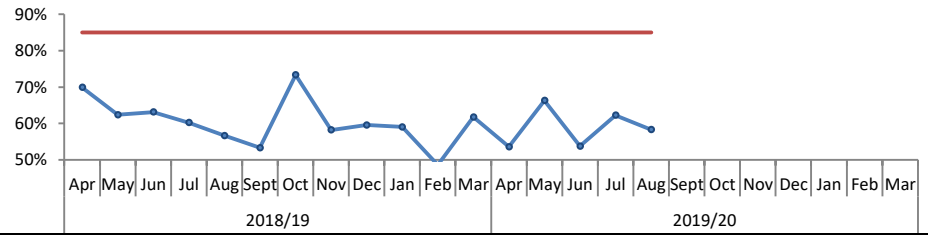
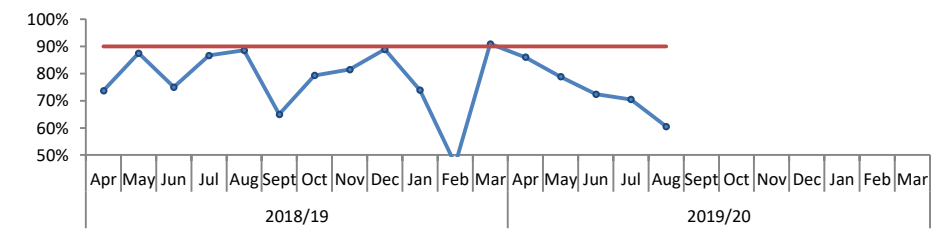
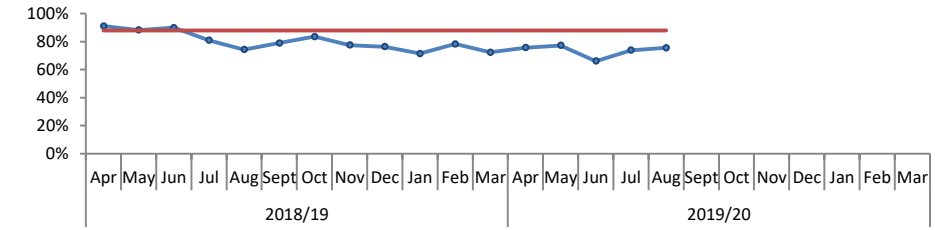
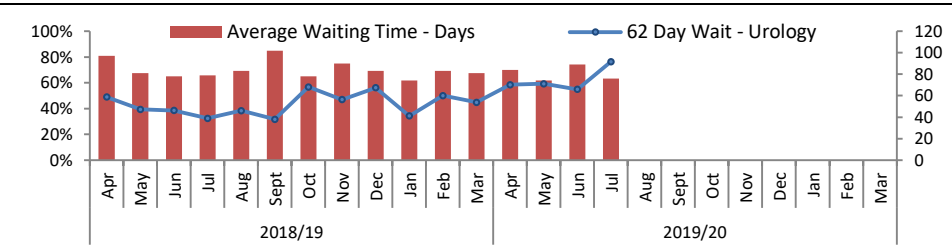
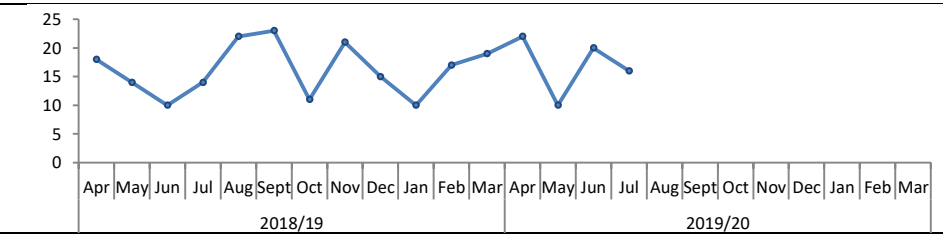
3.3 Mortality

Measure	Trend	Target	Assurance/Analysis
Mortality – SHMI (NHS Digital)		**N/A**	The SHMI for May 2018 to April 2019 is 1.1547. 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 documentation, coding, clinical analysis and associated learning and overarching staffing. WCCG monitors this action plan via the monthly CQRM.
Mortality – SHMI Observed vs. Expected Deaths		**N/A**	

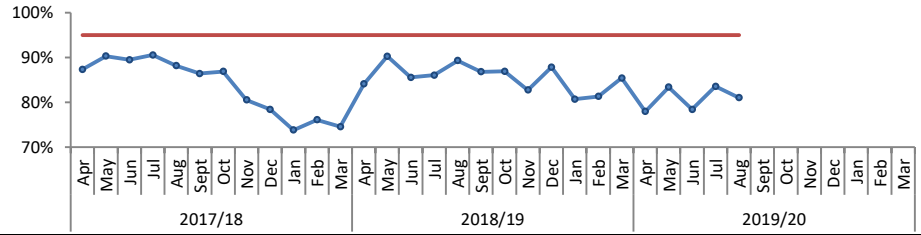
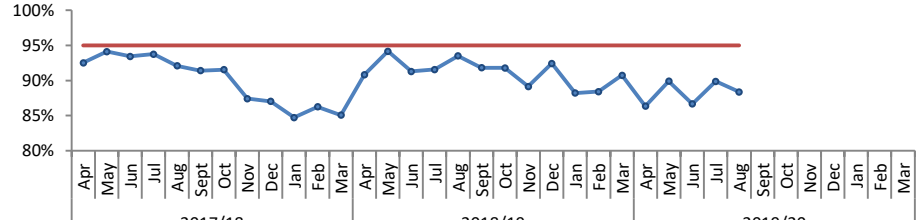
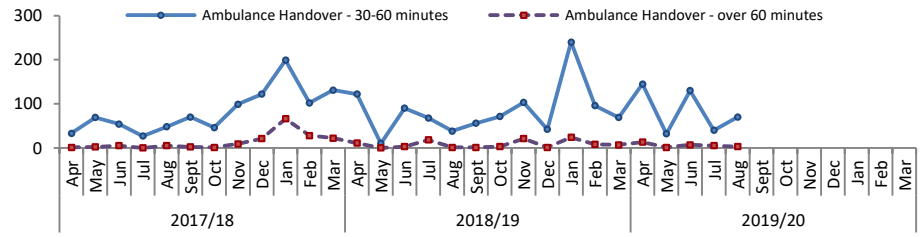
3.4 Cancer Waiting Times

Measure	Trend	Target	Assurance/Analysis
6 Week Diagnostic Test		**<1%**	Figure for August shows a sharp increase to 3.1%, up from 0.64% in July.

Measure	Trend	Target	Assurance/Analysis
2 Week Wait Cancer		**93%**	The 2 week wait cancer performance position in August is 77.16%.
2 Week Wait Breast Symptomatic		**93%**	August's figure 2.31%.
31 Day to First Treatment		**96%**	Despite an improvement to 88.72% in July, August is showing a decrease to 84.21%.
31 Day Sub Treatment - Surgery		**94%**	Figure for August has decreased slightly to 67.5% compared to 72.55% in July.
31 Day Sub Treatment - Radiotherapy		**94%**	31 day sub treatment radiotherapy dropped below target in August at 79.31% compared to July at 94.03%.

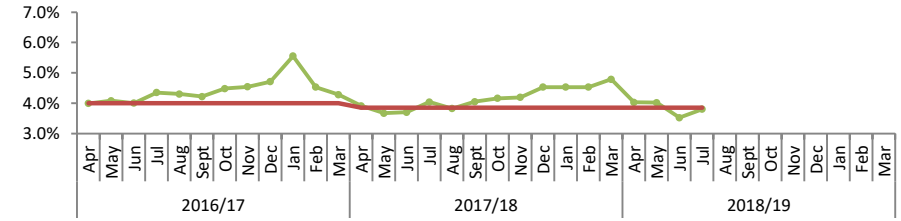
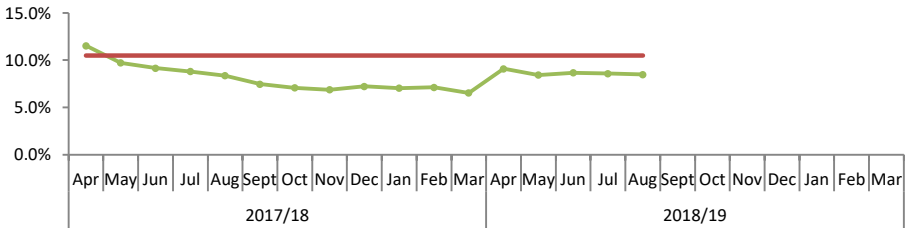
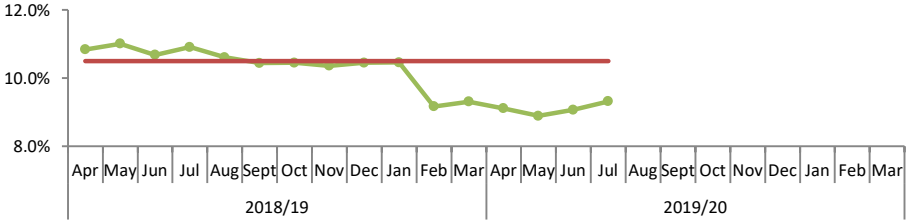
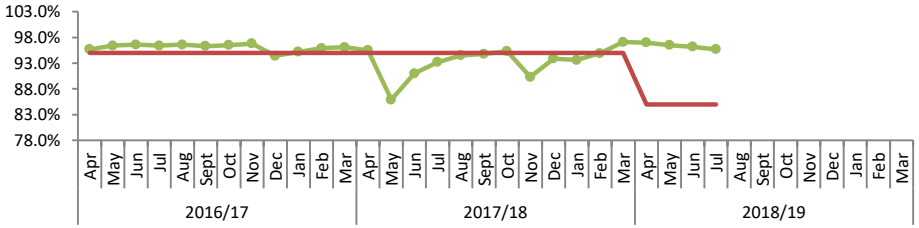
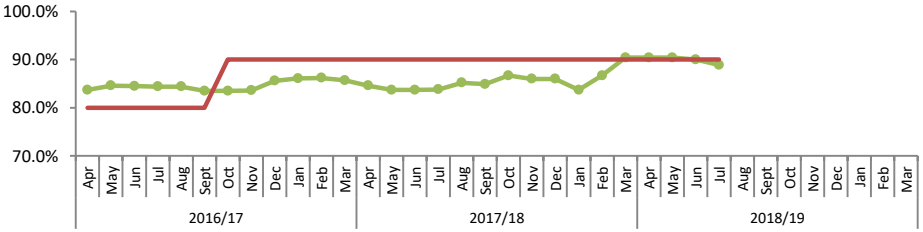
Measure	Trend	Target	Assurance/Analysis
62 Day Wait for First Treatment		**85%**	Performance continues to fluctuate. Figure for August shows 58.29% compared to July 62.23%.
62 Day Wait - Screening		**90%**	62-day wait showed a further decline in August to 60.53%.
62 Day Wait - Consultant Upgrade (local target)		**88%**	The 62-day wait consultant upgrade (local target) performance remained steady in August at 75.51%.
62 Day Wait - Urology		**85%**	The average waiting time in July was 76 days (reported one month behind). Performance for Urology in July was 76.36%%.
Patients over 104 days		**N/A**	16 patients identified over 104 days in July 2019 compared to 20 in June 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%**	August performance = 81.04%.
Time Spent in ED (4 hours) - Combined		**95%**	Overall performance continues to fluctuate. August data shows 88.39%.
Ambulance Handover		**N/A**	70 ambulances breached the 30-60 minute ambulance handover target during August. 3 ambulances breached the >60 minutes handover target during the month.

3.6 Workforce and Staffing

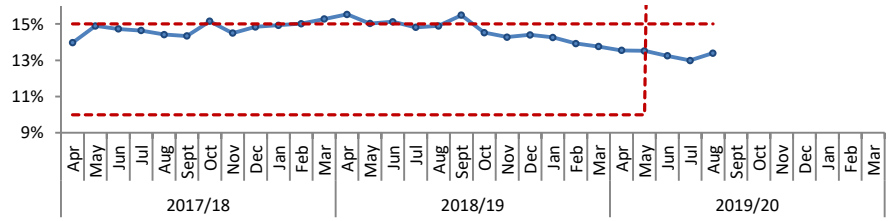
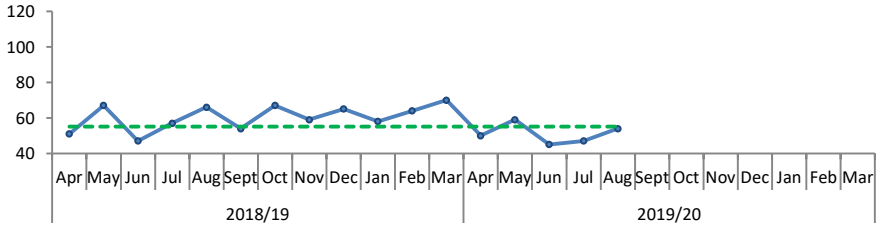
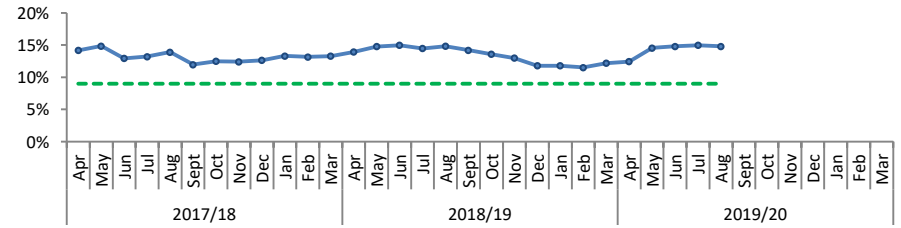
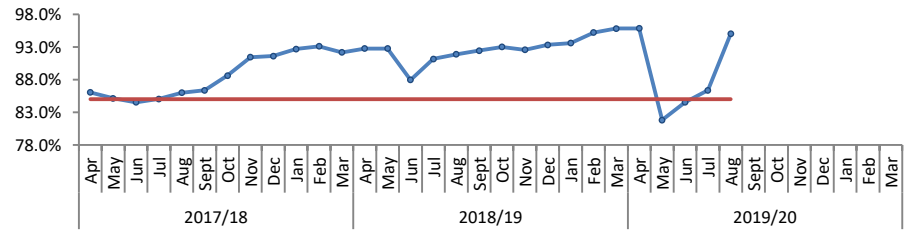
Measure	Trend	Target	Assurance/Analysis

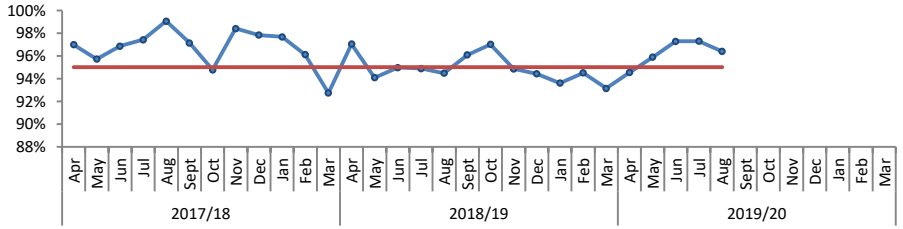
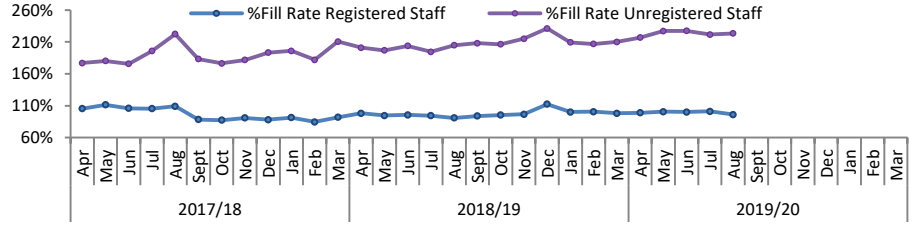
Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**3.85%**	Latest data shows that staff sickness absence rates improved in July at 3.8% and remains slightly under target.
Vacancy Rates (%)		**10.5%**	The vacancy rate remains steady at 8.48% in August.
Staff Turnover Rates (%)		**10.5%**	Turnover rates show 9.32% for July 2019 a slight increase on 8.95% in June. Turnover performance is meeting the standard in all but unregistered clinical staff groups, where it is at or slightly over target.
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. Data for July shows 95.7%.
Appraisal Rate (%)		**90%**	July 88.9%. Appraisal compliance has deteriorated slightly such that it is not meeting the Trust target. The Trust is undertaking work to improve the position in this regard.

4. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

A full report detailing the findings of the initial Duty of Candour visit to Black Country Partnership in June 2019, together with follow up visit in August 2019, was presented at Quality & Safety Committee in September.

4.1 Workforce and Staffing

Measure	Trend	Target	Assurance/Analysis
Staff Turnover Rates (%)		**10-15%**	Turnover rate increased slightly in August to 13.4% and remains within target.
Average Time to Recruit		**55**	Average time to recruit KPI has shown a further increase during August to 55 working days.
Vacancy rate (%)		**<9%**	Vacancy rate remains steady in August at 14.8% but is still above target.
Mandatory Training Rate (%)		**85%**	Annual specialist mandatory training performance improved considerably in August to 95% against a target of 85%.

Measure	Trend	Target	Assurance/Analysis
% of Shifts filled (Bank and Rostered)		**95%**	Overall figure for August was 96.4%. Registered fill rate for August was 96.1%. Unregistered fill rate was 223.3%.
Safe Staffing - %Fill Rate Registered Staff		**N/A**	

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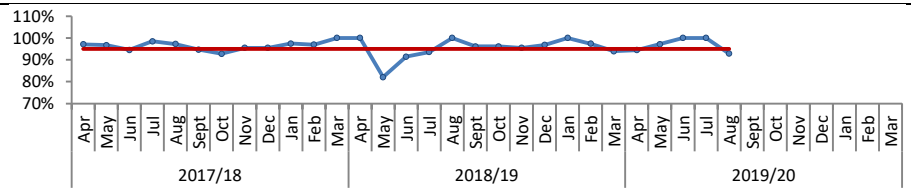
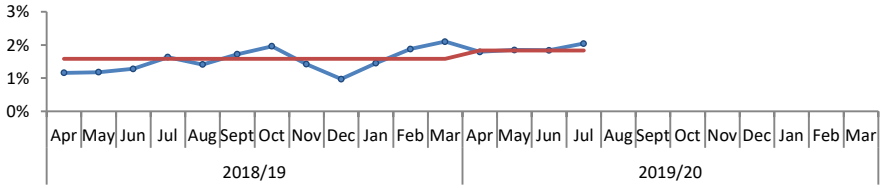
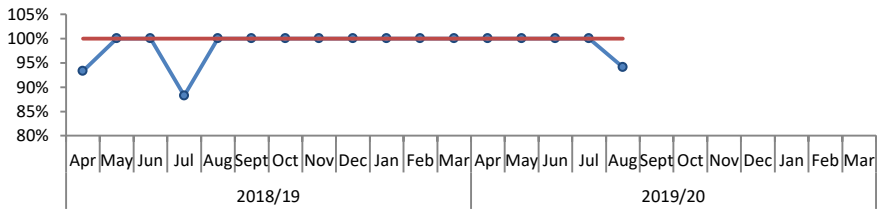
4.2 Quality Performance Indicators

Measure	Trend	Target	Assurance/Analysis
CRA % of Service Users followed up within 7 days of discharge		**95%**	August showed a decrease to 92.86% against a target of 95%.
% of people with anxiety or depression entering treatment		**1.83%**	July data 2.04%. August data awaited.

Measure	Trend	Target	Assurance/Analysis
% of inpatients with Crisis Management plan on discharge from secondary care		**100%**	Trust failed to achieve target in August 2019 for the first time since July 2018. August data shows 94.12% against target of 100%.

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.

6.0 SAFEGUARDING

6.1 Safeguarding Adults and Children

Learning Disability Mortality Review update for Wolverhampton:

- Total number of notifications to date: 23
- Number of reviews in progress: 11 (includes 1 CDOP case)
- Number of reviews to be allocated: 0
- Number of completed reviews: 12

DHR 11: IMR's and Chronologies have been submitted and scrutinised by the DHR Panel. Further Chronologies have been requested, for submission in October to extend the scoping period for the review.
There are no Safeguarding Adult Reviews in progress, however scoping of agency contact has been carried out for 2 new SAR referrals, awaiting decisions if these will progress

6.2 Children's Safeguarding

- Designated professionals continue to attend key meetings to progress the SCR for Child N and the Learning Review for Child P.
- Continuing to work in collaboration with colleagues across the STP to progress arrangements for the Learning Event – Our Voices – Our Shoes.

- A Black Country Multi-Agency SUDIC Protocol is being produced in view of the 2018 guidance, led by WCCG Designated Doctor, and is out for consultation with agencies across the Black Country.

6.3 Children and Young People in Care (CYPiC)

August saw Wolverhampton CYPiC numbers drop below 600 (599) for the first time since 2012.

Designated CYPiC professionals met as part of the STP work-stream to ensure a consistent approach across the STP foot print and reduce unwarranted variation in the way health services are commissioned for our CYPiC. As a result task and finish groups were attended in July and August to:

i) Review all tools and establish a standard quality assurance audit tool for statutory health assessments across STP.

ii) Gain clarity around the commissioning of CAMHS across the STP to identify gaps and ensure equity across the area.

The Designated Nurse CYPiC attended an urgent Care Planning Meetings in August around concerns for children who are placed outside Wolverhampton. This is to ensure strategic oversight of health needs and monitor risk. Subsequent discussions were had with RWT Named professionals and local CCG's where the children are placed.

A Wolverhampton sibling group were removed from their foster carer in June 2019 due to safeguarding concerns. Subsequent information given by the children resulted in an emergency placement being sought and an investigation commenced around the care they received. The Designated Nurse CYPiC attended the following strategy meeting, and met with the CYPiC local authority lead in August to discuss concerns from a health perspective. Having discussed with the Designated Nurse Safeguarding Children, it was agreed that the case will be referred to the Learning and Improvement Committee.

6.2 Care Homes

Bentley Court Nursing Home remains in suspension. A joint quality assurance visit conducted by City Wolverhampton Council (CWC) Quality and Compliance Officer and QNA significant identified areas of improvement. The QNA team continues to work closely with CWC quality teams to monitor care home position and provide support. Provider multiagency meetings are being held to monitor sustained improvement.

Newlyn Court Nursing Home suspension continues since receiving an inadequate CQC rating on 19th June 2019. The home is making good progress on its improvement action plan with monthly reporting back to CQC. A joint quality visit by LA & CCG Quality team has been completed. There has been no new quality or safeguarding concerns reported.

Primrose Hill – there is a risk this nursing home will be unable to deliver to the Step Down contract and have an impact on DTA from the Trust. The QNA team is currently providing intensive support with twice weekly contact with the home, and will be supporting to deliver improvements against an agreed

action plan. The Manager is accessing support via Managers' meetings and development opportunities. A joint visit with CWC quality assurance officer is being planned.

Quality Improvement - there were no reported pressure ulcers acquired within nursing homes who took part in the Quality Improvement survey during the month of August. Numbers of reported falls with harm remain low compared with occupied bed days.

August's A&E attendance from survey monkey data has been compared with WMAS call out and conveyance data. On the whole this correlates, with the exception of 3 care homes where there are slight discrepancies. The home with the highest call out and conveyance rates from the WMAS data continues to be Sunrise of Tettenhall, followed by Wulfrun Rose. The QNA team continues to target these homes with specific training in frailty, deterioration and EOLC.

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 July 2019	Mitigation for August 2019	Date of expected achievement of performance	RAG rating
Serious Incidents	All RCAs are reviewed at SISG and escalated to PPIGG if appropriate.	Four further incidents reported to PPIGG	One incident referred to PPIGG Another potential SI identified	30th September 2019	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	Six incidents open all relating to IG breaches re: blood forms	Five incidents open, three are overdue and have been chased, three relate to IG breaches re: blood forms, one to inappropriate referral and one to staff behaviour	30th September 2019	1a
Practice Issues	No issues at present	No issues noted at present	No issues noted at present	None at present	1a
Escalation to NHSE	Four incidents due to be reviewed at PPIGG from Quality Matters	Four incidents referred to PPIGG this month. Two for management by CCG and two to be reviewed by PAG	One incident referred to PPIGG awaiting outcome	30th September 2019	1b
Infection Prevention	IP audit cycle has recommenced for 2019/20	New audit cycle has commenced	Eight practices audited, every practice improved from previous	On going	1a

			annual audit. Issues identified relate to waste management, environment and PPE.		
Flu Programme	Flu planning meetings have recommenced for 2019/20 flu season	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	Sufficient vaccine is available in the city but MHRA rules will not be relaxed this year. Monthly CCG/PH meetings have recommenced. Monthly NHSE teleconferences have commenced	31st March 2020	1b
Vaccination Programme	Vaccination programmes continue to be monitored	NHSE/PHE meeting identified issues with MMR uptake and susceptibility. Risk identified to discuss and consider adding to risk register. Continue to work with colleagues in PH and other CCGs	There are plans to add MMR uptake to collaborative contracting visit agenda as an ongoing item and to share data with locality managers	On-going	1b
Sepsis/ECOLI	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.	Continue to work with Medicines Optimisation and IP teams	Ongoing work against action plan	30th November 2019	
MHRA	No issues at present.	No further update	No further update	None at present	1a
Complaints	No issues at present – quarterly report due July 2019	No further update – awaiting NHSE data	Seven complaints received in Q4 • 6 closed 1 open • 2 relate to the same practice • 4 not-upheld; 1 partially upheld; 1 upheld Themes include: • Prescriptions • Communication • Clinical treatment and errors • Staff attitude –this area the number of complaints has significantly reduced	On going	1a
FFT	Quarterly full report due in July	In June 2019	In July 2019	On-going	1a

	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	• 2 practices did not submit • 1 submitted fewer than 5 responses • Uptake was 2.5% compared with 0.8% regionally and 0.6% nationally.	• 6 practices did not submit • 2 submitted fewer than 5 responses Uptake was 2.2% compared with 0.9% regionally and 0.5% locally. Practices have been reminded to nominate someone to upload their data if the main person is on leave. Full report to be provided next month		
NICE Assurance	No actions at present – next NICE meeting in August 2019	Next meeting in September	Next meeting in September	None at present	1a
Collaborative contracting visits	All practices now complete new cycle to commence in October 2019	As of 23rd July 2019 two practices are outstanding in this visit cycle – due to restart in September	All practices now complete, 5 action plans outstanding (minor issues only). Template reviewed again for new cycle from October.	On going	1b
CQC	There has been another practice given requires improvement rating.	Practices now undergoing their annual reviews by telephone. CQC reporting issues as they occur.	Three practices now have a requires improvement rating, these are being supported by CCG Quality and Primary Care teams	On going	1b
Workforce Activity	Work continues to promote primary care as a desirable place to work and to promote current programmes	GPN strategy launch booked for 3rd October 2019 at Science Park Retention and apprenticeship programmes continue. Regional GPN meeting now set up with rolling chair	GP strategy launch planning continues – venue now Himley Hall. GPN retention plan work streams under development.	On-going Strategy 3rd October	1a
Workforce Numbers	Awaiting NHS Digital workforce data release.	No change to status	No change to status – data available but this is from September 2018 which is not new data.	On-going	1b
Training and Development	None flagged at present	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	Further flu training will be held in September Spirometry training is due in September and December Immunisation training for HCAs will be available c/o Training Hub MERIT Diabetes training is being provided by pharma PMP will include immunisations	On-going	1a

		Medical assistant training	and cytology		
Training Hub/HEE/HEI update	To continue monitoring, risk reduced and closed.	Training Hub cover now identified to continue with work as planned	Sandwell CCG are now providing Training Hub cover, GPN facilitation remains with Dudley TH no issues noted	On-going	1a

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WOLVERHAMPTON CCG

GOVERNING BODY – 12 November 2019

Agenda item 12

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 24th September 2019**
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	• **Receive** and **note** the information provided in this report.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The organisation has a number of finance and performance related statutory obligations including delivery of a robust financial position and adherence with NHS Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG must secure the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best

	value for money; and has effective systems in place to ensure compliance with its statutory functions, meet a number of constitutional, national and locally set performance targets.
• **Domain2:** Performance – delivery of commitments and improved outcomes	The CCG must meet a number of constitutional, national and locally set performance targets.
• **Domain 3:** Financial Management	The CCG aims to generate financial stability in its position, managing budgets and expenditure to commission high quality, value for money services. The CCG must produce a medium to long term plan that allows it to meet its objectives in the future.

1. FINANCE POSITION

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

Financial Targets				
Statutory Duties	**Target**	**Out turn**	**Variance o(u)**	**RAG**
Expenditure not to exceed income	£13.178m surplus	£13.178m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£451.205m	£438.027m	(£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	£383k	£30k	(£353k)	G
Maximum closing cash balance %	1.25%	0.10%	(1.15%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	99%	(4%)	G
QIPP	£16.686m	£16.686m	Nil	G
Programme Cost *	£179,589k	£180,858k	£1,269k	G
Reserves *	£1,188k	£0k	(£1,188k)	G
Running Cost *	£2,298k	£2,216k	(£82k)	G

BPPC NHS by Value (cum)	95%	100%	(5%)	G
BPPC non NHS by Value (cum)	95%	99%	(4%)	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) M4 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 revised 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 M05									
		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	213,565	88,985	89,521	535	0.6%	215,489	1,925	0.9%		0	1,925
Mental Health Services	42,554	17,731	17,831	100	0.6%	42,637	83	0.2%		0	83
Community Services	45,416	18,923	18,815	(109)	(0.6%)	45,147	(268)	(0.6%)		0	(268)
Continuing Care	16,092	6,705	6,591	(114)	(1.7%)	15,911	(181)	(1.1%)		0	(181)
Primary Care Services	58,702	24,459	24,599	140	0.6%	59,091	389	0.7%		0	389
Delegated Primary Care	37,573	15,655	15,894	238	1.5%	37,573	0	0.0%		0	0
Other Programme	15,759	7,130	7,609	479	6.7%	16,144	385	2.4%		0	385
Total Programme	**429,661**	**179,589**	**180,858**	**1,269**	**0.7%**	**431,993**	**2,332**	**0.5%**		**0**	**2,332**
Running Costs	5,516	2,298	2,216	(82)	(3.6%)	5,316	(200)	(3.6%)		(200)	0
Reserves	2,850	1,188	0	(1,188)	(100.0%)	718	(2,132)	(74.8%)		0	(2,132)
Total Mandate	**438,027**	**183,074**	**183,074**	**0**	0.0%	**438,027**	**0**	**0.0%**		**(200)**	**200**
Target Surplus	13,178	5,491	0	(5,491)	(100.0%)	0	(13,178)	(100.0%)		0	(13,178)
Total	**451,205**	**188,565**	**183,074**	**(5,491)**	(2.9%)	**438,027**	**(13,178)**	(2.9%)		**(200)**	**(13,178)**

- The Acute over performance relates in the main to RWT. Having received Month 4 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.

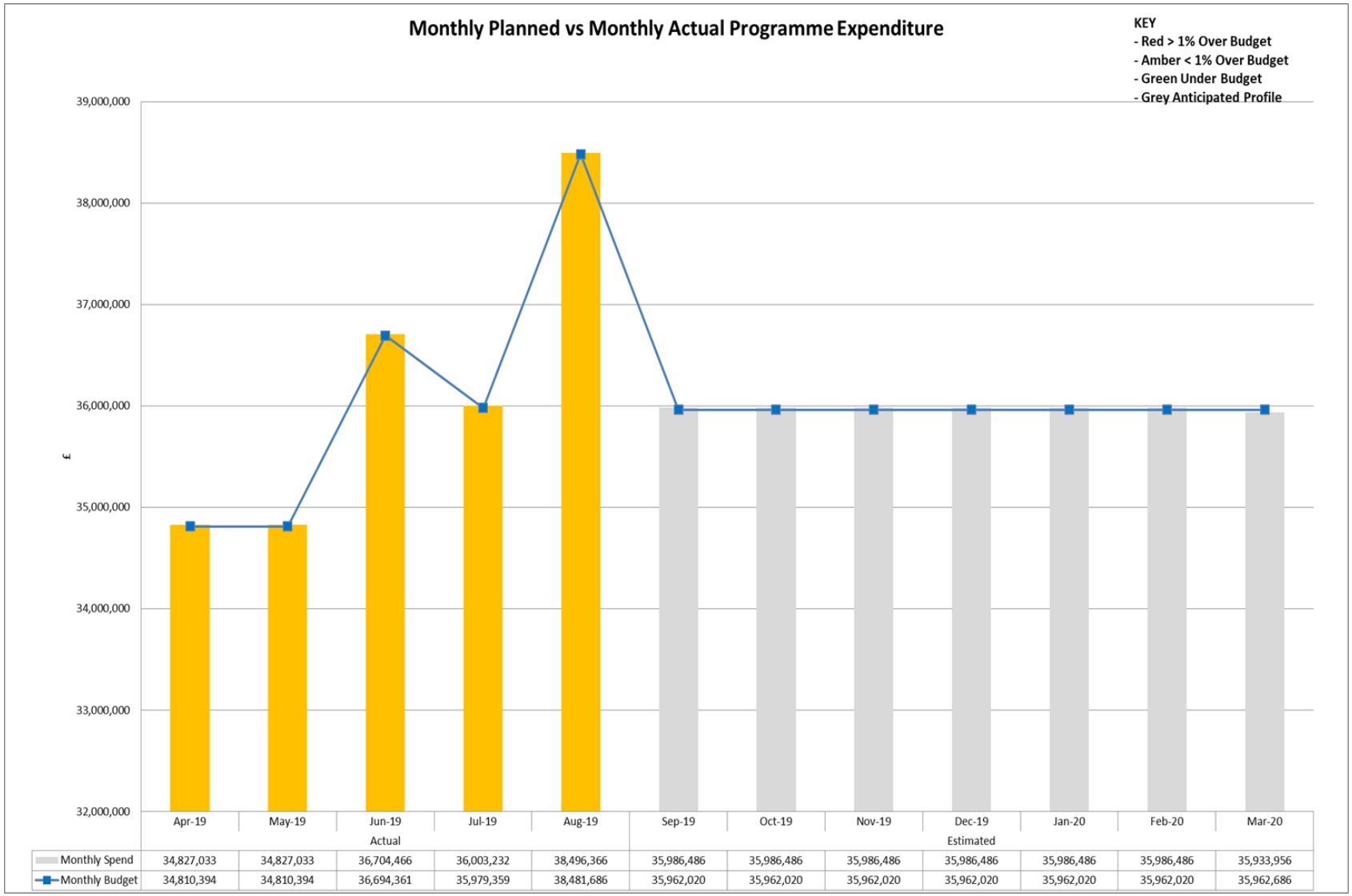
- The Mental Health over performance relates to the recognition of the recurrent impact of NCA activity.

- 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.

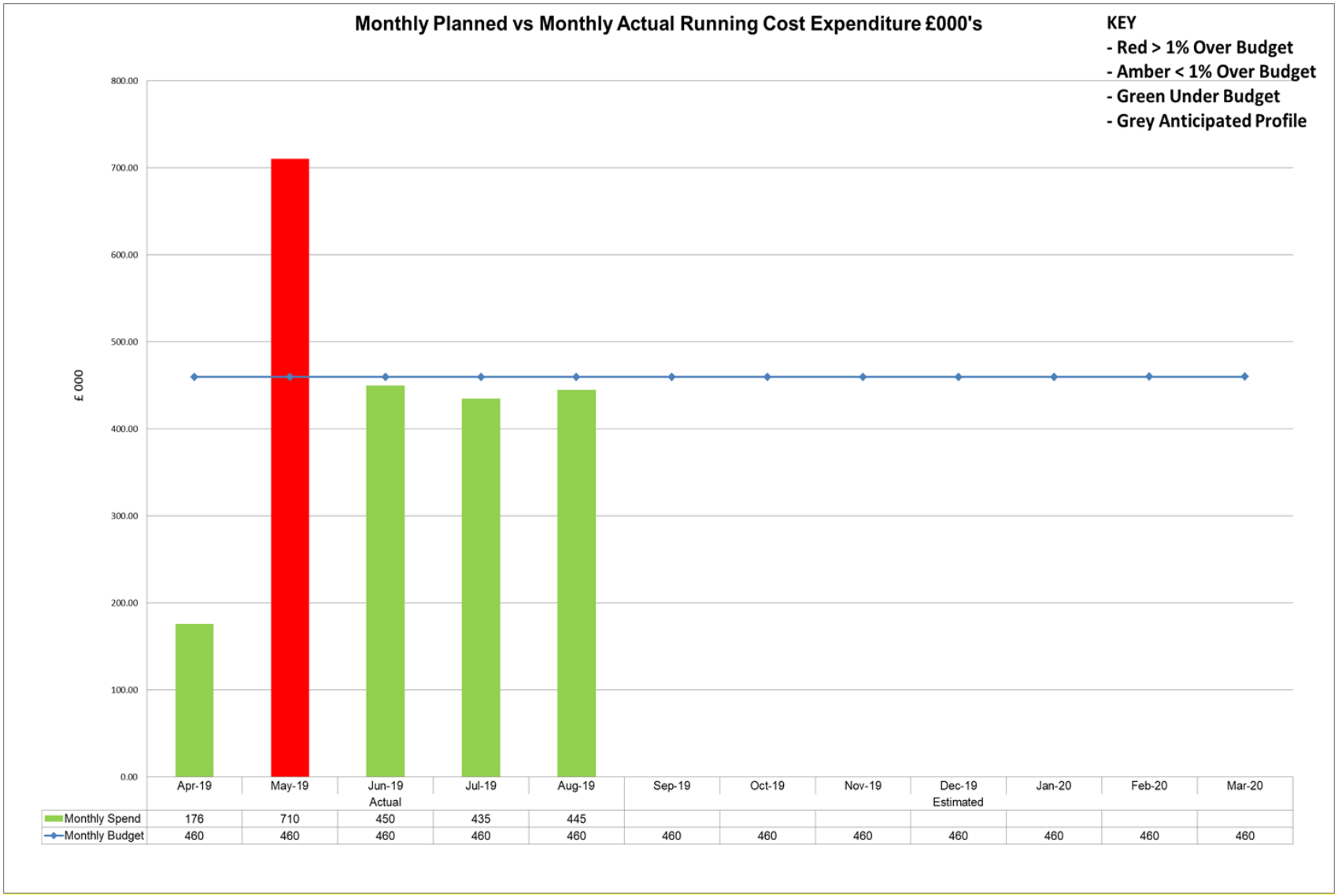
- The CCG is now required to report on its underlying financial position, a position which reflects the recurrent position and financial health of the organisation and is meeting the planning requirements of a 1% recurrent surplus as shown below.

- The extract from the M5 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)	**441.177**				(14.786)						426.391
Acute Services	**213.565**	**215.489**	(1.925)	(0.9%)	(5.659)	1.110		(2.926)			208.014
Mental Health Services	**42.554**	**42.637**	(0.083)	(0.2%)	(2.134)	-		(0.220)			40.283
Community Health Services	**45.416**	**45.147**	0.268	0.6%	-	-		0.159			45.306
Continuing Care Services	**16.092**	**15.911**	0.181	1.1%	(0.020)	-		0.022			15.913
Primary Care Services	**58.702**	**59.091**	(0.389)	(0.7%)	(4.826)	0.500		0.191			54.956
Primary Care Co-Commissioning	**38.145**	**38.145**	-	0.0%	-	-	(0.191)	0.111			38.065
Other Programme Services	**18.037**	**16.290**	1.747	9.7%	(2.147)	1.540	(2.132)	1.088			14.639
Commissioning Services Total	**432.511**	**432.711**	(0.200)	(0.0%)	(14.786)	3.150	(2.323)	(1.576)	-	-	417.176
Running Costs	**5.516**	**5.316**	0.200	3.6%	-	-					5.316
TOTAL CCG NET EXPENDITURE	**438.027**	**438.027**	0.000	0.0%	(14.786)	3.150	(2.323)	(1.576)	-	-	422.492
IN YEAR UNDERSPEND / (DEFICIT)	**3.150**	**3.150**	0.000	0.0%					**Underlying Underspend / (Deficit)**		3.899
									% RRL		0.9 %



- 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.


Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£ 000
800.00
700.00
600.00
500.00
400.00
300.00
200.00
100.00
0.00
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 176 710 450 435 445
Monthly Budget 460 460 460 460 460 460 460 460 460 460 460 460

DELEGATED PRIMARY CARE

- The Delegated Primary Care allocation for 2019/20 as at M5 is £38.145m. At M5 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 5:

	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	9,384	9,384	0	23,842	23,842	0		0	0
General Practice PMS	605	605	(0)	2,895	2,895	0		0	0
Other List Based Services APMS incl	1,172	1,172	0	1,531	1,531	0		0	0
Premises	997	997	0	2,505	2,505	0		0	0
Premises Other	35	35	0	65	65	0		0	0
Enhanced services Delegated	790	790	0	758	758	0		0	0
QOF	1,530	1,530	0	3,751	3,751	0		0	0
Other GP Services	1,143	1,381	238	2,226	2,226	0		0	0
Delegated Contingency reserve	80	0	(80)	191	191	0		0	0
Delegated Primary Care 1% reserve	159	0	(159)	381	381	0		0	0
Total	**15,894**	**15,894**	**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:

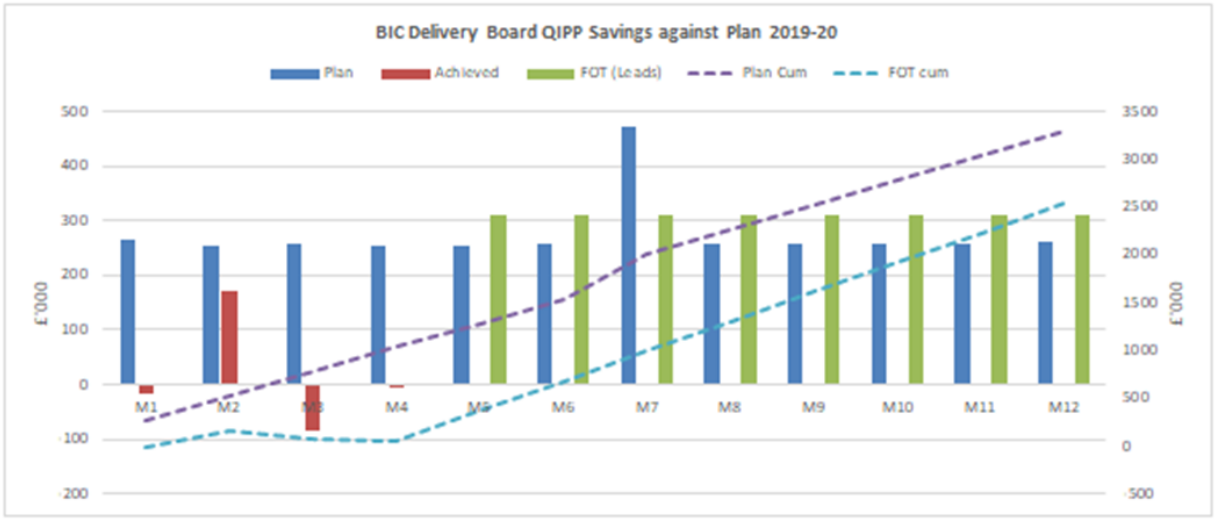
- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686m,(4.1%) the additional QIPP being identified at a high level as follows :
    - Prescribing £500k
    - Other Programme Services £1.54m
    - Acute service Independent/Commercial sector £1.1m

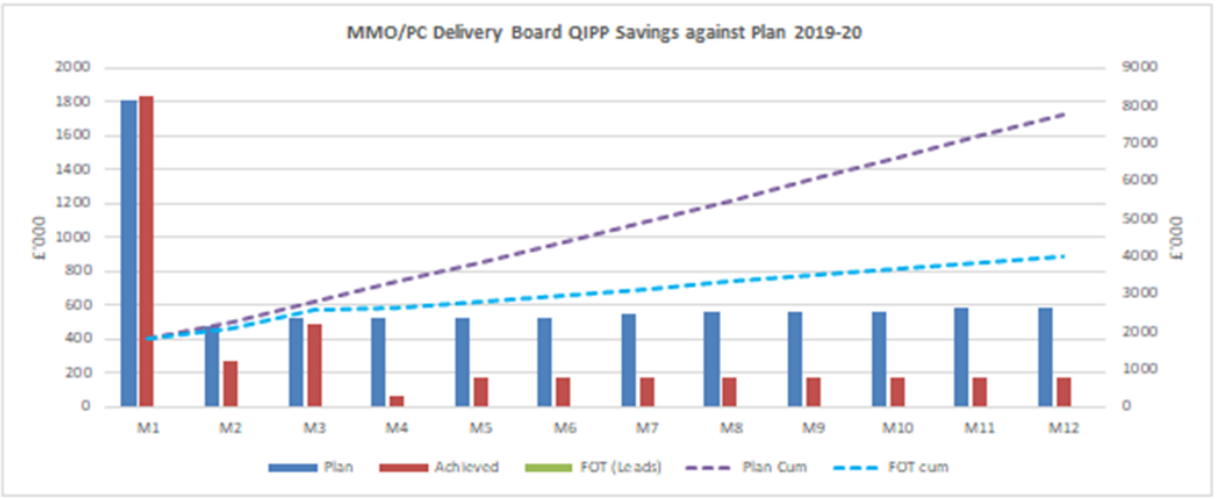
  The above categories represent the areas under higher levels of scrutiny by NHSEI.

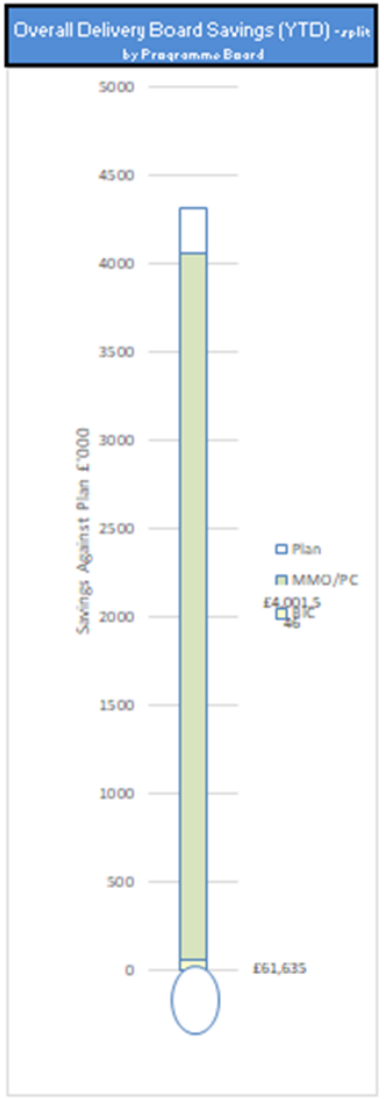
- The plan assumes full delivery of QIPP on a recurrent basis (with the exception of the additional QIPP required to support the revised control total) as any non-recurrent QIPP will potentially be carried forward into future years.
- The CCG is formally reporting QIPP being delivered as the CCG is achieving its financial metrics.
- Within BIC the key points are as follows:
    - At M5 QIPP delivery is behind plan ytd and unlikely to deliver the annual taget
    - The increase in QIPP target in M7 is due to 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 M5 QIPP delivery is behind plan ytd.
    - Prescribing has yet to report their QIPP position due to timing of data received to support the QIPP. Prescribing is confident its QIPP target will be delivered.
    - The increase in QIPP target in M7 is due to the decommissioning of Blakenhall
- The table below details the QIPP programme and the level of savings assigned to each Programme Board and forms the basis of monitoring for 19/20.

QIPP Programme Delivery Board







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3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st August 2019 is shown below:

	31 August '19 £'000	31 July '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	1,723	3,000	-1,277
Cash and Cash Equivalents	30	52	-22
	1,753	3,052	
Total Assets	**1,753**	**3,052**	
Current Liabilities			
Trade and Other Payables	-43,404	-40,005	-3,399
	-43,404	-40,005	
Total Assets less Current Liabilities	**-41,652**	**-36,953**	
TOTAL ASSETS EMPLOYED	**-41,652**	**-36,953**	
Financed by:			
TAXPAYERS EQUITY			
General Fund	41,652	36,953	4,698
TOTAL	**41,652**	**36,953**	

Key points to note from the SoFP are:

- The cash target for month 5 has been achieved.
- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days, (98.6% for non-NHS invoices and 99.1% for NHS invoices);

- **PERFORMANCE**

Exception highlights were as follows;

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

3.1.1. Elective Care (EB3 – Referral to Treatment Time (RTT), EBS4 - 52 Week Waiters, EB4 – 6 Weeks Diagnostic from Referral)

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 (July 19):

- WCCG 86.4%, England 85.8%, STP 90.0%
- 92% WCCG patients started treatment within 21.6 weeks at any provider in England against the standard of 18 weeks (England was 23).
- There are no WCCG patients waiting 52+ weeks to start treatment.
- Specialities with the longest waiting times are Ophthalmology, Dermatology, Neurology and General Surgery.
- The CCG is in the final stages of agreeing a Recovery Action Plan (RAP) with the Trust to support recovery of Trust performance which will, in turn, improve the performance of the CCG.

The RWT SPQR shows a decrease in diagnostic performance for August and is under standard for the first time since January. Early indications are that this is due to an increase in Endoscopy referrals and will be raised for further discussion with the Trust at September CRM

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.

- 88.4% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in August.
- The Trust was ranked at 46th out of 122 Trusts in August, 10 Trusts achieved the national standard of 95%.
- Performance remains challenged across the country with England reported on NHS Stats at 86.5%* and the Black Country STP at 84.9%.
- Delayed Transfer of Care rates remain low at 1.32% (excluding Social Care) 3.23% (total including Social Care) for July indicating Trust is managing patient flow.
- Ambulance conveyances in to the Trust are under discussion at AEDB together with the triaging of patients from ED to the Urgent Care Centre.
- 70 ambulances breached the 30-60 minute ambulance handover target during August and 3 ambulances breached the >60 minutes.
- The 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 was one breach of the 12 hr standard in August bringing the total year to date to 5.
- There has been an increase in conveyances from the Strategic Cell and the Trust are seeing the ripple effect of significant issues in areas bordering on the STP such as Worcestershire where performance was reported at 78% with 50 patients breaching 12 hr standard.

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:***
  - July nationally published performance is 7.2% for the CCG and 5.6% for RWT.
  - STP performance is 69.8% and England is 82.4%
  - CCG is reliant on situation at RWT which has seen a 10% increase of breast referrals over the past 2 years.
  - RWT is currently (18/09/19) booking new referrals at day 51
  - Neither the CCG nor Trust will see performance return to standard until the backlog has reduced.

- Implementation of STP Breast diversion scheme from July; practices where alternative provider (Dudley/Walsall) is within 3 miles of the practice were asked to discuss with patients the option to refer to Dudley or Walsall rather than RWT.
- From 9th September STP agreed diversion at source for RWT receiving referrals from practices in the scheme to refer directly to Walsall/Dudley.
- RWT's backlog position which has reduced from 539 at 1 July to 232 by 16 September.
- Breast Pain pathway commenced in August.
- Recovery is currently forecast for end Q3.

- ***All Cancer standards – issues and actions:***
  - Remedial action plan is in place and reviewed monthly with revised improvement trajectories agreed.
  - The CCG has achieved the 31 Day standard for the first time since October '18 at 96%
  - The CCG's performance is showing improvement across the majority of standards.
  - Low numbers impact on performance for the two standards not showing improvement;
    - EB10 – 31 days (drugs) - 28/29 (96.55%)
    - EB13 – 62 days referral from screening service – 10/13 (76.9%)
  - RAP anticipates return to 62 day performance by November 2019
  - Impact of delays on the 2WW cancer pathways (in particular Breast referrals) will start to effect performance against the 31 and 62 day standards.
  - .

Cancer performance data for July 19

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	73.38%	77.85%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	3.82%	7.21%
EB8	31 Day (1st Treatment)	96%	89.61%	96.03%
EB9	31 Day (Surgery)	94%	79.59%	87.50%
EB10	31 Day (anti-cancer drug)	98%	100%	96.55%
EB11	31 Day (radiotherapy)	94%	94.33%	100%
EB12	62 Day (1st Treatment)	85%	55.69%	69.39%
EB13	62 Day (Screening)	90%	71.74%	76.92%
EB14	62 Day (Consultant Upgrade)	No Standard	73.53%	78.85%

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

3.2.1. Mental Health

3.2.2. E.H.11: CYP Eating Disorders (Routine within 4 weeks)

- Exception reports are provided for each patient breaching the standard which shows that the running theme is that of appointments cancelled due to patient choice. The Trust does reschedule the appointments but this will be then >4 weeks.
- Low numbers (18/20 on a rolling 12 month basis) affect performance against the national standard of 95%.
- 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.

3.2.3. *E.A.3 - IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence).*

- Performance is assessed against a quarterly performance target of 4.75% Q1-Q3 and 5.5% Q4
- NHS England published figures are based on a rolling quarter and confirm the June19 performance as 5.46% and above threshold of 4.75% for Q1.
- 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.

3.2.4. E.H.13 – Physical Health Checks for People with a Severe Mental Illness

- Q1performance achieved 39.3% against a planned trajectory of 45%.
- CCG is currently under the planned activity and this has been escalated to primary care colleagues.
- The CCG has included SMI PHC in QOF+ for 2019/20.
- Performance is assessed on a rolling 12 month basis.
- National requirement to achieve 60% in 2019/20 which will be assessed based on March 2020 position.

4. RISK and MITIGATION

The CCG was required to resubmit a plan which demonstrates £6.3m risk which is currently fully mitigated based on the assumption that the Black Country CCG Risk share arrangements 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

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. Devolvement of Mental Health Non-Contracted Activity (NCA) Budget to Black Country Partnership NHS Foundation Trust

The Committee noted the contents of the report and supported the proposal to devolve the budget to the Trust to support transformation across the system by providing positive incentives to manage patient flow to avoid costly out of area placements.

8. OTHER RISK

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

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

9. RECOMMENDATIONS

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

Name: Lesley Sawrey
Job Title: Deputy Chief Finance Officer
Date: 25th September 2019

Wolverhampton CCG Performance against the NHS Constitution Standards

Finance and Performance (F&P) 2019/20 - Wolverhampton CCG (06a)

Current Month: Jul-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	Jul	92.0%	86.44%	↓	↓	87.88%													
		CCG Validated		Jul	92.0%	86.45%	↓	↓	87.89%													
		RWT		Jul	92.0%	85.07%	↓	↓	86.50%													
		Black Country STP		Jul	92.0%	89.95%	↓	↓	92.16%													
		National		Jul	92.0%	85.78%	↓	↓	86.35%													
EB4	Diagnostic Waits (6wks)	CCG Provisional	Mth	Jul	1.0%	0.68%	↑	↓	0.77%													
		CCG Validated		Jul	1.0%	0.68%	↑	↓	0.77%													
		RWT		Jul	1.0%	0.64%	↑	↓	0.75%													
		Black Country STP		Jul	1.0%	0.66%	↑	↑	1.47%													
		National		Jul	1.0%	3.52%	↑	↑	3.74%													
EB5	A&E (Waits Within 4hrs)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		No Data	95.0%	-																
		RWT		Aug	95.0%	88.39%	↓	↓	88.24%													
		Black Country STP		Aug	95.0%	84.95%	↓	↑	84.66%													
		National		Jul	95.0%	77.90%	↑	↓	79.65%													
EB6	Two Week Waits (2WW)	CCG Provisional	Mth	No Data	93.0%	-			-													
		CCG Validated		Jul	93.0%	77.85%	↑	↑	72.01%													
		RWT		Jul	93.0%	77.62%	↑	↑	73.57%													
		Black Country STP		Jul	93.0%	90.40%	↑	↑	89.64%													
		National		Jul	93.0%	90.91%	↑	↑	90.43%													
EB7	Two Week Waits (2WW) Breast Symptoms	CCG Provisional	Mth	No Data	93.0%	-			-													
		CCG Validated		Jul	93.0%	7.21%	↑	↑	6.62%													
		RWT		Jul	93.0%	5.56%	↑	↑	2.90%													
		Black Country STP		Jul	93.0%	69.84%	↓	↓	71.53%													
		National		Jul	93.0%	82.42%	↑	↑	78.69%													
EB8	31 Day Cancer Treatment	CCG Provisional	Mth	No Data	96.0%	-			-													
		CCG Validated		Jul	96.0%	96.03%	↑	↑	91.38%													
		RWT		Jul	96.0%	89.61%	↑	↑	87.21%													
		Black Country STP		Jul	96.0%	95.48%	↑	↑	94.35%													
		National		Jul	96.0%	96.49%	↑	↑	96.20%													
EB9	31 Day Cancer Treatment (Surgery)	CCG Provisional	#N/A	No Data	94.0%	-			-													
		CCG Validated		Jul	94.0%	87.50%	↑	↑	84.29%													
		RWT		Jul	94.0%	79.59%	↑	↑	74.83%													
		Black Country STP		Jul	94.0%	92.45%	↑	↑	90.38%													
		National		Jul	94.0%	92.23%	↑	↑	91.73%													
EB10	31 Day Cancer Treatment (anti cancer drug)	CCG Provisional	Mth	No Data	98.0%	-			-													
		CCG Validated		Jul	98.0%	96.55%	↓	↓	99.06%													
		RWT		Jul	98.0%	100.00%	↑	↑	99.50%													
		Black Country STP		Jul	98.0%	96.84%	↓	↓	98.45%													
		National		Jul	98.0%	99.17%	↓	↑	99.17%													
EB11	31 Day Cancer Treatment (Radiotherapy)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		Jul	94.0%	100.00%	↑	↑	90.85%													
		RWT		Jul	94.0%	94.33%	↓	↑	90.74%													
		Black Country STP		Jul	94.0%	94.97%	↓	↑	84.00%													
		National		Jul	94.0%	97.10%	↑	↑	96.71%													
EB12	62 Day Cancer Treatment 1st Definitive Treatment	CCG Provisional	Mth	No Data	85.2%	-			-													
		CCG Validated		Jul	85.2%	69.39%	↑	↑	66.16%													
		RWT		Jul	85.2%	66.39%	↑	↑	61.54%													
		Black Country STP		Jul	85.2%	78.06%	↑	↑	76.43%													
		National		Jul	85.2%	77.59%	↑	↓	77.78%													

Current performance is as published validated national data for Wolverhampton CCG unless indicated otherwise, i.e. only available at Trust level.

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		Jul	90.0%	76.92%	↓	↑	73.17%													
		RWT		Jul	90.0%	71.74%	↓	↓	76.05%													
		Black Country STP		Jul	90.0%	86.67%	↓	↓	89.60%													
		National		Jul	90.0%	85.54%	↑	↓	86.93%													
EB14	62 Day Cancer Treatment (Consultant Upgrade)	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		Jul	0.0%	78.85%	↑	↓	76.37%													
		RWT		Jul	0.0%	73.53%	↑	↓	73.51%													
		Black Country STP		Jul	0.0%	82.55%	↑	↓	81.38%													
		National		Jul	0.0%	83.31%	↑	↓	82.96%													
EB18	52 Week Waiters (RTT)	CCG Provisional	Mth	Jul	0	0	→	→	0													
		CCG Validated		Jul	0	0	→	→	0													
		RWT		Jul	0	0	→		0													
		Black Country STP		Jul	0	1	↑	↓	10													
		National		Jul	0	1119	↓	↓	4336													
EH1	IAPT Programme: Treated within 6 wks	CCG Provisional	Mth	No Data	75.0%	-																
		CCG Validated		Jun	75.0%	87.88%	↑	↑	85.15%													
		BCPFT		No Data	75.0%	-																
		Black Country STP		Jun	75.0%	86.36%	↑	↑	85.71%													
		National		No Data	75.0%	-																
EH2	IAPT Programme Referral to Treatment (18wks)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		Jun	95.0%	100.00%	↑	↑	98.02%													
		BCPFT		No Data	95.0%	-																
		Black Country STP		Jun	95.0%	98.48%	↑	↑	97.76%													
		National		No Data	95.0%	-																
EH3	Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment.	CCG Provisional	Mth	No Data	0.0%	-																
		CCG Validated		No Data	0.0%	-																
		BCPFT		No Data	0.0%	-																
		Black Country STP		No Data	0.0%	-																
		National		No Data	0.0%	-																
EH4	EIP 1st Episode (within 2 wks)	CCG Provisional	Mth	Jul	57.1%	80.00%	↑	↓	76.92%													
		CCG Validated		Jul	57.1%	80.00%	↑	↓	76.92%													
		BCPFT		Jun	57.1%	40.00%	↓	↓	53.33%													
		Black Country STP		Jul	57.1%	66.67%	↑	↑	56.90%													
		National		Jul	57.1%	77.42%	↑	↑	76.06%													
EH9	CYP Access Rates	CCG Provisional	Mth	No Data	34% Full Yr	-																
		CCG Validated		Jun	34% Full Yr	3.88%	↓		13.75%													
		BCPFT		No Data	34% Full Yr	-																
		Black Country STP		Jun	34% Full Yr	2.72%	↓		3.36%													
		National		No Data	34% Full Yr	-																
EAS1	Dementia Diagnosis (65+)	CCG Provisional	Mth	No Data	71.4%	-																
		CCG Validated		Jul	71.4%	73.37%	↑		72.81%													
		Primary Care		No Data	71.4%	-																
		Black Country STP		Aug	71.4%	66.66%	↑	↑	66.48%													
		National		No Data	71.4%	-																
EAS2	IAPT Recovery Rate (Moving to Recovery)	CCG Provisional	Mth	No Data	50.0%	-																
		CCG Validated		Jun	50.0%	40.63%	↓		48.45%													
		BCPFT		No Data	50.0%	-																
		Black Country STP		Jun	50.0%	47.69%	↓		53.16%													
		National		No Data	50.0%	-																
EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		Aug	0	0	→	→	1													
		RWT		Aug	0	0	→	→	0													
		Black Country STP		Aug	0	0	→	↑	4													
		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
EAS5	Minimise rates of Clostridium Difficile	CCG Provisional	Mth	No Data	CCG: 48 Full Yr	-																
		CCG Validated		Aug	CCG: 48 Full Yr	1	↑	↑	16													
		RWT		Aug	RWT: 40 Full Yr	0	→	↑	6													
		Black Country STP		Aug	STP: 288 Full Year	6	↑	↑	101													
		National		No Data	TBC	-																
EBS5	12 hr Trolley Waits	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		No Data	0	-																
		RWT		Aug	0	1	↓	↑	5													
		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		Jul	0	0	→	→	0													
		Black Country STP		No Data	0	-																
		National		No Data	0	-																
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%																
		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%																
		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%																
		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% by Yr End	-																
		CCG Validated		Jun	60% by Yr End	39.27%			39.27%													
		Primary Care		No Data	60% by Yr End	-																
		Black Country STP		No Data	60% by Yr End	-																
		National		No Data	60% by Yr End	-																
EA3	IAPT Roll Out Access Rate	CCG Provisional	Mth	No Data	22% Full Yr (1.83% per mth)	-																
		CCG Validated		Jun	22% Full Yr (1.83% per mth)	1.85%	→	↓	5.46%													
		BCPFT		No Data	22% Full Yr (1.83% per mth)	-																
		Black Country STP		Jun	22% Full Yr (1.83% per mth)	7.36%	↑	↑	7.22%													
		National		No Data	22% Full Yr (1.83% per mth)	-																
EH12	OoAPs - Out of Area Placements (STP target)	CCG Provisional	Mth	No Data	STP Wide Traj 978 by Yr End	-																
		CCG Validated		Jun	STP Wide Traj 978 by Yr End	275	↑	↓	990													
		Black Country STP		Jun	STP Wide Traj 978 by Yr End	710	↓		2225													
		National		No Data	STP Wide Traj 978 by Yr End	-																
EO1	% of Children Waiting more than 18 weeks for a Wheelchair	CCG Provisional	Qtr	No Data	93%	-																
		CCG Validated		Jun	93%	100.00%			100.00%													
		Black Country STP		Jun	93%	95.79%			95.79%													
		National		No Data	93%	-																

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
EK3	AHCs delivered by GPs for patients on the Learning Disability Register	CCG Provisional	Mth	No Data	14.3% Yr End	-																
		CCG Validated		Aug	14.3% Yr End	46.51%																
		Black Country STP		No Data	14.3% Yr End	-																
		National		No Data	14.3% Yr End	-																
EN1	Cumulative number of Personal Health Budgets (PHBs)	CCG Provisional	Mth	No Data	320 Yr End	-																
		CCG Validated		Jun	320 Yr End	174																
		Black Country STP		No Data	320 Yr End	-																
		National		No Data	320 Yr End	-																

WOLVERHAMPTON CCG

GOVERNING BODY
12 November 2019

Agenda item 12

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

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

1. FINANCE POSITION

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

Financial Targets				
Statutory Duties	**Target**	**Out turn**	**Variance o(u)**	**RAG**
Expenditure not to exceed income	£13.178m surplus	£13.178m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£450.990m	£437.812m	(£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	£401k	£174k	(£227k)	G
Maximum closing cash balance %	1.25%	0.54%	(0.71%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	99%	(4%)	G
QIPP	£16.686m	£16.686m	Nil	G
Programme Cost *	£215,725k	£217,226k	£1,501k	G
Reserves *	£1,402k	£0k	(£1,402k)	G
Running Cost *	£2,758k	£2,659k	(£99k)	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.
- 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 M06							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	212,085	106,042	106,600	558	0.5%	214,388	2,303	1.1%		0	2,303
Mental Health Services	42,730	21,365	21,467	102	0.5%	42,881	150	0.4%		0	150
Community Services	45,482	22,741	22,568	(173)	(0.8%)	45,133	(349)	(0.8%)		0	(349)
Continuing Care	16,072	8,036	7,965	(71)	(0.9%)	16,122	50	0.3%		0	50
Primary Care Services	58,734	29,367	29,613	246	0.8%	59,157	423	0.7%		0	423
Delegated Primary Care	37,573	18,786	19,072	286	1.5%	37,573	0	0.0%		0	0
Other Programme	16,816	9,387	9,941	553	5.9%	16,571	(246)	(1.5%)		0	(246)
Total Programme	**429,492**	**215,725**	**217,226**	**1,501**	**0.7%**	**431,824**	**2,332**	**0.5%**		**0**	**2,332**
Running Costs	5,516	2,758	2,659	(99)	(3.6%)	5,316	(200)	(3.6%)		(200)	0
Reserves	2,804	1,402	0	(1,402)	(100.0%)	672	(2,132)	(76.0%)		0	(2,132)
Total Mandate	**437,812**	**219,884**	**219,884**	**0**	0.0%	**437,812**	**(0)**	**(0.0%)**		**(200)**	**200**
Target Surplus	13,178	6,589	0	(6,589)	(100.0%)	0	(13,178)	(100.0%)		0	(13,178)
Total	**450,990**	**226,473**	**219,884**	**(6,589)**	(2.9%)	**437,812**	**(13,178)**	(2.9%)		**(200)**	**(13,178)**

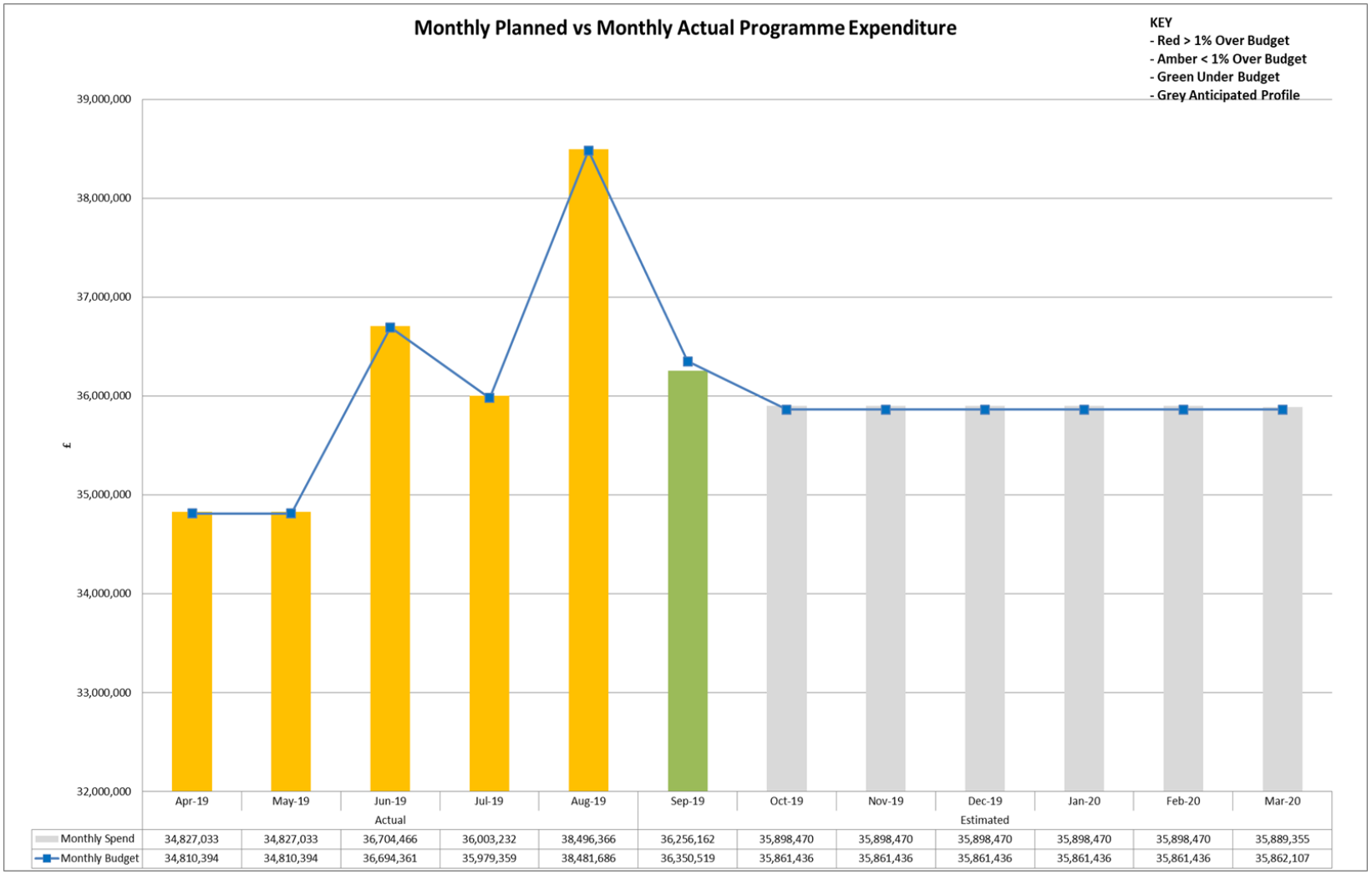
- The Acute over performance relates in the main to RWT. Having received Month 5 data the CCG has considered the level of performance reported and has reflected a level of over performance which it considers to be appropriate based on historic activity patterns.

- 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.

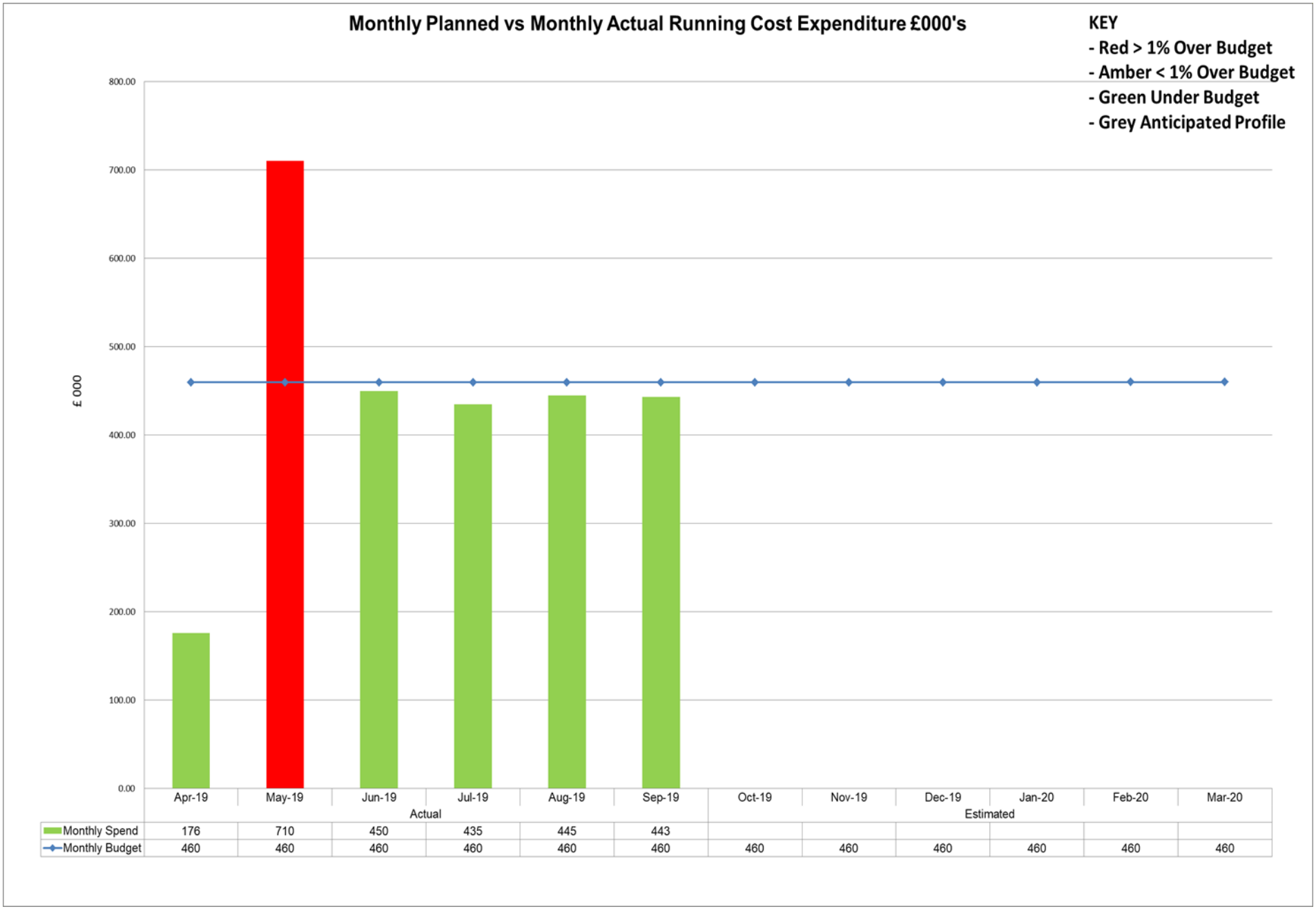
- The CCG is now required to report on its underlying financial position, a position which reflects the recurrent position and financial health of the organisation and is meeting the planning requirements of a 1% recurrent surplus as shown below.

- The extract from the M5 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)	**440.962**				(14.571)						426.391
Acute Services	**212.085**	**214.388**	**(2.303)**	**(1.1%)**	(4.179)	1.110		(3.191)			208.128
Mental Health Services	**42.730**	**42.881**	**(0.150)**	**(0.4%)**	(2.310)	-		(0.278)			40.293
Community Health Services	**45.482**	**45.133**	**0.349**	**0.8%**	(0.020)	-		0.205			45.318
Continuing Care Services	**16.072**	**16.122**	**(0.050)**	**(0.3%)**	-	-		(0.039)			16.083
Primary Care Services	**58.734**	**59.157**	**(0.423)**	**(0.7%)**	(4.858)	0.500		0.157			54.956
Primary Care Co-Commissioning	**38.145**	**38.145**	**-**	**0.0%**	-	-	(0.191)	0.191			38.145
Other Programme Services	**19.048**	**16.671**	**2.378**	**12.5%**	(3.204)	1.540	(2.132)	1.459			14.334
Commissioning Services Total	**432.296**	**432.496**	**(0.200)**	**(0.0%)**	**(14.571)**	**3.150**	**(2.323)**	**(1.496)**	-	-	**417.256**
Running Costs	**5.516**	**5.316**	**0.200**	**3.6%**	-	-					5.316
TOTAL CCG NET EXPENDITURE	**437.812**	**437.812**	**(0.000)**	**(0.0%)**	**(14.571)**	**3.150**	**(2.323)**	**(1.496)**	-	-	**422.572**
IN YEAR UNDERSPEND / (DEFICIT)	**3.150**	**3.150**	**-**	**0.0%**					**Underlying Underspend / (Deficit)**		**3.819**
									% RRL		**0.9 %**



- 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.


Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£ 000
800.00
700.00
600.00
500.00
400.00
300.00
200.00
100.00
0.00
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 176 710 450 435 445 443
Monthly Budget 460 460 460 460 460 460 460 460 460 460 460 460

DELEGATED PRIMARY CARE

- The Delegated Primary Care allocation for 2019/20 as at M5 is £38.145m. At M6 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 6:

	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	11,260	11,260	0	22,521	22,521	0		0	0
General Practice PMS	726	726	(0)	1,452	1,452	0		0	0
Other List Based Services APMS incl	1,407	1,407	0	2,814	2,814	0		0	0
Premises	1,196	1,196	0	2,393	2,393	0		0	0
Premises Other	42	42	0	83	83	0		0	0
Enhanced services Delegated	948	948	0	1,896	1,896	0		0	0
QOF	1,836	1,836	0	3,672	3,672	0		0	0
Other GP Services	1,371	1,657	286	2,743	2,743	0		0	0
Delegated Contingency reserve	95	0	(95)	191	191	0		0	0
Delegated Primary Care 1% reserve	191	0	(191)	381	381	0		0	0
Total	**19,072**	**19,072**	**(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.

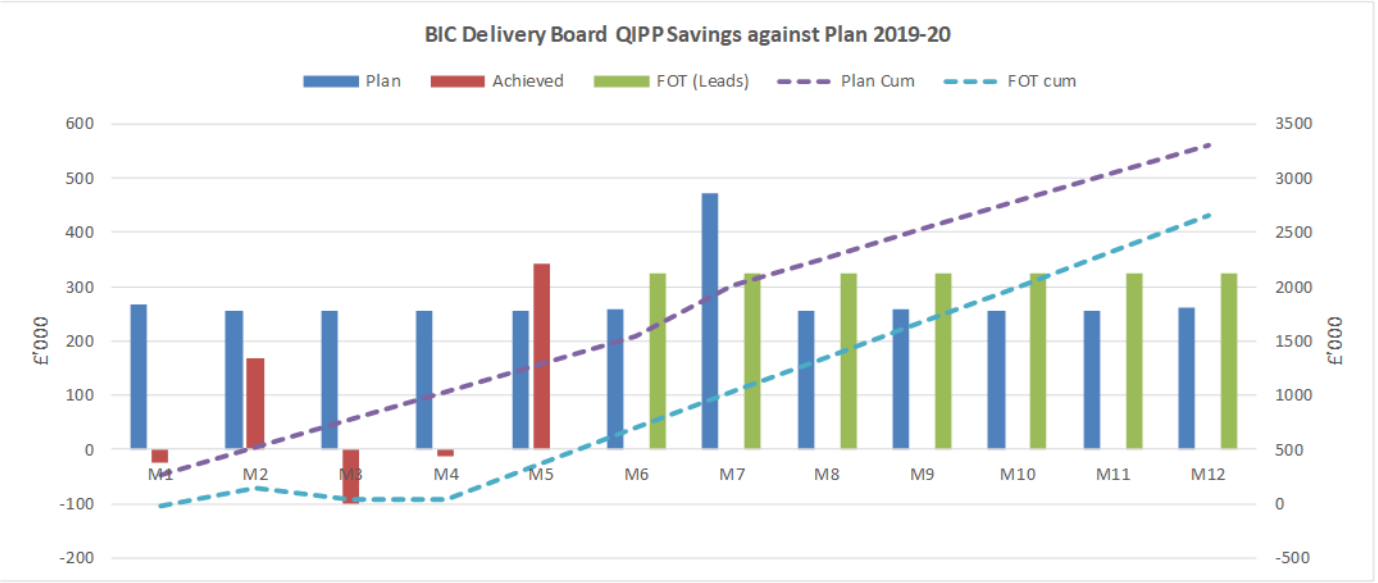
2. QIPP

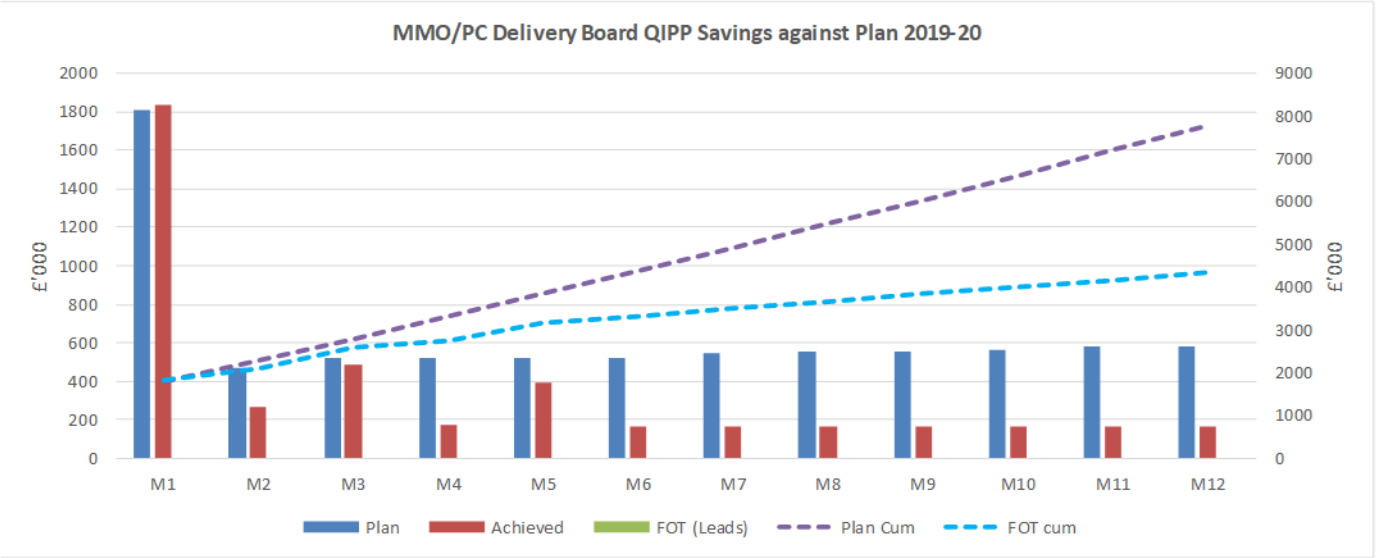
The key points to note are as follows:

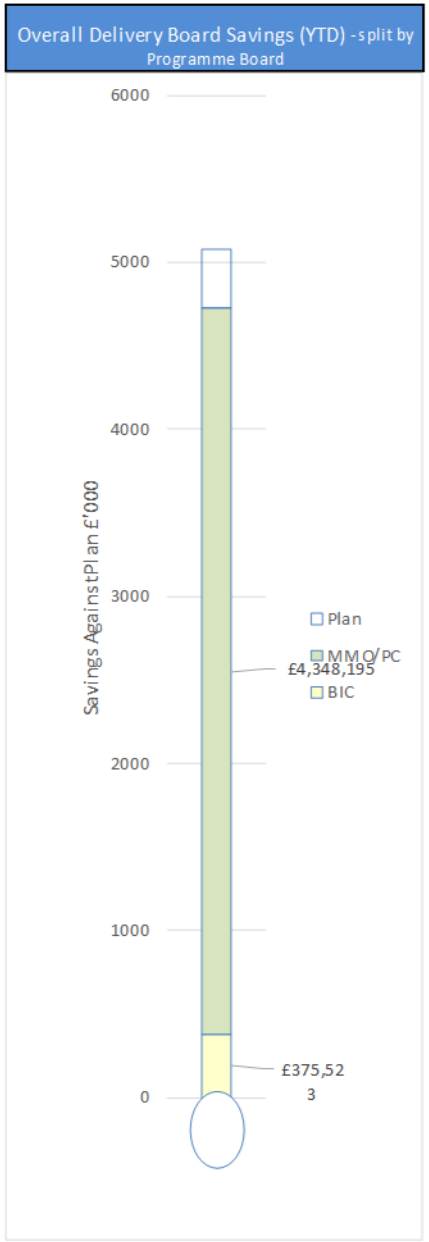
- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP target of £16.686m,(4.1%) the additional QIPP being identified at a high level 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.
- Within BIC the key points are as follows:
    - At M6 QIPP delivery is behind the year to date plan and is unlikely to deliver the annual taget
    - The increase in QIPP target in M7 is due to 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 M6 QIPP delivery is behind plan ytd.
    - Prescribing has yet to report their QIPP position due to timing of data received to support the QIPP. 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







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3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 30th September 2019 is shown below:

	30 September '19 £'000	31 August '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	1,770	1,723	47
Cash and Cash Equivalents	175	30	145
	1,945	1,753	
Total Assets	**1,945**	**1,753**	
Current Liabilities			
Trade and Other Payables	-44,657	-43,404	-1,253
	-44,657	-43,404	
Total Assets less Current Liabilities	**-42,712**	**-41,652**	
TOTAL ASSETS EMPLOYED	**-42,712**	**-41,652**	
Financed by:			
TAXPAYERS EQUITY			
General Fund	42,712	41,652	1,060
TOTAL	**42,712**	**41,652**	

Key points to note from the SoFP are:

- The cash target for month 5 has been achieved.
- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days, (98.6% for non-NHS invoices and 99.8% for NHS invoices);

- **PERFORMANCE**

Exception highlights were as follows;

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

3.1.1. Elective Care (EB3 – Referral to Treatment Time (RTT), EBS4 - 52 Week Waiters, EB4 – 6 Weeks Diagnostic from Referral)

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 (August 19):

- WCCG 85.9%, England 85.0%, STP 89.5%
- 92% WCCG patients started treatment within 22.6 weeks at any provider in England against the standard of 18 weeks (England was 23.7).
- There are no WCCG patients waiting 52+ weeks to start treatment during August. Assurances have been requested from University Hospitals of North Midlands regarding a 51 week waiter (Thoracic Medicine).
- Specialities with the longest waiting times are Thoracic Medicine, Trauma & Orthopaedics, Ophthalmology and General Surgery.
- The CCG has now agreed a Recovery Action Plan (RAP) with the Trust to support recovery of Trust performance which will, in turn, improve the performance of the CCG.
- The RAP will be monitored and managed via the monthly Contract Review Meeting.
- RTT waiting list remains above the March 19 position for both the CCG and RWT. Waiting list validation commenced in August, the impact of which is expected to be seen on October performance.

There has been a decrease in diagnostic performance for August and is under standard for the first time since January (RWT = 3.10%, WCCG = 2.68%). The Trust are investigating support from the private sector to alleviate pressure on the Endoscopy Department and expect full recovery by October 2019.

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.

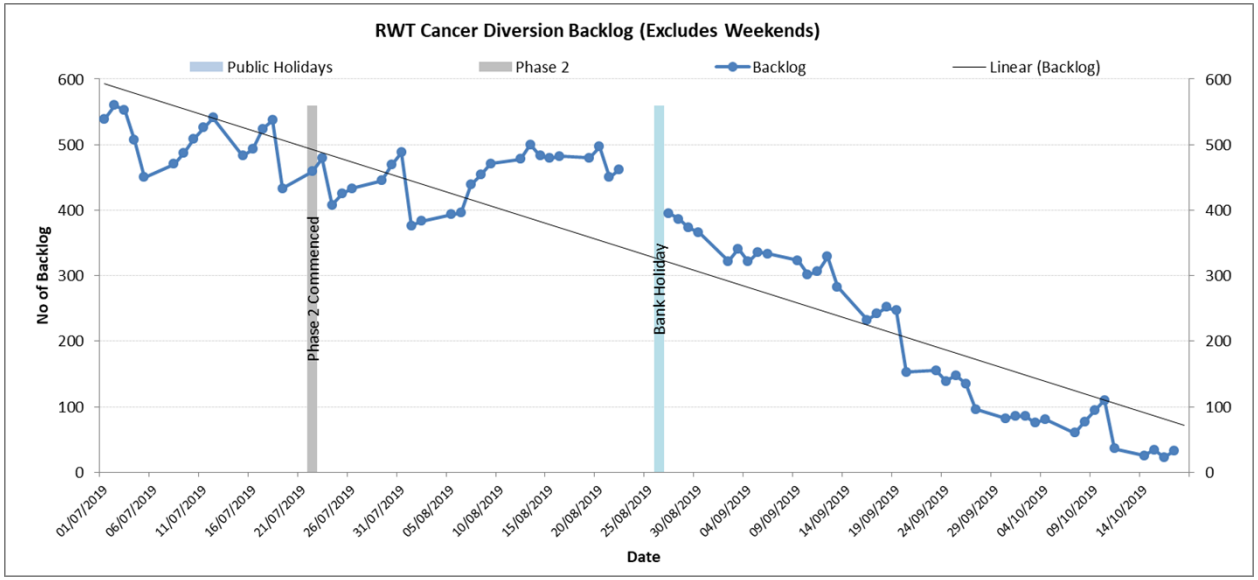
- 88.5% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in September.
- The Trust was ranked at 34th out of 121 Acute Trusts in September; 7 Trusts achieved the national standard of 95% (2 of which did not have a T1 A&E Department).
- Performance remains challenged across the country with England at 77.0% and the Black Country STP at 83.2%.
- DToC rates remain low at 1.65% (excluding Social Care) 3.13% (total including Social Care) for August indicating Trust is continuing to manage patient flow.
- Packages of care remain an issue due to capacity in the domiciliary care market & the withdrawal of 2 existing service providers from the market. The A&E Delivery Board has funded schemes to enable patients to be discharged and supported at home for 7 days until a package of care can be put in place.
- 160 ambulances breached the 30-60 minute ambulance handover target during September and 5 ambulances breached the >60 minutes.
- There was one breach of the 12 hr standard in September bringing the total year to date to 6.

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. The Royal Wolverhampton NHS Trust (RWT) 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:***
  - August nationally published (provisional) performance is 4.0% for the CCG and 2.24% for RWT.

- STP performance is 62.3% and England is 85.9%
- CCG performance is reliant on the situation at RWT, neither the CCG nor Trust will see performance return to standard until the backlog has reduced.
- Implementation of STP Breast diversion scheme from July; practices where alternative provider (Dudley/Walsall) is within 3 miles of the practice were asked to discuss with patients the option to refer to Dudley or Walsall rather than RWT.
- From 9th September STP agreed diversion at source for RWT receiving referrals from practices in the scheme to refer directly to Walsall/Dudley
- Wolverhampton CCG Breast Pain pathway commenced in August.
- As at the time of reporting RWT is currently (17/10/19) booking new referrals at day 16
- RWT's backlog position which has reduced from 539 at 1st July to 32.
- Recovery to standard is currently on track, as forecast, for end Q3.
- Discussions are taking place to agree next steps to ensure sustainable performance across RWT, Dudley and Walsall.



- ***All Cancer standards – issues and actions:***
  - Remedial action plan is in place and reviewed monthly with revised improvement trajectories agreed.
  - Capacity in August was affected by the summer period.

- The backlog of patients waiting over 62 day is remaining relatively steady with the largest cohorts of patients being on the Urology and Colorectal pathways followed by Breast.
- The Trust has successfully recruited 8 additional radiographers, 6 of which have commenced in post with the remaining 2 due to start before the end of the year.
- The Trust is running monthly "super clinics" in Breast and Gynaecology.
- The first biopsy list took place in August, the effect of which should be a reduction in the prostate cancer pathway by a minimum of 7 days by moving Template Biopsy to an outpatient procedure.
- Current waiting time for an outpatient Hysteroscopy is down to 13 days in August from 19 in June.

Cancer performance data for August 19

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	78.67%	74.97%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	2.24%	4.00%
EB8	31 Day (1st Treatment)	96%	88.05%	93.28%
EB9	31 Day (Surgery)	94%	75.76%	85.71%
EB10	31 Day (anti-cancer drug)	98%	100.0%	100.0%
EB11	31 Day (radiotherapy)	94%	82.64%	89.47%
EB12	62 Day (1st Treatment)	85%	59.60%	58.18%
EB13	62 Day (Screening)	90%	59.46%	50.00%
EB14	62 Day (Consultant Upgrade)	No Standard	77.27%	76.55%

3.1.4. E.A.S4 and E.A.S5 – MRSA and Clostridium Difficile

- The were no MRSA for the CCG during August, however the breach in June has already taken the CCG over the zero threshold for the year.
- C.Diff cases have increased over the last few months with the August Public Health data confirming :
  - CCG = 6 cases (against threshold of 4), 21 YTD
  - RWT = 7 cases (against threshold of 4), 22 YTD
- The RWT figures are for healthcare associated cases only; with all cases (including community associated) total cases for August was 9, 35 YTD.

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

3.2.1. Mental Health

3.2.2. E.H.12: Out of Area Placements (STP target)

- The national Out of Area Placements (OOA) publication report captures the details of all inappropriate out of area placements in acute adult mental health inpatient services in England from both NHS and independent providers.
- The CCG has breached the local threshold for July 2019 (410 bed days against a 296 threshold); however this indicator is assessed against 12 rolling month activity and an STP threshold.
- CCG = 410 bed days (114 above threshold), STP = 904 (136 within threshold).
- Bed capacity across the Black Country is sufficient to meet needs, however underutilised, so beds are sold out of area.

3.2.3. E.H.4: Early Intervention in Psychosis (1st episode within 2 weeks)

- The validated published figures for August confirm that both the CCG and Black Country Partnership failed to achieve the 53% target with no patients meeting 2 weeks (0%).
- With the exception of Walsall CCG, all the CCGs within the Black Country STP were unable to achieve standard. Performance is affected by small number variation; the total number of patients for August within the STP starting treatment within 2 weeks totalling 6 (out of 12 patients).

3.2.4. E.A.3 - IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence).

- Performance is assessed against a quarterly performance target of 4.94% in Q1, 5.13% Q2, 5.31% Q3 and 5.5% Q4
- NHS England published figures are based on a rolling quarter and confirm the July19 performance as 5.82% and above the Q2 target of 5.31%.
- Updated prevalence figures (denominator for indicator) have been made available, however as the figures have seen a wide increase, analytical tools will be made available to CCGs to map current trajectories to the latest prevalence estimates over the next 5 years to reduce sudden increases and potential unachievable goals.
- The Long Term Plan updates have also confirmed that from 2020/21 performance will be accessed via STP level numbers of patients and not percentage against prevalence estimates.

3.2.5. E.H.13 – Physical Health Checks for People with a Severe Mental Illness

- Q2 performance achieved 42.07% against a planned trajectory of 45%.
- CCG is currently under the planned activity and this has been escalated to primary care colleagues.
- Lower performing areas remain tests that include a more invasive procedure (blood taking), and the CCG are investigating implementation of Point of Care Testing within practices which will be less invasive for patients with no waiting for results.
- Performance is assessed on a rolling 12 month basis with the National requirement to achieve 60% in 2019/20 which will be assessed based on March 2020 position.

3.2.6. E.B.S3 – CPA Follow Up within 7 days of Discharge

- Performance is assessed nationally each Quarter, however local monthly data has indicated that there has been a decrease in performance during August 19 (84.8% against 95% target).
- The Trust have confirmed that this relates to 2 individual patients (1 x No Fixed Abode, 1 x Absent Without Leave).
- Performance is discussed monthly with the Trust at the Contract Review Meeting with further assurance requested around correct contact details for patients before discharge.

4. RISK and MITIGATION

The CCG was required to resubmit a plan which demonstrates £5.95m risk which currently is fully mitigated based on the assumption that the Black Country CCG Risk share agreement 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 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 reduced 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	£19.128	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. Concerns regarding mobilisation of the re-procured Dermatology service were considered. It was noted that the related risks are being overseen by Commissioning Committee.

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 Office
Date: 30th October 2019

Wolverhampton CCG Performance against the NHS Constitution Standards

Finance and Performance (F&P) 2019/20 - Wolverhampton CCG (06a)

Current Month: Aug-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	Aug	92.0%	85.89%	↓	↓	87.47%													
		CCG Validated		Aug	92.0%	85.89%	↓	↓	87.47%													
		RWT		Aug	92.0%	84.51%	↓	↓	86.08%													
		Black Country STP		Aug	92.0%	89.52%	↓	↓	91.61%													
		National		Aug	92.0%	84.95%	↓	↓	86.07%													
EB4	Diagnostic Waits (6wks)	CCG Provisional	Mth	Aug	1.0%	2.69%	↓	↓	1.13%													
		CCG Validated		Aug	1.0%	2.68%	↓	↓	1.13%													
		RWT		Aug	1.0%	3.10%	↓	↓	1.19%													
		Black Country STP		Aug	1.0%	1.74%	↓	↑	1.52%													
		National		Aug	1.0%	4.32%	↓	↓	3.85%													
EB5	A&E (Waits Within 4hrs)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		No Data	95.0%	-																
		RWT		Sep	95.0%	88.53%	↑	↑	88.29%													
		Black Country STP		Sep	95.0%	83.19%	↓	↓	84.42%													
		National		Sep	95.0%	76.99%	↓	↓	84.54%													
EB6	Two Week Waits (2WW)	CCG Provisional	Mth	No Data	93.0%	66.85%			66.85%													
		CCG Validated		Aug	93.0%	74.97%	↓	↑	72.60%													
		RWT		Aug	93.0%	78.67%	↑	↑	74.55%													
		Black Country STP		Aug	93.0%	88.28%	↓	↓	89.36%													
		National		Aug	93.0%	89.36%	↓	↓	90.22%													
EB7	Two Week Waits (2WW) Breast Symptoms	CCG Provisional	Mth	No Data	93.0%	-			-													
		CCG Validated		Aug	93.0%	4.00%	↓	↓	6.10%													
		RWT		Aug	93.0%	2.24%	↓	↑	2.78%													
		Black Country STP		Aug	93.0%	65.25%	↓	↑	70.48%													
		National		Aug	93.0%	85.94%	↑	↑	79.95%													
EB8	31 Day Cancer Treatment	CCG Provisional	Mth	No Data	96.0%	-			-													
		CCG Validated		Aug	96.0%	93.28%	↓	↑	91.77%													
		RWT		Aug	96.0%	88.05%	↓	↑	87.37%													
		Black Country STP		Aug	96.0%	93.85%	↓	↑	94.25%													
		National		Aug	96.0%	96.09%	↓	↑	96.18%													
EB9	31 Day Cancer Treatment (Surgery)	CCG Provisional	#N/A	No Data	94.0%	-			-													
		CCG Validated		Aug	94.0%	85.71%	↓	↓	84.52%													
		RWT		Aug	94.0%	75.76%	↓	↑	75.00%													
		Black Country STP		Aug	94.0%	91.36%	↓	↓	90.56%													
		National		Aug	94.0%	91.46%	↓	↓	91.68%													
EB10	31 Day Cancer Treatment (anti cancer drug)	CCG Provisional	Mth	No Data	98.0%	-			-													
		CCG Validated		Aug	98.0%	100.00%	↑	↑	99.24%													
		RWT		Aug	98.0%	100.00%	→	↓	99.59%													
		Black Country STP		Aug	98.0%	100.00%	↑	↑	98.76%													
		National		Aug	98.0%	99.38%	↑	↑	99.21%													
EB11	31 Day Cancer Treatment (Radiotherapy)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		Aug	94.0%	89.47%	↓	→	90.58%													
		RWT		Aug	94.0%	82.64%	↓	↓	89.26%													
		Black Country STP		Aug	94.0%	88.82%	↓	↓	84.76%													
		National		Aug	94.0%	96.27%	↓	↓	96.62%													
EB12	62 Day Cancer Treatment 1st Definitive Treatment	CCG Provisional	Mth	No Data	85.2%	-			-													
		CCG Validated		Aug	85.2%	58.18%	↓	↓	64.43%													
		RWT		Aug	85.2%	59.60%	↓	↓	61.16%													
		Black Country STP		Aug	85.2%	72.14%	↓	↓	75.56%													
		National		Aug	85.2%	78.54%	↑	↑	77.93%													

Current performance is as published validated national data for Wolverhampton CCG unless indicated otherwise, i.e. only available at Trust level.

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		Aug	90.0%	50.00%	↓	↓	70.21%													
		RWT		Aug	90.0%	59.46%	↓	↓	73.04%													
		Black Country STP		Aug	90.0%	88.24%	↑	↓	89.37%													
		National		Aug	90.0%	87.75%	↑	↑	87.09%													
EB14	62 Day Cancer Treatment (Consultant Upgrade)	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		Aug	0.0%	79.55%	↑	↑	76.99%													
		RWT		Aug	0.0%	77.27%	↑	↑	74.19%													
		Black Country STP		Aug	0.0%	80.50%	↓	↑	81.21%													
		National		Aug	0.0%	83.48%	↑	↑	83.07%													
EB18	52 Week Waiters (RTT)	CCG Provisional	Mth	Aug	0	0	→	→	0													
		CCG Validated		Aug	0	0	→	→	0													
		RWT		Aug	0	0	→		0													
		Black Country STP		Aug	0	1	→	↑	11													
		National		Aug	0	1366	↓	↓	5702													
EH1	IAPT Programme: Treated within 6 wks	CCG Provisional	Mth	No Data	75.0%	-																
		CCG Validated		Jul	75.0%	79.07%	↓	↓	83.33%													
		BCPFT		Jul	75.0%	86.52%	↓	↓	88.42%													
		Black Country STP		Jul	75.0%	85.71%	↓	↑	85.71%													
		National		No Data	75.0%	-																
EH2	IAPT Programme Referral to Treatment (18wks)	CCG Provisional	Mth	No Data	95.0%	-																
		CCG Validated		Jul	95.0%	97.67%	↓	↑	97.92%													
		BCPFT		Jul	95.0%	98.88%	↑	↑	98.60%													
		Black Country STP		Jul	95.0%	97.84%	↓	↑	97.78%													
		National		No Data	95.0%	-																
EH3_C1	IAPT Completed Appointments versus Single Treatment Appointments	CCG Provisional	Mth	No Data	TBC	-																
		CCG Validated		Jul	TBC	63.24%	↑	↓	51.61%													
		BCPFT		Jul	TBC	77.91%	↓	↓	105.17%													
		Black Country STP		Jun	TBC	88.39%	↑	↓	81.72%													
EH3_C2	IAPT Mean Number of Treatments	CCG Provisional	Mth	No Data	TBC	-																
		CCG Validated		Jul	TBC	6.40	↑	→	5.95													
		BCPFT		Jul	TBC	6.10	↑	↓	5.90													
		Black Country STP		Jun	TBC	25.50	↓	↑	27.10													
EH3_C3	IAPT First to Second Treatment over 28 days Rate	CCG Provisional	Mth	No Data	TBC	-																
		CCG Validated		Jul	TBC	30.61%	↓	↑	34.10%													
		BCPFT		Jul	TBC	63.33%	↑	↓	87.15%													
		Black Country STP		Jun	TBC	65.13%	↓	↓	65.89%													
EH3_C4	IAPT First to Second Treatment over 90 days Rate	CCG Provisional	Mth	No Data	TBC	-																
		CCG Validated		Jul	TBC	14.29%	↓	↑	15.61%													
		BCPFT		Jul	TBC	43.33%	↑	↓	57.83%													
		Black Country STP		Jun	TBC	43.28%	↓	↓	44.17%													
EH4	EIP 1st Episode (within 2 wks)	CCG Provisional	Mth	Aug	56.0%	0.00%	↓	↓	66.67%													
		CCG Validated		Aug	56.0%	0.00%	↓	↓	66.67%													
		BCPFT		Aug	56.0%	0.00%	↓	↓	46.15%													
		Black Country STP		Aug	56.0%	50.00%	↓	↓	55.71%													
		National		Jul	56.0%	77.42%	↑	↑	76.06%													
EH9	CYP Access Rates	CCG Provisional	Mth	No Data	34% Full Yr	1.94%	↓															
		CCG Validated		Jul	34% Full Yr	4.21%	↑		17.96%													
		BCPFT		Jul	34% Full Yr	-																
		Black Country STP		Jul	34% Full Yr	2.44%	↓		3.13%													
		National		No Data	34% Full Yr	-																
EAS1	Dementia Diagnosis (65+)	CCG Provisional	Mth	No Data	71.4%	-																
		CCG Validated		Aug	71.4%	73.42%	↑	↑	72.93%													
		Primary Care		No Data	71.4%	-																
		Black Country STP		Aug	71.4%	66.66%	↑	↑	66.48%													
		National		No Data	71.4%	-																
EAS2	IAPT Recovery Rate (Moving to Recovery)	CCG Provisional	Mth	No Data	50.0%	-																
		CCG Validated		Jul	50.0%	47.62%	↑	↓	48.20%													
		BCPFT		No Data	50.0%	-																
		Black Country STP		Jul	50.0%	52.65%	↑	↓	53.02%													
		National		No Data	50.0%	-																

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
EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		Aug	0	0	⇨	⇨	1													
		RWT		Aug	0	0	⇨	⇨	0													
		Black Country STP		Aug	0	0	⇨	⇧	4													
		National		No Data	0	-																
EAS5	Minimise rates of Clostridium Difficile	CCG Provisional	Mth	No Data	CCG: 48 Full Yr	-																
		CCG Validated		Aug	CCG: 48 Full Yr	6	⇩	⇩	21													
		RWT		Aug	RWT: 40 Full Yr	7	⇩	⇩	22													
		Black Country STP		Aug	STP: 288 Full Year	20	⇧	⇧	115													
		National		No Data	TBC	-																
EBS1	MSA Breaches	CCG Provisional	Mth	No Data	0	0			1													
		CCG Validated		Aug	0	0			1													
		RWT		Aug	0	0			0													
		BCPFT		Aug	0	0			0													
		Black Country STP		Aug	0	14			108													
		National		Aug	0	1199			6637													
EBS5	12 hr Trolley Waits	CCG Provisional	Mth	No Data	0	-																
		CCG Validated		No Data	0	-																
		RWT		Aug	0	1	⇨	⇨	6													
		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		Jul	0	0	⇨	⇨	0													
		Black Country STP		No Data	0	-																
		National		No Data	0	-																
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%																
		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	Sep	95%	100.00%			100.00%													
		CCG Validated		Jun	95%	100.00%			100.00%													
		BCPFT		Jun	95%	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	Sep	95%	93.75%			91.67%													
		CCG Validated		Jun	95%	90.00%			90.00%													
		BCPFT		Jun	95%	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% by Yr End	-																
		CCG Validated		Sep	60% by Yr End	42.07%			40.68%													
		Primary Care		No Data	60% by Yr End	-																
		Black Country STP		No Data	60% by Yr End	-																
		National		No Data	60% by Yr End	-																
EA3	IAPT Roll Out Access Rate	CCG Provisional	Mth	No Data	Q1 = 4.94%, Q2 = 5.13%, Q3 = 5.31%, Q4 = 5.50%	-																
		CCG Validated		Jul		5.82%	⇧	⇧	22.86%													
		BCPFT		No Data		-																
		Black Country STP		Jul		8.15%	⇧	⇧	7.45%													
		National		No Data		-																
EH12	OoAPs - Out of Area Placements (STP target)	CCG Provisional	Mth	No Data	STP Wide Traj 978 by Yr End	-																
		CCG Validated		Jul	STP Wide Traj 978 by Yr End	410	⇩	⇩	1400													
		Black Country STP		Jul	STP Wide Traj 978 by Yr End	904	⇩		3129													
		National		No Data	STP Wide Traj 978 by Yr End	-																

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
ED16	% of the population with access to online consultations	CCG Provisional	Mth	No Data	75.2% Yr End	-																
		CCG Validated		No Data	75.2% Yr End	-																
		Black Country STP		No Data	75.2% Yr End	-																
		National		No Data	75.2% Yr End	-																
ED17	% Extended Access Appointmnet Utilisation	CCG Provisional	Mth	No Data	85% Yr End	-																
		CCG Validated		No Data	85% Yr End	-																
		Black Country STP		No Data	85% Yr End	-																
		National		No Data	85% Yr End	-																
ED18	% population that the Urgent Care System (NHS111) can directly book appointments for in contracted extended hours	CCG Provisional	Mth	No Data	100% Yr End	-																
		CCG Validated		No Data	100% Yr End	-																
		Black Country STP		No Data	100% Yr End	-																
		National		No Data	100% Yr End	-																
EK1a	Rate (per million GP Registered Population) Inpatient Care for People with LD or Autism (CCG Commissioned)	CCG Provisional	Mth	No Data	20.02 by Yr End	-																
		CCG Validated		No Data	20.02 by Yr End	-																
		Black Country STP		No Data	20.02 by Yr End	-																
		National		No Data	20.02 by Yr End	-																
EK1b	Rate (per million GP Registered Population) Inpatient Care for People with LD or Autism (NHSE Commissioned)	CCG Provisional	Mth	No Data	20.02 by Yr End	-																
		CCG Validated		No Data	20.02 by Yr End	-																
		Black Country STP		No Data	20.02 by Yr End	-																
		National		No Data	20.02 by Yr End	-																
EO1	% of Children Waiting more than 18 weeks for a Wheelchair	CCG Provisional	Qtr	No Data	93%	-																
		CCG Validated		Sep	93%	97.87%			98.86%													
		Black Country STP		Jun	93%	95.79%			95.79%													
		National		No Data	93%	-																
EK3	AHCs delivered by GPs for patients on the Learning Disability Register	CCG Provisional	Mth	No Data	14.3% Yr End	-																
		CCG Validated		Sep	14.3% Yr End	46.51%																
		Black Country STP		No Data	14.3% Yr End	-																
		National		No Data	14.3% Yr End	-																
EN1	Cumulative number of Personal Health Budgets (PHBs)	CCG Provisional	Mth	No Data	320 Yr End	-																
		CCG Validated		Sep	320 Yr End	262																
		Black Country STP		No Data	320 Yr End	-																
		National		No Data	320 Yr End	-																

Finance and Performance (F&P) 2019/20 - Wolverhampton CCG (06a)

Current Month: Aug-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

RAG ratings based on % variance (+ or -) from Plan

R = More than 5.1% variance from Plan

A = between 2.6% and 5% from Plan

G = Less than or equal to 2.5% from Plan

Activity Against Plan

*Note : The Wolverhampton CCG Activity and Plan excludes Outpatient activity that is not paid for or contracted as OP attendances, but has to be recorded through SUS. This can vary the RAG rating status for the CCG if activity is not excluded at NHSE/I reporting level.

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
EM7	Total Referrals made for a First Outpatient Appointment (G&A)	CCG Provisional	Mth	Aug	Seasonal Variation	6196	↓	↓	37365													
		CCG Validated		Aug	Seasonal Variation	4199	↓	↓	23455													
EM8	Consultant Led First Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Aug	Seasonal Variation	7899	↓	↓	40635													
		CCG Validated		Aug	Seasonal Variation	7899	↓	↓	40661													
EM9	Consultant Led Follow-Up Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Aug	Seasonal Variation	13439	↓	↓	72710													
		CCG Validated		Aug	Seasonal Variation	13439	↓	↓	72805													
EM10	Total Elective Spells (Specific Acute)	CCG Provisional	Mth	Aug	Seasonal Variation	2551	↓	↓	13798													
		CCG Validated		Aug	Seasonal Variation	2551	↓	↓	13791													
EM11	Total Non-Elective Spells (Specific Acute)	CCG Provisional	Mth	Aug	Seasonal Variation	2217	↓	↓	12055													
		CCG Validated		Aug	Seasonal Variation	2217	↓	↓	12054													
EM12	Total A&E Attendances (Excl. Planned Follow Up Attendances) *Awaiting confirmation of Vocare submissions	CCG Provisional	Mth	Aug	Seasonal Variation	10126	↓	↓	52675													
		CCG Validated		Aug	Seasonal Variation	10126	↓	↓	52700													
EM12a	Type 1 A&E Attendances (Excluding Planned Follow Up Attendances)	CCG Provisional	Mth	Aug	Seasonal Variation	7875	↓	↑	40654													
		CCG Validated		Aug	Seasonal Variation	7875	↓	↓	40675													
EM18	Number of completed admitted RTT pathways	CCG Provisional	Mth	Aug	Seasonal Variation	990	↓	↓	5501													
		CCG Validated		Aug	Seasonal Variation	990	↓	↓	5501													
EM19	Number of completed non-admitted RTT pathways	CCG Provisional	Mth	Aug	Seasonal Variation	4911	↓	↓	26300													
		CCG Validated		Aug	Seasonal Variation	4911	↓	↓	26300													
EM20	Number of new RTT pathways (clock starts)	CCG Provisional	Mth	Aug	Seasonal Variation	7764	↓	↓	41610													
		CCG Validated		Aug	Seasonal Variation	7764	↓	↓	41609													
EM21	Consultant Led Outpatient Attendances with Procedures (Specific Acute)	CCG Provisional	Mth	Aug	Seasonal Variation	1944	↓	↑	10473													
		CCG Validated		Aug	Seasonal Variation	1944	↓	↓	10472													
EM22	Average number of G&A beds open per day (specific acute)	CCG Provisional	Mth	No Data	Seasonal Variation	-																
		CCG Validated		No Data	Seasonal Variation	-																

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WOLVERHAMPTON CCG

GOVERNING BODY MEETING
12 November 2019

Agenda item 13

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 3 September 2019 and 1 October 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 meetings of the Primary Care Commissioning Committee held on 3 September 2019 and 1 October 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	Primary Care Quality Report 5 practices received an infection prevention audit in September 2019. There was an improvement from the previous year with an increase from 94% to 97%. Primary Care Operational Group The Tettenhall Medical Practice consultation process in relation to the proposed closure of the Wood Road Surgery branch site continues.
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 3 September 2019 and 1 October 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 – 3 September 2019

2.1 Q1 Finance Report April – June 2019

2.1.1 The Director of Finance (WCCG), Tony Gallagher, advised the Committee that the revised report format showed a more granular analysis of spend within primary care and included areas outside of delegated commissioning such as the Prescribing Incentive Scheme.

2.1.2 The current status showed as breakeven which was largely a consequence of not having received all claims in relation to the last financial year. The intention was to create a non-recurrent reserve against which to plan non-recurrent schemes. It was noted that it was likely that primary care would underspend again this financial year with a probable value of £1m however this would become clearer after the end of August when all claims were received.

2.2 Primary Care Quality Report

2.2.1 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:

- An information governance issue was raised relating to blood forms being given to the wrong patient.
- Breaches reported to the CCG by the phlebotomy service at the hospital.
- Work being undertaken with Public Health to increase the take up of under 65 years flu vaccines.
- A Wolverhampton practice that has been identified by the Care Quality Commission as requiring improvement was being monitored and supported going forward.
- The Practice Nurse Strategy for the Black Country was due to be launched on 3 October 2019 at Himley Hall with national speakers in attendance.

2.3 **Primary Care Operational Management Group (PCOMG) Update**

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

- The Tettenhall Medical Practice consultation process in relation to the proposed closure of Wood Road Surgery branch site continues.
- Building work at East Park was on track to be completed by the end of the financial year.
- A meeting has taken place with the Care Quality Commission around some of the issues highlighted in the Quality report such as the support provided to the practices and the programme of inspections.

2.4 **Primary Care Contracting Update**

2.4.1 The Primary Care Contracts Manager (WCCG), Gill Shelley, presented a report to inform the Committee of a request to merge Parkfields Medical Centre with Grove Medical Practice, part of the Health and Beyond Group. Benefits to patients were noted as increased access, patient choice of clinician, full range of enhanced services and appointments at a variety of locations. The public and patient engagement process undertaken was outlined to the Committee.

2.4.2 The Committee approved the merger application.

2.5 **Milestone Review Board (Q1 2019/20)**

2.5.1 The Head of Primary Care (WCCG), Sarah Southall, informed the Committee that the Milestone Review Board had met in April and the final assurance report was based on Quarter 1 which was then considered at the July meeting. Therefore the updated assurance pack appended was based on the outputs of the July Board meeting.

2.5.2 Primary Care Assurance Pack (Q1 2019/20)
Report highlights included the progress that had been made with regards to digital transformation with online and video consultation continuing to be rolled out to practices. Currently 70% of practices have this functionality with a target of 100% by December 2019.

2.5.3 GP at Hand Briefing Note
The report on Digital First Primary Care stated that following a consultation led nationally from June to 23 August 2019, there was a call to action shared with Clinical and Executive Directors in regard to the contractual change that NHS England were exploring.

2.5.4 It was noted that there is a view at national level that primary care should be digital first rather than face to face appointments. The Committee were informed that

practices in London and now Birmingham were currently marketing and providing digital services which would be open to taking on Wolverhampton patients, this was being monitored closely. A further update on Digital First Primary Care would be provided to Committee in October 2019.

2.5.5 Wolverhampton Primary Care Strategy 2019-2021
The Strategy had been updated and, given the time available, it was agreed that the report should be read by members and any feedback shared with the Head of Primary Care.

2.6 **STP Primary Care Strategy**
It was agreed that the report should be read by members and any feedback shared with the Head of Primary Care.

2.7 **STP GP Forward View Programme Board Update**
The Committee noted that many of the items discussed at the STP GP Forward View Programme Board had already been covered at the Committee meeting. The Head of Primary Care stated that a synopsis of the discussion from the Board would be circulated to members.

2.8 **Primary Care Commissioning Committee (Private) – 3 September 2019**

2.8.1 The Committee met in private to receive updates on the Wolverhampton Local Medical Committee meeting, patient list sizes and GP Resilience Funding.

Primary Care Commissioning Committee – 1 October 2019

2.9 **Primary Care Quality Report**

2.9.1 The Primary Care Quality Assurance Co-ordinator (WCCG), Liz Corrigan, provided the Committee with a summary of the report which gave detail around a number of issues including the following:

- 5 practices received an infection prevention audit in September 2019. There was an improvement from the previous year with an increase from 94% to 97%.
- The flu vaccine programme is underway with most practices having received their over 65 vaccine.
- A report on Friends and Family Testing which had been submitted to the Quality and Safety Committee would be circulated to members.

2.10 **Primary Care Operational Management Group (PCOMG) Update**

2.10.1 The Corporate Operations Manager (WCCG), Peter McKenzie, provided an update from the PCOMG meeting and highlighted the following areas of discussion:

- The Tettenhall Medical Practice consultation process in relation to the proposed closure of Wood Road Surgery branch site continues.
- Discussion had taken place around the development of the primary care contract review programme and assurance arrangements for Primary Care Networks.
- Wolverhampton Healthwatch had shared patient feedback collected from GP practices. Discussion had taken place as to how to best present the information and it was agreed that the information would be shared on a quarterly basis, with the next update due in January 2020.

2.11 **New Draft Communication and Engagement Strategy**

2.11.1 The Corporate Operations Manager (WCCG), Peter McKenzie, presented the draft Communications and Engagement Strategy for information.

2.11.2 The report provided a high level overview of the communications and engagement work to be undertaken and how it contributes to the commissioning cycle. Comments on the Strategy were invited as the report was in the draft stage.

2.12 **Digital First Primary Care Update**

2.12.1 The head of Primary Care (WCCG), Sarah Southall, provided a verbal update further to the submission of the Digital First report last month. It was noted that the consultation had since closed and Wolverhampton CCG had made a submission to the National Team in response to the consultation.

2.12.2 The Committee noted that a piece of work was being undertaken across the STP associated with the intended digital offer for Primary Care Networks for the CCG and the wider STP.

2.13 **Wolverhampton Primary Care Strategy 2019 – 2021**

2.13.1 The head of Primary Care (WCCG), Sarah Southall, advised that further to the submission of the early draft and final draft to the Committee in September, there had been further minor changes made. Updates would be provided to the Committee as part of the quarterly Milestone Review Board updates. A suggestion was made to include a glossary defining the abbreviations but otherwise the Committee were happy to approve the Strategy.

Primary Care Commissioning Committee (Private) – 1 October 2019

2.14.1 The Committee met in private to receive updates on feedback following the Wolverhampton Local Medical Committee Meeting, NHS Benchmarking Network Primary Care Report 2018, Proposed Primary Care Assurance Arrangements, a PMS Review Dispute and an application to join Royal Wolverhampton NHS Trust Primary Care Network (Vertical Integration).

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: 15 October 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)	**Sue McKie**	**15/10/19**

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WOLVERHAMPTON CCG

Governing Body
12 November 2019

Agenda item 14

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: 2.1.1 Annual General Meeting success 2.2.3 The future for CCGs in the Black Country and West Birmingham -Listening Exercise 2.2.4 Draft Communication and Participation Strategy
RECOMMENDATION:	• **Receive** and **discuss** this report • **Note** the action being taken
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG

	Improvement and Assessment Framework.

1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place September and October 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 **Annual General Meeting success –** Wednesday 18 September 2019
We were delighted to see over 70 patients and members of the public, along with CCG senior members, staff and patient representatives at the Molineux stadium for our AGM

The event began with a performance from Gazebo Theatre, who brought to life the Flu Fighters story; part of a campaign to increase the number of children who receive their nasal spray in Wolverhampton. We invited primary school children to attend the AGM to watch the performance. They were enthralled and vowed to become Flu Fighters themselves by getting their vaccine.

Dr Salma Reehana, Chair of Wolverhampton CCG, formally opened the AGM and attendees heard an overview of the work that had taken place during 18/19 and what the CCG's plans are for the future. You can view the presentation here. If you would like a copy of the presentation posted to you, please email wolccg.comms@nhs.net

We finished the afternoon with engagement on the NHS Long Term Plan and the feedback we received will be used to inform the plan.

2.1.2 **Press Releases**
Press releases since the last meeting have included:

October 2019

- EU Exit – Information for patients
- People in Wolverhampton asked to 'think pharmacy' this October half term
- Dr Doreen Tipton says Get the Flu Jab!
- Reminder to regularly check for signs of breast cancer
- AGM 2019 success
- Thousands urged to protect their health before deadly flu virus hits
- Split up with smoking this October
- Speak up this World Mental Health Day – Wolverhampton event
- Wolverhampton supports 'Every Mind Matters', the first national NHS mental health campaign

September 2109

- NHS Wolverhampton CCG appoints a new provider to manage the local Community Dermatology Service
- Flu Fighters set to return at Wolverhampton CCG's Annual General Meeting
- Flu Fighters return for The Battle of Planet Bogey
- Wolverhampton residents urged to know their numbers to combat high blood pressure and reduce their risk
- Tettenhall Medical Practice consultation drop-in event for proposed closure of Wood Road Branch Surgery

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 October included the following:

- EU Exit and continuity of medicines supply
- GPN Champions – call for Expressions of Interest
- Thrive into Work targets in sight
- WCCG appoints new provider to manage local Community Dermatology Service
- Cervical Screening Programme Conversion to HPV Primary Screening
- Breast Cancer awareness month
- Grants available for boilers, radiators and heating systems
- Practice vacancies
- Latest news from the BCWB STP
- Training and Events

2.2.3 The future for CCGs in the Black Country and West Birmingham -Listening Exercise

At the last Governing Body there was agreement to proceed with a listening exercise to seek the views of key stakeholders in relation to the future of the Black Country and West Birmingham CCGs.

Throughout October there have been events in each CCG area to listen to staff, member practices, public representatives and other stakeholders. The events have offered an opportunity to explain the local and national context in which change is being considered. There was detail on the options that have been considered and what the case for change might be for a move towards a single CCG. There was also detail on what some of the challenges might be to a single CCG before moving on to ask people to consider the following with regard to future CCG arrangements:

- What do you value from the current CCGs?
- What would good look like to you in terms of future CCG arrangements?
- Do you have any concerns in terms of future CCG arrangements?
- How might these concerns be resolved?

- What questions would you want answered before you could make a decision?

The feedback will prove invaluable in determining what the next steps should be and to inform a decision on whether we move to a formal consultation. The themes from these sessions is currently being analysed and will be presented to the Transition Board meeting on 14 November.

2.2.4 Draft Communication and Participation Strategy

WCCG Communications and Participation Team has now refreshed its Communications and Participation Strategy to align activity to support delivery of the NHSE Long Term Plan, the development of integrated care, and the growth of primary care networks and place-based care. This draft strategy sets out Wolverhampton CCG's priorities for communications and participation activity over the coming two years.

It lists our communications and participation principles, draws on our partnership working across the Black Country and beyond, and looks at the tools, techniques and channels we will use to deliver communications and participation.

This draft has been developed with the help of commissioners, CCG staff and CCG Lay Member for PPI.

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 **Phase 3 of the Harmonised Clinical Treatment Policy Project.**

Between Thursday 5 September and Friday 11 October, we engaged with clinical colleagues and the public regarding Phase 3a. This harmonised approach across Wolverhampton is to facilitate consistent, evidence-based policy development for planned patient care.

During this engagement period in Phase 3 treatment policies we asked for feedback from clinical colleagues to ensure our next phase of treatment policies are as clinically robust as possible for our local patients.

Draft policies and leaflets available online https://wolverhamptonccg.nhs.uk/contact-us/current-engagement-and-consultations/941-harmonised-clinical-treatment-policy-phase-3

4.2 **Have your say on proposed closure of GP branch surgery – Wood Road, Tettenhall Wood, Wolverhampton**

The consultation on the proposed closure of the branch surgery in Wood Road closed on Sunday 15 September by which time more than 1300 people had responded to the consultation survey.

A consultation report has been drafted outlining the activity undertaken during the consultation and the feedback received. On 30 October a panel of stakeholders, including HealthWatch; the practice PPG, Save Wood Road campaign group and local politicians, met to consider the report and provide assurance that it reflected what their members and constituents had been telling them.

Tettenhall Medical Practice will bring their response to the consultation to the PCCC on 5 November for the committee's consideration. The PCCC papers, including the consultation report are available on the CCG website https://wolvesnhs.moderngov.co.uk/ieListDocuments.aspx?CId=169&MId=1337&Ver=4

4.3 **Tell us about your experience of hospital eye services**
We are encouraging patients, carers and people who work in hospital eye services to share their experiences of hospital eye services as part of the 100 Voices campaign; a national campaign to improve ophthalmology services.

EyesWise is an NHS project that aims to save sight and improve lives. Since April 2018, work has been underway in hospital eye services across the country to streamline and speed up outpatient treatment for patients at highest risk of sight loss. The 100 Voices campaign looks to find out what it feels like to use those services.

People have until 30 November to share their experiences via this link: https://www.engage.england.nhs.uk/survey/hospital-eye-services/consultation/subpage.2019-06-18.1141929393/

4.4 WCCG Medicines of Limited Clinical Value - Updated Guidance
We are asking for people's views about a recent update of guidance published by NHS England on medicines which should not be regularly prescribed in your GP practice. The NHS is working on spending its money better. Research shows that some medicines can be replaced with other medicines that work better, are safer or cost less money.

NHS England has been working with clinical commissioners, pharmacists and other services to help the NHS spend money better, and to give patients better care. Together, they came up with a list of eight medicines and medicinal products that should not be prescribed regularly in your GP practice. For the list please go to https://wolverhamptonccg.nhs.uk/contact-us/current-engagement-and-consultations/969-wccg-medicines-of-limited-clinical-value-updated-guidance

Please take a few minutes to complete the survey and let us know what you think.

4.5 PPG Chairs and Citizen Forum

PPG Chair meetings are now conducted at Primary Care Network (PCN) level with variable attendance; representation from practices is wider than was previously seen at the bi-monthly city wide meeting but there is still work to do to increase attendance. CCG officers are providing support to the PCN Clinical Directors to manage and develop these meetings which are at varying stages of progress.

Discussions have taken place relating to the production of a Newsletter to inform our Citizens Forum representatives, this is now in hand. Alongside this we are also due to review and ratify their current contact details.

The CCG AGM in September was well attended by patient representatives, a number of which had questions for the Executive Team.

5 LAY MEMBER MEETINGS – attended:

5.1 Primary Care Commissioning Committees (Public and Private)
CCG Governing Body
CCG Governing Body Development
Strategic communications
1:1 meetings with CCG Officers
1:1 meeting with Patient representative
Engagement Cycle
Black Country Non-Executive Directors (NED) meetings Dudley and Walsall
SAS Appeals
Wolverhampton Total Health PPG Chairs PCN Meeting
Wolverhampton North Network PPG Chairs PCN meeting
Unity PPG Chairs PCN 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: 30 October 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

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**n/a**	
Public / Patient View	**Sue McKie**	**30 October 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**	**30 October 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

Communications and Participation Strategy

2019/20

Introduction

This strategy sets out Wolverhampton CCG's priorities for communications and participation activity over the coming two years. It looks at the context in which we will deliver communications and participation, including the delivery of the NHSE Long Term Plan, the development of integrated care, and the growth of primary care networks and place-based care.

It also lists our communications and participation principles, draws on our partnership working across the Black Country and beyond, and looks at the tools, techniques and channels we will use to deliver communications and participation.

We are using this strategy to build on our achievements over the past five years. During this time, we have honed our processes and provided clear, timely information to our many stakeholders and audiences through multiple channels. We have also developed trusted processes for engaging and consulting local people and communities, our staff, GP members and providers about what matters to them.

Most importantly, we have embedded a culture of participation within the CCG so that all our staff understand the importance of public and patient involvement in our commissioning decisions.

This is activity that has helped make Wolverhampton an outstanding CCG for four successive years and we believe it will continue to support our activity over the coming two years as we work with or partners to integrate health and social care in Wolverhampton and across the Black Country.

Purpose of our Communications and Participation Strategy

- Outline our communications and engagement priorities for the next two years
- Uphold and promote Wolverhampton CCG's vision, values and organisation priorities, in particular, the delivery of its operating plan
- Support the CCG in delivering our commitment to partners in the Black Country integrated care system
- Support the development of place-based care in Wolverhampton
- Demonstrate how we will involve local people and communities, colleagues, GP members and providers, with an emphasis on the needs of hard to reach groups
- Set out how we will fulfil our statutory duties
- Summarise our communications and engagement processes and channels

A changing NHS

We have developed this communications and participation strategy against a background of major changes to the way the health service works. The NHS England Long Term Plan, released in January 2019, set out a pathway for integrating care nationally, regionally and locally. Key elements for Wolverhampton CCG are:

- Black Country integration – more specialist services that can be delivered best at scale, via the Sustainability and Transformation Partnership (STP) and the Black Country Joint Commissioning Committee (JCC).

- Wolverhampton place-based care – shifting towards an Integrated Care Alliance (ICA) that will bring health, social care, community and voluntary organisations together to achieve improved health and wellbeing.

- Primary care networks – bringing GP practices together to provide more services in the community to a population of circa 30,000-50,000 people. PCNs are the building blocks of place-based care and key to preserving the integrity of NHS service provision.

Transforming primary care

Over the next two years, a key focus for our participation and communications activity will be the development of PCNs as they become the nerve centres of the Wolverhampton Integrated Care Alliance – our model for place-based care.

We will support the development of PCNs and their capacity to deliver more services in primary and community settings in collaboration with social care partners. We will do this through a range of channels (see p14) including surveys and face-to-face engagement with Wolverhampton residents to secure feedback on what matters to them when it comes to the provision of local healthcare. We have also adjusted our Participation Framework to take account of the changing role of practice-based Patient Participation Groups as they work within PCNs (see p12).

The feedback we receive will be used to shape our commissioning intentions and provide residents in Wolverhampton with a seamless healthcare journey, closer to home, making sure they receive the right care, at the right time, in the right place.

Our initial engagement around PCNs will focus on people's current experience of NHS services, what they feel needs improving and how they would like to access services in the future. Therefore, we will also be able to use participation feedback to shape our digital services agenda.

Our communications and participation principles and objectives

A set of principles underpins everything we do, guides our work and sets the standards for the relationships the CCG has with all its stakeholders. These principles are:

Trust and know-how
We will engender confidence and provide reassurance that we are good custodians of the local NHS. We will always explain who we are and what we do. The CCG's website will be a 'one-stop shop' for all the CCG's documents, activities and participation opportunities.

Timely and easy-to-understand
We will communicate in a timely manner using easy-to-understand language

Participation wherever possible
We will involve people where reasonably possible, promoting opportunities for people to get involved and arranging them to suit different interests and lifestyles. We will always use feedback to help us make decisions and show people how they have influenced the CCG.

Quality surveillance
We will gather patient experience through all that we do, supporting the CCG to act and respond in line with its duties.

Inclusive
We are committed to equality and diversity in all aspects of employment and service delivery. We will work towards eliminating discrimination, advancing equality of opportunity, and fostering good relations in the course of our work. Wherever possible, we focus on understanding the needs of hard to reach groups and community.

Working together, not in competition
We will work with our partners and share knowledge and experiences to help guide our work. The CCG and its partners will always aim to speak with one voice. This is especially important given the development of the Black Country Integrated Care System and the Wolverhampton Integrated Care Alliance and we will fulfil our commiment to both.

High quality and fulfilling statutory duties
Our communications and participation will meet statutory requirements, such has the NHS Act 2006, section 242 (duty to engage on changes to services), along with industry best practice, such as NHS Institute for Innovation and Improvement engagement cycle.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how CCGs will function. These amendments include two complementary duties for CCGs with respect to patient and public participation.

These principles ensure all our communications and participation activity is of the high standard that local people, our staff, members and other stakeholders expect of the NHS in Wolverhampton. They frame the way in which we report our communication and participation activity to the NHS, our Governing Body and local people and they support us in achieving an 'outstanding' rating from NHS England.

Working in Partnership

The progress of integrated care is putting greater emphasis on our partnership working.

- Sustainability and Transformation Partnership – bringing together health and social care partners across the Black Country
- Black Country Joint Commissioning Committee – working with neighbouring CCGs to commission services at scale
- Better Care Fund – redesigning care pathways and promoting integration to allow health and care in Wolverhampton to work more closely together pooling budgets where possible
- Integrated Care Alliance and Primary Care Networks – shifting resources out of hospital so more people are cared for at home and in their community.
- Healthwatch, voluntary sector, housing and patient groups

Our communications and engagement also need to be delivered in partnership as set out in our principles. We already contribute to the Black Country and West Birmingham STP communications and engagement activity

The STP is composed of 18 NHS and local authority organisations working together to provide better integrated and improved health and social care for people living in Wolverhampton, Walsall, Dudley, Sandwell and West Birmingham.

Communications and engagement leads from the different partner organisations meet regularly and leadership for communications and engagement activities for the different work streams has been allocated to the leads from the different organisations. The communications and engagement lead from Wolverhampton CCG supports the mental health work stream

All partners have signed up to a communications agreement, called a concordat, to ensure consistent messages about the STP are circulated across the Black Country and West Birmingham. All messages are based on the following principles:

- Partnership
- Innovation
- Local community
- Involving local people
- Better health and care.

It is this collaborative approach to communications and participation that ensures the success of our activities.

The STP and local care alliances are also in the process of developing a communications and engagement strategy.

Participation and communications objectives 2019-21

Continue to develop our reputation with partners, GP members, patients and public as a high performing organisation that is responsive to patient need and trusted to deliver high quality services and value for money.

Build continuous and meaningful engagement with our stakeholders using effective two way channels including surveys, formal consultation, engagement events, publications and online/digital tools. Ensure we are listening to our hard to reach groups and communities. Use the feedback we receive to inform our decisions.

Raise awareness of the CCG's activities including our work in partnership with the Black Country and West Birmingham STP and Wolverhampton ICA.

Use our communications and engagement to support Wolverhampton residents in making healthy choices by providing accessible information and guidance.

Provide advice and support for CCG staff to support their engagement and communications with stakeholders as part of the CCG's commissioning process.

Stakeholders

This strategy will oversee how we interact with our five main stakeholder groups:

- **Staff -** everyone who is employed by us, or who works alongside us, such as CSU staff or external consultants.
- **GP members -** GPs, Practice Managers, Practice Nurses and support staff working within the CCG's 40 member practices.
- **Commissioning partners –** including City of Wolverhampton Council and other Black Country JCC, STP and Better Care Fund partners.
- **Public bodies, individuals, voluntary/ community groups, third sector and providers** we work with in carrying out our statutory duties and transforming health and social care.
- **Patients and public -** current and future NHS service users registered with a GP member practice in the city, including carers.

Our understanding of our stakeholders and their needs will be based on: demographic information provided by Public Health in the Joint Strategic Needs Assessment, information the CCG holds and publishes on its website as part of its Public Sector Equality Duty; data from our health providers, and our stakeholder mapping expertise. This enables us to analyse the differing communications and engagement needs of our different stakeholder groups and develop the appropriate tools and messages for them.

The CCG will use these data sets to ensure our participation tools and messages are appropriate for different stakeholder groups and give due regard to the population and localities in question.

Using participation and communications to reduce health inequalities

Our approach to participation and communication supports our determination to reduce inequality in healthcare in Wolverhampton. We are committed to designing and implementing policies and procedures, and commissioning services that meet the diverse needs of our local population and workforce, such that no one is placed at a disadvantage over others.

We report on our progress in our Annual Equality Report. This sets out our key actions and progress to date, and demonstrates that equality, inclusion and human rights remain at the heart of what we do. In this way, the CCG ensures the best possible outcomes for the local community, our staff and those seldom heard groups who experience health inequalities.

Ultimately the whole CCG approach is designed to ensure that Equality, Inclusion and Human Rights remains at the heart of what we do. By doing so, the CCG ensures the best possible outcomes for the local community; CCG staff and especially those seldom heard groups who experience Health Inequalities.

The CCG's participation activities also link to the NHS Equality Delivery System 2 (EDS2) framework and our equality objectives. Our objectives for 2018-21 are:

- To work towards a comprehensive understanding of the barriers to accessing services experienced by patients. To work to reduce the barriers identified with partner organisations and stakeholders.

- Ensure that due regard is given to the needs of the CCG's population during service change, including vulnerable and hard to reach groups, through effective engagement aligned with the profile of the population affected by particular changes.

- Use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive, supportive values and competencies across the workforce.

- CCG leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country

Our Annual Equalities Report and information about our equality objectives can be found on our website https://wolverhamptonccg.nhs.uk

Our legal responsibilities

We have a range of statutory duties that we must meet under the Health and Social Care Act 2012. Most relevant to this strategy is our statutory duty to involve local people in:

- planning services
- developing our proposals for service change
- taking decisions that may affect how services operate.

We also have a duty to consult the City of Wolverhampton Council Overview and Scrutiny Committee and the Health and Wellbeing Board on any proposal for substantial development or variation of health services.

In addition, the Health and Social Care Act 2012 places specific duties on CCGs to reduce health inequalities. For more detail on our statutory duties and responsibilities see Appendix 1.

Involving local people in our commissioning decisions

Our primary function as a CCG is to commission healthcare services for the people we serve. The nature and practice of commissioning is likely to change fundamentally over the next few years as care becomes more integrated both within Wolverhampton on a place-based level, and across the Black Country and West Birmingham STP footprint. We are already commissioning more care such as learning disabilities and maternity services, across the Black Country and this will increase.

We will continue to follow the annual commissioning cycle: learning about the city's health needs, choosing and buying the right services to meet these needs and monitoring services to ensure they work well.
Our Communications and Participation Strategy ensures feedback from all stakeholders supports our decision making at every stage.
Our Engagement Cycle (Figure 1) illustrates how the cycle guides our work and outlines how we engage with people at each stage of commissioning.

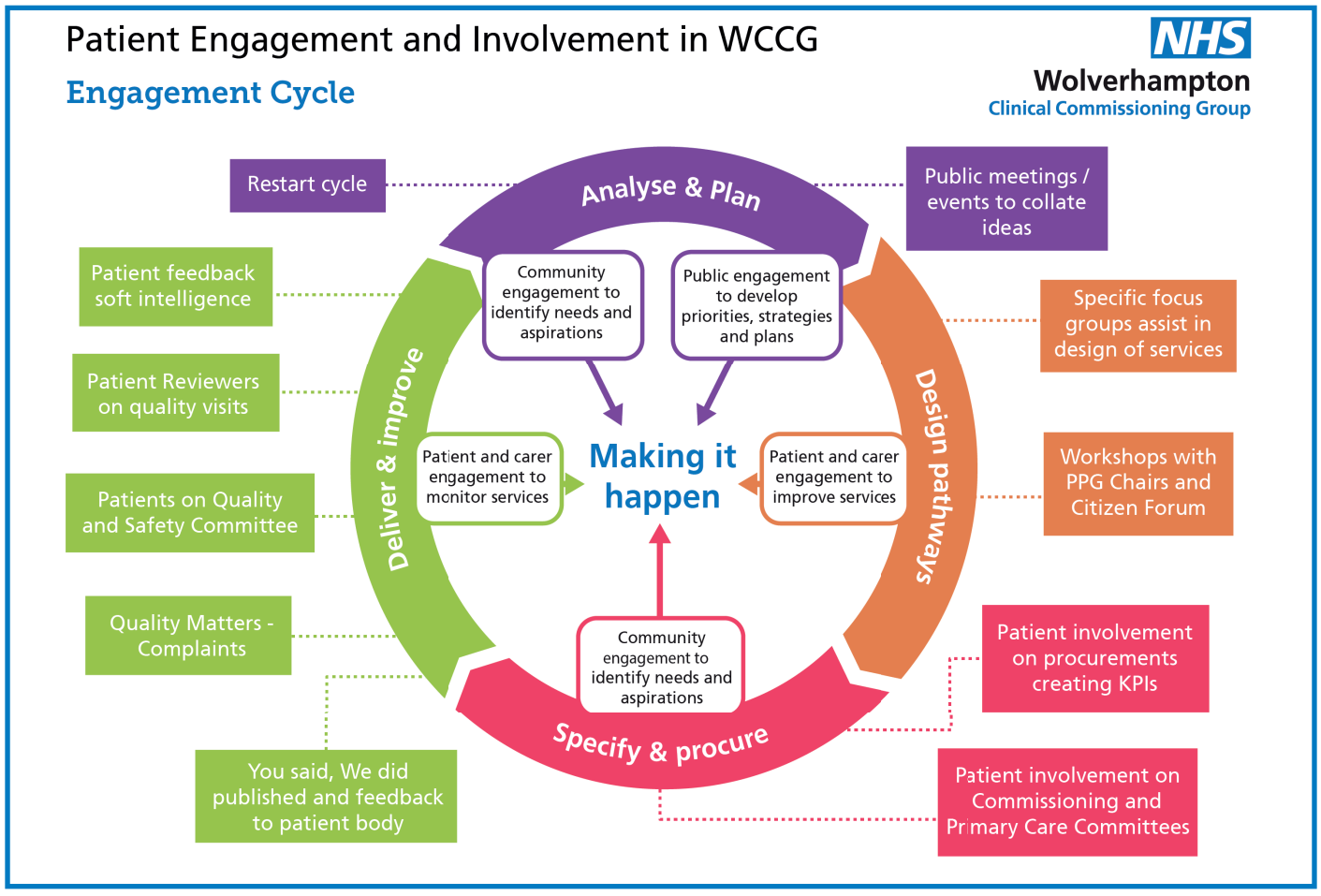

Figure 1: Wolverhampton CCG commissioning cycle

Participation framework

Commissioning decisions are clinically-led with Primary Care Networks expected to take a key role in the process. We have a comprehensive framework for participation (Figure 2), that enables us to gather information robustly, triangulate and report the insight we receive from patients and community groups.

Through this framework, which comprises a range of forums, the CCG collaborates with a diverse range of representative groups – residents, PPGs, patients, community groups, clinicians and allied health professionals, and Healthwatch. The groups can report their experiences, but also scrutinise and influence the CCG's plans and strategies, which are presented by CCG leaders to these groups.

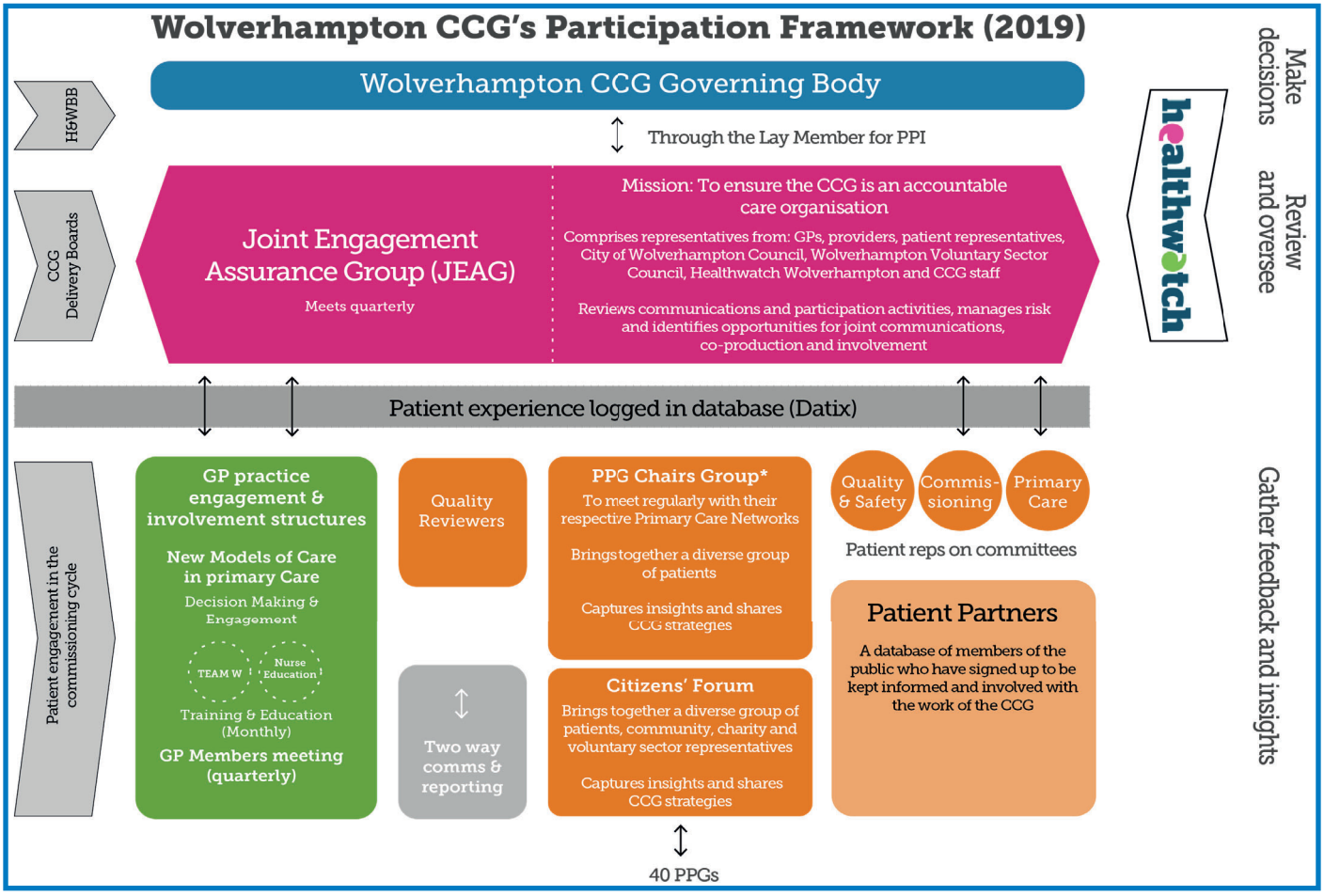

Figure 2: Wolverhampton CCG Participation Framework

* PGGC Chairs Group: aligned to the Primary Care Network (PCN) DES, section 4.4.4. Networks are responsible for meeting their PPGs with support from the CCG. The CCG will hold regular update meetings with Chairs from each PCN

All the activities that take place within our Participation Framework are there specifically to enable our stakeholders to work with us to:

- understand our health priorities and the areas of greatest need
- improve the way services work together
- draw-up specifications for the services we wish to buy and evaluate proposals from potential providers of care, such as hospitals
- monitor and improve services by learning from people's experience and feedback.

We have updated our Participation Framework for 2019-21 in recognition of the progress primary care networks are making and the impact this has on the role of PPGs. For example, the PPG Chairs Group is now aligned to primary care networks which are responsible for meeting their PPGs regularly. The CCG will support PCNs in meeting this duty and hold regular update briefings for the CCG Chairs Group. Integration of care across a Black Country footprint and the development of an Integrated Care System is likely to result in further changes to our Participation Framework, For example, we are working with our STP partners to develop a Citizens Forum that will enable us to receive regular, detailed patient and public feedback on Black Country-wide plans to transform care.

Robust reporting, demonstrating the value of participation, underpins the engagement activity that takes place within the commissioning cycle. We will continue to record and report on the impact of participation and engagement in our decision-making, showing the extent to which decisions have been influenced by the feedback we have received.

Delivering our participation and communications strategy

Our participation and communications strategy is delivered by our Communications and Engagement Service, which we purchase from NHS Arden & GEM CSU. This includes an embedded Head of Communications and Engagement, a support officer and access to the Arden & GEM communications and engagement 'hub' team.

However, the strength of our communications and participation lies in our collaborative approach to delivery both within the CCG and across our partner organisations. All our staff including our safeguarding, quality and commissioning teams, understand the importance of a robust approach to participation and take an active role. We also work closely with the communications and engagement teams in partner organisations to ensure consistent and timely communications across the City of Wolverhampton and the wider Black Country health economy.

We use a full range of tools, processes and channels to deliver our communications and participation and ensure we inform and listen to all our stakeholder groups (Figure 3). These include surveys, events, forums, printed material and digital/online tools. With each new project or activity, we ensure we understand the key information different stakeholder groups needs and that we use the tools, channels and messages that are appropriate for them. See Fig 3.

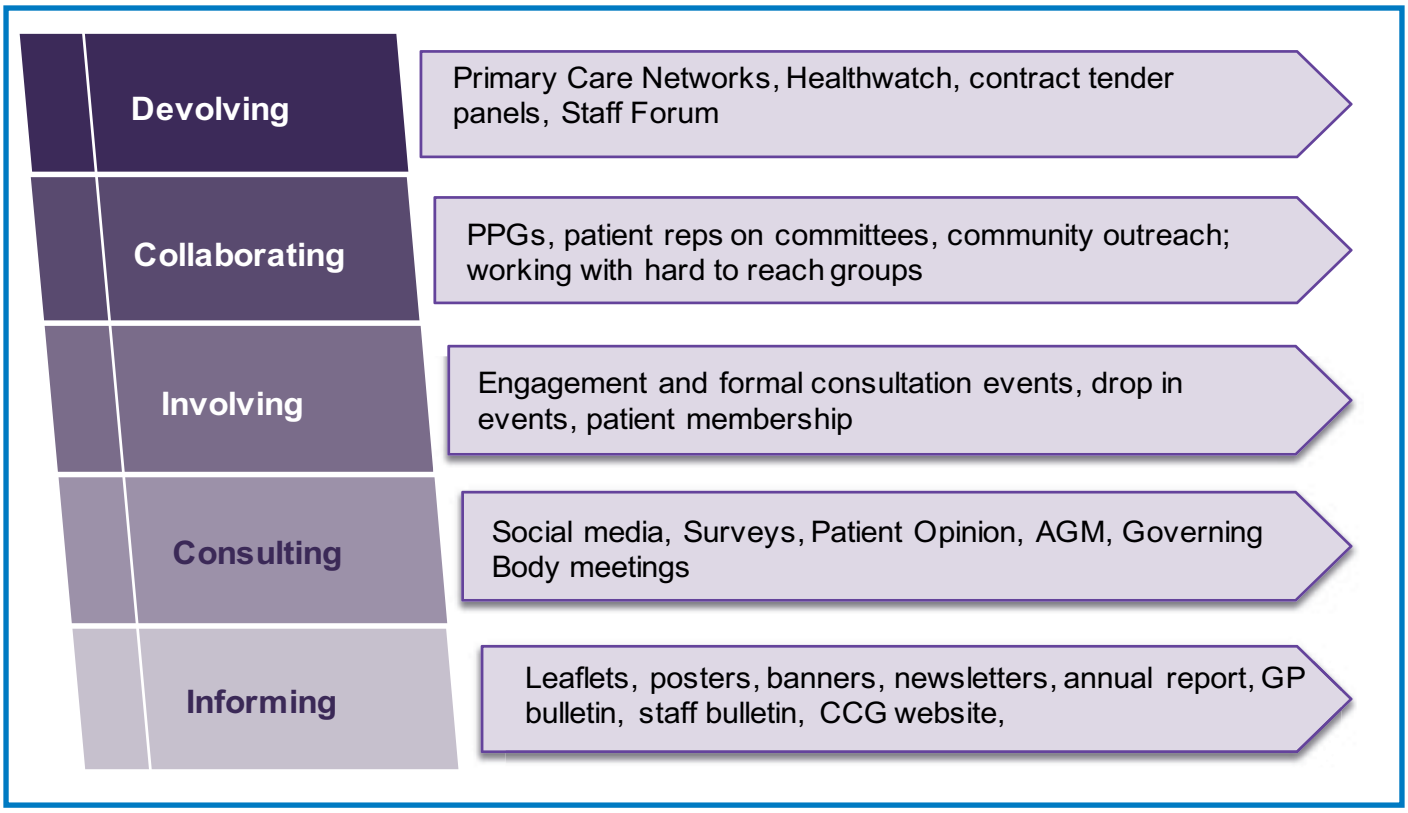

Figure 3: Communications and participation tools

All activity is underpinned by robust planning and oversight which ensures we understand what outcomes we are trying to achieve and follow best practice processes at all times.
Our planning and delivery are further supported by a set of policies and procedures that include:

- Media handling and crisis management protocols (appendix 2)
- Social media policy (appendix 3)
- NHS brand guidelines
- Consultation Institute guidelines for public consultation https://www.consultationinstitute.org

The service reports to the Governing Body via the Lay Member for PPI. Reports are linked to the CCG's Business Assurance Framework and assure our Governing Body that the CCG meets its duty to involve patients and public in their care and commissioning decisions. In addition, the service provides annual returns to NHSE via the Improvement and Assessment Framework, which has rated the CCG's engagement activity as good.

Appendix 1: Our legal duties

Participation theme/duty	What we will do	Relevant Act
Involve patients in decisions about their care	• Provide personalised care planning, including 'patient choice' and the option of a personal health budget • Shared decision making regarding individual episodes of care and longer-term care. • Provide self-care and self-management support to help patients manage their health better and prevent illness. • Develop targeted information and support to give patients more control of their health	• S.14U of the NHS Act 2006 (as amended) - Duty to promote involvement of each patient • S.13H of the NHS Act 2006 (as amended) - Duty to promote involvement of each patient
Involve patients in commissioning processes and decisions	• Work with stakeholders throughout our Participation Framework to: • Identify local health needs • Co-develop plans to address health needs and challenges • Gather and act on patient experience insight to maintain service quality and safety, or to develop proposals to change how a service is delivered • Shape our procurement process, helping us to set specifications or criteria for services we wish to renew or buy, and assessing tenders. • Consult as appropriate on any proposal that may affect services or how they are delivered - but look at each project individually	• S.14Z2 of the NHS Act 2006 (as amended) - Public involvement and consultation by clinical commissioning groups • S.13Q of the NHS Act 2006 (as amended) - Public involvement and consultation by the Board • Chapter 2, Section 242 of the NHS Act 2006 – Duty to involve • Cabinet Office Consultation Principles
Remove or minimise disadvantages suffered by those who share one of the nine protected characteristics	• Work with the Wolverhampton Equalities Group to develop inclusive and accessible consultation and participation approach. • Annually assess our Patient Partners membership to ensure it represents the demography of the wider community. • Ask respondents to complete surveys or expression of interest forms for their characteristics so that we can verify the reach and inclusivity of our participation methods.	• Equality Act 2010 • Section 149 of the Equality Act 2010 • Section 2 and 3 of the Equality Act (specific duties) regulations 2011 • Human Rights Act 1998 • Sections 14P, 14T, and 14Z1 Health and Social Care Act 2012 - Duties to promote NHS Constitution, reduce inequalities and promote integration
Consult the relevant Local Authority Health Scrutiny Committee around the planning and delivery of service change in certain circumstances	• Share and discuss any proposals on service change with the city's Health & Wellbeing Board and Health Scrutiny Committee. • Share and discuss proposed consultation plans and methods with the city's Health & Wellbeing Board and Health Scrutiny Committee prior to commencing a 12-week consultation.	• S.244 of the NHS Act 2006 (as amended)

Appendix 2: Media protocol Responding to media enquiries

To contact the communications and engagement team there is a dedicated telephone number 0121 611 0611 and email address agem.communications@nhs.net. Any calls received out-of-office hours are directed to the on-call communications team, tel: 01522 537887;
email: agem.communications@nhs.net

To enable the communications and engagement team to respond accurately and swiftly, all journalists who contact us by phone will be asked to email their enquiry and their deadline to agem.communications@nhs.net

Reactive media

Media statements must be approved by the appropriate CCG lead and copied into the Accountable Officer and/or appropriate VSM so they can request amendments, if necessary. No statement should be sent out to the media without being signed off by all relevant parties.
All media enquiries are logged and responses kept on file.

Interview handling

Any journalist requesting an interview with a CCG or CSU representative should be asked to email their request to agem.communications@nhs.net. Interview requests should include the following information:

- Name of the programme or publication/website
- Broadcast/publication date and time
- Whether the programme is live or pre-recorded (for broadcast media)
- When the journalist would like to carry out the interview – date and time
- Name of the presenter or interviewer
- How long the interview is scheduled to last
- Questions the interviewer wants to ask
- Names of other people/organisations being interviewed for this feature/news item

Proactive media work

The communications and engagement team supports proactive media work across the CCG, and is the first point of contact for drafting and distributing news releases and arranging interviews.

All news releases must be signed off by the appropriate CCG lead, and other partners as required, before being issued to the media.

If a news release requires a quote, this should be approved by the spokesperson before it is issued to the media. The spokesperson should see, and have the opportunity to comment on, the entire news release.

News releases are issued to the relevant press, posted on the CCG website (www.wolverhamptonccg.nhs.uk) and shared via social media, including the CCG's Twitter feed.

Use of images

Any members of the public who are photographed for publicity purposes should sign consent forms before the pictures can be used. Completed consent forms should be returned to the communications and engagement team, who will scan them so that electronic versions can be kept on record.

Work such as photographs, video, written word and sound recordings have copyright protection. Photographs from the internet or any other sources should not be used without the written permission of the copyright owner. Using resources without permission could potentially lead to court action for infringing copyright.

Crisis management

In the event of a crisis, the communications and engagement team will manage the media as follows:

- Holding statement to be agreed and issued within four hours
- Timetable of future responses to be agreed
- CCG Governing Body, CSU senior management team, NHS England and Public Health England (if necessary) communications teams to be informed as soon as possible
- A log kept of all media request
- Media to be monitored on a regular basis with cuttings logged, stored and circulated.

Appendix 3: Social Media Policy

These guidelines cover the use of social media by Wolverhampton Clinical Commissioning Group (WCCG). They are deliberately framed in broad terms to help WCCG staff use these tools for the good of the organisation

Introduction

Social media is the term commonly given to websites and online tools which allow users to interact with each other in some way by sharing information, opinions, knowledge and interests. It involves building communities or networks, encouraging participation and engagement.

WCCG recognises that its employees have a right to a private life that is distinct and separate from their working lives. This distinction can become blurred through the use of social media, including smart phone applications, and other online activities. These guidelines are therefore intended to provide advice to all employees, to ensure that their online activities do not interfere with their working lives.

Employees should be aware that any failure to follow this policy could be subject to investigation under the WCCG disciplinary policy.

Guidelines

These guidelines should be followed by all WCCG staff, including interns, apprentices, and volunteers, as well as interim and agency staff. They cover normal working hours, but also extend to personal time when any public reference to the WCCG is made.

The guidelines apply across all social media platforms, including but not limited to:

- Twitter
- Facebook
- LinkedIn
- YouTube
- Flickr
- Pinterest
- Instagram
- Tumblr
- Smartphone applications, such as Snapchat, WhatsApp

Social media use

During work hours, social media activity should be limited to where it is directly related to your role, or current project. It is not appropriate, for example, to use Facebook or Smartphone applications during working hours for personal use.

Privacy settings

It is important to take precautions when using social media as anyone can access and use social media. A small minority of users will take the opportunity to promote extreme views or cause trouble.

You should carefully consider who you allow to join your network and who you disclose personal information to. Adjusting your privacy settings on a social networking site will restrict who can access your profile and will prevent strangers finding out personal information about you.

Personal opinions

If you choose to identify that you work for WCCG on a personal social account you should be aware that members of the public may associate your personal thoughts, actions and behaviours with WCCG and indeed the wider NHS. Any comments made on social media about colleagues, managers or patients stand to be linked to the workplace.

Behaviour/bullying and harassment/equality and diversity

Personal accounts that are not private should not be used to publically criticise colleagues, or vent grievances, which should be directed in the first instance to your line manager. WCCG will not tolerate these behaviours in its workforce. Activities that might be classed as discriminatory will also be investigated.

Confidentiality

WCCG staff must not publish sensitive or confidential information via any form of social media. If you are unsure of whether something is classed as confidential/sensitive, ask your line manager.

Communications and Participation Strategy

2019/20

NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 13th August 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Mike Hastings – Director of Operations, WCCG
Ankush Mittal – Public Health, Wolverhampton Council
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Sally Roberts – Chief Nurse, Director of Quality, WCCG

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

Patient Members:
Marlene Lambeth – Patient Representative

In attendance:
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG
Annette Lawrence – Designated Lead Safeguarding Adults, WCCG
Lorraine Millard – Designated Nurse Safeguarding Children, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG

APOLOGIES:
Yvonne Higgins – Deputy Chief Nurse, WCCG

QSC/19/074 Apologies and Introductions

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

QSC/19/075 Declarations of Interest

No declarations of interest.

QSC/19/076 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/076.1 Minutes from the meeting held on 9th July 2019 (Item 3.1)

The minutes from the last meeting were read and agreed as a true record.

QSC/19/076.2 Action Log from meeting held on 9th July 2019 (Item 3.2)

QSC/19/068.4 - Quality Report - MERIT Group: To share the link with Mr Parvez so he can ask RWT to advise whether they use the capacity element of MERIT.

Mr Hastings advised that he had got a meeting with MERIT on 14th August 2019.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/068.6 - Cancer and End of Life Update - End of Life EPACS system: To speak with Ms Whatley about this.

Mr Hastings advised that he had had a conversation with RWT and stated that a pilot is commencing soon with Primary Care, Mental Health and Compton Care but NOT RWT.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/068.10 - FOI Report - DPO for Practices – To follow up for an update on this for Dr Rajcholan.

Dr Rajcholan stated that she had not received an update on this and asked Mrs Hough to follow this up with Mr McKenzie.

ACTION: Mrs Hough

QSC/19/069.1 - Risk Register – RTT: To look at the data with Mrs Moon to see if there should be a RTT risk similar to mortality.

Mr Hastings advised that they were awaiting the RAP which has now been received but is to be re-submitted.

Mrs Roberts added that an additional request has been submitted.

It was **agreed** to keep this action **open** on the action log.

QSC/19/072 - Any Other Business: Australian Flu - To share the dates of the next Health Protection Forum to see if someone from Quality could go.

Mr Hastings advised that he would send the dates to Mr Parvez.

Dr Mittal added that there had been a meeting recently and therefore the next meeting will be in two months' time.

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. To share the Health Scrutiny Panel paper that accompanies 'The Vision for Public Health 2010' electronically with the Committee members.

Mrs Hough shared the paper with Committee members on the 15th July 2019.

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 a link on the first GP newsletter to help the GPs. To follow up with Mrs Lisa Holder that Dr Rajcholan couldn't access the link at her surgery but could access it from other surgeries.

Mr Hastings advised that Mrs Holder had visited the surgery to review the link.

Dr Rajcholan confirmed that it was now all working at her surgery.

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.

The audit results were shared at APC (May 2019) please see minutes (item 7.4). Actions agreed as a result of this meeting are Pre-registration pharmacists to review TTOs and assess for gaps/anomalies and prepare guidance to train junior doctors who are responsible for prescribing TTOs in order to reduce the incidence. The outcome will be reviewed at APC and a re-audit will be completed.

Mr Price advised that an item had been discussed around fraudulent usage of prescriptions at the Audit Committee and thought it would be good to share at the Committee once the re-audit has been done.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/049.3 - Safeguarding Report: To include a summary sheet at the front of the report with key issues (Quarterly report).

This was updated on the Safeguarding paper under agenda item 5.5.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/077 Matters Arising

Ms Lambeth asked about radiologists and the issues with Cancer.

Mr Hastings advised that there was a national issue with radiologists; but RWT had recruited seven new staff members who were starting their employment between July and September 2019 and added that with regards to the 2 week wait patients were currently waiting 52 days for an appointment.

Mrs Roberts added that Walsall Trust was currently at 19 day wait and Dudley was 7 or 8 day wait.

Mr Hastings advised that some patients are willing to wait to be seen at RWT.

Mr Price enquired as to whether patients understand.

Dr Rajcholan replied that some patients are willing to wait especially if they are not symptomatic.

Mrs Roberts stated that RWT hold a one stop breast clinic.

Mr Hastings added that the CCG are reviewing the situation on a daily basis.

Ms McKie enquired whether many people are choosing to go elsewhere.

Dr Mittal advised that RWT also hold the contract for screening and they might need to keep an eye on that.

Discussions took place about screening and there may be an issue at other trusts.

Mr Hastings asked about bowel screening.

Mrs Roberts replied that she had spoken about this to contracting colleagues.

Dr Mittal explained the bowel screening numbers and noted it was going in the right direction.

Mrs Roberts advised that CQC are in at RWT; they have visited OPD, Paeds and ITU last week, they were doing ED and maternity. Initial feedback for OPD was good; Paeds was excellent. The well led review will commence in September.

QSC/19/078 Performance and Assurance Reports

QSC/19/078.1 Quality Annual Report (Item 5.1)

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

The report had been updated as requested at last month's meeting to include governance arrangements and to show items that were challenges.

QSC/19/078.2 Safeguarding Annual Report (Item 5.2)

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

Mrs Roberts advised that it would be good for the annual reports to go to staff briefing or Team W so that the information could be shared with the wider group.

Mr Price stated that it was a great report and it shows good practice scenarios.

Mrs Roberts commented that she felt it was good to share the information and suggested doing a comms piece around it.

ACTION: Mrs Roberts

QSC/19/078.3 Quality Report (Item 5.3)

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

Cancer (Red rated) – With regards to the two week wait for breast; this was proving to be a significant challenge, the trust are now working on a 50 day wait for the 2 week wait; mitigations are in place. A diversion pathway has been put in place whereby patients are offered to attend a different trust for patients who live within a three mile radius of other hospitals. There are about 42 practices in phase two of this pathway. So far, 109 patients have moved to different trusts.

With regards to radiotherapy, RWT have employed an extra seven radiotherapists who will hopefully be in post by September.

There have been 22 harm reviews carried out in May for over 104 days and there was no harm identified.

104 late tertiary referrals – these should be in place by 38 days with none less than 40 but there are some coming through above 62 days.

STP Cancer Board – Mrs Roberts attended this meeting on 5th August 2019 where they discussed performance at Wolverhampton. Healthwatch was also in attendance at the meeting along with cancer clinicians were also around the table. There has been a bid for national monies whereby they pushed for Wolverhampton forward for diagnostics.

Mortality (Red rated) – Recent SHMI was at 119; Mrs Roberts advised that the latest was expected to be at 117. The Crude Mortality Rate was currently at 2.47.

CQC Mortality Alerts – There had been a new request for COPD and the trust are looking at the data and trends; the trust had also commissioned PWC to review their trend analysis.

Mrs Roberts added that PWC have looked at coding and from this they are starting to see an improvement. She stated that work is currently being undertaken around the Medical Examiners which is positive.

Dr Mittal commented on the CQC initial feedback and stated that it looks good. With regards to the SHMI a lot has been learned about Sepsis etc. He added that from a Public Health point of view the mortality rates are now not unduly concerning.

Ms McKie asked about the Child Deaths in the City.

Mrs Roberts replied that she had met with the Child Death auditor and added that the trust is a CQC outlier for neonatal deaths; however, on reviewing them it has been highlighted that it is a coding issue. She advised that she attends the Mortality Review Group at the trust and learning is being highlighted and added that consultants are asking key questions.

Mr Price wondered if it was right to keep Mortality as red rather than downgrading it to amber.

Mrs Roberts asked the Committee if it could be kept as red for now as it is still early days for another review in a month.

The Committee agreed to keep it as red for another month.

Reduced CQC Rating of Wolverhampton Nursing Home (Red rated) – The Committee was advised that Ms Henriques-Dillon will provide an update later in the meeting as she was on the agenda.

Mrs Roberts advised that they recently had a meeting about a specific nursing home. The Local Authority were keen as were the CCG to keep the home open. CQC were pursuing an 'inadequate' rating and maybe cease CQC registration; they have not yet received any formal notification, there are currently three CCG CHC patients in the home; there were no major concerns highlighted by the QNA team but if a closure is forced then the CCG will go with policy.

Mr Oatridge commented that there were three of our patients in the home and wondered how big the home was.

Mrs Roberts replied that the home housed about 50 patients.

Mrs Roberts advised that she was going to raise an 'Any Other Business' item around Discharge to Assess arrangements but thought it would be a good idea to discuss this at this point. She added that Primrose Hill was a new home and of last Friday the staff were adamant that they would not transcribe medications; this is a common practice everywhere else with lots of guidance. Mrs Roberts stated that the CCG are meeting with the home this week to understand issues.

BCP Workforce (Amber rated) – The CCG undertook a visit and carried out a Duty of Candour audit; they were not assured about the procedure, they analysed 15 Serious Incidents/ moderate harm incidents and the CCG advised that out of the 15 all except one hadn't met Duty of Candour and a meeting has been arranged for next week. . The CCG has invited Sandwell and West Birmingham CCG to attend.

With regards to 12 hour breaches; since July we have had 10; there were nine who were Mental Health patients and the other was a very sick child. The CCG had done a thematic analysis of last year's breaches for Walsall, Sandwell and Dudley but they had only reported a few breaches.

Mrs Roberts advised that she was on call over the weekend and there was a dementia patient in RWT in the Emergency Department as place of safety; by 10am the patients had already had a nine hour breach, they were left for 24 hours; there are definitely process issues. She added that Mr Hastings has pulled together an urgent meeting with BCP, Local Authority etc. this Thursday morning. Issues that are being identified other than beds are ambulances/transport etc. an update to be provided at the next meeting.

ACTION: Mr Hastings

Suicide Data – The Team are looking themes for the suicide data but they are mainly Sandwell patients, they have reviewed the last three years of data and they have done a draft report. Sandwell have also done a deep dive and their report is going to the October CQRM.

Black Country Partnership (BCP) – Mrs Roberts advised that BCP is getting dark amber/red with regards to Duty of Candour, Serious Incidents, Staffing/Capacity, Risks and Penrose. Penrose is an assessment unit; concerns with managing patients with autism/ADHD and the amount of agency staff they utilise have been raised.

Mr Price commented on the risk rating and wondered if it should be red.

Mrs Roberts advised that they are fact finding at the minute and added that for the next report they would look at doing a breakdown and it may go to red once all information has been collected and reviewed.

Mrs Corrigan joined the meeting.

Dr Rajcholan commented that patients with psychiatric issues have to go on long waiting lists.

Dr Mittal stated that from a Public Health point of view who don't commission Mental Health services he would try and get perspective around this. With regards to suicide, they do a case review over GP records for all patients and the suicide cases often have alcohol abuse as well as drug misuse issues.

LOTUS – There was an issue around the process however assurance has been gained.

Mrs Roberts advised that she would look to de-escalate this next month.

Dr Rajcholan enquired if any referrals for Lotus have to go through Healthy Minds.

Mrs Roberts replied that LOTUS can refer to Healthy Minds and they have got safeguarding through that route too.

Ms Millard and Ms Lawrence joined the meeting.

Mr Price referred to page 17 of the report and the maternity graph as May data was missing and wondered why that was.

Mrs Roberts advised that she would check that out but wondered whether it was when they went over to Badger.net.

Mr Price commented on the Complaints section of the report and wondered if the Committee could have a breakdown of themes and trends detail in a future report.

Mrs Roberts replied that yes that could be arranged for the CHC report and added that there was a Mental Health complaint which they are having a round table event for tomorrow for a BCP patient.

Mr Hastings asked for clarification on page 22 of the report around workforce and staffing and the vacancy rates; there were two graphs and he wondered if there was one graph for clinical and the other for whole organisation.

Mrs Roberts replied that yes that was correct.

QSC/19/078.4 Primary Care Report (Item 5.4)

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

Quality Matters and Incidents – There were several issues that were sent to NHSE last month; two were involving NHSE going in and two were being dealt with by the CCG**.** Six incidents were currently open and they were all relating to Information Governance breaches; blood forms given to incorrect persons.

Infection Prevention – The new audit cycle has now re-commenced for 2019/2020; they are still overseeing the VI practices; detail will be in next month's report there is some improvement on last year and they are benchmarked against the hospital data.

Flu Programme –The flu meetings commenced again for 2019/2020 last month and the CCG are working closely with Public Health; there is an issue with the flu vacine this year whereby they have been delayed by two weeks, they will come through in batches

and Mrs Corrigan has got a list of who has ordered from where etc.

Vaccinations – Vaccinations as a whole the MMR uptake is not good across the City.

Mrs Roberts asked for update next month.

ACTION: Mrs Corrigan

Ms Henriques-Dillon joined the meeting.

Sepsis – They are meeting regularly and more training is to be provided in November 2019.

FFT – the uptake was 2.5% this month which is the best they have ever had.

CQC – One practice was identified as 'requires improvement' rating and work with them is ongoing; they have got action plan and are monitoring this.

Contractive Visits – Only one action plan outstanding now. Awaiting DBS forms to be returned which is out of their control.

Workforce Numbers – There is a Practice Nurse Strategy Launch which is taking place on 3rd October 2019 at Himley Hall, Dudley; it is Black Country wide and there are a few people booked onto it already.

Mrs Roberts stated that the Practice Nurse Strategy is a really big piece of work as it is one strategy across the Black Country.

Mrs Corrigan stated that there are Practice Nurse training sessions taking place as well as training for other practice staff.

Dr Rajcholan commented on the Medical Assistant training and asked what that post was.

Mrs Corrigan replied that it was so that admin staff have the skills to highlight issues when letters are received and added that they now have training hub support from Sandwell.

Mrs Corrigan left the meeting.

QSC/19/078.5 Safeguarding Adults, Children and Children and Young People in Care Report (Item 5.5)

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

Adult Safeguarding

Ms Lawrence advised that the report was for quarter 1 and advised that for the statutory responsibilities a draft version of the Commissioning Assurance Toolkit (CAT) has been circulated by NHSE for comment, prior to its publication in late Summer 2019, they are awaiting the final version. She added that the toolkit replaces the Safeguarding Assurance Tool (SAT). The SAT was very lengthy and time consuming.

Training – A CCG wide safeguarding training needs analysis is in progress; all staff have level 1 and there are some staff within the CCG that require higher level training.

Reviews:
Domestic Homicide Reviews – **DHR 07:** there has been a delay as the family were abroad. **DHR10**: there was a delay in the trial of the alleged perpetrator. **DHR11:** has commenced and the IMR is to follow

Safeguarding Adult Reviews (SAR) - The team are awaiting the SAR for Edith.

Migrant – This has now come to an end but NHSE have given an extra £10,000 as the plan is to engage a worker for this.

Mr Strickland joined the meeting.

GP Domestic Violence – There are 13 Primary Care Domestic Violence Champions identified.

Learning Disabilities Mortality Review (LeDeR) Programme – The CCG are making good progress; seven reviews have been allocated and there are none outstanding.

Mrs Roberts added that this was the best in the Black Country.

RWT and BCP Exceptions – For RWT there are relatively minor issues on the dashboard; with regards to training all staff are currently booked on so should go to 100% very soon. For BCP they are down on PREVENT training.

Safeguarding Children

Ms Millard referred the Committee to page 128 of the pack in relation to 'Child N' there has been a delay in completing the report but it is all in hand, the final report was due the afternoon of the meeting, the sign off date is to be confirmed and media interest is expected. Learning lessons briefing to be done.

Working Together 2018 - Working Together 2018 requires new arrangements to be made in relation to Child Death Partners (CCG and Local Authority) and Multi-agency Safeguarding Partners (CCG, Local Authority and Police). The new arrangements came into place from 30th June 2019.

Mrs Roberts added that there is a first meeting next week.

Children and Young People in Care

Ms Lawrence advised that Mrs Brennan had sent her apologies.

There was a case example included in the report; Ms Brennan had worked really hard in supporting and managing her colleague in Sandwell in connection with this case.

Mrs Roberts added that she had really helped out; the child was placed in Wolverhampton but was not a Wolverhampton child.

Mr Parvez left the meeting.

Mr Price stated that the report was really helpful.

Ms Lawrence, Ms Millard and Dr Mittal left the meeting. Mr Parvez rejoined the meeting.

QSC/19/078.6 Quality Assurance in Care Home Report (Item 5.6)

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

Pressure Ulcers – There was a slight increase in Pressure Ulcers as the homes have had some really poorly patients.

Lessons Learned – Ms Henriques-Dillon referred the Committee to page 3 especially to the lessons learned and advised that the staff are managing hydration and skin integrity. The QNA team have launched the policies with the care homes and are working with Public Health to reduce pressure ulcers.

Slips, Trips and Falls - Ms Henriques-Dillon stated that there was good news with regards to this as there were none reported in quarter 1.

Mr Oatridge left the meeting.

Ms Henriques-Dillon advised that they are trying to triangulate information which is collected from survey monkey, WMAS and the RIT team data.

A&E Attendances and Call Out – The highest reason for this is chest infections.

RIT Team – Usage has increased, which is good.

Mortality – More patients are dying in their Preferred Place of Care and their Preferred Place of Death. For the City wide Mortality Improvement Group work they are doing some after death analysis with RWT; no trends have been identified.

Dr Mittal rejoined the meeting.

Dr Rajcholan commented on the work that is being doing with RWT and asked if they were looking at all deaths or just those in the acute settings.

Ms Henriques-Dillon replied that the data is for all deaths.

Mrs Roberts stated that this was a good piece of work with both qualitative and quantitative data etc.

Ms Henriques-Dillon added that it is based on Multi-Disciplinary Team (MDT) working.

Mrs Roberts stated that they need to have RCAs for all deaths.

Ms Henriques-Dillon advised that they had picked up a lack of MDT working and added that there may have been a different outcome if there was MDT working.

Dr Mittal stated that they had managed to get residential data from across the city as there had always been a gap on this and added that he could share this with Ms Henriques-Dillon.

ACTION: Dr Mittal

CQC – Nine out of 18 homes were rated 'good'. The team are struggling to help move homes from 'Requires Improvement' to 'Good' rating; CQC are helping with principal issues.

- Bentley Court was rated 'Inadequate' and are still awaiting the final report.
- Newlyn Court was rated 'Inadequate' which Ms Henriques-Dillon was disappointed with as the care provided is very good. The 'Inadequate' rating was mainly to do with the Health and Safety element e.g. PAT testing of electrical equipment etc. The team are working with the home on robust action plans and are hoping for an early inspection the care is not compromised.

Safeguarding Referrals – There is a high number of referrals for safeguarding; the referrals come from the MASH team and the QNA team are supporting them.

Best Practice Guidelines – They have recently launched 11 Best Practice Guidelines to the homes.

Mrs Roberts advised Ms Henriques-Dillon that there had been discussions around D2A earlier in the meeting.

Mr Price commented that if this paper going to Governing Body he feels there is a need to review what goes in the public domain.

Ms Henriques-Dillon left the meeting.

QSC/19/078.7 Public Health Update (Item 5.7)

Dr Mittal advised that he was looking at developing the reports that come to this Committee going forward. With regards to Health Visiting and School Nursing he will look at core services and trajectories and added that they could agree the reporting elements.

Mrs Roberts stated that they could review this with RWT IQPR that is presented at CQRM as it would be nice to join them up.

QSC/19/078.8 Quarterly CQUIN Update (Item 5.8)

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

Mrs Roberts advised that RWT were challenging the anti-biotic consumption and total usage, there is some variation on published data. It has been agreed to put it on hold for now; RWT achieved 67% complete. For 2018/2019 there was 77% of CQUIN completed. CQUIN set at 90%. Work with RWT on CQUIN.

QSC/19/079 Risk Review

QSC/19/079.1 Risk Register (Item 6.1)

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

Committee Risks:

Flu vaccination – (New) – This was discussed and was also in the quality report.

QSC/19/069.1 - Risk Register - Workforce – To consider there being two risks around workforce and to recommend what is best.

Workforce – This is being captured in the Primary Care report and there are lots picked up at the CQRMs.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/079.2 Tolerate or Treat Risk Review

Mr Strickland advised that there were currently seven risks on the Risk Register for this Committee and they should be reviewed on a quarterly basis to see if the Committee feels that they need any extra scrutiny.

Mrs Roberts stated that potentially they could have one risk to be upgraded and one risk to be downgraded next month.

Mr Hastings added that there might also be one for RTT.

Mr Strickland left the meeting.

QSC/19/080 Feedback from Associated Forums

QSC/19/080.1 Governing Body Minutes (Item 7.1)

The Governing Body minutes from 14th and 21st May 2019 were received for information/assurance.

QSC/19/080.2 Commissioning Committee (Item 7.2)

The Commissioning Committee minutes from 27th June 2019 were received for information/assurance.

QSC/19/080.3 Primary Care Operational Management Group (Item 7.3)

The Primary Care Operational Management Group minutes from 12th June 2019 were received for information/assurance.

QSC/19/080.4 Area Prescribing Committee Minutes (Item 7.4)

The Area Prescribing Committee minutes from 21st May 2019 were received for information/assurance.

QSC/19/081 Items for Consideration

QSC/19/081.1 Terms of Reference (including membership and contract clauses) (Item 8.1)

Ms McKie commented that there are usually three lay members and one patient representative at the meetings and queried as to whether there should be two patient representatives.

Mrs Roberts replied that there were two patient representatives but often only one attends the meetings, and added that it is really good for there to be three lay members. With regards to the Secondary Care Consultant, somebody was interested in this and Mrs Roberts and Mr McKenzie had met with them but she was not sure what is happening with that but advised that she would get an update on this for the next meeting.

ACTION: Mrs Roberts

QSC/19/082 Items for Escalation/Feedback to CCG Governing Body

- BCP
- Mortality – good news
- Cancer – the Governing Body need to be sighted on this as there might be a reputational risk
- Care Homes – inadequate; as we move into Winter there could be a potential risk for capacity.

QSC/19/083 **Date of Next Meeting:** Tuesday 10th September 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Apologies received from Dr Rajcholan.

Meeting closed at 12.20pm

Signed: …… **Date**: ……
Chair

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Minutes of the Quality & Safety Committee
Tuesday 10th September 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Mike Hastings – Director of Operations, WCCG
Matt Leak – Public Health, Wolverhampton Council
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Sally Roberts – Chief Nurse, Director of Quality, WCCG

Lay Members:
Jim Oatridge – Lay Member (Chair)
Peter Price – Independent Member – Lay Member

Patient Members:
Marlene Lambeth – Patient Representative

In attendance:
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG
David King – EIHR Manager, WCCG
Katrina McCormick – Children's SEND Programme Officer, WCCG
Matt Reid – Acting Head of Nursing - Corporate Support Services
Sukvinder Sandhar – Deputy Head of Medicines Optimisations, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG

APOLOGIES:
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sue McKie – Patient/Public Involvement – Lay Member
Ankush Mittal – Public Health, Wolverhampton Council
Dr R Rajcholan – WCCG Board Member (Chair)

QSC/19/084 Apologies and Introductions

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

QSC/19/085 Declarations of Interest

No declarations of interest.

QSC/19/086 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/086.1 Minutes from the meeting held on 13th August 2019 (Item 3.1)

The minutes from the last meeting were read and agreed as a true record.

QSC/19/086.2 Action Log from meeting held on 13th August 2019 (Item 3.2)

QSC/19/078.2: Safeguarding and Quality Annual Reports **-** To share the Safeguarding and Quality Annual Reports to staff briefing or Team W and suggested doing a comms piece around the good work that has been done.

Mrs Roberts has spoken to Helen Cook about this.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/078.3: Quality Report - BCP Workforce**:** To provide an update at the next meeting regarding issues that are being identified around A&E breaches.

Mr Hastings there was a meeting on 15th August 2019 which Mrs Roberts chaired with actions and a follow up meeting planned for 13th September 2019.

This item is to be kept **open** with feedback being given next month.

QSC/19/078.4: Primary Care Report - Vaccinations – To provide an update on Vaccinations as the MMR uptake is not good across the City.

An update is provided in the Primary Care Report – item 5.2.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/078.6: Quality Assurance in Care Home Report **–** To share the residential data from across the city with Ms Henriques-Dillon.

Mr Leak will chase this.

ACTION: Mr Leak

This item is to be kept **open** with feedback being given next month.

QSC/19/081.1: Terms of Reference – To provide an update with regards to the Secondary Care Consultant at the next meeting.

The person who was interested in doing this is no longer able to do so. Going forward the members felt as there may be imminent changes to the CCG arrangements that perhaps the Terms of Reference could indicate an independent clinical representative.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/068.10: FOI Report - DPO for Practices – To follow up for an update on this for Dr Rajcholan. To follow this up with Mr McKenzie.

Mrs Hough sent Mr McKenzie an e-mail RE: this issue. Awaiting a response.

This item is to be kept **open** with feedback being given next month.

QSC/19/072: Any Other Business: Australian Flu - To share the dates of the next Health Protection Forum to see if someone from Quality could go.

The next two dates for the Health Protection Forum are the 11th September and 18th December at 11am until 1pm at the Civic Centre.

Mr Hastings asked if somebody was able to go to the meeting from the Quality Team.

Mrs Roberts replied that yes there was somebody going to attend the meeting from Quality.

It was **agreed** to **close** this action and **remove** it from the action log.

QSC/19/087 Matters Arising

There were no matters arising.

QSC/19/088 Performance and Assurance Reports

QSC/19/088.1 Quality Report (Item 5.1)

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

Cancer (Red rated) – This is the trust's biggest significant challenge at the moment, especially with regards to the two week wait for breast; the trust are working on a 50 day wait for symptomatic ladies. A diversion pathway has been put in place whereby patients are offered to attend a different trust for patients who live within a three mile radius of other hospitals. RWT are now looking at referring patients at source as the current arrangement is not having the planned impact expected. There have now been flags set up at GP surgeries telling them what the daily waits are at the other trusts. With regards to the backlog, they are working on a trajectory to about 20-30. They are currently down to 320 with an additional 55 patients per week coming off the backlog. This is based on seven day working and a radiologist starting at the trust in December; improvement should be seen on 62 day wait by December. With improvement expected against the 14 day pathway by Oct. With regards to Urology, this can't be sorted by Wolverhampton alone. Wolverhampton is now part of the BCWB urology workstream where a review of the whole pathway at system level will commence shortly. Mrs Roberts attended the first Cancer Board meeting in August. Harm reviews are continuing and there has still only been one patient harmed with regards to long waits.

Mr Oatridge commented on the 104 days harm reviews and queried as to whether they do 62 day harm reviews.

Mrs Roberts replied that the 104 days harm reviews go to a MDT robust review. With regards to the 62 day harm reviews these go through PTL on a weekly basis and are discussed at a MDT.

Mr Oatridge asked if there was evidence if a patient is waiting more than 62 days.

Mrs Roberts replied that this is the activity discussed at the weekly PTL meeting which the CNS in quality team attends.

Mr Oatridge wondered if this could be showed in the report.

Mrs Roberts replied that she could make sure this was added and also a paragraph on the process. She added that Staffordshire had challenged the current referral at source activity and that this was being worked through.

Mortality: Standardised Hospital Mortality Index (SHMI) (Amber rated) – This is an improving picture; the impact for increases in tariff cost is starting to be looked at by our Finance colleagues, this year we are fine as it is part of the risk/gain share but they are looking at the implications for next year.

CQC Mortality Outlier Alerts – The trust are predicting the alerts before they get to them and are able to respond quickly. Mrs Roberts advised that the trust has recently published a good 'Learning from Deaths' page on their website and asked Mrs Hough to share the link with the Committee.

ACTION: Mrs Hough

Mrs Roberts advised that they had appointed 11 mortality reviewers of which two are nurses and they are now in place. With regards to the backlog for the mortality reviews they are hoping to get on track in December. SJRs are being undertaken; there are two consultants leading on deterioration; they came to CQRM (RWT) for a deep dive review of the pathway in July. Ms Higgins and Mr Parvez have also walked the pathway and are actively engaged in supporting this workstream.

Mr Oatridge commented about the last bullet point on page 19 of the pack and wondered if it was about timeliness.

> *The CCG is supporting a review of the current response to Deteriorating Patients within the Trust and an improvement plan has been requested to ensure timeliness of observations improves.*

Mrs Roberts replied that this is in relation to the timeliness of the 'Sepsis 6' triggers, which the analysis through audit.

Mr Parvez stated that the SHMI is now at 1.17, an improving picture and as predicted.

CQC – Mrs Roberts advised that CQC are currently undertaking the well led inspection at RWT; there is a whole day of interviews around mortality. So far, the work is positive. CQC undertook the unannounced inspection over four weeks (Tuesday, Wednesday and Thursday) and they have looked at three areas per week at the trust, they have visited every clinical area and feedback has been positive so far with no major areas of concern; ICU and ED had really good feedback. With regards to the medical areas, the trust Chief Nurse was concerned about staffing, as this remains a challenge, despite an overall trust improvement on nurse recruitment. MCA/DoLS has come up as an issue, but this is a challenge for lots of trusts. The well-led inspection started this week and they are focussing on Mental Health; ED is being used as a place of safety for children and young people, they are just unpicking this at the moment.

Escalating Concerns Regarding Position of a Nursing Home (Red rated) – Bentley Court had environmental issues with their inspection. The CCG has no concerns around quality. There are 47 Wolverhampton patients in the home.

Mr Price wondered if the home was stepping up to the challenges.

Mrs Roberts replied that the home is part of the Priory Group, there is a new manager in place and the QNA team are in there supporting the staff.

Some Emerging concerns regarding Nursing Home being unable to deliver to the Step Down Contract (Red rated) – Primrose Hill; this is a new home in Wolverhampton, it is a brand new home and they have got a 'Dementia Street' the manager said they wouldn't transcribe, but the trust couldn't discharge patients to their home without them doing this. The CCG have put some medication support in and as a result of that they are transcribing and are receiving step down patients now. Further work is underway with the trust and home, including a planned 'walk in your shoes' event to further support Discharge to Assess pathways for the home to accept patients.

Mr Oatridge enquired as to if this was with regards to transferring medication from hospital to home and asked if it was not electronic.

Mrs Roberts agreed that it was about transferring medication and unfortunately it isn't electronic.

Mrs Corrigan joined the meeting.

Mrs Roberts thought this could be stepped down to amber.

Concerns around Sepsis Pathways (Amber rated) – Discussions around this had already taken place. With regards to the CQUIN for last year, the trust didn't achieve it.

BCP Workforce (Amber rated) – The CCG is picking up 12 hour breaches for Mental Health patients in A&E visits. Mrs Roberts was on call and had two patients who hit the 12 hour indicator in ED; this is not the right place for them to be. However, there have been none in the last two weeks. Mrs Roberts has had a few meetings with the interim Chief Nurse at BCPFT and there are improvements in workforce and breaches. Bed capacity (BCPFT) is currently at 98% which is quite high; questions are being asked around are they risk adverse, do they review their patients regularly etc.

Mr Price referred to page 26 of the pack 'Serious Incidents' and there had been an increase in the number of incidents for both RWT and BCP over the last few months.

Mr Parvez replied that there were no trends identified.

Mr Oatridge referred the Committee to page 33 of the report and especially the '62 day wait – screening' and added that it was elevating a little.

Mrs Roberts replied that screening performance has been challenged this was delivered under the Dudley team and there is some work being undertaken around this. There was a meeting at the beginning of August and they are expecting to see improvements soon.

Mr Oatridge commented that the Urology 104 day wait appeared to be increasing too.

Mrs Roberts replied that they saw a bit of a peak in activity from Worcester; the pathway should be to Coventry and Warwickshire, but more recently some had been referred to Wolverhampton and advised that the late tertiary for urology also links with this.

Mr Oatridge asked about Black Country Partnership and Dudley and Walsall Mental Health Partnership.

Mrs Roberts commented that a lot of work has been done around the workforce at the two Mental Health trusts and their merger.

Mr Oatridge stated that he is having discussions this week about student nurses and commented on the need to link more with the University of Wolverhampton as there is a big intake of student nurses who are usually local and they stay local once they qualify.

Mrs Roberts agreed and discussed the panned event re: workforce with chief nurses from across the patch.

Mrs Roberts advised that she attended an extra-ordinary safeguarding case review yesterday whereby they signed off and completed the review with publication on 4th October 2019. There were 10 recommendations for the victim, the perpetrator was known to Mental Health services and they are doing a table top review for him and this will be included in next month's report. Mrs Roberts has also been appointed as the new chair of adult and children safeguarding boards for the first 12 months.

Mr Oatridge commented that there were four pressure ulcers reported in the last two months.

Mr Price commented that the pressure ulcers that occur within the Nursing Homes say that they happened within the home.

Mrs Roberts replied that these are across the local system and include independent sector. Mrs Roberts advised that full RCAs are always undertaken and in care homes some pressure ulcers are on admission; will provide an update next month as to further analysis of this data and will include origin of PU.

ACTION: Quality Team

Mrs Roberts advised that the SPACE and Best Practice Guidelines appendices were for information and commented that this is excellent work.

QSC/19/088.2 Primary Care Report (Item 5.2)

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

Serious Incidents – There were not many Serious Incidents that come through the CCG from Primary care but there have been a couple recently that had come through NHSE with regards to fitness to practice for nurses; this was closed as there was no

case.

Quality Matters – This has been really busy; there was an IG breach which has been run by Mr McKenzie it clearly was a breach as a member of staff accessed the system for another member of staffs family member.

Mr Price enquired as to if that would be a lesson learned for other areas.

Mrs Corrigan replied that yes it would and added that a lot of work is being done around Datix too.

Mrs Roberts stated that quality matters queries are appropriate and of relevance from primary care with some real improvements to patient care being made as a result.

Ms McCormick joined the meeting.

Infection Prevention – Audits are ongoing and they have already seen an improvement across the practices.

Flu Programme – The flu programme has started up now with deliveries of vaccinations expected the week after next; there has been a delay with the under 65s vaccinations but they should get them through by the end of this month. The CCG is working closely with Public Health.

Mr Oatridge commented that rules are not being relaxed.

Mrs Corrigan replied that some practices were selling them to each other and this year they won't be able to. Monthly teleconferences and face-to-face meetings will be taking place.

Vaccination Programme – They are monitoring the MMR uptake as this has been low and they have an offer to support the trust and NHSE are monitoring it too.

Complaints – NHSE data is shared with the CCG; they are the same issues as quality matters e.g. reception staff being rude, the majority of complaints are not upheld, there is one around prescriptions.

FFT – The uptake is really good, six practices did not submit. However, this is the submissions for July which included a holiday period with some key staff being away.

Collaborative Contracting Visits – There is a new cycle now which will commence from October 2019.

CQC – Three practices have received 'requires improvement' ratings by CQC and they are being supported by Gill Shelley and Jane Worton and Mrs Corrigan.

Mr Price wondered if there were any themes identified.

Mrs Corrigan replied that the themes highlighted were around leadership and estate issues; action plans are in place. Compared to other CCGs we do not have any 'inadequate' rated practices.

Ms Sandhar joined the meeting.

Workforce Activity – There is a Black Country wide initiative with a launch of the Practice Nurse Strategy Launch at Himley Hall. Workstreams have been approved by the STP GP group. Strategy Launch there are lots of people attending with attendance from the University too.

Mrs Roberts stated that Mrs Corrigan had led on a lot of good work both locally and nationally.

Mrs Corrigan added that there is a GPN leads meeting next week. They are working very closely with the University and they are asking practices to send their HCAs on courses too. The retention programme is around care navigation.

Mr Hastings queried as to whether this had taken Digital First into account.

Mrs Corrigan replied that there was nothing about Digital First in the strategy but added that it could be developed.

Mr Hastings stated that he attended a meeting recently with clinical directors and added that it was agreed that we will supply the tools and they need to supply staff or they supply it all and then they will determine the scope.

Mrs Corrigan replied that once they know what is happening they will have to review that document on its own.

Mr Oatridge enquired as to how wide the digital across GP land is in the Black Country.

Mr Hastings advised that acute care will all have different systems but coding is the same for primary use. Primary care also uses two different systems. National stand on IT systems now is don't buy single systems. Talking to PCNs and providers to see what is needed and looking at group-by-group basis. In primary care, coding is the same. With regards to Digital First; 73% of practices are using the system; others haven't got any but have plans and the national stand on this is that all GPs are to have this in place by April next year (2020) but he felt that we will be done by December this year (2019). Babylon in Hand is being used in Birmingham; this is capped with how many patients they can register. Looking to go into the Black Country and West Birmingham. Working with PCN to put this in place. Can get an appointment within 20 minutes.

Mr Reid and Mr King joined the meeting.

Mr Oatridge suggested that with regards to Digital First need to consider the access issues and asked if we could get something here and/or Governing Body.

ACTION: Mr Hastings

Mrs Corrigan stated that the system would need training available to staff too. She added that she had been asked to speak at the Best Practice Conference.

Mrs Corrigan left the meeting.

QSC/19/088.3 SEND Update (Item 5.3)

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

SEND and local offer review is now complete and the SEND local strategy is at review stage. The review commenced in February 2019 and was driven by an increase in numbers of special school places and numbers of SEND health provision. There has been a 10% increase in child numbers and are the most complex children. Much clearer around commissioning arrangements now.

Mr Strickland joined the meeting.

The review covered lots of areas and gave lots of information around the current health provision and provided up-to-date information on the following:

- SEND cohort in Wolverhampton
- SEND school provision
- Current Health provision – their local offer, costs, contracts, activity, team structure, waiting times etc.
- Governance arrangements
- Perspectives of current provision.

Strengths identified by the review:

- Co-location of staff in the GEM centre
- Voice4Parents
- Attendance at Children and Young People in Care – health budgets etc.
- The commissioning of 'Changing our Lives' to work with SEND children and young people
- Production of the new JSNA in collaboration with the Local Authority to ensure there is a shared and complete understanding of the SEND cohort
- Engagement with parents
- Clinics and services provided on site in special schools which is good practice, children not having to leave school.
- Children Development Centre based in the Gem Centre
- Community Paediatric Consultants collaboration with the Acute team
- Children's Community Nursing Service (CCNS)
- Quality and Advice from Occupational Therapy and Physiotherapy for EHC plans
- Portal – Health client data is accessible through the portal for all SEND health services
- Dual job roles.

Recommendations – there were a number of recommendations including producing a three year SEND Health Strategy with strategic priorities and short term objectives. The strategy is currently out for consultation. The strategic priorities were

- Effective organisations
- SEND Workforce Development
- Work together to get the best SEND services
- Fair and equal access to all SEND services and support.

The strategy will link with city wide aims and objectives.

Mrs Roberts advised that there was positive, ongoing work with LA and parents voices on this agenda and the review had been shared with partners.

Further Recommendations included:

- **Commissioned Services -** Some information was out of date so have now got new schedules. Data is already in place and a means of effectively offering and providing choice for Personal Health Budgets should be developed.
- **Health Community Provision/Accessibility** – Consider moving school based surgeries into community provision and open access to all SEND children and young people – need to work on this.
- **Work with schools** – SLA's to be put in place with schools - working on this.
- **Communications** – Establish and implement a health communications plan – bulletin to go out to providers.
- **Signposting/promoting of the local offer** – This is the responsibility of Council we need to work with this.
- **Parents/Carers and Children and Young People – Strategic Engagement and Service Engagement** – SEND workforce. Properly funding Voice4Parents to establish peer support networks.
- **Workforce Development** – big area to look at; looking at road map.
- **Rolling out of SEND passport** – Need to increase the pace of this.
- **Awareness of SEND** – would like to do an online module.
- **SEND agenda** – Improving outcomes.
- **Systems and Processes** – Develop a model to help engage providers.
- **Access to Mental Health Support** – Deliver more widely accessible Health and Well-being services for SEND children and Young people - delivering some of this but it is not all about CAMHS.
- **Data** – around data collection requirements.
- **Waiting lists** –There were three recommendations around this.
- **Pathways** – Provider services need to develop pathways approved by SEND Steering Group in a consistent way and in a way that children understand.
- **Transition 0 to 25** – Continue to work with the council and to improve

governance structure.

- **Public Health, Council** – To engage with Public Health in strategy and planning and to develop integrated systems and processes for sharing information.

Recommendations – An action plan has been pulled together and will be overseen by the SEND steering group.

The Council are going to review the school places; they have now engaged the CCG with this.

Next Steps – The strategy will be discussed tomorrow evening with Children and Young People and will also go to the commissioning committee on 26th September 2019.

Risks – The main risk is not implementing the recommendations in a timely manner and all risks are being monitored by the SEND steering group.

Mr Strickland asked about the risk around SEND.

Ms McCormick confirmed that it could be closed.

Mr Oatridge asked how many children require a plan.

Ms McCormick replied that out of 7,500 there are 1,800 that require a plan.

Mr Oatridge asked if that was normal.

Mrs Roberts replied that yes it was and we are in the middle range.

Mr Oatridge enquired as to if we have enough workforce.

Mrs Roberts replied that ASD is the biggest gap.

Mr Oatridge commented that the strategy was out for consultation and wondered when the consultation period was likely to end.

Ms McCormick replied that the consultation period ends at the end of September.

Mr Price asked if they were going to prioritise the risks.

Ms McCormick replied that she will review the risks and will RAG rate them.

Ms McCormick left the meeting.

QSC/19/088.4 Medicine Optimisation Report (Item 5.4)

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

Ms Sandhar advised that the report was a summary of work that had been undertaken; the team are working heavily with the STP. An Integrated Pharmacy and Medicines Optimisation (IPMO) Regional Engagement STP Event took place on 24th July 2019 which informed stakeholders and interested parties of the work being undertaken. The IPMO are one of seven STPs in a pilot programme trying to get best value for medicines, it has been very successful and are showing prioritising. Work has been taking place around the Transfer of Care around Medicines (TCAM) which has focussed on transferring between secondary and primary care. STOMP has been looking after autism and Learning Disabilities patients. There has been a launch of COPD events which was attended by 400 clinicians. Medicines Optimisation in Care Homes has been up and running since July to help with medicines. Prescribing Incentive Scheme (PIS) and the anti-biotic report shows that Wolverhampton are 'good' in this area. It also showed that there was an inappropriate prescribing of co-loxamov in ED. The CCG

offered a Prescribing Incentive Scheme which was very successful last year.

Mr Oatridge stated that we are doing really well not only in the CCG but as a STP too.

Mrs Roberts advised that Hemant Patel is starting the Elizabeth Garrett Anderson leadership course soon.

Ms Sandhar left the meeting.

QSC/19/088.5 Equality and Diversity Report (Item 5.5)

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

Mr King advised that there were two tables in the report in section 2 for RWT and BCP; there was a red on RWT table with regards to the trust not publishing an EDS2 report; however, things remain better than they were two years ago but the website is not reflective of their position, this is a key focus for NHSE and they have got their own issues with staffing. There are no risks to patients and no concerns from NHSE. We have got a list of when both trusts will present what at their relevant CQRMs. Next year, there will be a big push on EDS.

Mrs Roberts stated that this had been challenged at the CQRM and they said that it would be on the website in August but if not we will follow up in CQRM in September.

Mr King commented that he had not seen anything about Disability workforce (DES/WDES) and added that CQC do not have to publish it for two years.

Mr Oatridge stated that there are some really positive issues in the report around the CCG position; however he disagreed on the overall rating of green as there were some red risks he wouldn't grade them green.

Mrs Roberts agreed with Mr Oatridge.

Mr King agreed to change the overall rating to amber.

Mrs Roberts advised that they have got an internal audit starting in September around Equality and Diversity.

Mr King left the meeting.

QSC/19/088.6 Infection Prevention Report (Item 5.6)

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

Norovirus – There was 3 episodes in care homes (2 in April and 1 in May) and they were managed accordingly. Advice and support was given by the IP Team and treatment prescribed by the RIT team in the care homes and the same will be available for any potential flu cases. There were no GP audits undertaken in Quarter 1; however, they will be picked up for the remainder of the year.

C *Diff* – There have been changes to the reporting mechanisms; the number of days to apportion hospital-onset HCAIs has been reduced from three or more (day 4 onwards) to two or more (day three onwards) days following admission. The trajectory has been set for 2019/2020 and is no more than 48 cases for the CCG and no more than 40 cases for the trust.

MRSA Cases – There is a small reduction in MRSA acquisition, treatment and follow up patients continues to ensure decolonisation is completed.

***Gram* Negative Bacteraemia** – There has been a change in position from the Department of Health around the ambition to reduce the number of Healthcare Associated Gram-Negative Bloodstream Infections (GNBSI) by 50% by March 2021 this

goal has been revised to March 2024 with a 25% reduction by March 2021.

E Coli – The trust has a meeting with the CCG tomorrow to discuss preventions.

Urinary Catheters – There is lots of work being done about urinary catheters and the data is improving.

Mrs Roberts stated that there is a lot to work on with urinary catheters.

Mr Reid advised that he has been working with primary care and there is a newly formed group looking at catheters and they are doing some process mapping

Mrs Roberts commented that the CCG is really keen to work with Mr Reid and the team.

Mr Reid advised that there were some graphs in the report to show E Coli bacteraemia and the graphs show fluctuations throughout the three years.

Mrs Roberts stated that they have identified a SRO for MRO for STP; Dr Odum was identified.

Mr Reid commented that there was a blood infection attributed to June and all care was provided by the family and the patient developed pressure ulcers.

Mr Oatridge commented on the graphs on page 240 of the pack and enquired about the definition of attributable to the CCG.

Mr Reid replied that this was to do with E Coli and patients passing through ED from homes.

Mr Oatridge commented on the gram negative and asked how that was determined.

Mr Reid replied that it was all hospital and acute.

Mr Reid left the meeting.

QSC/19/089 Risk Review

QSC/19/089.1 Risk Register (Item 6.1)

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

Committee Risks:

QS13: Supply of Flu Vaccination 2019/2020 (12) – The practices should have all flu vaccines by December 2019.

QS11: Safeguarding Transition from LSCB to MASA (8) – This continues; a Task and Finish Group has also been set up.

QS12: SEND Inspection and Local Offer (6) – Closed as previously.

Risks to be added/discussed:

Mr Hastings queried if Digital First and/or Babylon first was on a risk register.

Mr Strickland replied that it was on the risk register for the Commissioning Committee.

Mr Price commented that there could be a risk for pharmacy and Brexit.

Mr Hastings advised that there was lots of work being done in NHS looking at warehousing and immunisations.

QSC/19/090 Feedback from Associated Forums

QSC/19/090.1 Commissioning Committee (Item 7.1)

The Commissioning Committee minutes from 25th July 2019 were received for information/assurance.

QSC/19/090.2 Primary Care Operational Management Group (Item 7.2)

The Primary Care Operational Management Group minutes from 3rd July 2019 were received for information/assurance.

QSC/19/091 Any Other Business

QSC/19/091.1 QSG

Health visiting was flagged as an issue for Birmingham; there were 60 vacancies in Birmingham and Solihull CCG; there was quite a lot of learning from that, we are not in that position. With assurance provided by RWT.

Mr Strickland left the meeting.

QSC/19/091.2 Public Health Data

Mr Leak presented the Public Health NHS Functions paper and the dashboard data; this would give the Committee an idea of indicators from providers and TB etc. He added that he was pulling this information together for the report and he needed to see what information was needed and to what depth.

Mrs Roberts advised that she would like some data on school readiness and two and half year checks and suggested having a meeting outside of this meeting with Ms Higgins and Mr Parvez to see what is required.

ACTION: Mr Leak, Ms Higgins and Mr Parvez

Mr Oatridge stated that it would be good to have a monthly report from Public Health going forward.

Mr Leak advised that there had been a couple of successes he wanted to share with the Committee. With regards to flu, they have gone from the bottom 8% in the Country into the top quartile. There were 11,000 invites sent out last year compared to 6,000 the year before. Internal targets are also set. Children's Flu last year – a book was devised and they have done a follow on books this year for children to better understand it; this also helps parents and teachers. Dudley, Walsall and Sandwell have got their own books. With regards to the two and half year checks Public Health are aware of the issues now.

QSC/19/091.3 Scope of Nursing Home Beds (Item 10.1)

Mrs Roberts advised that the report gives the Committee a position of where we are, going into the Winter. This is proposed as a briefing note through the Care Homes.

Mr Oatridge commented on the last but one paragraph (below) which states that we are not engaged with and asked Mrs Roberts to pick this up with the Local Authority.

> *The LA have three times weekly bed state returns which it would be helpful for them to regularly share with both the CCG and RWT; thus minimising the requirements to contact separate providers on an individual basis.*

Mrs Roberts replied that yes she would pick the issue up and asked the Committee to receive the briefing note for information.

Mr Oatridge asked if there were any Nursing homes that we have lost or have concerns about.

Mrs Roberts replied that we lost Oxley which was run by Accord Housing.

QSC/19/092 **Items for Consideration**

QSC/19/092.1 **Terms of Reference (including membership and contract clauses) (Item 8.1)**

Secondary Care Consultant – Discussions took place about this and it will be reviewed shortly.

QSC/19/093 **Items for Escalation/Feedback to CCG Governing Body**

- The four items from last month.

QSC/19/094 **Date of Next Meeting:** Tuesday 8th October 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.50pm

Signed: …… **Date**: ……
Chair

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 27th August 2019
Science Park, Wolverhampton

Present:

Mr T Gallagher	Director of Finance
Mr S Marshall	Director of Strategy and Transformation
Mr V Middlemiss	Head of Contracting and Procurement
Mr L Trigg	Independent Committee Member (Chair)

In attendance

Mrs G Moon	Business Operations Manager
Mrs L Sawrey	Deputy Chief Finance Officer
Mrs H Pidoux	Business Operations Support Manager

1. Apologies

Apologies were submitted by Mr Green, Mr Hastings and Dr Bush

2. Declarations of Interest

FP.403 There were no declarations of interest.

3. Minutes of the last meetings held on 30th July 2019

FP.405 The minutes of the last meeting were agreed as a correct record with the following amendment to be made;

- Item FP399 – Contracting and Procurement report - The contract with Accord for services at Probert Court ended on 30th June 2019 not 31st July 2019 as stated.

Resolved: the above amendment was noted.

4. Resolution Log

FP.406 Item 146 (FP.376) – Risk relating to stranded costs associated with the Community Dermatology Service procurement will be added to the Committee Risk Register - the final outcome from RWT was awaited. The CCG had challenged on a number of assumptions including the utilisation of estates and the amount to be recovered through potential new

business. It had been confirmed by the Trust that estates would not be included in the stranded costs. Once the final figure is agreed this will be confirmed with the Committee, however, it is not anticipated that this will be significant enough to be included on the risk register.

Item 148 (FP.397) – Performance report – clarification to be sought re Referral to Treatment performance figures for England are different for Commissioners (84.0%) and Providers (96.9%), Whether this is because of cross border patients – clarification given that the NHSE figure is for services commissioned by the organisation and the providers figure is for all providers in England.

Item 149 (FP.397) – Performance report – 2 week wait breast symptomatic waiting times – report on the impact of the joint programme to reduce pressure on RWT with target practices to be shared at the next meeting – update given in Performance report, item 7 on agenda. A further verbal update to be given at the next meeting as part of the performance report.

5. Matters Arising from the minutes of the meeting held on 30th July 2019

FP.407 There were no matters arising to discuss from the last meeting.

6. Review of the Risk Register

FP.408 There were no updates to either the corporate or committee risk registers to be noted.

9. Contract and Procurement Report

FP.409 Mr Middlemiss presented the following key points;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment – performance had further deteriorated during June (85.09% against 92%). Some of the reasons for this were capacity issues at sub-speciality level and reduction in the number of Waiting List Initiatives clinics undertaken due to tax and pension issues for consultants. The areas that had deteriorated the most were Ophthalmology, Gynaecology and Pain Management.

  The CCG had received a Remedial Action Plan (RAP) however this had not been signed off as it did not contain sufficient detail. Dialogue is ongoing between the Trust and the CCG.

- Dermatology – the procurement process had been completed and the standstill part had passed. The Award letter had gone out to bidders and the successful bidders details, Circle Health, had been made public.

Staffs CCGs procurement for this service had paused, with the new service not due to go live until 1st April 2020. This presented a risk as to how their patients were going to be managed as Wolverhampton services goes live on 1st December 2019 is only for Wolverhampton patients. After discussions with RWT it had been agreed that the Trust would continue to provide the support for Staffs patients until their new service goes live.

- Phoenix Walk in Centre – a formal letter had been sent to the Trust confirming acceptance of the business case to expand the service to meet the requirements of transitioning to an Urgent Care Centre by 1st December 2019. The main caveat of the investment is a requirement to make available to the CCG information for all attendances, based on the national data set for Emergency Care. This will be included as part of normal reporting from Month 9 onwards.

Black Country Partnership Foundation Trust (BCPFT)

- Improving Access to Psychological Therapies (IAPT) target – the sourcing of suitable primary care accommodation is being discussed and direction had been given that this should not delay the signing of the Remedial Action Plan.

- Transfer of the Non Contract Activity funding to the Provider – The provider needs to undertake considerable due dilligence before they can accept this budget. To aid this, the CCG had recently issued a Partnership Agreement outlining the responsibilities of the two parties, the service scope and the risk/gain share arrangements. Further meetings had been scheduled with the Trust with the aim of formalising the Partnership Agreement by mid-September.

Other Contracts

- Non-Emergency Patient Transport Services (NEPTS) – The re-procurement Invitation to Tender stage had now closed. The evaluation of bidder responses is underway and due to be completed by 6th September 2019.

- Accord Housing Association Limited – Victoria Court – a proposal had been put forward to Accord to change the current bed utilisation at Victoria Court by commissioning more step-down beds and less rehabilitation beds. The proposal was to be taken to the Commissioning Committee and the outcome would be brought back to this meeting for information.

- BMI Priory Health Care – From April 2019 the CCG had taken on the responsibility for contracting the Diep Flap Breast Reconstruction service from RWT. The CCG manages this on behalf of Wolverhampton residents and associate CCGs to the RWT Contract.

One of the key changes of the transfer affected the invoice and payment arrangements. The processes and new working arrangements had recently been clarified and both parties had an agreed mutual understanding of these.

Resolved: The Committee noted the updates given and actions undertaken

7. Monthly Performance Report

FP.410 Mrs Moon introduced the report and explained that changes to the report had commenced to ensure it was CCG focused. The following key points were discussed and noted;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment (RTT) –
  Underperforming against national target. It had been discussed at the recent contract review meeting that the national pension issue was impacting on performance as consultants were not undertaking additional work including additional clinics to reduce waiting lists. A meeting is due to be held with the Trust to discuss the RAP.

  Waiting lists are increasing month on month. Ophthalmology work, mainly cataracts, is being outsourced to clear the back log. Work by RWT to validate waiting lists had not commenced as expected and is due to begin in September.

- Urgent care – A&E performance for RWT in July was 89.9% (England at 86.5% and Black Country STP at 86.8%).

- Delayed Transfers of Care rates remain low at 2.89% for June indicating the Trust is managing patient flow.

- Cancer – referrals continue to remain high which is impacting on RTT performance.

  A joint programme to relieve pressure on RWT waiting list for 2 week wait breast referrals 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. This had been extended to cover practices within 3 miles of borders. The uptake is still limited. The CCGs Chief Nurse had met with representatives from the Primary Care Networks to gain an understanding of what was required to improve uptake and it was felt that further communication was

required to increase knowledge of the initiative. The waiting list is currently 51 days for RWT, Walsall 15 days and Dudley 9 days.

The CCG is investigating the option of commissioning a Community Breast Pain Clinic together with the introduction of pain management prior to referral.

A RAP for all cancer standards is in place and reviewed monthly with revised improvement trajectories agreed. The Trust is achieving the RAP actions; however, the trajectories are not being achieved. Mega clinics, seeing up to 40 patients in one day are planned from September.

Black Country Partnership Foundation Trust (BCPFT)

- IAPT – performance is measured based on quarterly performance, however, is monitored monthly. NHSE figures are based on a rolling quarter and confirmed the April performance as 5.86% and above threshold of 4.75% for Quarter1 – Quarter 3. 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.

- Eating Disorder– 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 regarding options available to support access. Low numbers (18/20 on a rolling 12 month basis) affect performance against the national standard of 95%.

It was discussed that IAF and Quality Premium figures will be brought to the next meeting if the information is available as the 2019/20 guidance is yet to be published.

Resolved: The Committee noted the update given and the actions undertaken.

8. Finance Report

FP.411 Mrs Sawrey introduced the report relating to Month 4, July 2019;

- Financial metrics are being met
- The cash target for M4 had been achieved
- Q1 allocation for Thrive into Work has been received
- RWT Month 3 data required further analysis

Mrs Sawrey highlighted that there are 2 areas that have the potential to create financial challenges;

Prescribing including the impact of high cost drugs and devices, insulin pumps for children and adults.

Activity at RWT had increased and the CCG had undertaken an analysis of trends utilising the actual 18/19 expenditure to inform the potential forecast outturn for 19/20. This indicated a potential Aligned Incentive Scheme (AIS) overspend of £3.5-4.5m. A forecast overspend of £3.0m had been assumed in the CCG's financial position (of which £0.5m was managed through reserves).

Non–electives in M4 were indicating 2% overspend. Work was being undertaken to review activity and coding changes. A report would be compiled in September for the CCG Executive Team's consideration.

Resolved: The Committee;

- Noted the contents of the report

9. Additions/updates to Risk Register

FP.412 The potential of continued acute over performance and coding issues to be reviewed by Mr Gallagher and anything appropriate to be raised as a risk to be brought forward.

10. Primary Care – Financial Position as at Month 3, June 2019

FP.413 Mr Gallagher explained that this report was brought to the Committee for information as it goes to the Primary Care Commissioning Committee for consideration on a quarterly basis. The table showing performance against budget across all areas of primary care spend was discussed.-

Resolved: The Committee noted the contents of the report.

11. Any other Business

FP.414 There were no items to discuss under any other business.

12. Date and time of next meeting

FP.415 Tuesday 24th September 2019 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 24th September 2019
Science Park, Wolverhampton

Present:

Dr M Asghar	Deputy Clinical Lead for Finance and Performance
Mr T Gallagher	Director of Finance
Mr J Green	Chief Finance Officer
Mr M Hastings	Director of Operations
Mr S Marshall	Director of Strategy and Transformation
Mr V Middlemiss	Head of Contracting and Procurement
Mr L Trigg	Independent Committee Member (Chair)

In attendance

Mrs G Moon	Business Operations Manager
Mr P McKenzie	Corporate Operations Manager

1. Apologies

Apologies were submitted by Dr Bush and Mrs Sawrey

2. Declarations of Interest

FP.416 There were no declarations of interest.

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

FP.417 The minutes of the last meeting were agreed as a correct record.

Resolved: The above was noted.

4. Resolution Log

FP.418 Item 146 (FP.376) – Risk relating to stranded costs associated with the Community Dermatology Service procurement will be added to the Committee Risk Register - it was noted that, following further information in respect of the costs, the risk in relation to this matter was mitigated and did not need to be added to the risk register – Action to be closed.

5. Matters Arising from the minutes of the meeting held on 27th August 2019

FP.419 There were no matters arising to discuss from the last meeting.

6. Review of the Risk Register

FP.420 It was noted that, risk FP05 – Overperformance of the acute contract was in the process of being reviewed in the light of work being undertaken to understand the potential impact of coding changes and service levels at RWT. An update would be provided at the next meeting.

The Chair asked whether there was a financial risk associated with Brexit that needed to be added to the risk register. Mr Hastings confirmed that currently it was not expected that there would be a financial impact.

RESOLVED: That the update be noted.

9. Finance Report

FP.421 Mr Gallagher introduced the report relating to Month 5, August 2019 highlighting the following key points;

- All metrics in relation to financial performance were currently being met, including QIPP performance;
- Additional allocations had been received during the month, including system development funding in relation to cancer services
- A reported overspend in relation to acute overperformance at RWT was being analysed. It was noted that it was expected that work at the trust to reduce waiting lists would contribute to the overperformance.
- The risk gainshare agreement in place with the trust was mitigating the impact of the forecast overspend.
- Spend relating to Continuing Healthcare and Funded Nursing Care was reporting an overall underspend.
- It was noted that there was a potential that the prescribing budget would be impacted by issues relating to no cheaper stock being available following EU Exit.

RESOLVED: That the report be noted.

FP.422 **Contracting report**

Mr Middlemiss presented the following key points;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment – the Trust's Recovery Action Plan (RAP) had now been signed off. This would mean that key actions, including validating waiting lists could be monitored. In response to a question from Mr Gallagher, it was confirmed that the RAP included activity targets that could now be modelled to understand the financial impact. In response to a further question, it was confirmed that the validation of waiting lists had not yet started due to staff training not yet being completed.

- Breast Cancer two week waits – performance was beginning to improve following the introduction of diversion of referrals to Walsall and Dudley.

- Diagnostics – performance across diagnostics was deteriating, particularly in relation to endoscopy. The Trust was considering providing access for private sector providers to run additional sessions to address the issues. Performance on MRI and CT scans were improving.

- Dermatology – work was underway to support the mobilisation of the new community dermatology provider. This was happening in conjuction with a change in pathway for RWT services. There was a potential risk associated with the commissioning of services in Staffordshire being discussed at the Commissioning Committee.

- Phoenix Walk in Centre – Mr Marshall highlighted that, following agreement of the contract variation, the Trust had now confirmed that they would provide information in relation to patient flow in line with the emergency data set.

Other Contracts

- Nuffield – issues had been discussed in relation to the reporting of waiting times on ERS. Nuffield were looking into the issue. Mr Hastings agreed to discuss the issue with the IM&T team.

- Grants – in addition to the continuation of grants provided to Compton Care for their Isolation and Prevention Service and the Disability Resource Centre's Fit for Life Programme a grant had been issued to First Person plural to offer training and forums in support of the Wolverhampton Sexual abuse fourm.

Resolved: The Committee noted the updates given and actions undertaken

7. Monthly Performance Report

FP.423 Mrs Moon introduced the report The following key points were discussed and noted;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment (RTT) – As reported in the contracting report, a Recovery Action Plan had been agreed. Opthamology waiting times were increasing, possibly in response to additional demand from Staffordshire.

- Urgent care – performance remains challenging nationally. A new performance target was being trialled in some trusts. West Midlands Ambulance Service had now taken over the 111 provision, which was intended to deliver benefits in terms of patient coordination and flow through the system.

- Cancer – as highlighted in the contracting report, the diversion of referrals was having a positive impact on performance at RWT. The impact on performance at Walsall and Dudley was being monitored. Performance against other cancer standards was also improving.

Black Country Partnership Foundation Trust (BCPFT)

- IAPT – performance against access to treatment was in line with trajectory. Performance against moving to recovery was being closely monitored.

- Physical health checks – performance was under trajectory and work was being undertaken with colleagues in primary care to raise with practices. Further work was required to understand the split of activity between primary and secondary care.

Mr Hastings advised that the report had been presented in its current format for the first time and committee members' feedback was requested.

Resolved: The Committee noted the update given and the actions undertaken.

8. Additions/updates to Risk Register

FP.424 There were no updates to the register on this occasion.

9. Devolvement of Mental Health Non-Contracted Activity (NCA) Budget to Black Country Partnership NHS Foundation Trust

FP.425 Mr Middlemiss introduced the report, which outlined a proposal, due to be considered by the Commissioning Committee, to devolve management of the budget for non-contracted activity in Mental Health to Black Country Partnership Trust.

The report outlined that this spend related to to mental health patients placed out of area due to capacity in the local trust. Currently, when capacity was not available, bed managers within the trust sourced an alternative placement, that was then paid for by the CCG. It was proposed that, following financial modelling, the expected budget for this activity will be transferred to the trust as part of their contract, on a shadow basis initially. Mr Marshall highlighted that it was intended to support transformation across the system by providing positive incentives to manage patient flow to avoid costly out of area placements.

Mr Marshall advised the committee that, following discussions with the trust, a query about liability for patients had been raised. This was being escalated to the trust's Chief Executive.

Resolved: The Committee noted the contents of the report and supported the proposal.

10. Any other Business

FP.426 NHS Oversight Framework – Mrs Moon tabled a report outlining details of the Oversight Framework for 2019/20. This framework replaced the CCG Improvement and Assessment Framework and provided an overall assessment of performance of services commissioned for the CCG's population. It was proposed that performance against this framework would be monitored quarterly using a balanced scorecard to identify priorities for action. A draft of the scorecard was presented for comment.

Resolved: The Committee noted the contents of the report.

11. Date and time of next meeting

FP.427 Tuesday 29th October 2019 at 2.00pm, CCG Main Meeting Room

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE (PUBLIC)

Tuesday 3rd September 2019 at 1.30pm
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)	No
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)	Yes
Dr Manjit Kainth	Locality Chair / GP (non-voting)	No

NHS England ~

Bal Dhami	Senior Contracts Manager – Primary Care, NHSE	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
Dr Ankush Mittal	Consultant in Public Health	Yes
Dr B Mehta	Wolverhampton LMC	No
Jeff Blankley	Chair of Wolverhampton LPC	Yes

In attendance ~

Helen Hibbs	Chief Officer (WCCG)	Yes
Tony Gallagher	Director of Finance	Yes
Liz Corrigan (on behalf of Sally Roberts)	Primary Care Quality Assurance Co-ordinator	Yes
Mike Hastings	Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Diane North	Primary Care Commissioning Committee Admin	Yes

Welcome and Introductions

WPCC543 The Chair welcomed attendees to the meeting and introductions followed.

It was noted that Dr Ankush Mittal would attend for Public Health going forward (previously John Denley).

Liz Corrigan was also attending on behalf of Sally Roberts and therefore remained for the duration of the meeting.

Apologies

WPCC544 Apologies were received from the following members

Les Trigg, Vice Chair

Dr Salma Reehana, Clinical Chair of Governing Body, CCG

Sally Roberts, Chief Nurse & Director of Quality (Mrs Corrigan in attendance)

John Denley, Director of Public Health (Dr Ankush Mittal in attendance)

Dr Manjit Kainth, Locality Chair/GP

Tracy Cresswell, Wolverhampton Healthwatch Representative

Declarations of Interest

WPCC545 The Chair declared she no longer had an interest in items relating to Primary Care as her role with the Child Death Overview Panel for Walsall and Wolverhampton had ended last week.

Helen Hibbs declared that she had an interest in the item relating to the merger of Parkfields and would leave the meeting during this discussion.

Minutes of the Meeting held on the 2nd July 2019

WPCC546 The minutes of the meeting held on 2 July 2019 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from Previous Minutes

WPCC547 There were no matters arising.

RESOLVED: That the above was noted.

Committee Action Points

WPCC548 **Action 37 (Minute No: WPCC525) – Wolverhampton Primary Care Strategy update**
Item on today's agenda, therefore action closed.

Action 38 (Minute No: WPCC526) – STP Primary Care Strategy Update
Item on today's agenda, therefore action closed.

Action 39 (Minute No: WPCC481) – Tettenhall Medical Practice – Wood Road Branch Closure
A further update to be provided today as part of the Primary Care Contracting report. Action remains open, as the public consultation has been extended to15th September 2019. To be discussed again in November.

Action 40 (Minute No: WPCC540) – Quality Assured Spirometry
A further update on the implementation of the Spirometry service to be provided to committee in October.

Action 41 (Minute No: WPCC541) – Practice Resilience Funding
It was confirmed that the proposals suggested by the Operational Management Group that were put forward to the GP Forward View (GPFV) Programme Board on 28th August 2019 were approved. There is £40,000 available for resilience support for Practices in Wolverhampton. A report has been submitted to the Private meeting today. Action closed.

RESOLVED: That the above was noted.

Primary Care Update Reports:

Q1 Finance Report Apr-Jun 2019

WPCC549 Mr Gallagher advised that the report was the first to committee in the new format. It showed a more granular analysis of spend within Primary Care and included areas outside of delegated commissioning such as the prescribing incentive scheme.

Future reports would describe why the variances had occurred and what actions would be taken to address them. The current status showed as breakeven largely a consequence of not having received all the claims in relation to the last financial year. The intention was to create a non-recurrent reserve against which to plan non-recurrent schemes. It was likely that primary care would underspend again this financial year with a probable value of £1m however this would become clearer after the end August when all claims were received. The intention was to give committee early sight of

the underspend in order to have time to take remedial action and spend within the original budget. Last year it had been January when the underspend of £900,000 had been realised.

The next update would show the exact value of the development reserves and would be looking for non-recurrent schemes and/or options to bring schemes forward from new financial year. The report format had been sighted already at Finance and Performance (F&P) committee so the question today was, did it meet this committee's needs or was supplementary detail required.

A question was raised, as August had now passed whether the value of the underspend was known. Mr Gallagher advised that it would be the middle of September before an update at month six could be provided.

RESOLVED: That the report and highlights above were noted.

Primary Care Quality Report

WPCC550 An overview of the report was provided by Mrs Corrigan.

A number of items submitted via Quality matters had been forwarded to the NHSE Practice and Performers Information Gathering Group (PPIG). These were things that would be easily resolved and weren't major issues.

An Information Governance (IG) issue was raised about blood forms being given to the wrong patient. It was felt this was predominately human error with a requirement for more vigilance. Mr McKenzie advised that under the new commissioning arrangements for IG support the Commissioning Support Unit (CSU) would now be responsible for providing support to practices and would be putting on training sessions and he would speak to the CSU to ensure these issues are covered. Members suggested that such issues could be taken forward via several routes such as the Group Leads meeting to reiterate the triple check; Primary Care Leads, Clinical Directors, the Learning newsletter which goes to Practice Managers and GPs, Quality and Safety meetings, Practice Managers forum, Practice makes Perfect and the Practice nurses forum.

Breaches had been reported to the CCG by the phlebotomy service at the hospital. Dr Bush suggested a solution could be not to give patients forms at all but use the information on the ICE system.

Work was being undertaken with Public Health to increase the under 65 year's flu vaccine. There would be a slight delay in the delivery of the under 65s vaccine, the Quadrivalent, and waiting on final dates.

Information on people's MMR and flu call and recall and uptake rates had been added to the collective contracting template because this had been

flagged up as low performance and the CCG was working with Public Health to improve this. Public health advised that the UK had been taken off the World Health Organisation measles elimination status achieved in 2017 but that Public confidence in the vaccine was higher now than before so there was a perception it could potentially be an access to care issue.

Another practice had been identified by CQC as requiring improvement and was being monitored as an ongoing issue. Currently there were three practices requiring improvement, none were inadequate. Action plans were in place and practices were actively working through the plans.

The Practice Nurse strategy for the Black Country was due to be launched on 3rd October at Himley Hall with national speakers in attendance.

The Practice Nurse retention was running alongside the GP retention programme and the workstreams identified were approved at the GP Forward View (GPFV) meeting on 28th August 2019.

A series of training was planned on topics such as blood collection tubes, cytology, and immunisation. The Association for Respiratory Technology & Physiology (ARTP) Spirometry training is due to start on 3rd September 2019 with 20 candidates signed up. Full training hub cover provided by Sandwell was now in place, which has reduced the risk around it.

RESOLVED: That the report and highlights above were noted.

Primary Care Operational Management Group Update

WPCC551 Mr McKenzie presented on behalf of Mr Hastings who would join the meeting later.

- The CCG continued to support Tettenhall Medical Practice with their patient consultation regarding their intention to close the Wood Road branch.
- Building work at East Park was on track to be completed by the end of the financial year. The Newbridge building work was complete. There had been a workshop in July to discuss having a Hub for the North-East.
- There had been a meeting with the Care Quality Commission (CQC) around some of the issues highlighted in the Quality report such as support provided to practices and programme of inspections. Work with the CQC and Local Authority will continue to make improvements.

An issue was raised by Ms Shelley with regard to item 10, Primary Care contracting in relation to Dr Mudigonda having 13 actions outstanding around CQC registration. This was incorrect and it was actually 13 actions outstanding from their contract monitoring review visit, one of which was around their CQC registration which had since been resolved

and the issue around the Practice fridge had also since been resolved.

RESOLVED: That the update was noted.

Primary Care Contracting Update

WPCC552 Ms Shelley presented the report, which provided an update on the Tettenhall Medical Practice branch closure. The consultation process that had been due to finish on 31st July had now been extended to 15th September to allow for a further consultation session with the public on 11th September and for comments from the Local Authority Health Overview and Scrutiny committee (on 12th September) to be fed into the consultation process.

A public meeting outside of the Practice and CCG consultation was held by the local community chaired by Eleanor Smith, the local MP. The meeting was well attended with circa 180-200 people.

The application to close Wood Road surgery will be presented to this committee in November.

Included in the report also was information on GMS contract variations and the Spirometry Enhanced Service giving details of which Primary Care Networks (PCNs) would be delivering the service.

Ms Southall added with regards to Spirometry that at the time of the report being compiled it was based on the networks that had expressed an interest and confirmed their delegates for the training. Since then the Royal Wolverhampton Trust (RWT) had confirmed that they would not be taking part but that Unity East & West and the North network would. RWT have access to the Spirometry service in-house.

RESOLVED: That the update was noted

Merger of Parkfields Medical Centre with Grove Medical Centre (Health & Beyond Partnership)

WPCC553 *Helen Hibbs left the meeting*

Ms Shelley presented her report to inform the committee of the request to merge the 2 Practices and to gain committee approval to go ahead.

The CCG had been served an application by Parkfields Medical Centre to merge with Grove Medical Practice, part of the Health & Beyond Group. Background information including the geographical locations of the Practices was provided. Benefits to patients included increased access, patient choice of clinician, full range of enhanced services, appointments at

any site.

Public and patient engagement had been undertaken in the form of leaflets, notices in Practice, messages on prescriptions, use of the local pharmacist, Practice website, 1 to 1 discussion, practice meetings, Patient Participation Group, and letters. Feedback from patients had been positive, keen to make use of the increase access. The Practice submitted a business plan appended to the report along with an Equality Impact Assessment.

Ms McKie read out comments submitted by Dr Kainth in an email commenting on Practice mergers asking when did big become too big and whether services would actually be better under a larger arrangement than a smaller one and whether there was any data around this. Discussion ensued but it was felt that the only real measure would be patient outcomes. Dr Mittal stated that at The Royal Wolverhampton Trust there was a patient population of circa 60,000 and this could serve as an example of larger working.

Ms Southall highlighted that an important factor in the Parkfields merger was the workforce challenges they were facing, in particular the recruitment and retention of GPs. This meant the practice had opted for a merger with another larger and more robust and delivery resilient Practice which could only be a positive move for patients.

A question was asked that on page 4 of the Business Case where it stated there would be no immediate change to service delivery and whether it could be read into that that, there may be future changes to service delivery.

Ms Southall replied to the effect that having had lengthy discussions with both Practices about their intentions there were two GPs who were planning to retire so the intention was to maintain the status quo whilst learning about the practices to ensure they got the medical model right. The Grove had already recruited a number of newly qualified GPs who would spread their wings into Parkfields and Woodcross as those GPs exit. The merger was not expected to affect patient access to a female GP.

In order to mitigate the risk pertaining to the systems merger and data collection the merger needed to be timely and was planned to go ahead before December 2019.

No objections were received from committee with regard to the merger. It was felt that there was still a need to support smaller, local practices operating in the traditional way.

RESOLVED: Approval for the merger of Parkfields and Grove Medical Centre was given.

RESOLVED: That the update was noted.

Helen Hibbs returned to the meeting

Milestone Review Board (Q1 2019/20)

WPCC554 Ms Southall began by saying that the Milestone Review Board had met in April and the final Assurance report was based on Quarter 1 which was then considered at the July meeting so the updated Assurance Pack appended was based on the outputs of the Milestone Review Board in July and there was also one new risk in response to the Digital First Primary Care national consultation.

The recruitment of Social Prescribing Link Workers was covered under the new roles of the PCNs Direct Enhanced Service (DES). The Wolverhampton Primary Care strategy appended had also been updated.

Primary Care Assurance Pack (Q1 2019/20) Appendix 1
The Milestone Review Board had considered the assurances within the pack with a number of suggested changes as detailed on page 3 of the report in relation to Bowel screening and Right Care packs utilisation. The Board had noted the new risk in relation to GP at Hand which is a London based practice as detailed in Appendix 2.

Report highlights included the progress that had been made in relation to digital transformation with online & video consultation continuing to be rolled out to Practices with currently 70% of them having the functionality with a target of 100% by December 2019 enabling them to offer such consultation types should patients wish to access them.

In relation to workforce the GP Nursing strategy had been approved for the STP. A number of retention schemes for practice nurses had been developed and there would be a single point of access nurse recruited for the Black County to ensure nurses had the support they needed in the workplace. A number of co-designed events which nurses had actively participated were detailed in the STP update. Training was planned for Healthcare Assistants and Spirometry and there was protected learning time sessions for Practice Managers.

The pack detailed the progress that Primary Care Networks (PCNs) were making which was based on the assurance statements and NHS England. The Quarter 1 level of assurance given along with plans for Quarter 2.

The commissioned services section of the report confirmed the Contract and Quality Review meetings that were in place for our commissioned services, confirming providers and meeting frequency. Referrals to the Social Prescribing provider had increased in quarter one however there was concern over the referral rates from within PCNs with measures taking place in Quarter 2 to address this.

A request was made by the Chair in relation to the Quarter 1 data which

stated that 51% of clients referred into Social Prescribing were over 60 and 49% 18-60, whether there could be a more detailed breakdown of the 18-60 group. Ms Southall agreed to this. The service did not allow self-referrals but received referrals from other professionals within the health and social care system. **Action 42 SS**

It was confirmed that the current referrals were for the embedded 5 Social prescribers. A question was raised regards to the additional 6 prescribers shortly to be coming in if there would be 6 times worth of social prescribing referrals expected. Ms Southall confirmed that the PCNs were very keen to have their own Social Prescriber to do targeted work with specific cohorts of patients. The expectation from Clinical Directors was that the new Social Prescribing Link workers (in post by 28 September) would be embedded within the networks whereas the existing service, currently receiving 2 referrals a day, sat outside of this. Ms Southall explained that the 2 referrals per day were solely new referrals and workers still had a caseload existing patients.
Discussion ensued about the other services currently on offer including Primary Care counselling from Relate and whether there was already sufficient IAPT provision and whether the provision was being used appropriately. Ms Southall felt that from a Social prescribing perspective it was too early to say whether there was too much provision as needed to allow Clinical Directors to demonstrate demand at network level. It was suggested by Ms Southall to do a feature on Social Prescribing for the December meeting. **Action 43 SS**

Ms Southall advised that next year from April 2020, the networks would have the opportunity to opt for additionality based on their own preferences, whether for more social prescribers, first contact practitioners or clinical pharmacists.

Public Health agreed that as data intelligence indicated there were many people with life problems and that social wellbeing was traditionally seen as the domain of the Local Authority and with carers, for example, only a quarter saying they had enough social contact and there were 7,000 registered carers so if there was any future spare capacity this might be one route for it.

Sound Doctor utilisation rates had increased greatly which, it was felt, was due to the use of text messaging and links being sent to cohorts of patients.

Care Navigation, a review session was due to take place later this month with a relaunch of care navigation. There had been a number of practices not recording navigation actively through their clinical systems which was being addressed.

Utilisation of Choose and Book Advice and Guidance remained an issue and discussions were taking place on how to liaise with consultants within the Trust.

Workflow optimisation, GPs and staff had taken part in some workflow training last year and the model had now been introduced where non-clinical staff were coding correspondence with the intention to free up GP time. A number of practices that should be providing evidence at audit were not quite there and this was being worked on.

Types and numbers of GP home visits were provided at Programme Board in October 19. The pilot had been extended until end October 19. The evaluation report would detail the destination of the patients and the cost of intervention.

There were no further comments around the report.

GP at Hand Briefing Note – Appendix 2
The report on Digital First Primary Care informed that following a consultation led nationally from June to August 23rd, there was a call to action shared with Clinical & Executive Directors in regard to the contractual change that NHS England were exploring.

There was a view at national level that Primary Care should be digital first rather than face-to-face appointments and within the Hammersmith & Fulham CCG was a practice that had grown its list size significantly to in excess of 50,000 patients with a significant number of them being out of area. Patients tend to work in the London area but live elsewhere where they were originally registered with a GP.

A practice in Birmingham was currently working with another provider of such infrastructure. Birmingham and Solihull CCG (BSOL) had experienced a significant impact on their day to day working and could potentially lose numbers of patients. Fortnightly conference calls were taking place involving Birmingham and Solihull (BSOL) CCG, Hammersmith & Fulham CCG, NHS England, Public Health England as there are significant issues with patient pathways particularly in relation to immunisation and screening programmes. Measures were in place to try and mitigate this in the Birmingham branch. The rate of patient registration for the BSOL practice was initially capped at 2,300, which had recently been lifted by NHS England with patients now able to register. The rate of registration had not been as rapid as initially expected but with fresher's week approaching registrations might exceed the initial cap.

GP at Hand, a GMS practice in Hammersmith & Fulham had a rapid expansion plan that has been suppressed by NHS England at this point but would be reconsidered for later in September. The Practice seeked to recruit registrants from surrounding areas which could affect Wolverhampton, Stafford, Telford and the Shropshire Boarders as patients who live and work within 40 minutes of the new branch opening in Birmingham would be eligible to register.

The report provided detail of the patient cohort that tended to register with this type of practice and these patients would be registered as out of area

patients and moved from their current registration to Hammersmith & Fulham CCG. The consultation would seek to rectify this and out of area registrations would be changed to place of residence to mitigate the financial consequences. The consultation had now ended and all responses were being considered.

The availability of digital technologies was now available at Practices within Wolverhampton but could be better utilised so the call to action was to remind Clinical Directors to increase this. A typical practice with a list size of around 6000 patients could lose a large cohort of 21-30 year olds possibly up to 800 patients if it grew at the rate it did in London.

Ms Southall stressed the importance of recognising the implication of the consultation, Digital First being the mantra that was being taken by NHS England, which would inform changes to contracting. If Wolverhampton were to be viewed as an under adopted area, which currently it was, it could potentially be subject to an APMS contract being imposed for one of the providers to be brought in to recruit patients to the Digital First model. Wolverhampton had responded firmly that it did not feel there was a need for another practice.

The issue was being taken seriously by the CCG Executives and the Clinical Directors and an amber risk had been raised but if registrations from the Wolverhampton population increased the risk would also increase. If another practice similar to that opening in Birmingham were to open within Wolverhampton there could be significant implications for the CCG.

It was felt that Practices using the technology currently in place was a very different thing to the GP at Hand offer. Ms Southall advised there would be a meeting on 9th September 2019 with Clinical Directors as to whether they would like to explore a Black Country model by collaborating with Livi, GP at Hand or Push Doctor and costs were being sourced by the Lead.

It was felt that the twenty minute response time on offer, was more of a triage service, than a consultation and in effect was no better than the referral being dealt with by telephone.

Another member stated that of the younger patients who register with such a service that 40% move back after time and to offer a “blended” service of traditional and digital within existing practices would be better.

Steps to be taken included a review of advertising and promotion of availability of such types of appointments within practices and monitoring the numbers of registrations.

A further update on Digital First Primary Care would be provided to committee in October. **Action 44 SS**

Wolverhampton Primary Care Strategy 2019-2021 – Appendix 3
The strategy had been updated and, given the time available, it was taken

that the report had been read by members with any feedback to please be provided it to Sarah Southall by close of day on Friday 13th September 2019 prior to the strategy being recommended for adoption by the Governing Body.

RESOLVED:

1) **That, pending any comments from members prior to 13 September, the revised Primary Care Strategy be recommended to the Governing Body for ratification.**

2) **That the update was noted.**

STP Primary Care Strategy

WPCC555

It was taken that the report had been read by members with any feedback to be please provided it to Sarah Southall by close of day on Friday 13th September 2019. The strategy has now been approved by NHS England.

RESOLVED: That the update was noted.

STP GP Forward View Programme Board update

WPCC556

Many of the items discussed at the STP GP Forward View Programme Board had already been covered at today's committee. Including online consultations, resilience funding approval, GP and Nursing strategy launch. There were many funding allocations that sat within the Programme Board and a synopsis of these discussions would be available by Friday 6th September and circulated to members. **Action 45 SS**

Funding had been allocated to various different projects including mentoring for new GPs, General Practice Nursing and GP fellowships with further details to be provided at future meetings. An event was planned for 10th October 2019 to provide network support for GPs returning to Practice and mid-career GPs. With regard to Portfolio careers all the PCNs were invited to access funding this year for portfolio careers that are beneficial to the PCN i.e. population health needs and specialisms.

RESOLVED: That the update was noted.

Any other Business

WPCC557

Discussion was had regarding the frequency of future meetings and it was decided to hold a meeting in October, December and February 2020 with an extraordinary meeting in November 2019.

Date of Next Meeting

WPCC558

Tuesday 1st October 2019, PA025 Marston Room, Ground Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE (PUBLIC)

Tuesday 1st October 2019 at 2pm
PA025 Marston 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)	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body (non-voting)	Yes
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	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
Dr Ankush Mittal	Consultant in 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
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Mike Hastings	Director of Operations (WCCG)	No
Diane North	Primary Care Commissioning Committee Admin	Yes

Welcome and Introductions

WPCC599 The Chair welcomed attendees to the meeting. No formal introductions were necessary.

Apologies

WPCC600 Apologies were received from the following members:-

Dr David Bush – Locality Chair/GP
Dr Manjit Kainth – Locality Chair/GP
Dr Ankush Mittal – Consultant in Public Health
Jeff Blankley – Wolverhampton LPC
Tracy Cresswell – Wolverhampton Healthwatch Representative

Declarations of Interest

WPCC601 There were no declarations of interest.

Minutes of the Meeting held 3rd September 2019

WPCC602 One amendment was requested to the previous minutes on page 9 paragraph 4 which was adjusted. Otherwise the minutes were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from Previous Minutes

WPCC603 There were no matters arising.

RESOLVED: That the above was noted.

Committee Action Points

WPCC604 **Action 39 (Minute No: WPCC481) – Tettenhall Medical Practice – Wood Road Branch Closure**
The public consultation had now closed (ended 15/09/19). The Consultation report & Equality Impact Assessment (EIA) to be presented to committee's extra-ordinary meeting in November.

Action 40 (Minute No: WPCC540) – Quality Assured Spirometry
A two month extension had been requested with the update to the Spirometry service implementation to be presented in December 2019. Ms

Southall confirmed that implementation had taken place in September with a follow up session planned for Dec 2019.

Action 42 (Minute No: WPCC554) – Social Prescribing – further level of data/detail
The further level of detail in relation to data provided to be presented at the December 2019 meeting.

Action 43 (Minute No: WPCC554) – Social Prescribing
An update on Social Prescribing including the progress of Primary Care Network (PCN) embedded staff to be provided in December 19.

Action 44 (Minute No: WPCC554) – Digital First Primary Care
A verbal update was provided by Ms Southall at today's meeting and future updates would be presented as part of the Milestone Review Board Quarterly update. Action closed.

Action 45 (Minute No: WPCC556) – STP GP Forward View Programme Board
An overview of discussion from the 6th September 2019 Programme Board to be circulated via email for discussion at December 2019 meeting.

RESOLVED: That the above was noted.

Primary Care Update Reports:

Primary Care Quality Report

WPCC605 Mrs Corrigan provided a summary of her report.

There was one incident for reporting to this Thursday's NHSE Practice and Performers Information Gathering Group (PPIG).

Some issues reported through Quality Matters had either been routinely dealt with or would go to PPIG. GPs had put in measures to tighten up processes and protocols as a result of feedback from PPIG.

Infection prevention. Five practices were audited in September. There was improvement on last year with a percentage increase from 94% to 97%. Actions included changing blinds, replacing bins and hand-wash basins.

The Flu vaccine programme was underway with most practices having received their over 65 vaccine. There continued to be some delay in receipt of the under 65s vaccine. Practices were informed last week to expect a further slight delay. Most Practices had some stock and should be inviting their eligible cohorts to attend. The specific read codes for recording of the under and over 65s vaccines had been implemented. Work with Public Health

had begun to develop a rolling Flu plan. The flu-fighters children's booklet had been circulated to schools and children had been invited to take up the vaccine.
Friends & Family Test (FFT). A report submitted to Quality & Safety committee with regard to activity over the preceding 12 months was due to be circulated to members. **Action 46 LC**

The FFT was a contractual obligation. Some Practices had issues submitting their data and were advised to contact CQRS (the people that managed the system). Others had sent evidence of reporting that had not appeared on outputs and Mrs Corrigan was investigating this. Practices with low uptake were being supported. It had been highlighted that where the GP survey indicated low satisfaction there was correlation with low numbers of FFT completion. A management plan will be in place with collaborative contracting reviews.
A question was raised in regard to the FFT calculation figures. Mrs Corrigan to review the data and recirculate. **Action 46 LC**

The Practice Nurse Strategy launch is this Thursday 3rd October at Himley Hall and would be looking at nurse retention and encouraging nurses back into post. Representatives from NHS England and Health Education England would be in attendance and the event had attracted much attention from other STPs and training hubs across the country. Wolverhampton to present at the Best Practice conference in October and Quality team members had been invited to a workforce event on 12th November in London.

The next Complaints report was confirmed as due in October. Complaints regarding staff attitudes had significantly reduced which, it was felt, was a result of Conflict of Resolution training. Ms Southall stated that the GP Survey report this year had advocated some definite improvements in responses from patients in regards to the friendliness and helpfulness of reception staff.

It was confirmed that the workforce numbers reported were for the STP and that there had been changes recently to the data collection which meant figures were only available at this level. Ms Southall highlighted that the work to develop Primary Care workforce was beginning to have an impact reducing the level of risk associated with being an under-doctored area to amber

RESOLVED: That the report and highlights above were noted.

Primary Care Operational Management Group Update

WPCC606 Mr McKenzie presented on behalf of Mr Hastings giving a summary of key items from the Primary Care Operational Management Group meeting of 11th September 2019.

There had been continuation of support for the consultation process in relation to the proposed closure of the Wood Road branch site.

There was discussion around the development of the contracting review programme and assurance arrangements for primary care networks.

Wolverhampton Healthwatch had shard, for the first time, patient feedback collected from GP Practices. Discussion to be had as to how best to format, incorporate and use this soft intelligence. Healthwatch to present quarterly with next update due at the January 2020 Operational Management Group meeting.

RESOLVED: That the update was noted.

New Draft Communications & Engagement Strategy

WPCC607 Mr McKenzie presented on behalf of Mr Hastings a draft of the new Communications & Engagement Strategy for information.

The report provided a high-level overview of the communications and engagement work to be undertaken and how it contributes to the commissioning cycle. In conjunction, a separate piece of work was being undertaken around direct engagement to develop a more detailed delivery programme to be written up and available in the next couple of weeks.

Comments on the Strategy can still be submitted as the report was not quite the final draft. The Strategy has been previously shared across the Senior Management Team and Wolverhampton Clinical Commissioning Group.

It was hoped that the Strategy would go to the Governing body in November 2019. An update on implementation and progress to be presented to this committee in March 2020. **Action 47 MH**

RESOLVED: That the update was noted

Digital First Primary Care Update

WPCC608 Ms Southall provided a verbal update further to submission of the Digital First report last month. Since the meeting the consultation had since closed. Wolverhampton CCG had made a submission to the National Team in response to the consultation.

A publication had been made by NHS England on 25th September 2019 in response to the consultation confirming a number of intentions in particular around the numbers of out of area registrations. If there were more than 1000 patients currently registered with Wolverhampton GPs who registered with an out of area provider then NHS England would issue an APMS contract to the provider. A dynamic framework is currently being built for practices and providers which will be implemented from 1st April led by NHS England.

Representatives from Wolverhampton will be attending a meeting on 28th October and findings will be provided next month to committee.
A piece of work was also being undertaken across the STP associated with the intended digital offer for Primary Care Networks for the CCG and wider STP. Conversations with Clinical Directors had revealed some frustration on the interoperability of the offer. A way forward had since been identified which would be shared with Clinical Directors in order to bridge the gaps and a further report would be provided to committee in December 2019. It will also be considered at October Milestone Review Board due to it being timely.

Ms Roberts joined the meeting

A question was asked if an APMS contract would be financially viable for 1000 patients. This had been highlighted to NHS England and the response was that it wouldn't necessarily be patients who were registered with one single provider but could be scattered across a number of providers. Wolverhampton CCG's response was that we should be engaged in any such conversations at the earliest opportunity, as the CCG would be able to offer alternative approaches to establishing a new practice. The NHS England view may however be different if we are still viewed as an under doctored area. There were plans in place to mitigate the situation now in readiness for 1st April by offering an equivalent service to patients and the promotion of its availability.

It was confirmed that the Global sum would continue to be paid annually but with changes to the calculations and different rates for out of area patients.

It was confirmed that Digital First would feature as part of the next Milestone Review report to committee in December **Action 44 SS**

RESOLVED: That the update was noted this item was for decision so it was approved as per the recommendations.

Wolverhampton Primary Care Strategy 2019-2021

WPCC609 Mrs Southall advised that further to submission of the early draft and final draft to committee in September there had been some minor changes to the Strategy such as an updated Primary Care Networks map and the inclusion of an implementation plan that would be overseen by the Milestone Review Board. Updates would be provided to this committee as part of the quarterly Milestone Review updates. A suggestion was made to include a glossary defining the abbreviations but otherwise committee were happy to approve the Strategy to go forward.

RESOLVED: The committee approved the Strategy for recommendation to the Governing Body.

Primary Care Contracting Update

WPCC610 Ms Shelley stated she had nothing further to add that hadn't already been discussed.

RESOLVED: That the update was noted.

Any other Business

WPCC611 There was no further business.

Ms McKie reported that she had contacted the Local Medical Committee (LMC) who has assured that they will notify us of their attendance or send apologies for future meetings.

Date of Next Meeting

WPCC612 Tuesday 5th November 2019 – Extraordinary Meeting – Venue TBC

Tuesday 3rd December 2019 at 2pm – PC108, Creative Industries Centre, Wolverhampton Science Park WV10 9RU

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 29th August 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	No

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
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
Mags Courts	Children's Commissioning Manager	Yes (part)
Sarah Fellows	Head of Mental Health	Yes (part)

Apologies for absence

Apologies were received from Sally Roberts and Cyril Randles.

Declarations of Interest

CCM821 There were no declarations of interest.

Minutes

CCM822 The minutes of the last committee meeting, which took place on 25th July 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM823 There were no matters arising

Committee Action Points

CCM824 There were no current actions to review.

Better Care Fund – Carers Budget

CCM825 Mags Courts, presented this report on behalf of Andrea Smith, Head of Integrated Commissioning. It was explained that there is a budget within the Better Care Fund Programme allocated to supporting carers, which has to be aligned to schemes involving supporting carers. Two schemes were proposed to support the population of Wolverhampton, over and above the duties of the existing Carers support team;

- Carers 'Information Pop-ups' – currently provided at RWT sites to provide information for patients, their families and carers when visiting the hospital which can help them learn about the support that may be available to them. The additional investment will be used to increase capacity to hold more sessions and in different locations across the area by funding 2 additional members of staff.

How productivity gains would be assessed was discussed and it was agreed that this would be confirmed with Andrea Smith.

- Emergency Home Based Respite Care – An area had been highlighted as a gap across Wolverhampton, which may be required when the carer is no longer able to care for the patient for a period of time, for example if they are ill or have an accident. Confirmation was given that the aim is to keep the individual in their own home if something happens to their carer.

RESOLVED: The Committee approved both schemes with two caveats relating to the Carers 'Information Pop-ups';

- the detailed costs are still to be confirmed but will not, in totality, exceed the budget available.
- how productivity gains are to be assessed is confirmed.

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).

CCM826 Mags Courts reported that funding had been provided on a permanent basis to BCPFT for an administrative post to support the development and implementation of an ASD diagnostic pathway. Work undertaken had identified that there was an outstanding waiting list for assessments to be undertaken which had not been clearly visible.

It was proposed that addition funding be provided 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.

Clarification was given that the money for the one off support was from money already received from NHSE and this would not compromise IAPT Training CYP. Clearer data would ensure that a hidden waiting list would not reoccur. The new diagnostic service, which is in line with NICE guidance, will give a clear understanding of future demand for referrals to ensure this does not happen

RESOLVED: The committee endorsed the additional funding with the caveat;

- this would not affect training
- the extent of how the investment will address the backlog is shown

Investing in Speech and Language Therapy (SLT) to provide a service to Youth Offending Team (YOT)

CCM826 Mags Courts informed the committee that research had shown that a high percentage of young people in the justice system have speech, language and communication needs. There is currently no speech and language provision for CYP who are part of the YOT as this is currently not a commissioned service. The proposes provision will not duplicate the current commissioned provision as the existing service accepts referrals for children within a set criteria and is likely that the young people in the criminal justice service will not necessarily be diagnosed with any of these conditions and therefore the referral in to the already commissioned service will not be accepted.

The role of the SLT, who will be specially trained in this area, will work within the multi-agency group in the YOT to work in partnership to prevent re-offending and support young people and their families to support the co-horts emotional mental health and wellbeing. The funding will come from the CAMHS transformational funding.

It was queried how the success of the investment will be monitored and clarification was given that this is through individuals completing rehabilitation programmes, engaging with health teams and health and care plans.

RESOLVED: The committee approved the additional funding as proposed with an update report to be brought back after 1 year.

Mags Courts left the meeting

Yvonne Higgins, Phil Strickland and Sarah Fellows joined the meeting

Trauma Counselling Business Case

CCM827 Sarah Fellows presented the service specification which aims to reduce spot purchasing high cost very specialised intervention from out of the area providers.

Trauma Counselling and Psychological Interventions is a critical gap in terms of the CCG's commissioning and there is an increasing focus on the provision of all mental health services becoming trauma informed trauma aware and trauma responsive across the whole mental health model as per the NHS Long Term Plan.

Trauma informed and Trauma aware staff training commissioned by the CCG commences in November and December, 200 plus places available.

It was queried whether this service was to meet unmet demand or to provide local provision and how a reduction in the use of the providers used at present could be ensured. It was stated that work is being carried out by the BI team to understand the current patient pathways and level of intervention required to inform the service redesign. Clarification was given that all referrals will go through BCPFT.

Cost was discussed and it was highlighted that there is a need to provide a cost comparison between spot purchasing out of area and the new provider. The Finance Team will also need to agree a forecast spend as finances are currently based on budget availability which may be exceeded.

The redesign plans to be reviewed and a risk to be added to the register if appropriate.

RESOLVED: The committee agreed the business case in principle based on an update of financial envelope and provider performance before the end of the year.

Eating Disorder Service

CCM828 Sarah Fellows presented this service specification which had been developed following a joint programme of work managed through the STP Mental Health work programme. The aim of the new specification was to provide a higher quality service for the population and in line with STP footprint partners. This had been collaboratively developed with provider clinicians. It requires sign off by all Black Country CCGs. It is anticipated that the new Eating Disorder Service can be provided within the current joint financial envelope. If this is not the case then consideration will be given to where compromise needs to be affected on a service by service consideration.

It was clarified that this is a well-known service in the Wolverhampton area and self-referrals can be made. The numbers of both urgent and routine referrals are reported to NHSE on a monthly basis.

RESOLVED: The committee approved the Eating Disorder Service Specification.

Contracting Update

CCM829 The Committee was presented with an update for the period August 2019.

Royal Wolverhampton NHS Trust

Performance Targets

Referral to Treatment (RTT) – performance saw further deterioration during June. The issues are being discussed through a number of forums. This includes the Finance and Performance Committee where it is included on the risk register. A Finance and Activity Group had been set up to assess risk mitigation.

A Remedial Action Plan (RAP) had been received including specific departmental actions and speciality level improvement plans to which the CCG had responded as additional information was required..

Contract Performance

Cancer – most significant and concerning issue remains 2 week wait performance for breast cancer patients (and those referrals for breast cancer symptomatic patients). Referrals continue to be greater than the capacity the Trust has to manage them, however, conversion rate are in line with the national rate indicating referrals are appropriate. There are some pathway issues which the Trust is addressing which are being impacted by consultants not covering additional clinics due to national pension issues.

The situation is being closely monitored locally and at an STP level. At the Contract Review meeting it had been clarified that the wait had reduced slightly but was still at 51 days.

RWT is being assisted by other Trusts taking patients that live nearby. GPs are being strongly encouraged/recommended to refer patients to other Trusts where the waiting time is nearer to the standard required.

GPs are also to be made aware that a reiteration of the breast pain pathway is due to comment at the beginning of September.

Other Contractual Issues

Dermatology – the procurement is complete and the contract award has gone to Circle Health. A first meeting had been held and will continue through to the commencement of the new service on 1st December 2019. The issue of stranded costs is close to resolution and are significantly lower than initially stated and at a manageable scale. As these are no longer a risk to the procurement it was recommended that this risk was closed.

Phoenix Walk In Centre – A formal letter had been sent to the Trust confirming acceptance of the business case to expand the service to meet the requirements of transitioning to an Urgent Treatment Centre by 1st December 2019.

The main caveat of the investment is a requirement to make available to the CCG information for all attendances, based on the national dataset for Emergency Care. This will be included as part of normal reporting from Month 9 onwards.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

Improving Access to IAPT

The Trust is still failing to achieve the monthly IAPT target. The Trust has recruited additional staff and is working with the CCG to source accommodation in local GP Practices for new staff. The CCG is in discussion with Primary Care Networks regarding clinical space availability. The Remedial Action Plan will be monitored through the Contract Review Meetings.

Transfer of the non-contract activity funding to the provider – the NHS Long Term Plan states that there should be no out of area placements by March 2021. The Trust has to undertake a considerable amount of due diligence before they accept the budget. To aid this, the CCG had issued a Partnership Agreement outlining the responsibilities of the two parties, the service scope and the risk/gain share agreements.

Other contracts

Accord Housing Association Ltd – Victoria Court

A proposal had been put forward to the provider to change the current bed utilisation by commissioning more step-down beds and less rehabilitation beds. The details of this proposal were to be considered within the private section of this meeting.

RESOLVED – The Committee noted the updates and actions being undertaken.

Review of Risk

CCM830 The Committee was presented with the current corporate and committee level risks. The recommendations to close the following two committee level risks were agreed as discussed earlier in the meeting;

CC15 – Stranded costs within Dermatology
CC14 – Acute Dermatology Provision

RESOLVED – That the above has been noted and the two committee level risks closed

Any Other Business

CCM827 There were no items raised for discussion.

Date, Time and Venue of Next Meeting

Thursday 26th September 2019 at 1pm in the CCG Meeting Room 1

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 26th September 2019 commencing at 1.00 pm in the CCG Meeting Room 1, Wolverhampton Science Park

MEMBERS ~

Clinical ~ **Present**

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	Yes

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Director of Finance	Yes
Sally Roberts	Chief Nurse & Director of Quality	No
Andrew Wolverson	Head of Service People - Commissioning - WCC	No

In Attendance ~

Peter McKenzie	Corporate Operations Manager	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Philip Strickland	Governance & Risk Coordinator	Yes (part)
Yvonne Higgins	Deputy Chief Nurse	Yes
Alan Hanna	Project Accountant	Yes (part)
Sukhi Sandhar	Deputy Head of Medicines Optimisation	Yes (part)

Apologies for absence
Apologies were received from Sally Roberts

Declarations of Interest
CCM828 There were no declarations of interest.

Minutes
CCM829 The minutes of the last committee meeting, which took place on 29th August 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM829 Mr Reynolds asked how patients would access the newly commissioned community dermatology service. Mr Middlemiss confirmed that the new service would operate as the current provider did with referrals from GPs for conditions other than where cancer was suspected. Cancer related referrals would be made to RWT and pathways for onward referrals from Circle were also open. In response to a further question, it was confirmed that Circle would operate at sites across the city but that the location of these sites had not yet been finalised. Mr Randles highlighted previous issues with patients having appointments at multiple locations and asked whether the CCG had influence on the provide to ensure locations were suitable. It was agreed that an update would be provided on plans for the location.

Committee Action Points

CCM830 There were no current actions to review.

Devolvement of Mental Health NCAs Budget to BCPFT

CCM831 Mr Hanna introduced the report, which outlined a proposal to devolve management of the budget for non-contracted activity in Mental Health to Black Country Partnership Trust.

The report outlined that this spend related to mental health patients placed out of area due to capacity in the local trust. Currently, when capacity was not available, bed managers within the trust sourced an alternative placement, that was then paid for by the CCG. It was proposed that, following financial modelling, the expected budget for this activity will be transferred to the trust as part of their contract, on a shadow basis initially. Mr Hanna outlined some of the technical work undertaken to identify potential spend, including excluding spend with a number of NHS providers.

Mr Marshall outlined some of the background to the development of the proposal, highlighting that it was intended to support transformation across the system by providing positive incentives to keep patients in area and aslto to avoid costly out of area placements.

Ms Higgins highlighted that, as part of the development of the proposal, it would be sensible to work with the Trust to strengthen their care coordination processes for out of area placements. Mr Marshall referred to standard operating procedures that were in place to support coordination for out of area patients. In response to a question from Mr Reynolds, it was confirmed that the intended impact of the proposal was for more of the budget to be spent locally and that patients would see improvements in service as a result. In response to a question from Mr Randles, Mr Middlemiss confirmed that the spend and impact of the proposals would be monitored through KPIs around bed availability and that an update could be provided prior to the end of the shadow period.

Mr Marshall advised the committee that, following discussions with the trust, a query about liability for patients had been raised. This was being escalated to the trust's Chief Executive.

RESOLVED: The committee supported the proposals and asked that an update be provided prior to the end of the shadow period.

Phil Strickland joined the meeting

Contracting Update

CCM832 The Committee was presented with an update for the period September 2019.

Royal Wolverhampton NHS Trust

Performance Targets

Referral to Treatment (RTT) – Mr Middlemiss advised that the Trust were reporting an overspend due to an increase in outpatient activity that had not yet been matched by a reduction in in-patient activity, Mr Marshall highlighted that there was a reduction in outpatient first appointments which could potentially lead to a reduction in outpatient procedures later in the year. Mr Gallagher also highlighted the work undertaken by the Trust to reduce their waiting list backlog and Mr Middlemiss advised that colleagues in Business Intelligence were analysing details from the Trust. He also confirmed the Recovery Action Plan for RTT had been agreed which would enable monitoring of specific action.

Mr Middlemiss advised that work to divert referrals for breast cancer was beginning to have a positive impact on performance. Ms Higgins advised that reductions in performance at Walsall and Dudley were being monitored and Dr Gulati referred to negative patient experience in consultant clinics as a result of pressure in the system.

Contract Performance

Mr Reynolds commented on the information provided in the report in relation to theatre utilisation as a result of consultants not being available. Mr Marshall highlighted the potential impact of changes in NHS pensions.

Other Contractual Issues

Dermatology – Mr Middlemiss referred to ongoing work to mobilise the contract for the new community Dermatology provider, highlighting the previously discussed work to establish provision across the City. He also advised that complications with commissioning arrangements in Staffordshire presented a potential risk, this would be discussed further and potentially added to the committee's risk register.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

Improving Access to IAPT

Mr Marshall advised that work was underway to make IAPT provision available in Primary Care settings by the end of September. Dr Gulati confirmed that GPs welcomed this provision but highlighted the associated challenges with estate in Primary Care.

Mr Randles asked about the reference in the report to the audit on duty of candour. Ms Higgins advised that the Trust had been receptive to the findings of the result of the audit and acted quickly to address the issues identifying. The CCG had been invited in to review performance.

RESOLVED – The Committee noted the updates and actions being undertaken.

Ms Sandhar joined the meeting

Review of Risk

CCM833 The Committee was presented with the current corporate and committee level risks. Mr Strickland advised that an update had been provided in relation to the risk identified relating to the emotional well-being service and that the risks had been re-aligned to the new Governing Body Assurance Framework. It was confirmed that potential risks in relation to dermatology and the issue in relation to liability for out of area patients would be considered for addition at the next meeting.

RESOLVED – That the above has been noted

Any Other Business

CCM834 Items which should not routinely be prescribed in Primary Care (Medicines of limited clinical value

The committee considered a report from the Head of Medicines Optimisation which outlined NHS England guidance issued to CCG's in relation to medicines not to be routinely prescribed in Primary Care. Ms Sandhar presented the report, highlighting that the guidance has been produced following a period of consultation and advising that the proposal was to implement the guidance using a phased approach with patients.

In response to a query from the Chair, Ms Sandhar confirmed that proposals to include blood glucose monitoring strips in the guidance had been removed following consultation. Work to reduce prescriptions in relation to these products was included in the CCG Oversight Framework.

RESOLVED – That the Committee support the implementation of the guidance on items that should not be routinely prescribed in Primary Care with a local communication and engagement exercise.

Date, Time and Venue of Next Meeting

Thursday 31th November 2019 at 1pm in the CCG Meeting Room 1

Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 8 August 2019

Members:
Ian Sykes (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
James Green, Chief Finance Office, Sandwell and West Birmingham CCG
Peter Price, Lay Member Wolverhampton CCG
Sharon Liggins (for Andy Williams), Chief Operating Officer, Sandwell and West Birmingham CCG
Neill Bucktin, Director of Commissioning, Dudley CCG (for Paul Maubach)
Paul Tulley, Director of Commissioning, Walsall CCG
Alastair McIntyre, Portfolio Director, Black Country and West Birmingham STP
Jonathan Fellows, Chair, Black Country and West Birmingham STP
Sally Roberts, Chief Nurse, Wolverhampton CCG

In Attendance:
Sara Saville, Head of Corporate Governance, Walsall CCG
Emma Smith, Governance lead, Dudley CCG
Jayne Salter-Scott, Communications, Sandwell and West Birmingham CCG
Jackie Eades, Executive Assistant, Walsall CCG (notetaker)

Apologies:
Anand Rischie, Chair, Walsall CCG
Andy Williams, Accountable Officer, Sandwell and West Birmingham CCG
David Hegarty, Chair, Dudley CCG
Les Trigg, Lay Member Wolverhampton CCG
Paul Maubach, Accountable Officer, Dudley CCG and Walsall CCG
Salma Reehana, Chair Wolverhampton CCG
Deborah Rossi, CCG Transition Director
Matt Hartland, Chief Finance and Operating Officer, Dudley CCG
Laura Broster, Director of Communications, Dudley CCG
Peter McKenzie, Corporate Operations Manager, Wolverhampton CCG

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 Dr Ian Sykes declared that he was a practicing GP within Sandwell and West Birmingham CCG.

1.4 The minutes of 11th July 2019 were accepted as an accurate record of the meeting.

The action log was reviewed and actions confirmed as delivered or others taken within the agenda.

- Action 140 deferred to Sept 2019.
- Actions 151, 159 completed.
- Actions 152, 153, 155 were on the agenda.

- Action 154 Transforming Care Partnership report being presented at all 4 Governing Bodies during September 2019. There is a further action that a report will be presented at September's JCC detailing the wider cohort of patients.
- Action 156 further update when more information is available at September's meeting.
- Action 157 Alastair McIntyre to discuss BCWB UEC Board with Andy Williams, AO Sandwell and West Birmingham CCG, remains outstanding.
- Action 158 update given by Helen Hibbs, a provider lead new care model is being developed and includes T4 CAMHS, Steve Marshall is involved for the STP and the work is being led by Birmingham CCG. More information will follow in due course.
- Action 160 not due until October 2019.
- Action 161 as above, although Paul Tulley stated there has been dialogue between 3 CCGs and BSOL 3 policies are aligned including POLCV but there is no formal agreement that all policies will align with BSOL more information required.
- Action 162 this action is to move to Alistair McIntyre and the respiratory paper to be shared with Paul Tulley and Neill Bucktin.

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 of the 19th July CLG meeting was given noting items that were discussed; Respiratory Workstream - review of priorities against the Long Term Plan (LTP), alignment of formulary, training in inhaler techniques for Primary Care. Children and Young People – agreed priorities with Academic Health Science Networks (AHSN), if there is local place based work is being scoped to see is there is alignment. Cancer update centred around 2WW and 62-day performance and how the STP can support Royal Wolverhampton Hospital Trust (RWHT) to improve the targets. Frailty collaborative application has been supported by NHS Improvement and will be part of the first wave. Clinical Strategy Group – Lucy Heath is working on this and looking to strengthen links across the STP. The stocktake of the CLG will continue to be looked at academically by Aston University. Dr Donald Dobie from RWHT has been identified as the STP antimicrobial lead. Networked maternal medicine – 2 areas have been identified that RWHT can apply for. Professor Nick Harding has now left Sandwell and West Birmingham CCG, the Chair of the CLG passes to Jonathan Odum.

4. MATTERS OF COMMON INTEREST – Performance and Assurance Return

4.1 Urgent & Emergency Care Transformation Plan

4.1.1 Alistair McIntyre highlighted areas for update detailed in his report on performance against the key constitutional standards. In terms of the A & E 4-hour standard all Black Country CCGs are above 80% but are unlikely to achieve the 95% national target.

NHS 111 concerns remain around Care UK being able to deliver the contract with a high proportion of calls transferred to 999 which is driving up ambulance conveyance in all areas.

RTT - the STP performance is a fraction away from the national target of 92% but diagnostic waits remain challenging.

Discussions ensued and questions were asked about the additional funding that the Prime Minister is providing for 20 hospitals, it was noted none of which are in the Black Country. The funding for the planned ED extension to the Manor Hospital in Walsall has already been agreed. Members queried the timeline for completion as it needs to be completed before MMH opens but there is believed to be slippage in this date.

ACTION: Helen Hibs and Alistair McIntyre agreed to look into this with Walsall Healthcare Trust.

There was a further discussion on the wider STP focus on performance and Regulators are expecting the Black Country to work together to improve targets in areas such as cancer 14-day referral rates. Sally Roberts informed members that the CLG had looked to identify other vulnerable services such as dermatology, urology and diagnostics looking at workforce, value for money, volume of patients and pathway issues. This work has now been transferred to Medical Directors in the Acute Trusts to take forward.

4.2 **The STP Elective Care Transformation Plan**

4.2.1 Work continuing to develop into 1 cohesive plan rather than 5.

ACTION: Helen Hibbs to provide an update at September's meeting.

4.3 **Specialised Commissioning**

4.3.1 No update at today's meeting.

4.4 **Place Based Commissioning Update – Dudley CCG**

Neill Bucktin stated that Harry Turner has been appointed as MCP Chair and Phil Evans has been appointed as Programme Director. Work continues on the organisational form and who will hold the MCP contract. Workstreams have commenced including work in care homes. The CCG is awaiting the national Integrated Care Contract to be published which is expected soon.

5. FORMALLY DELGATED AREAS

5.1 **Transforming Care Partnership**

5.1.1 A meeting has been arranged on 3rd September to discuss the TCP engagement report and the current status of the community model prior to presentation at the TCP Board for sign off. The Chairs of the five Overview and Scrutiny Committees have been invited to this meeting and reports will be presented at each Governing Bodies during September. The reports will include information around the bed closures within the region. There is satisfaction that there is enough bed capacity within the Black Country, 17 Specialised Commissioning, 17 CCG and 5 Children and Young People.

It was noted that an appendix was missing from today's pack.
ACTION: Helen Hibbs to share missing paper.

Helen Hibbs updated members stating that admissions are still a challenge, there have been 6 admissions in July, 3 of which were discharged within 48 hours and 2 were re-admissions due to mental health crisis. This is disappointing and RCA analysis is being carried out. Discharges however, are getting much better with appropriate plans in place to support patients in the community. Patients under Ministry of Justice (MOJ) restrictions and on a Section 17 still count in our figures even if on authorised leave.

Care and Support market work continues to develop, working with Local Authorities to address complex needs establishing what is required on a more person centred approach.

NHS E/I have funded a much needed TCP Programme Director who will start next week for 3 months.

In terms of the bed closures the Penrose Centre is to be re-built so it can be fit for purpose. Transport issues have been raised and have been addressed for patients that require treatment and assessment. Ridgehill in Dudley and a site in Walsall are earmarked to be closed.

Wolverhampton CCG commenced the community model earlier and has found there to be good evidence that it is working.

Julie Jasper asked if the National Team understand the complexities of these patients. Helen Hibbs stated that the national data set is showing a reduction mainly but the figures did increase last month. Young adults between 17 and 25 need to be in the community for assessment and treatment.

5.2 **Mental Health**

5.2.1 **Update on Bids**

Helen Hibbs updated members by stating that there is a tremendous amount of work being carried out across the STP in terms of the numbers of returns that need to be made to the Regulators.

There have been 4 funding bids submitted and 3 have been successful, these include crisis resolution/Home Treatment, Core 24 and Schools Trailblazer. This is a good news story and should be included in the next STP communication.

ACTION: Jayne Salter-Scott to ensure this is shared.

5.2.2 **Community Sentence Treatment Requirement Programme**

The West Midlands Combined Authority Board want to roll out into the Black Country a scheme to increase the community treatment orders as an alternative to prison sentences. The funding for this scheme is on a targeted approach from West Midlands Combined Authority.

6. RISK REGISTER

6.1 Update in October 2019.

7. FEEDBACK FROM GOVERNING BODIES

7.1 **ACTION: Sharon Liggins to share with the Directors of Commissioning a paper around our role as part of the ICP.**

James Green shared information from Sandwell and West Birmingham's Governing Body the Transition Board paper was supported, there is a further question around West Birmingham and how this will align to Birmingham. There is a paper going to the Transition Board in September setting out West Birmingham arrangements.

ACTION: JCC members asked that the West Birmingham paper is added to the agenda of September's JCC meeting.

There is a requirement for more work around funding and governance arrangements with the organisations within the ICS and to what extent they will be involved.

There were no updates from Walsall, Wolverhampton or Dudley CCGs.

8. UPDATE FROM STP

8.1 Jonathan Fellows gave an update on the progress looking at the development of the ICS and stated that focus groups have been set up including one looking at clinical pathways.

Further work is being undertaken around branding and better communications across all organisations.

The 4 Acute Trusts have had discussions on how they can work together, these discussions will remain on going.

In terms of governance there are 5 places for Primary Care Network (PCN) leads to be filled on the STP Board then the next steps will be to look at including Lay Members and Voluntary Sector representation.

Members made comments after update for assurance that in terms of repatriation funding will follow the patient and note the risk associated with this.

Paul Tulley asked if the CLG were linked with the STP Acute Trust conversations as there needs to be Commissioner input into clinical pathway discussions to ensure that governance is in place and commissioning decisions are taken into consideration. Sally Roberts reiterated this point.

The Chair of the STP Board does not attend the meetings between the Acute Trusts. He pointed out that this is the beginning of a process and a change in culture for the Trusts to work together.

Pathology was suggested as a good example of the 4 Trusts working together, the STP can take learning from this process which did take time but is now showing benefits.

9. ITEMS FOR INFORMATION

9.1 Information given in confidence, Andy Williams has not yet received a formal unconditional offer from Leicester CCG, therefore has not resigned from his AO position at Sandwell and West Birmingham CCG. The CCG has requested that he works his notice of 6 months. A formal announcement will be made next week.

9.2 James Green updated members on the step in arrangements by WMAS to provide NHS 111 service as Care UK cannot continue to provide this service. The due diligence exercise that is being undertaken cannot be completed in full due to the lack of granular detail to be provided by WMAS. The activity figures cannot be validated without this detail. The transfer date is 5th November 2019 and Sandwell and West Birmingham CCG as the commissioner have given the go ahead to WMAS but with the assurance that the due diligence work will continue during the year. The in-year funding is an extra £1.5m increasing to £8m full year effect. This arrangement does include the CAS service. A letter was issued by Rachael Ellis on 6th August asking all CCGs to respond by close of play on 7th August.

An Implementation Board will be set up and Rachael Ellis is asking for representation from all CCGs.

Paul Tulley asked if the Regulators were challenging this decision. In response James stated that there has been no challenge therefore it is assumed they agree with the arrangements that WMAS have put forward. Helen Hibbs agreed with Paul Tulley and questioned the openness and transparency of this decision. There is a risk to all CCGs in accepting this arrangement. It is unclear if the Regulators have given the go ahead for this step in arrangement.

In terms of the patients, do we know what benefits will be provided to patients within these new arrangements. The CCGs cannot be assured about the workforce as the detail is not available to validate.

10. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

10.1 None declared, actions detailed below.

11. DATE OF NEXT MEETING

Thursday 12th September 2019, 09:00-10:30, Board Room, Dudley CCG, Brierley Hill Health and 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	08/08/19 – Revised deadline, update at Sept 12th meeting.
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	12/09/19 – On Agenda. Action to be closed.
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	12/0/19 – Discussion took place 02/09, UEC Board to be established, Richard Beeken to chair with first meeting in October
160	11 July 2019	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.	Sharon Sidhu	8 August 2019	Update to be given after AO appointment 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.	Alistair McIntyre	8 August 2019	Revised action - Respiratory paper to be shared with all Directors of Commissioning.

No.	Date	Action	Lead	Deadline	Status Update
163	8 August 2019	Helen Hibbs and Alistair McIntyre investigate the slippage in opening of the new ED department at the Manor Hospital, Walsall.	Helen Hibbs and Alistair McIntyre	12 Sep 2019	Update at the next meeting
166	8 August 2019	Jayne Salter-Scott to ensure that good news story around the 3 x successful STP bids is included in Comms	Jayne Salter-Scott	31 August 2019	
167	8 August 2019	Sharon Liggins to share with all Directors of Commissioning the paper on the CCGs role as part of the ICP	Sharon Liggins	31 August 2019	Shared – action to be closed.
168	8 August 2019	Report on the arrangements for West Birmingham which is planned for Sept. Transition Board also to be added to JCC agenda for September	Sharon Liggins	12 Sep 2019	On agenda

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Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 12 September 2019

Members:
Salma Reehana, Chair, Wolverhampton CCG (Chair)
Clare Hamilton, Executive Assistant to Paul Maubach, Dudley CCG (note taker)
Alastair McIntyre, Portfolio Director, Black Country and West Birmingham STP
Anand Rischie, Chair, Walsall CCG
Ian Sykes, 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
James Green, Chief Finance Office, Sandwell and West Birmingham CCG
Peter Price, Lay Member Wolverhampton CCG
Jayne Salter-Scott, Head of Communications, Sandwell and West Birmingham CCG
Matt Hartland, Chief Finance and Operating Officer, Dudley CCG
Paul Maubach, Accountable Officer, Dudley CCG and Walsall CCG
Deborah Rossi, CCG Transition Director
Sharon Liggins (for Andy Williams), Chief Operating Officer, Sandwell and West Birmingham CCG

Apologies:
Andy Williams, Accountable Officer, Sandwell and West Birmingham CCG
David Hegarty, Chair, Dudley CCG
Laura Broster, Director of Communications, Dudley CCG
Helen Moseley, Lay Member Dudley CCG
Paula Furnival, Executive Director for Adult Social Care, Walsall Council
Jonathan Fellowes, STP Chair
Julie Jasper, Lay Member, Sandwell and West Birmingham CCG

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above.

1.3 No declarations of interest were made.

1.4 The minutes of 8 August were accepted as an accurate record of the meeting. The action log was reviewed and the action log has been updated accordingly.

Dr Anand Rischie joined the meeting.

2. CLG Update

Sally Roberts submitted a paper, in her absence, the paper was accepted as read.

3. Matters of Common Interest

3.1 Performance and Assurance Return

Alastair McIntyre presented the STP Performance Report for information. Key points noted were:

- A&E performance deteriorated in June,

- 111 deteriorated in performance in that period too
- RTT continue to have challenges in meeting 92% standard.
- Cancer raised as an issue at system review meeting. Deep dive meeting being held with NHSE/1 in attendance on 10 October.
- Mental health performance is improving.

3.1a Urgent and Emergency Care Transformation Plan

Alastair McIntyre advised that this document was submitted and has been accepted by NHSE/I.

ACTION: Alastair McIntyre - It was agreed to ask Rachel Ellis' team what the plan is for a primary care engagement strategy, specifically in relation to future GP appointments being made via 111. Anand Rischie advised that he is happy to converse with West Midlands Ambulance Service regarding starting primary care engagement.

3.2 Place Based Commissioning Update – Wolverhampton

Helen Hibbs presented the Wolverhampton place based commissioning update and stated that all their work streams have a primary and secondary care led. The CCG now run the Better Care Fund programme in parallel to the Integrated Alliance Work with one programme management approach across the two functions.

3.3 Information Governance Briefing

Paul Maubach updated all on the recent information governance workshops that have been held to explore IG 'rules' and explore how information sharing can take place across organisations, specifically relating to multi-disciplinary team working.

The group plan to produce a standard IG proposal and collectively approve and submit. Matt Hartland confirmed that a submission has been made for ETTF funding to support the workstream.

3.4 Brexit Update

Alastair McIntyre provided an update for information. Concerns were raised regarding potential shortages in medication following brexit.

ACTION: Mike Hastings - to provide an update to the next JCC meeting regarding potential shortages in medication following Brexit.

4. Formally Delegated Areas

4.1 Transforming Care Partnership

Helen Hibbs updated all on the challenge presented to all CCGs to meet TCP trajectories and advised that there is a lot of pressure to meet the targets from NHSE/I. Helen Hibbs advised that Claire Murdoch is leading on TCP at a national level now.

Alastair McIntyre is working on a performance plan. The team plan to refresh the programme, review governance, utilise the care and support market, commission of an autism support pathway and refresh the pathways group.

ACTION: AOs agreed to encourage chief nurses to attend the TCP Board.

4.2 Mental Health - Collaborative Commissioning Update

JCC received an interim report and noted that Steven Marshall will bring a more detailed report to the next meeting regarding potential use of MH funding.

Deborah Rossi joined the meeting.

5. CCG Transition Board

Deborah Rossi presented the CCG transition board update, this paper was accepted as read.

5.1 Arrangements for West Birmingham

Sharon Liggins presented on the current collaborative commissioning arrangements for West Birmingham. The purpose of the paper was to inform Black County CCG partners about the partnership arrangements, so that they can be considered when planning closer collaboration between the Black Country CCGs.

6. Risk Register

An update will be provided in October.

7. Feedback from Governing Bodies

It was noted that Andy Williams has formally accepted his new post and his last working day is yet to be confirmed.

8. Update from STP

Helen Hibbs updated all on the STP. STP stocktake meeting is taking place on 8 October and will then cycle quarterly. This meeting is close to the August date to accommodate Dale Bywater attendance. The agenda will be jointly agreed with NHSE/I.

Matt Hartland advised that the long term plan working draft is with workstream leads and AO's/CEO's/DPHs. The Draft document is due to be submitted to NHSE/I on 27th September, with a final copy to be submitted mid-November. Discussions with HWBB/OSC are planned to take place during this period.

10. Any Other Business

Helen Hibbs updated all on a letter received yesterday regarding a new 26 week pathway being put in place. Helen Hibbs will share with Neill Bucktin who is leading elective care work with a view to it being on the next Elective Care Board meeting.

Meeting closed

11. Date of Next Meeting

Thursday 10 October 2019, 09:00-10:30, Stephenson Room, Wolverhampton CCG, Wolverhampton Science Park, Glaisher Drive, Wolverhampton, WV10 9RU

JCC Action Log

No.	Date	Action	Lead	Deadline	Status Update
160	11 July 2019	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.	Sharon Sidhu	8 August 2019	Update to be given after AO appointment 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.	Sharon Liggins	8 August 2019	Revised action - Respiratory paper to be shared with all Directors of Commissioning.
163	8 August 2019	Helen Hibbs and Alistair McIntyre investigate the slippage in opening of the new ED department at the Manor Hospital, Walsall.	Helen Hibbs and Alistair McIntyre	12 Sep 2019	CLOSED
169	12 September 2019	Feedback from 10 September CSU place based care workshop	Alastair McIntyre	10 October 2019	Verbal Update to be given
170	12 September 2019	BCWB STP Urgent and Emergency Care Board Terms of Reference and Update to be shared with JCC	Alastair McIntyre	10 October 2019	On agenda
171	12 September 2019	Request to add 'financial risk of the Walsall ED development' to the agenda for the BCWB STP Urgent and Emergency Care Board.	Alastair McIntyre	October 2019	Papers for Board shared in pack CLOSED
172	12 September 2019	The IUC team to be asked 'what the plan is for a primary care engagement strategy' *Anand Rischie happy to converse with IUC and West Midlands Ambulance Service regarding primary care engagement.*	Alastair McIntyre	10 October 2019	Verbal Update to be given
173	12 September 2019	To provide an update to the next JCC meeting regarding potential shortages in medication following Brexit.	Mike Hastings	10 October 2019	On agenda
174	12 September 2019	To encourage chief nurses to attend TCP Board.	AO's	Immediate action requested	Has been actioned
175	12 September 2019	26 week choice letter to be brought to attention of Elective Care Board	Neill Bucktin	10 October 2019	This was considered by the Elective Care Transformation Board. DG NHS

No.	Date	Action	Lead	Deadline	Status Update
					FT are to be our “first mover” site and an outline plan will be submitted on 30 September. An STP workshop will be held on this issue later in October.

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