NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 11 February 2020 commencing at 1.00 pm at Wolverhampton Science Park in the Stephenson Room

A G E N D A

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		2	Declarations of Interest		
		3	Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body held on 12 November 2020		1 - 8
		4	Matters arising from the minutes		
		5	Committee Action Points - no actions		
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			Item for Discussion		
		7	Safeguarding Memorandum of Understanding	Ms S Roberts	9 - 18
			Items for Assurance		
		8	Better Care Fund (BCF) Quarterly report • BCF Section 75	Ms A Smith	19 - 110
		9	Update from Transition Board Future Form Black Country and West Birmingham - next steps following listening exercise	Mr S Marshall / Mr M Hastings	111 - 158
		10	Board Assurance Framework (BAF)	Mr P McKenzie	159 - 172
		11	Commissioning Committee	Dr M Kainth	173 - 184
		12	Quality and Safety Committee	Ms S Roberts	185 - 214
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		26	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 14 April 2020		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 12 November 2019
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~ Dr S Reehana **Clinical**	Chair
Dr M Asghar	Board Member
Dr M Kainth	Board Member
Management	
Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Mr J Green	Joint Chief Finance Officer for Sandwell/Wolverhampton CCG
Mr M Hastings	Director of Operations
Dr H Hibbs	Chief Officer
Ms S Roberts	Chief Nurse Director of Quality
Lay Members/Consultant	
Ms S McKie	Lay Member
Mr J Oatridge	Lay Member
Mr P Price	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member

In Attendance	
Ms K Garbutt	Business Operations Officer
Ms S Gill	Health Watch Wolverhampton
Mr P McKenzie	Corporate Operations Manager
Dr A Mittal	Public Health
Ms D North (observer)	Project Management Office Administrator
Ms S Southall	Head of Primary Care

Apologies for absence

Apologies were received from Dr R Rajcholan, Dr D Bush, Mr J Denley, Ms H Ryan, Dr R Gulati and Mr S Marshall

Declarations of Interest

WCCG.2491 No declarations of interest were declared.

RESOLVED: That the above is noted.

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

WCCG.2492 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group (WCCG) Governing Body meetings held on the 10 September 2019 be approved as a correct record. However, Mr P Price and Ms S Roberts stated they were not included in the list of the attendees.

Matters arising from the Minutes

WCCG.2493 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2494 There were no Committee Actions

RESOLVED: That the above is noted.

Chief Officer Report

WCCG.2495 Dr H Hibbs presented the report she pointed out that following the recruitment process held on the 25 September 2019, Mr Paul Maubach has been selected as the Accountable Officer for the Black Country and West Birmingham Clinical Commissioning Groups (CCGs). He will be commencing from the 1 December 2019.

Dr Hibbs stated the Long Term Plan for the Sustainability Transformation Plan is currently being developed involving a lot of work. Submission to this meeting currently cannot take place at this time due to purdah.

She pointed out that the General Practice Nurse Strategy across the Black Country and West Birmingham has been launched and has had a very positive response.

RESOLVED: That the above is noted.

Clinical Commissioning Group Constitution

WCCG.2496 Mr P McKenzie stated that the Clinical Commissioning Group's (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 a Governance Handbook published on the CCG's website.

In order to adopt the new model constitution the CCG will need to make an application to NHS England who is responsible for agreeing changes to CCG constitutions.

Mr McKenzie pointed out that 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. He referred to the table on page 22 which aims to provide an initial guide of what would deemed to be substantive and non-substantive.

Mr P Price asked what the maximum term for lay members to serve. Mr McKenzie confirmed this is 5 years.

RESOLVED: That the Governing Body approved the draft constitution for inclusion in an application to NHS England to vary the constitution.

Clinical Commissioning Groups Primary Care Strategy

WCCG.2497 Ms S Southall presented the report and revised strategy. The Primary Care Strategy was approved by the Governing Body in 2016 and since then a lot of work has taken place. This report provides an overview of the priorities captured in the 2019 strategy.

The implementation plan at the back of the report details 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.

Dr M Kainth asked if targets for reducing secondary care are taking place. Mr M Hastings stated work is being carried out to reduce the activity in secondary care, working with colleagues this is not being carried out in isolation. Dr Kainth also gave an example of the difficulties in recruiting practice nurses within practices. Ms Southall confirmed the CCG are aware of this and there are measures in place to try and manage this to ensure smooth movement working with practices to develop and promote general practice nursing as a career for the future. Ms Roberts added that more work needs to be carried out to develop and strengthen the workforce. As part of Liz Corrigan's new General Practice Nurse role she will take clinical leadership across Wolverhampton and the Black Country.

Ms S Gill raised that Patient Participation Groups were not specifically mentioned within the strategy. A discussion took place and it was pointed out that this is included on page 58 within the Engagement section. However Ms Southall will look into whether this needs to be more explicit.

RESOLVED: That the Governing Body confirmed their endorsement of the decision to approve the 2019 strategy noting that Primary Care Commissioning Committee will be kept signed on progress being made to achieve the delivery objectives detailed in Appendix 1.

Emergency Preparedness, Resilience and Response (EPRR)

WCCG.2498 Mr M Hastings presented the report. He pointed out that the CCG will be stepping up preparation regarding the EU Exit in the New Year to ensure everything is in place

Dr Agarwal arrived

Ms Gill asked if the CCG or GPs were aware of any issues regarding supplies of medicines. Mr Hastings stated he has attended regional meetings on behalf of the CCG and no issues have been communicated to us however this is not to say there will be any issues. However there are continual issues with supply chains on an ad hoc basis but these are not related to the EU Exit.

Commissioning Committee

WCCG.2499 Dr M Kainth presented the reports. He pointed out the devolvement of Mental Health National Assessments (NCAs) budget to Black Country Partnership Foundation 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 was presented with a report relating to Children and Young Peoples Continuing Care to implement a Resource Allocation System which will ensure equality for allocated funding to children and young people in need of continuing care in alignment with their clinical needs.

Dr Kainth stated that the Committee supported a twelve month pilot post for a social care worker to carry out holistic assessment of frailty patients and cares, this post will support the preparation for the winter pressures with a view to reducing and preventing avoidable admissions.

Mr Hastings gave assurance that the 62 day referral treatment has improved.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2500 Ms Roberts presented the report she pointed out the key points outlined on page 89.

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.

Referral to treatment time – incomplete pathway performance has not achieved the 92% target and is deteriorating.

Mortality – the number of deaths has decreased when compared to last month, along with the Standardised Hospital Mortality Index which currently stands 1.1547, however the crude mortality rate has risen slightly.

There has been a slight increase in the number of self-harm/suicide serious incidents reported by the Black Country Partnership Foundation Trust.

Further analysis continues in relation to the regional comparison of 12 hour breach data in relation to mental health patients.

At the Quality and Safety Committee meeting which took place this morning discussions have taken place around preparedness for winter, there has been a positive flu campaign.

Dr Mittal stated there are a number of barriers to negotiate around and it would be useful to look at the templates. There has been a shortage around the nasal sprays for children; however the uptake rates are better than last year. At present this is a small issue and likely to be resolved, however if this becomes a quality and safety issue this will be looked at. Dr Kainth pointed out the delivery of flu vaccinations is not in the correct order. This is a national programme. Dr Mittal will raise these local concerns and how this could be carried out better next time.

Mr Price highlighted there have been No Never events or complaints for three months.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2501 Mr T Gallagher presented the reports. He focused on the report for October 2019. Finance performance is meeting all the financing metrics. Essentially we are on target to meeting our surplus. In terms of forecasting at present this is not as volatile as in previous years.

He referred to page the table on page 143 which shows the CCG are meeting the underlying current surplus.

The delegated Primary Care allocation for 2019/20 as at month 5 is £38.145m. At month 6 the CCG forecast outturn is £38.145m delivering a breakeven position.

The Quality, Innovation, Productivity and Prevention (QIPP) financial plan, prior to request to increase the control total, required a QIPP of £13.536m or 3.5% of allocation.

The CCG was required to resubmit a plan which demonstrated £5.95m risk which currently is fully mitigated based on the assumption that the Black Country CCG Risk share agreement will be applied.

RESOLVED: That the above is noted.

Primary Care Commissioning Committee

WCCG.2502 Ms S McKie presented the report. She referred to the Tettenhall Medical Practice consultation process in relation to the proposed closure of Wood Road Surgery branch. An extraordinary meeting took place at Christ Church in Wood Road which was very well attended. The practice has withdrawn its application for closure and provided an alternative proposal to keep the branch practice open by reducing the sessions from 7 to 4.

The public are relived that the surgery is not going to close; this was an excellent piece of work. Ms Gill added it was nice to see the CCG come out into the community setting and listening to peoples' views.

Ms McKie highlighted there is an organisation in Birmingham using face to face technology to offer GP appointments. There is concern that patients are changing practices. Ms Southall stated this is happening nationally and this is being monitored.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2503 Ms S McKie referred to the report. She highlighted the Annual General meeting which took place on the 18 September 2019.

Listening exercises with stakeholders. They have now commenced and feedback will be provided at the next Governing Body meeting

Practice Participation Group Chair meetings are now conducted at Primary Care Network 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.

Dr Mittal pointed out that at present Wolverhampton Council are reviewing how we collect data and capture information regarding people who attend. Our methods could be shared with Wolverhampton CCG.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.2504 RESOLVED: That the above minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2505 RESOLVED: That the above minutes are noted

Minutes of the Primary Care Commissioning Committee

WCCG.2506 RESOLVED: That the above minutes are noted

Minutes of the Commissioning Committee

WCCG.2507 RESOLVED: That the above minutes are noted

WCCG.2508 RESOLVED: That the above minutes are noted

Any Other Business

WCCG.2509 Dr Reehana mentioned that volunteers are needed in respect of the interview for the deputy Accountable Officer taking place on the 29 November. One lay member and one GP is required. Dr Reehana will ask Mr Paul Maubach to forward relevant details.

Dr Reehana presented Dr Hibbs with flowers and thanked her for the work which she has carried out for Wolverhampton CCG. Dr Hibbs stated it has been a privilege and honour to work with everyone at Wolverhampton. Mr Price thanked Dr Hibbs on behalf of the Audit and Governance Committee. Dr Mittal expressed thanks for navigating us, you are a very good facilitator. Sorry to see you leave and wished Dr Hibbs the best of luck..

RESOLVED: That the above is noted.

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

WCCG.2510 There were no public or press present at the meeting.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2511 The Board noted that the next meeting was due to be held on **Tuesday 11 February 2020** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.20 pm

Chair……..

Date ……

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
11th February 2020
Agenda item 7

TITLE OF REPORT:	Memorandum of Understanding - Safeguarding
AUTHOR(s) OF REPORT:	Michelle Carolan, Chief Officer Quality Sandwell and West Birmingham CCG
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse, Director of Quality Wolverhampton CCG
PURPOSE OF REPORT:	Safeguarding across the Black Country Needs to continue to work collaboratively, whilst maintaining local leadership and representation within the CCG's as four legal entities, as well as supporting our statutory partners, including each of the local authorities. A hub and spoke model arrangement for safeguarding would best facilitate this need, supported by a hosted Head of Service arrangement to oversee the operational functions, facilitated with a Memorandum of Understanding (MOU) between the CCG;s to ensure robust and appropriate governance. This would not affect existing arrangements of accountability and representation at local boards, which would need to remain to provide strategic leadership with our statutory partners to this important agenda.
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	Public
RECOMMENDATION:	Note the report and approve the MOU to facilitate a single head of service for safeguarding across the Black Country, ensuring operational oversight of the safeguarding statutory functions.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Ensure on-going safety and performance in the system
2. Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton
3. System effectiveness delivered within our financial envelope	Greater integration of health and social care services across Wolverhampton Proactively drive our contribution to the Black Country STP Continue to meet our Statutory Duties and responsibilities

BLACK COUNTRY SAFEGUARDING UPDATE (MOU)

INTRODUCTION

The NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework (SAAF) sets out the NHS statutory framework for safeguarding children and adults, to support CCGs in discharging their statutory requirements.

More recently there has also been a requirement for the safeguarding system to respond to the reforms set out in Working Together (2018) which identifies CCG's as a statutory organisation having increased responsibility and accountability in the safeguarding system. Significant work has been undertaken across the Black Country to implement the reforms, however the challenge for health moving forward is still immense given the backdrop of a changing health landscape, limited resources available and the necessity to ensure that the children and adult's safeguarding agendas are very closely linked.

The health safeguarding system needs to evolve to meet the new challenges following the introduction of the NHS Long Term Plan (January 2019), which outlines the establishment of Integrated Care Systems' (ICS's) by 2021 and it is worth acknowledging the changing landscape of place-based system leadership with the introduction of Primary Care Networks (PCNs). Safeguarding must be considered in these new integrated partnerships.

Currently, CCG's are responsible in law for the safeguarding element of services they commission. The requirements of this constitutional requirement are laid down within NHSE 'Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework' and as commissioners of local health services, CCG's also need to assure themselves that organisations from which they commission have effective safeguarding arrangements in place.

The Black Country Chief Nurses and Designated Professionals propose that the most effective way of sustaining these requirements across the system would be to develop a model of safeguarding aligned across the Black Country footprint. Work has already been taking place across the STP footprint on what this may look like, led by local Safeguarding leads and a series of work streams considering operational alignment of this work are already underway. A transformational redesign to safeguarding has been achieved in Lancashire and South Cumbria ICS, and the learning from the CCG's has been shared with us. This has been recognised by NHSE and NHSI colleagues as an area of good practice. A similar approach in the Black Country could incorporate the ability to create a safeguarding structure aligned across the Black Country, whilst still ensuring CCG's fulfil their statutory requirements for safeguarding within the place.

Legislation for all		
The Crime and Disorder Act 1998 Female Genital Mutilation Act 2003 Mental Capacity Act 2005 Convention on the Rights of Persons with Disabilities 2006 Mental Health Act 2007 Children and Families Act 2014 Modern Slavery Act 2015 Serious Crime Act 2015 Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019		
Safeguarding legislation specific to children	**Safeguarding legislation specific to young people transitioning into adults and children in care**	**Safeguarding legislation specific to adults**
United Nations Convention on the Rights of the Child 1989		
Children Act 1989 and 2004		The Care Act 2014
Promoting the Health of Looked After Children Statutory Guidance 2015		
Children and Social Work Act 2017		Care & Support Statutory Guidance- Section 14 Safeguarding
Working Together to Safeguard Children Statutory Guidance 2018		
Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019	Looked After Children: Knowledge, Skills and Competencies of Health Care Staff 2015	Adult Safeguarding: Roles and Competencies for Health Care Staff 2018

Vision for safeguarding across the Black Country

The Chief Nurses, and executive leadership team within the Black Country CCG's have reviewed and considered the various options and recommend that a combined adult and children safeguarding model is created, which will align the functions of Designated Professionals, and CCG resources. However, although there is a need to continue to be able to work collaboratively, we still need to maintain the local leadership and representation within the CCG's whilst they exist as legal entities, as well as supporting our statutory partners, including each of the Local Authorities. A hub and spoke model, as depicted in Appendix 1, would best facilitate this need, which would be supported by a hosted head of service arrangement to oversee the operational functions, facilitated with a Memorandum of Understanding (MOU) between the CCG's to ensure robust and appropriate governance, as detailed in Appendix 2. This would not affect existing arrangements of accountability and representation at local boards, which would need to remain to provide strategic leadership with our statutory partners to this important agenda.

Existing finance arrangements would also remain unchanged, in order for contributions to leach local Board to continue.

The key opportunities envisaged from the proposed model are outlined below:

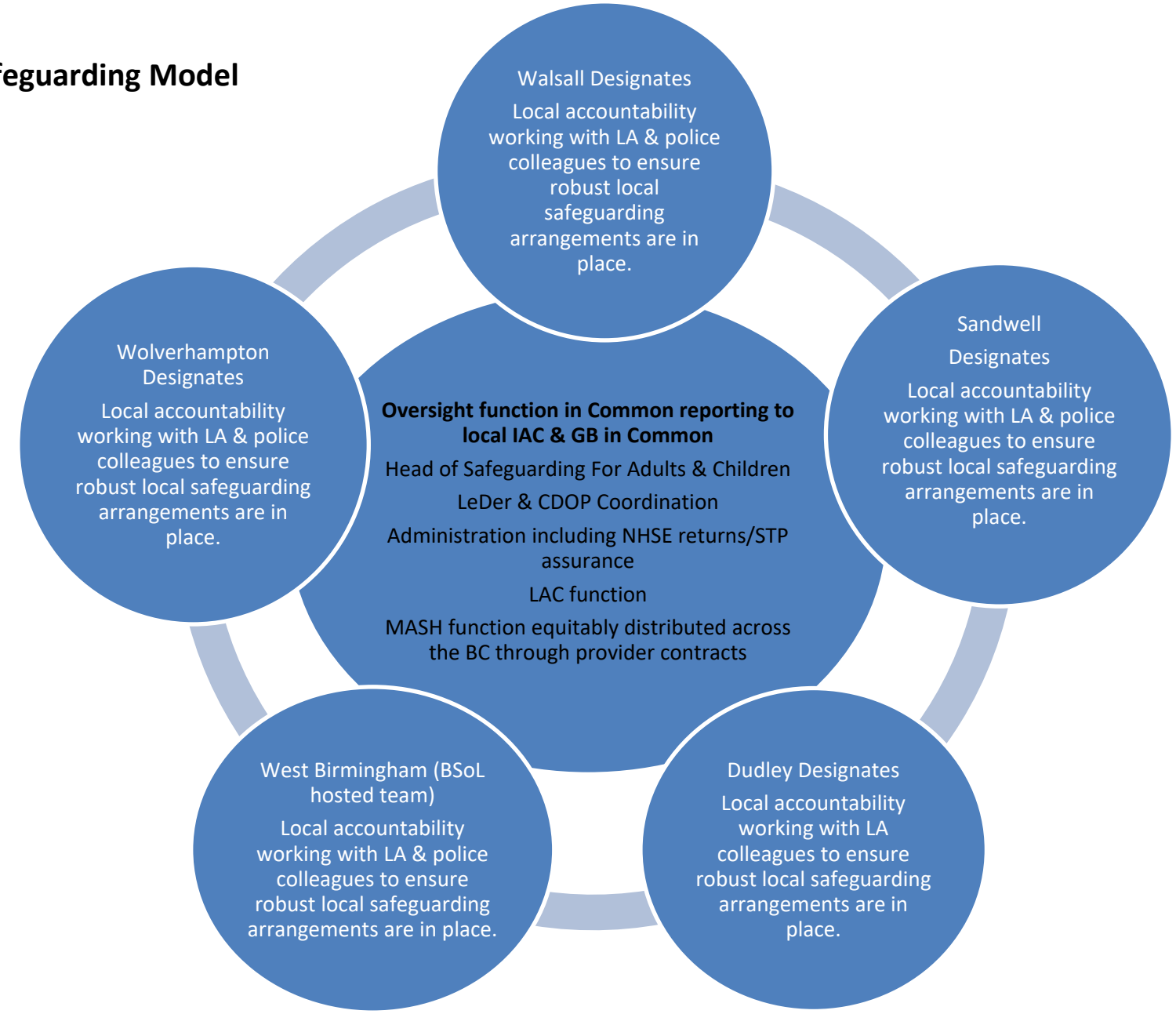
- Reduce duplication and unwarranted variation
- Opportunity to develop 'special interest roles' building resilience and portfolio careers.
- Allows for more flexibility and innovation
- System assurance at both STP /Place level
- Clear leadership and co-ordination across the safeguarding system as well as local place
- Support the dissemination of learning to effect system wide change
- Better position to respond to the increased accountability and responsibility for health as a key safeguarding partner
- System leadership, promoting and building resilience

Recommendation

1. Support the recommendation that there is a single Head of Safeguarding arrangement that works across the Black Country footprint, overseeing the operational functions of the Safeguarding teams. This will not replace accountability of Chief Nurses.
2. To note that as part of this next phase of work a memorandum of understanding (MOU) will need to be implemented to allow the head of service access to Safeguarding functions across the Black Country, as well as supporting collaborative working, and to ensure a robust Governance Framework for statutory duties and responsibilities.

Appendix 1

Proposed BC Safeguarding Model



Appendix 2

Memorandum of Understanding (MOU)

BETWEEN

NHS Sandwell and West Birmingham
Clinical Commissioning Group (SWB CCG)

AND

NHS Walsall Clinical Commissioning Group
(WSCCG)
NHS Wolverhampton Clinical Commissioning Group
(WVCCG)
NHS Dudley Clinical Commissioning Group
(DYCCG)

This is an agreement between WSCCG, WVCCG, DYCCG and SWB CCG.

This agreement is valid from 1st April 2020 outlined herein and valid until 31st March 2021 and is for the delivery of the single Head of Service for safeguarding across the Black Country and to ensure oversight of Designated Professionals Safeguarding Service.

1. Purpose and Scope

The purpose of this MOU is to facilitate a single head of service for safeguarding, ensuring oversight and collaboration across the Black Country for each of the aforementioned CCG's, to continue to deliver and discharge on safeguarding duties.

In particular, the MOU is intended to;

- Provide a clear reference to service ownership, accountability, roles and responsibilities
- Provide a clear, concise and measurable description of the service

2. Background

Each year an amount of monies is available from each CCG to provide designated professional services across the Black Country. The monies provide designated professionals services, including the designated doctors and nurses for children, adult safeguarding, Mental Capacity Act (soon to be LPS - Liberty Protection Safeguards) and the Prevent Lead as outlined within the NHS England Safeguarding Assurance Framework 2015 (as amended).

3. Responsibilities under this MOU

The Black Country CCG safeguarding head of service will;

- As agreed by the each CCG, and as invited by the Local Safeguarding Boards/ Partnerships and including the Community Safety Partnerships, be Members of the respective Executive Boards, and sub-committee structures, as appropriate and required, in co-ordination with the Executive and designated professionals' team, in carrying out their CCG assurance and statutory roles.
- Oversight of the Designated Nurse and Doctor statutory functions for Safeguarding Children and Children Looked After by the Local Authority as outlined within the Working Together to Safeguarding Children 2018 (as amended), and subsequent guidance.
- Oversight of the Safeguarding Adults professional's role in regards to the CCG strategic functions and duties under the Care Act 2014 in relation to Chapter 14 of the Care and Support Statutory Guidance.
- Oversight of the Named GP operational and nurse function related to Named professional's roles by undertaking scopes, information reports and Individual Management Reports from domestic homicide reviews
- Undertake oversight of arrangements for Channel and Prevent case activities for the Black Country
- Permit the head of service for safeguarding to be a member of any of the Safeguarding Assurance Groups established within the Black Country, as appropriate, and will receive papers for information and assurance purposes.
- Share received and approved final safeguarding papers for CCG assurance committees. Schedule of papers is as determined by the Quality Safeguarding Committee.
- Share learning, promote good practice and local initiatives across the Black Country, including Member Practices Safeguarding Leads
- Oversight of arrangements for Black Country Domestic abuse services

4. **Exclusion;**

- Chief Nurse representation and accountability at local safeguarding boards (existing arrangements will remain until the Black Country CCG single executive team is finalised).
- The West Birmingham Locality, which is delivered as a pan Birmingham arrangement via the Birmingham and Solihull CCG hosted team.
- Child Death Arrangements/ SUDIC related to the CCGs/ Black Country footprint.
- Named GP for Safeguarding function.

5. **NHS Sandwell and West Birmingham CCG will**;

    - Host the head of service for safeguarding for the Black Country CCGs.

6. **Agreed Costs**

Agreed staffing costs for this service will be split across the four CCG's. This will be issued to Sandwell & West Birmingham as safeguarding recurrent funds transfer.

7. **Effective date and signature**

This MOU shall be in effect upon the signature of the Accountable Officer for NHS Sandwell and West Birmingham and NHS Walsall CCG, NHS Wolverhampton CCG and NHS Dudley CCG authorised officials.

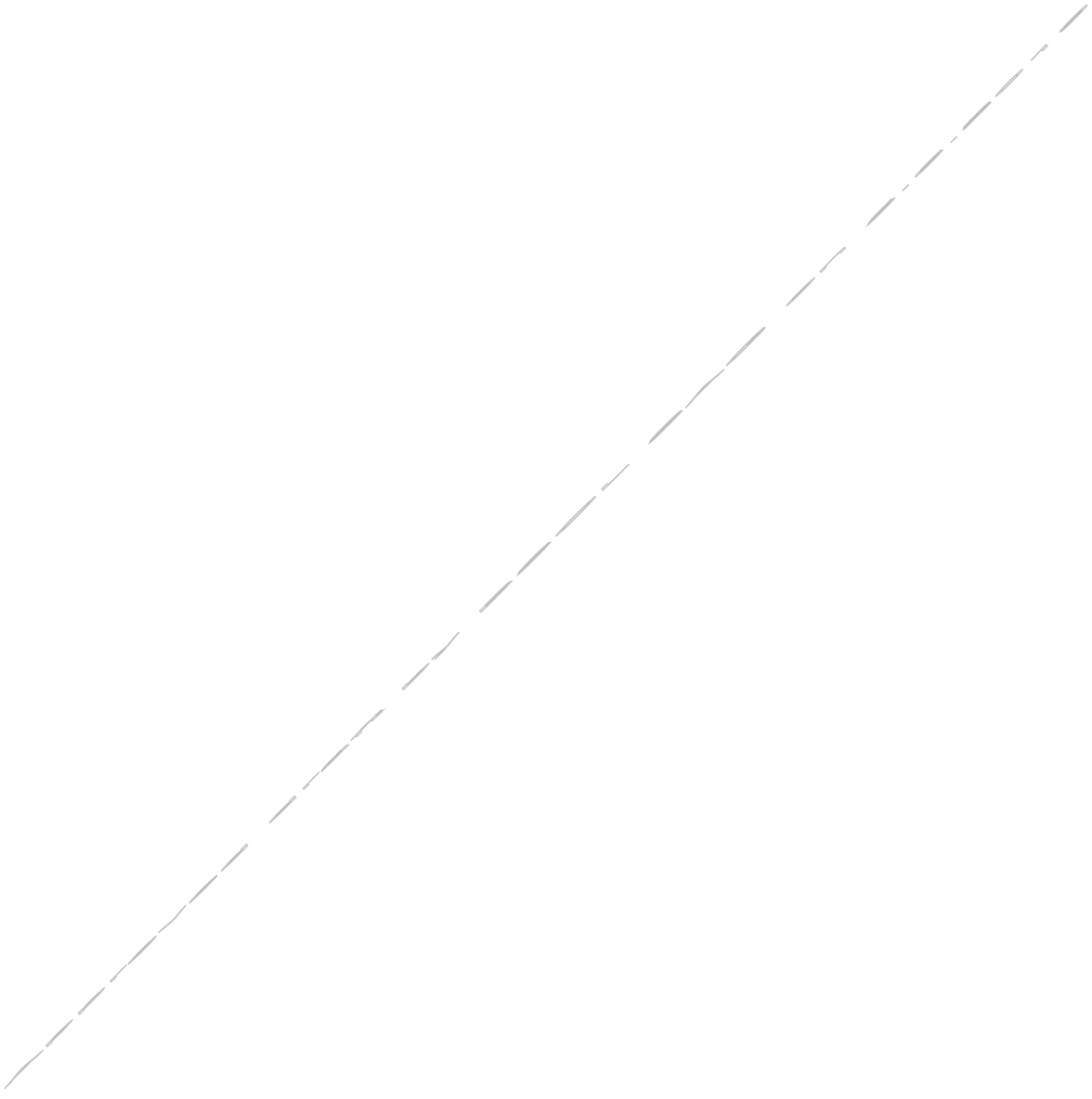
NHS Sandwell and West Birmingham CCG, NHS Walsall CCG, NHS Wolverhampton CCG and NHS Dudley CCG indicate agreement with this MOU by their signatures.

Signature and dates SWB CCG

Signature and dates Walsall CCG

Signature and dates Wolverhampton CCG

Signature and dates Dudley CCG



NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
11th February 2020

Agenda item 8

TITLE OF REPORT:	Quarterly Update Better Care Fund Programme
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning
MANAGEMENT LEAD:	Andrea Smith
PURPOSE OF REPORT:	To provide an update on progress of the Better Care Fund Programme. To gain approval for the Section 75 agreement for 2019/20
ACTION REQUIRED:	☒ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• This report presents and **seeks approval for** the 2019/20 Section 75 agreement which underpins the BCF Pooled Budget • This report provides key highlights, risks and Issues across the programme • This report details progress against national metrics
RECOMMENDATION:	To inform the Governing Body on the work being undertaken within the Better Care Fund Programme To approve the 2019/20 BCF Section 75
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both the quality and the patient experience.
2. Reducing Health Inequalities in	The BCF programme strives to ensure that health inequalities are reduced across the City. The plan is based on data and evidence which allows us to understand the health inequalities that we are

Wolverhampton	aiming to address
3. System effectiveness delivered within our financial envelope	The Better Care fund programme is supported by a pooled budget with the City of Wolverhampton Council. The pooling of resources gives us the opportunity to use our resources more effectively together

1. BACKGROUND AND CURRENT SITUATION

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

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

1.3.

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

1.5. This is visualised below:-

Figure 1 BCF Vision

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

2. NATIONAL METRICS

2.1 Delayed Transfers of Care.

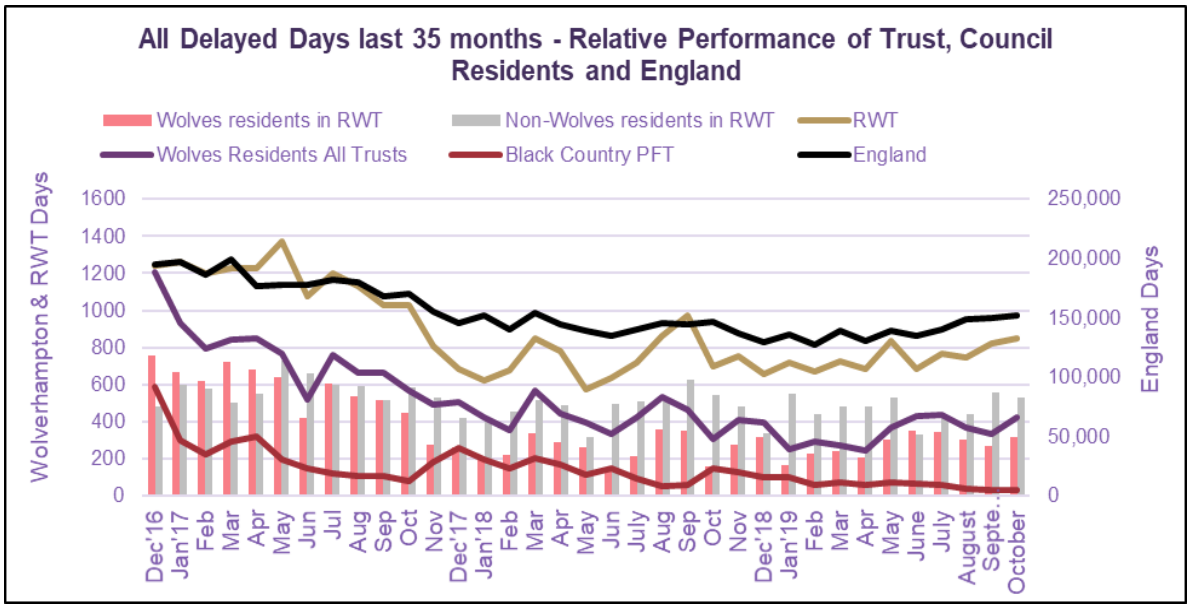


Figure 1 - Relative performance between December 2016 and October 2019 (Source: NHS Statistics)

2.1.1 The last 35 months data from December 2016 to October 2019, is set out in **Figure 1** above. This shows a significant overall reduction in the levels of monthly delayed days over the period, however several months have seen reversals in this trend with increases in delays both locally and nationally. The last ten months has seen several of the best DToC performances for Wolverhampton residents for many years and although recently there has been some upward movement in the numbers of delays the overall totals each month have been within the NHSE target.

2.1.2 The latest delays **daily delays rate per 100,000 population aged 18 and over** in October for Wolverhampton residents when calculated over the last twelve months (Moving Annual Total) is **5.8** against an NHS England 'ambition' of **7.4** and so remains within the target.

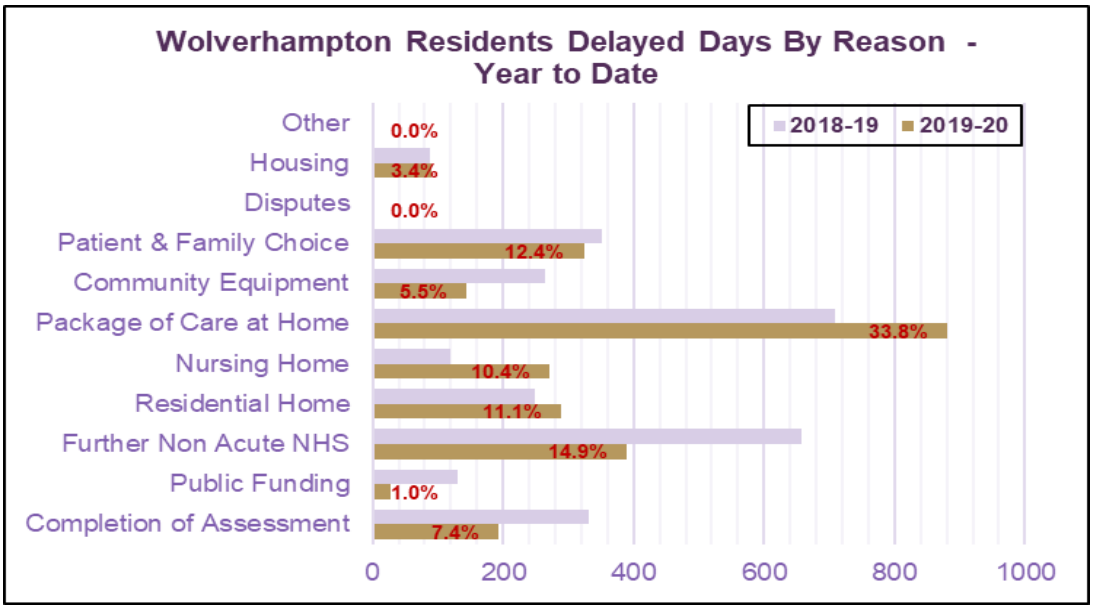
2.1.3 Additionally, the last twelve months relative performances against comparators are shown below. October saw a change in the 14 councils that make up the CIPFA Comparator group with 4 replaced by new 'statistical neighbours'.

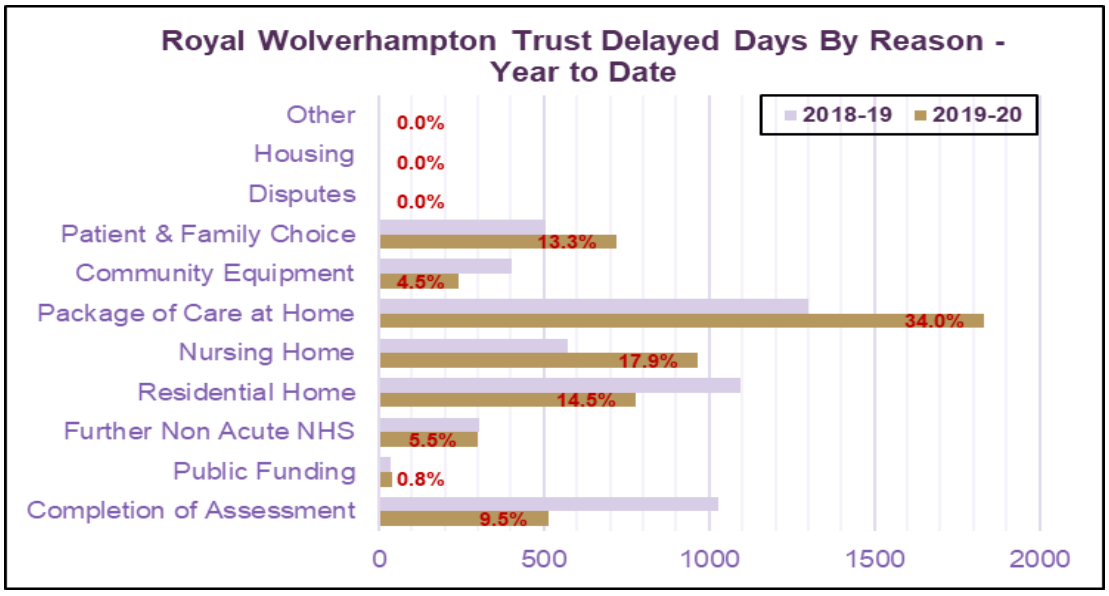
Daily Delays Rate per 100,000 18+

	Nov	Dec'18	Jan'19	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct
England	10.5	9.5	10	10.4	10.2	10	10.2	10.2	10.3	10.9	11.3	11.2
Wolverhampton	6.8	6.4	4.1	5.2	4.4	4	5.9	7.2	7.1	5.9	5.6	6.8
West Midlands	12.1	9.9	11.6	12.5	12.1	10.8	10.3	10.6	11.2	11.9	12.6	13
CIPFA Group	9.2	9.4	9.6	10.3	10.3	10.7	10.2	10.1	9.7	9.5	10.8	9.6

2.1.4 In terms of the total delayed days recorded so far for RWT, the residents of **Staffordshire** now account for **45.7%, Walsall 9.5%** and **CWC 38.8%** which, although reflecting a rise on last year's outturn of 34%, is a significant reduction for the city when compared to the figure of 61% seen in December 2016 (Figure 1).

2.1.5 The relative proportions of the reasons attributed to have caused the delays for both CWC and RWT are shown in **Figures 3 & 4** below. A significant increase in the proportions of delays due to Packages of Care feature prominently in both cases although the numbers of these for residents of the city have reduced slightly over the last two months.





Figures 3 & 4 – Delay Reason Comparison between CWC and RWT Year-to-Date 2019-20 (Source: NHS Statistics)

2.2 Reduction of Non-Elective Admissions.

2.2.1 Since 2015 there has been an overall steady reduction in non-elective admissions.

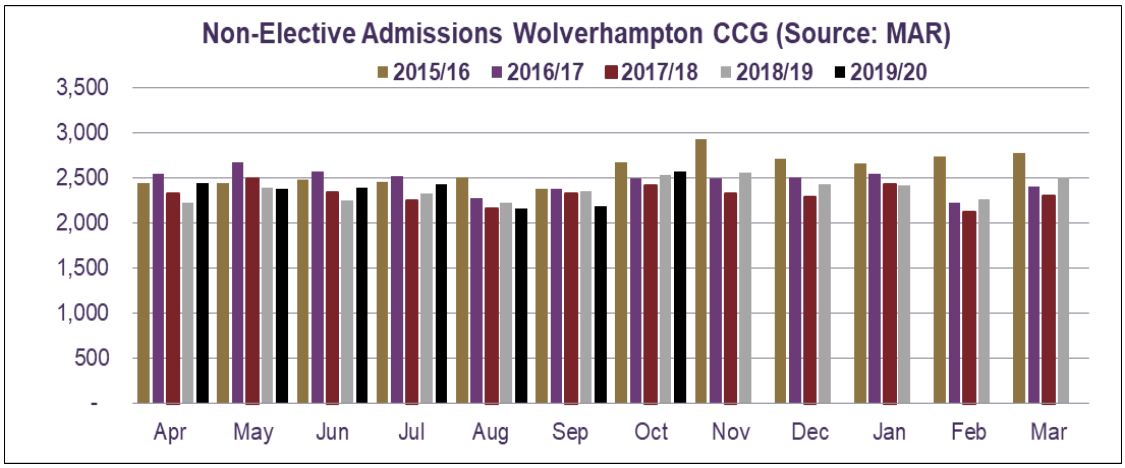


Figure 7 – Monthly Non-Elective Admissions performance over the last 53 months (Source: NHS Statistics)

2.2.2 There is a continued reduction of non-elective admissions that are aligned the schemes within the BCF Programme. For Care Closer to Home there has been a reduction of 1728 emergency admissions against the Gross plan and 1181 against the net plan from April 2019

to November 2019. This is a demonstration that the admission avoidance schemes, in part, are successful and are targeting an appropriate cohort of people.

2.2.3 We continue to review and expand on admission avoidance schemes such as:- Rapid Intervention Team (RIT), Rapid Access to Social Care (RASC), Red Bag, Trusted Assessors, Social Worker in ED etc.

2.3 Permanent Admissions to Residential Homes.

2.3.1 The latest reported number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of December (**Figure 5**) at **18** is 47% lower than in the previous year. However, the graph highlights the overall rise in admissions since the start of the 2018-19 reporting year with the monthly target of just under 22 admissions (260 in the year) only being achieved four times and the current average in 2019-20 running at just under 25.

2.3.2 This 2018-19 target has been carried over into the current financial year and reflects the average rate per 100,000 18+ population for the West Midland region in which Wolverhampton has remained an outlier

2.3.3 The final year-end outturn for 2018-19 was **342** which was **31.5%** above the target figure of 260 and 59 admissions (21%) above 2017-18. The year-end total in 2016-17 was 385.

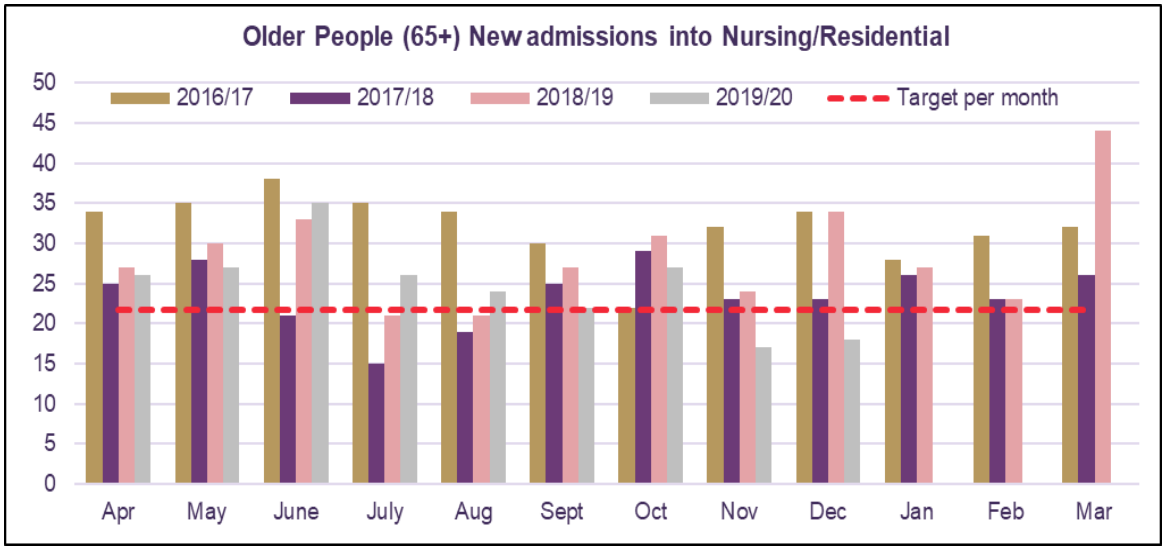


Figure 5 – Permanent Admissions of Older People to Care Homes over the last 45 months (Source: CareFirst)

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

This figure is currently only calculated once a year and is made available each October . the results for 2019/20 therefore will be available in October 2020

3 HIGHLIGHTS

3.1 Adult Community Care (Co-Location of Community Neighbourhood teams)

Space has been identified at Bilston Health Centre and floor plans have been drawn up. Costings have been prepared and agreed. The plan will involve a refurbishment of the old Dental suite area at Bilston Health Centre and which enable Social Care staff to be re-located from their current base. The teams will then be re-organised so that there are two health and social care teams working from the building, occupying the existing nursing team area and the newly refurbished area.

Work will be started imminently with a view to completion early Spring.

The NE team, based at the Science Park recently celebrated their 1 year Anniversary, having moved in December 2019. A press release marking the occasion is attached.

3.2 Adult Community Care (MDT working)

Work is being undertaken to re-model the Primary Care based MDTs to work on a PCN level, working with the RWT Community Transformation Programme to ensure that community services are wrapped around PCNs and can deliver proactive and reactive responses to patients including those with complex needs.

3.3.2 D2A

Some issues with hospital discharge are still being raised and therefore a group are continuing to review hospital discharges, identify where these could be improved and to introduce measures to prevent recurrence. Work is also being undertaken by the CCG quality team alongside RWT to address some clinical quality issues that have recently arisen with patient discharge.

3.4 Dementia

The BCF Dementia workstream is responsible for the delivery of the Joint Dementia Strategy.

Following a recent presentation by Dementia UK, funding has been found to pilot an Admiral Nurse working in the City. Admiral Nurses are specialist Dementia nurses. They currently offer a discreet service to ex-service personnel but this additional funding will allow a bespoke service for people with Dementia and their families and carers in Wolverhampton. Discussions are ongoing to determine the model of delivery.

"Admiral nurses offer specialist one-to-one support, expert guidance and practical solutions to support the entire family. Admiral Nurses work together with families and other ehalth and social care services, using their experience and expertise to foresee and avoid crises. They also work alongside other professionals in the dementia care pathway, sharing best practice. Their way of working is proven to deliver vital cost savings to health services and better outcomes for people living with dementia." (DementiaUK; Helping families face dementia)

3.5 Mental Health

The Mental Health workstream is now merged with the ICA Mental Health work stream and is clinically co-chaired by a GP and a MH Clinician. The group have now developed a plan on a page and are working towards a joint commissioning plan by April 2020 and a re-designed integrated community model of care by October 2020.

3.6 BCF Planning

We now have confirmation that Wolverhampton BCF Plan for 2019/20 is approved by the national team. The letter of approval is attached.

3.7 Section 75

As in previous years there is a requirement for a Section 75 agreement to underpin the BCF Pooled budget. This document is very much a refresh of the previous agreement with updates being made to reflect the progress of the worksteams and to the financial content of the Pooled budget.

The financial content is broken down below:-

Workstream	CCG Contribution (£000)	City Council Contribution (£000)
Adults Community Services	31,096	25,591
Dementia	3,581	280
Mental Health	10,217	3,550
CAMHS	201	125
Care Act	713	
Total Revenue Contribution	45,808	29,546
Capital - Ring Fenced Grant	-	3,147
Total Contribution to Pooled Fund	45,808	32,693

The Section 75 Agreement for 2019/20 is attached and The Governing Body are asked for their approval of this agreement.

3.8 Future Delivery of BCF

Work to bring together the BCF programme with the Integrated Care Alliance work is now underway. The Mental Health workstreams are now working as one and the Adult Community Care workstream is being reviewed alongside the ICA Frailty and End of Life groups to identify duplication and gaps etc.

This should result in a better use of the limited resources we have to deliver both of these significant programmes of work.

4 CLINICAL VIEW

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

5 PATIENT AND PUBLIC VIEW

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

6 KEY RISKS AND MITIGATIONS

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

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

7 IMPACT ASSESSMENT

Financial and Resource Implications

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

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

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

Other Implications

7.7 N/A

Name: Andrea Smith
Title: Head of Integrated Commissioning
Date: 29.01.20

ATTACHED:

- Press release Co-location of Health and Social Care Team – NE
- BCF Plan approval letter

RELEVANT BACKGROUND PAPERS

REPORT SIGN-OFF CHECKLIST

	Details/ Name	**Date**
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team	**Lesley Sawrey**	
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager	**Peter McKenzie**	
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		

Signed off by Report Owner (Must be completed)	**Andrea Smith**	

NHS
Wolverhampton
Clinical Commissioning Group

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

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

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

NHS England
Skipton House
80 London Road
London
SE1 6LH

neil.permain1@nhs.net

08 January 2020

To: *(by email)*

Councillor Jasbir Jaspal	Chair, Wolverhampton Health and Wellbeing Board
Dr Helen Hibbs	Clinical Commissioning Group Accountable Officer (Lead)
Tim Johnson	Local Authority Chief Executive

Dear Colleagues

BETTER CARE FUND 2019-20

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance and approval. We recognise that the BCF has again presented challenges in preparing plans at a late stage and at pace and we are grateful for your commitment in providing your agreed plan.

I am pleased to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. The Clinical Commissioning Group (CCG) BCF funding can therefore now be formally released subject to the funding being used in accordance with your final approved plan, and the conditions set out in the BCF policy framework for 2019-20 and the BCF planning guidance for 2019-20, including transfer of funds into a pooling arrangement governed by a Section 75 agreement. Your Section 75 agreement should aim to be confirmed by the end of January 2020.

These conditions have been imposed through the NHS Act 2006 (as amended by the Care Act 2014). If the conditions are not complied with, NHS England is able to direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

The Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant are also pooled along-side the CCG allocations. The DFG, iBCF and Winter Pressures grants are paid directly to local authorities via a Section 31 grant from the Ministry of Housing, Communities and Local Government. These grants are subject to grant conditions set out in their respective grant determinations

made under Section 31 of the Local Government Act 2003, as specified in the BCF Planning Requirements.

Ongoing support and oversight will continue to be led by your local Better Care Manager (BCM). Following the assurance process, we are asking all BCMs to feedback identified areas for improvement in your plan and share where systems may benefit from conversations with other areas.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

Neil Permain
Director of NHS Operations and Delivery and SRO for the Better Care Fund

NHS England and Improvement

Copy (by email) to:

David Watts	Local Authority Director of Adult Social Services (or equivalent)
Andrea Smith	Better Care Fund Lead Official
Clare Nye	LA Section 151 Officer
Dale Bywater	Regional Director of Delivery, NHS England Midlands Region
Jeffrey Worrall	Director of Performance & Improvement
Rosie Seymour	Programme Director, Better Care Support Team, NHS England
Stephen Corton	Better Care Manager, Midlands

NHS
Wolverhampton
Clinical Commissioning Group

DRAFT PRESS RELEASE

Wolverhampton's first integrated health and social care community hub sees benefits for patients following its first year of success

Patients in Wolverhampton are benefitting from better integrated health and social care thanks to a new community hub model developed by NHS Wolverhampton Clinical Commissioning Group (CCG) along with its partners in the Better Care Fund (BCF) programme; The Royal Wolverhampton NHS Trust, City of Wolverhampton Council, Black Country Partnership NHS Foundation Trust, Housing and the Voluntary Sector.

The CCG, along with its BCF partners, brought together over 60 health and social care professionals under one roof, at Wolverhampton Science Park, to form an integrated community hub in December 2018.

The model has enabled health and social care professionals to have face-to-face conversations about the patients and families they are supporting, ensuring the patient receives the right interventions at the right time.

Karen Evans, Strategic Transformation Manager at Wolverhampton CCG, said: “I’m delighted that the hub is working so well. The hard work to get the teams to work together has paid off and we are now reaping the benefits.”

Ben Ngundu, Senior Social Work Manager at City of Wolverhampton Council said: “The hub has removed the barriers of communication that previously existed between health and social care. It is amazing to be able to just walk across the office to speak to healthcare staff about a patient, rather than having to wait to receive a call back from a member of the team.

The success of the hub is testimony to the team’s hard work and resilience. Everybody should be proud of what we have achieved over the last year. While it wasn’t easy to move offices, we have settled into this new way of working which has had a positive impact for our patients.”

Nicola Dimmock, Locality Nurse Manager at The Royal Wolverhampton NHS Trust, said: “Joint visits are much easier to organise now that health and social care colleagues are based at the same office. We have managed to complete the same number of joint visits in two months as we did in a whole year before the hub was introduced.”

Melvena Anderson, Deputy Director at Black Country Partnership NHS Foundation Trust, said: “The interface between all agencies has meant the patient pathway to services is more seamless. This has had a positive impact on them due to the timeliness and quality interventions at the right time.

I am proud of our achievements and I am looking forward to continuing the working partnership, and development of further hubs in Wolverhampton.”

The inception of community integrated hubs in Wolverhampton was one of the main incentives of the BCF programme; to bring health and social care services closer together.

The model has proved to be successful and Wolverhampton CCG, The Royal Wolverhampton NHS Trust, City of Wolverhampton Council and Black Country Partnership NHS Foundation Trust are looking to implement the next community hub in Wolverhampton in 2020.

ENDS

Wolverhampton's first integrated health and social care community hub sees benefits for patients following its first year of success: link to press release on website

Patients in Wolverhampton are benefitting from better integrated health and social care thanks to community hub model: link to press release on website

City of Wolverhampton Council

and

NHS Wolverhampton Clinical Commissioning Group

Framework partnership agreement relating to the commissioning of health and social care services under the Better Care Fund

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Contents

THIS AGREEMENT is made on the *[insert date]* 2019

PARTIES

(1) City of WOLVERHAMPTON COUNCIL of Civic Centre, St Peter's Square, Wolverhampton WV1 1RG (the "Council")

(2) NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP of Technology Centre, Wolverhampton Science Park, Glaisher Drive, Wolverhampton WV10 9RU (the "CCG")

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the City of Wolverhampton.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the City of Wolverhampton.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services and

d) support the delivery of the overall vision for the social care and health economy for Wolverhampton of one ambition, working as one for everyone.

(G) The Partners will jointly be carrying out consultations on the services affected by proposals in this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this

Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.
2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref.No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Metrics means the metrics specified in Part 1 to schedule 9.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

Better Care Pooled Fund means the Pooled Fund as specified in Schedule 1.

Better Care Fund Programme Director means the member of staff appointed by the Council or jointly appointed by the Council and the CCG who Is the Pooled Fund Manager;

Care Act 2014 is the Act which places additional responsibilities upon Local Authorities to help to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Change In Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.

Commencement Date means 00:01 hrs on 1 April 2019.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which Is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not Include any Default Liability or Performance Payment.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Demographic Growth means anticipated population changes Including size, structure, and distribution.

Financial Contributions means the financial contributions made by each Partner to the Better Care Pooled Fund for each Individual Scheme in any Financial Year. Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

In each case where such event is beyond the reasonable control of the Partner claiming relief.

Functions means the NHS Functions and the Health Related Functions.

Health Related Functions means health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification. This is subject to the exclusions listed in Regulation 6(a)(i) to (vi) of the Regulations together with such exclusions and limitations as specified in the relevant Scheme Specification.

Host Partner means for the Better Care Pooled Fund, the Council.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Local Performance Metrics means those metrics for each scheme specified in Part 2 of Schedule 9.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses

(including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non-Recurrent Payments means funding provided by a Partner to the Better Care Pooled Fund in in respect of an Individual Scheme in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

Overspend means any expenditure from the Better Care Pooled Fund in a Financial Year for any Individual Scheme which exceeds the Financial Contributions to the Better Care Pooled Fund for that Individual Scheme for that Financial Year save where such overspend results from Payment for Performance Fund payments not being available to the Better Care Pooled Fund.

Partner means each of the CCG and the Council, and references to "Partners" shall be construed accordingly.

Partnership Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 3;

Pay for Performance Fund means the ring-fenced element of the Better Care Fund Pooled Fund as specified in Schedule 1, paragraph 3 and Schedule 4 which shall be used for the purposes set out in Schedule 1, paragraph 3 and Schedule 4.

Performance Measures means the Better Care Fund Metrics and the local Performance Metrics.

Performance Payment Arrangement means any arrangement agreed with a Provider and one or more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Partner which includes a

Section 113 Officer for the Better Care Pooled Fund as is nominated by the Host Partner from time to time to manage the Better Care Pooled Fund in accordance with Clause 7.6.4.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1July to 30 September

1October to 31 December

1January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Ring Fenced Capital Grants means one or more of the grants specified at Schedule 1.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement which shall, in all cases be agreed prior to any such scheme becoming operative.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners In accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under

the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision snail be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff' and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or Implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 21.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (Including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 The Partners enter into this Agreement in order to support the delivery of the overall shared vision for the Wolverhampton health and social care economy of one ambition, working as one for everybody.

3.4 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning; and

4.1.3 the establishment of a Pooled Fund.

in relation to Individual Schemes (the "Flexibilities")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specifications are set out in Schedule 12 parts 2 to 5.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Partnership Board.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavor to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavor to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in respect of any Individual Scheme in the Better Care Pooled Fund.

6.5 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.6 Where there are Lead Commissioning Arrangements in respect of an Individual

Scheme the Lead Commissioner shall:

6.6.1 exercise the NHS Functions in conjunction with the Health Related Functions as Identified in the relevant Scheme Specification;

6.6.2 endeavor to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.6.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.6.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.6.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.6.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform Its obligations with all due skill and attention;

6.6.7 undertake performance management and contract monitoring of all Service Contracts, reporting on performance by exception to the Partnership Board;

6.6.8 in consultation with the programme director, undertaking any enforcement action pursuant to any Services Contract;

6.6.9 make payment of all sums due to a Provider pursuant to the terms of any Services Contract;

6.6.10 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend for any Individual Scheme in the Better Care Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In the exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain the Better Care Pooled Fund for revenue expenditure as set out in the Scheme Specifications.

7.2 The Better Care Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in the Better Care Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Third Party Costs;

7.3.5 Approved Expenditure

("Permitted Expenditure")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Better Care Pooled Fund may not be expended on Default Liabilities unless this Is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for the Better Care Pooled Fund. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Better Care Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Better Care Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 The Pooled Fund Manager in respect of the Better Care Pooled Fund shall have the following duties and responsibilities:

8.1.1 the day to day operation and management of the Better Care Pooled Fund;

8.1.2 ensuring that all expenditure from the Better Care Pooled Fund is in accordance with the provisions of this Agreement and the Scheme Specifications;

8.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Better Care Pooled Fund;

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the Better Care Pooled Fund;

8.1.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;

8.1.6 ensuring action is taken to manage any projected under or overspends relating to any Individual Scheme within the Better Care Pooled Fund in

accordance with this Agreement;

8.1.7 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Better Care Pooled Fund for all Individual Schemes and the Better Care Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Better Care Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met; and

8.1.8 preparing and submitting reports to the individual partners or the Health and Wellbeing Board as required by them.

8.2 In carrying out their responsibilities as provided under Clause 8.1 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

8.3 Save where otherwise agreed by the Partnership Board, there shall be no viring of funds between Individual Schemes within the Better Care Pooled Fund.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the CCG and the Council to the Better Care Pooled Fund for the first Financial Year of operation of each Individual Schemes shall be as set out in Schedule 1.

9.2 For future years during the term of this Agreement, the Pooled Fund Manager will be responsible for making proposals to the Partnership Board to determine the Financial Contribution of the CCG and the Council to the Better Care Pooled Fund.

9.3 Financial Contributions will be paid as set out in Schedule 1.

9.4 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Better Care Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Partnership Board minutes and recorded in the budget statement as a separate Item.

10 NON FINANCIAL CONTRIBUTIONS

10.1 The non-financial contributions of each Partner including staff {including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement {including, but not limited to, management of service contracts and the Better Care Pooled Fund) will be set out in a separate agreement between the CCG and the Council to support wider integration across the Health and Social Care economy in Wolverhampton .

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 4, which provide for financial risks arising within the commissioning of services from the Better Care Pooled Fund.

Overspends in Pooled Fund

11.2 Subject to Clause 11.1, the relevant Partner for the Better Care Pooled Fund shall manage expenditure from the Better Care Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

11.3 The relevant Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that the only expenditure from the Better Care Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 11.4.

11.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Underspend

11.5 In the event that expenditure from the Better Care Pooled Fund for any Individual Scheme for which Financial Contributions within the Better Care Pooled Fund are made in any Financial Year Is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

12 CAPITAL EXPENDITURE

12.1 The Better Care Pooled Fund shall not (subject to any Ring Fenced Capital Grant) normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13 VAT

13.1 The Partners shall agree the treatment of the Better Care Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

13.2 Subject to Clause 13.1, Services commissioned by the Council will be subject to the VAT regime of the Council and Services commissioned by the CCG will be subject to the VAT regime of the National Health Service.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

14.2 All Internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

14.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an Intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 13.4 the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts,

documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Better Care Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The CCG is subject to the CCG Statutory Duties and these incorporate both a duty to act effectively, efficiently and economically and duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Better Care Pooled Fund is therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the agreed policy for Identifying and managing conflicts of interest as set out in Schedule 7.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working across the health and social care economy is vested In the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established the Partnership Board to oversee the delivery of the Individual Schemes and Better Care Pooled Fund and their associated action plans and performance monitoring arrangements in accordance with the Better Care Fund Plan, this Agreement and any requirements of the Health and Wellbeing Board.

18.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have responsibility to make decisions in accordance with the Governance arrangements of each Partner which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 3.

18.4 The terms of reference of the Partnership Board shall be as set out in Schedule 3.

18.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Partnership Board shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

18.7 Each Scheme's Schedule shall conf rm the governance arrangements in respect of the Individual Service and how that Individual Service is reported to the Partnership Board and Health and Wellbeing Board.

19 REVIEW

19.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review c-Annual Review") of the operation of this Agreement of the Better Care Pooled Fund or the Individual Schemes the subject of the Better Care Fund Plan and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, In accordance with the governance arrangements set out in Schedule 3.

19.3 The Partnership Board snail within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. A copy of this report shall be provided to both Partners and the Health and Wellbeing Board.

19.4 In the event that the Partners fail to meet either the requirements of the Better Care Fund Plan or any other relevant statutory requirement the Partners shall provide full co-operation with any regulatory bodies (including NHS England) to agree a recovery plan.

20 COMPLAINTS

20.1 The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21 TERMINATION & DEFAULT

21.1 Subject to the statutory requirements of the Better Care Fund, this Agreement may be terminated by either Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes which are operational at the date of such notice being given.

21.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

21.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 22.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

21.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

21.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the Integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.5.3 where either Partner has entered into a Service Contract such Partner shall use all reasonable endeavors to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place that Partner in breach of the Service Contract) where the other Partner requests the same In writing provided that the Partner that has entered into such Service Contract shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.5.4 where a Service Contract held by either Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service

Contract allows the other Partner may request that the Partner holding the Service Contract assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.5.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.5 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

22.1 The Partnership Board shall, in the first instance, operate as the forum for discussion of issues relating to this Agreement. This shall be based on the outlined principles of openness and treating Partners with equal esteem to resolve, as far as possible, any issues in a collective, consensual manner.

22.2 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

22.3 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.4 If the dispute remains after the meeting detailed in Clause 22.3 has taken place, the Partners' respective chief executive and accountable officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

22.5 If the dispute remains after the meeting detailed in Clause 22.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and

will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

22.6 Nothing in the procedure set out in this Clause 22 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 Neither Partner shall be entitled to bring a Claim tor a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all best endeavors to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "Discloser") and subject always to the remainder of this Clause 24, each Partner (the "Recipient") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.4.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees and advisors to carry out their duties under the Agreement;

24.4.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; and

24.4.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26 OMBUDSMEN

26.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27 INFORMATION SHARING

27.1 The Partners will follow the Information Governance Protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act.

28 NOTICES

28.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be

deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice Is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

28.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received Informing the sender that it had not been received by the recipient (as the case may be).

28.3 The address for service of notices as referred to in Clause 28 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the Head of Governance; and

28.3.2 if to the CCG, addressed to The Corporate Operations Manager.

29 VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

29.2 The members of the Partnership Board shall have delegated authority from their respective organisations to agree the addition of schemes to the agreement following consideration of a detailed business case at a Partnership Board meeting.

29.3 Any other variation to the agreement, including any proposed variation following a review under the terms of Clause 19, will be subject to signed agreement from each of the Partners.

30 CHANGE IN LAW

30.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

30.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavors to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

30.3 In the event of failure by the Partnes to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

31 WAIVER

31.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

32 SEVERANCE

32.1 If any provision of this Agreement, not being of a fundamental nature, shall be held

to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

33 ASSIGNMENT AND SUB CONTRACTING

33.1 The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

34.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

34.2.3 bind the other in any way.

35 THIRD PARTY RIGHTS

35.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

36 ENTIRE AGREEMENT

36.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

36.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

37 COUNTERPARTS

37.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

38 GOVERNING LAW AND JURISDICTION

38.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

38.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

Signed for and on behalf of Wolverhampton City Council by:

_____
Authorised Officer

_____
Name

_____
Position

Signed for on behalf of NHS Wolverhampton Clinical Commissioning Group by:

_____
Authorised Officer

_____
Name

Position

Schedule 1 - Better Care Pooled Fund

The Better Care Pooled Fund is made up of contributions of the CCG and the Council as specified below.

The Ring Fenced Capital Grants referred to in the Table below may only be paid out of the Better Care Pooled Fund for use by the Council in accordance with the conditions attached to those grants.

All monies in the Better Care Pooled Fund allocated to Individual Schemes may only be spent on those Individual Schemes and shall be accounted for and reported accordingly.

Financial Year 2019-2020

Workstream	CCG Contribution (£000)	City Council Contribution (£000)
Adults Community Services	31,096	25,591
Dementia	3,581	280
Mental Health	10,217	3,550
CAMHS	201	125
Care Act	713	
Total Revenue Contribution	45,808	29,546
Capital - Ring Fenced Grant	-	3,147
Total Contribution to Pooled Fund	45,808	32,693

1. HOST PARTNER

1.1 The Host Partner for the Better Care Pooled Fund is the Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2. FINANCIAL GOVERNANCE ARRANGEMENTS

2.1 As in the Agreement with the following changes:

2.1.1 Management of the Better Care Pooled Fund

(a) The other Partner shall make monthly payments to the Host Partner

(b) Each month in monthly closedown estimates for over or under performance will be shared for accruals purposes in line with the following closedown timetable:

(i) The relevant Partner to submit pooled budget figures for each Individual Scheme to the Host Partner by the 8th Working Day of the month. The First reconciliation point will be at the end of Q2 (Month 6) to include any over/under performance to date but will not include assessment of performance payment

(ii) The Second reconciliation point will be the end of Q3 (Month 9) with potential to include assessment of performance payment preferred.

(iii) Over performance will be paid separately so as to keep a clear audit trail in line with Standard Financial Instructions and Standing Orders

(iv) Month 11 reporting will incorporate year end estimate on pooled budgets.

(c) The year-end reporting will be shared in line with the following closedown timetable:

(i) The relevant Partner to submit draft figures for each Individual Scheme within the Better Care Pooled Fund to the Host Partner to enable the Host Partner to provide draft figures for the Better Care Pooled Fund by the 3rd Working Day following year end (to meet national accrual deadline)

(ii) The relevant Partner to submit budget Information for each Individual Scheme within the Pooled Fund to the Host Partner to enable the Host Partner to submit budget information for inclusion in the annual accounts by the 10th Working Day following year end (to meet national deadline for submission of draft and audited accounts.)

2.1.2 The Host Partner's Agresso financial system will be used for financial management purposes:

(a) Budget holders will submit forecasts by the 10th Working Day of each month. These will then be reviewed by the appropriate Heads 'of Service and Service Directors by the 15th Working Day of the month.

(b) A budget report will contain:

(i) Financial codes and description of code

(ii) Original, revised and year to date budgets

(iii) Actual spend to date and commitments

(iv) Previous months and current forecasts

(v) Comments

(c) Budget Holders for each Individual Scheme will be detailed in each Scheme Specification and will be required to follow the established working rules and will be bound by the Host Partner's organisation's scheme of delegation.

(d) Where budget holders are not employed by the Host Partner, they will need to sign an undertaking to abide by the established rules.

(e) Training will be provided to budget holders and managers in the use of the Agresso financial system by the Host Partner.

(f) Budget Holders for each Individual Scheme will be responsible for all financial transactions for their budget including raising invoices (sales notes) and authorising both pay and non-pay expenditure.

(g) The fund will not include a contingency reserve, however this will be kept under review.

(h) Means testing for any social care payments will be carried out by the Host Partner.

2.1.3 Changes to Contribution levels

(a) The contribution levels to the Better Care Pooled Fund for each Individual Scheme have been agreed in principle as outlined above in Schedule 1.

(b) Any changes to contribution levels will need to be agreed through the governance structure outlined in Schedule 3.

(c) Audit Arrangements

(d) The current Internal and External Auditors for both Partners will need to provide audit opinions on the operation of the pooled fund and sign off substantive audits.

(e) Grant Thorntons have been appointed to manage the External Audit process for the Host Partner.

(f) The Finance Department within the Host Partner will manage and act as the point of liaison with the auditors.

The Audit arrangements for the Better Care Pooled Fund will comply with the external audit regimes of both parties.

3. REPORTING AND ASSURANCE ARRANGEMENTS

3.1 In line with the Guidance for the Operationalisation of the BCF in 2019-2020 the Host Partner in partnership with the relevant Partner shall provide quarterly and annual reports on the overall operation of the arrangements for the Better Care Pooled Fund.

3.2 The quarterly and annual reports shall include the following information to allow both monitoring of the effectiveness of the pooled fund arrangements and to provide assurance to NHS England as to the appropriate use of the fund.

3.2.1 Summary of Income and Expenditure;

3.2.2 Summary of Payment for Performance;

3.2.3 Summary of Non-elective admissions performance;

3.2.4 Summary of Support Metric performance; and

3.2.5 Confirmation of compliance with BCF national conditions.

3.3 The Better Care Fund Programme Board shall prepare the reports and submit them for approval to the Health and Wellbeing Board in order to meet the deadlines for the submission of the quarterly reports to the Department of Health set out in the template released each quarter.

3.4 Additional quarterly reporting for improved Better Care Fund (iBCF) funding was introduced for 2017-19. A narrative that explains iBCF can be found at Appendix A. The Quarterly iBCF reports shall be completed by the Council as hosts of the iBCF monies and owners of associated projects.

3.5 Quarterly reports shall be presented to BCF Programme Board for approval prior to submission in accordance with the schedule below:

Quarterly reporting deadline 2019-2020	BCF Programme Board presentation (dates as currently stand)
Q1 - no reporting	Not applicable
Q2 - 30 October 2019	7 November (retrospective sign off)
Q3 - 24 January 2020	2 January 2020
Q4 - 1 May 2020	2 April 2020

Appendix A - improved Better Care Fund narrative

The Improved Better Care Fund (iBCF) was first announced in the 2015 Spending Review and is paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan. The Government distributed the funding to ensure all local authorities receive some of the additional funding. The distribution comprises:

The allocation for 2019-20 for the City of Wolverhampton Council is £13.0 million, reducing significantly over the following two years. The grant conditions confirm funding can be spent on three purposes:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

Initiative/Project	Objectives and Expected Outcomes
Home First – re-ablement	Increase the availability of community based re-ablement to provide short-term care and re-ablement in people's homes to bridge the gap between hospital and home meaning that people no longer need to wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges, improves patient flow and reduces long term admissions to bed-based care.
Demand Management	Commission external support to address DToC, manage overall demand and improve performance Including intelligence gathering for continued Improvement. Promote independence by developing personal support networks and increase options available, which reduces reliance upon formal support and informs commissioning intentions. Investment In equipment & adaptations in order to increase independence and reduce reliance on social care and health services.
Increasing Choice and Control for People	Encourage people to be more resilient by accessing their local communities including universal services or Voluntary Council Sector services as alternatives to social care and health services. Development of Community Navigator type models which encourage and improve people's connectivity to informal and community support. These roles also help the Council to connect to local communities and support or stimulate community responses to local problems. Provide low level support upon discharge for short time-limited periods, which reduces dependency on traditional services, inappropriate referrals to re-ablement, diversion from A&E and facilitates timely discharge through the availability of additional support during the transition period home. Enable soft market testing to establish voluntary sector opportunities.

There is no requirement to spend across all three purposes, or to spend a set proportion on each. The local authority is not required to share the funding with hospitals or CCGs according to the grant conditions. IBCF funding does not replace and must not be offset against the NHS minimum contribution to adult social care. There is however, a grant condition that local authorities must work with their local CCG to meet the fourth national condition - to implement the High Impact Change Model for Managing Transfers of Care- however there is no requirement to spend the grant on this purpose. The national condition applies to both City of Wolverhampton Council and Wolverhampton CCG and both are

expected to agree how the model's implementation will be funded. This will include other funding streams, some of which may be outside the BCF.

Schedule 2 – Service Specifications

Part 1- Template Services Schedule

TEMPLATE SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1. OVERVIEW OF INDIVIDUAL SERVICE

This Individual Scheme is the [Insert name] Scheme.

Monies attributable to this Individual Scheme are derived from the Better Care Pooled Fund as more particularly set out in for this Scheme in Schedule 1.

The Host Partner for the Better Care Pooled Fund is Wolverhampton City Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2. AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme.

3. THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

(1) Lead Commissioning

(2) [Integrated Commissioning]

(3) the allocation of monies from the Better Care Pooled Fund to the Individual Scheme

(4) co-production.

4. FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions).

5. SERVICES

What Services are going to be provided within this Scheme? Are there contracts already in place? Are there any plans or agreed actions to change the Services?

Who are the beneficiaries of the Services?

6. COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

Contracting Arrangements

Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms? What contract management arrangements have been agreed? What happens if the Agreement terminates? Can the partner terminate the Contract in full/part? Can the Contract be assigned in full/part to the other Partner?

Access

Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

7. FINANCIAL CONTRIBUTIONS

Monies attributable to this Individual Scheme are derived from the Better Care Pooled Fund as more particularly set out for this Scheme in Schedule 1.

Financial resources in subsequent years to be determined in accordance with the Agreement.

8. FINANCIAL GOVERNANCE ARRANGEMENTS

As in the Agreement and Schedule 1 to this Agreement.

9. GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

This section deals with bespoke arrangements for the relevant scheme. Would it be the responsibility of the Lead Officers or a sub group of the Partnership Board to review the Individual Scheme? Whichever is responsible should report to the Partnership Board.

10. NON FINANCIAL RESOURCES

[The commissioning arrangement for this Scheme will be supported by a separate

agreement between the Council and the CCG that setting out how non-financial arrangements (including staffing) will be dealt with.]

11. STAFF

Consider:

- Who will employ the staff in the partnership?
- Is a TUPE transfer secondment required?
- How will staff increments be managed?
- Have pension arrangements been considered?

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.
If the staff are being seconded to the CCG this should be made clear.

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.
If the staff are being seconded to the Council this should be made clear.

12. ASSURANCE AND MONITORING

The assurance framework and performance measures in relation to the Individual scheme needs to be included here only - so include the detailed metrlcs for it.

Also consider how specific performance measures for each Scheme will be reported in context of performance of the BCF Plan overall and meeting National Conditions.
Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme. In relation to the Better Care Fund you will need to include the relevant performance outcomes. Consider the following:

- What is the overarching assurance framework in relation to the Individual Scheme?
- Has a risk management strategy been drawn up?
- Have performance measures been set up?
- Who will monitor performance?
- Have the form and frequency of monitoring information been agreed?
- Who will provide the monitoring information? Who will receive it?

13. LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone number	Email address	Fax number
Council					

CCG					

14. INTERNAL APPROVALS

- Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;
- Consider the scope of authority of the Pool Manager and the Lead Officers;
- Has an agreement been approved by cabinet bodies and signed?

15. RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?

Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

16. REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

17. INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?

How will charges be managed (which should be referred to in Part 2 above) What data systems will be used?

Consultation - staff, people supported by the Partners, unions, providers, public, other agency.

Printed stationary.

18. DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all the Individual Scheme be terminated on notice by a party? Can part/all the Individual Scheme be terminated as a result of breach by either Partner? What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement.

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

Consider also arrangements for dealing with premises, records, information sharing and the connection with staffing provisions set out in the Agreement.

19. OTHER PROVISIONS

Consider, for example:

- Any variations to the provisions of the Agreement
- Bespoke arrangements for the treatment of records
- Safeguarding arrangements.

Part 2 - Adult Community Care Scheme Specification

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1. OVERVIEW OF ADULT COMMUNITY CARE SCHEME

1.1 This Individual Scheme is the Adult Community Care Scheme

1.2 Monies attributable to the Adult Community Care are derived from the Better Care Pooled Fund as more particularly set out in for this Scheme in Schedule 1.

1.3 The Host Partner for the Better Care Pooled Fund is the Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2. AIMS AND OUTCOMES

2.1 To provide a truly integrated, person-centered community-based adult care service to the local population. Supporting people to remain as independent as possible by managing their condition confidently through access to a professional, skilled community-based workforce when necessary. This will reduce the demand on other services (e.g. emergency care portals, GP out of hour's services and walk-in centers) during times of crisis. Given the Importance of supporting people who are both frail and elderly the programme will also include the development of a clear frail elderly pathway and End of Life pathway.

2.2 In light of the development of the Wolverhampton Integrated Care Alliance (ICA), and apparent overlaps between projects within this and within the BCF, a proposal has been agreed to bring together the two programmes of work during 2019/20. This will bring together the BCF Adult Community Care workstream with the ICA End of Life and Frailty workstreams. This may result in some changes to the project management/support to the workstream in the future therefore the detail within this agreement is the “as is” position.

2.3 The merger of the BCF and ICA programmes will not impact on the Pooled Budget arrangements for 2019/20.

2.4 During discussions to determine the content of the Pooled budget for 2017-19 it was agreed to undertake a joint review and redesign of Continence services and pathways.

3. THE ARRANGEMENTS

3.1 The following applies in relation to the Adult Community Care work stream:

- Lead Commissioning;

- The allocation of monies from the Better Care Pooled Fund to Adult Community Care; and
- Co-production.

3.2 This Individual Scheme will be supported by an integrated commissioning arrangement. This will set out how combined resources will be defined and their use will be planned to ensure the delivery of sustainable, demonstrable quality and best value services which will improve outcomes for the people of Wolverhampton. This will involve, where appropriate:

- Developing Integrated commissioning intentions for the population groups of Wolverhampton
- Developing a strategic commissioning plan which maximises the ability to achieve the identified outcomes required
- Development of an integrated market strategy.

3.3 This integrated commissioning arrangement will be supported by a separate agreement between the Council and the CCG that will detail how non-financial arrangements (including staffing) will be set out.

4. FUNCTIONS

4.1 NHS Functions

4.1.1 The functions of NHS bodies prescribed under regulation 5 of the Regulations subject of this Scheme are as follows:

1. The functions of arranging for the provision of services under sections 3, 3A and 38 of, and paragraphs 9 to 11 of Schedule 1, to the 2006 Act. including rehabilitation services and services

   intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services;

2. The functions of providing the services referred to in paragraph 1, pursuant to arrangements made by a clinical commissioning group or the National Health Service Commissioning Board (the Board);

3. The functions of making direct payments under:

   (a) section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and

   (b) the National Health Service (Direct Payments) Regulations 2013;

4.2 Health Related Functions

4.2.1 The Health Related Functions prescribed under regulation 6 of the

Regulations subject of this Scheme are the health-related functions of local authorities set out in section 2B to the 2006 Act as referred to in paragraph 6(m) of the Regulations.

5. SERVICES

5.1 This Individual Scheme will deliver the following specific work:

a) The continuing development of three locality based Integrated Health and Social Care Community Neighbourhood Teams, wrapped around Primary Care and supported by specialist teams and Voluntary Sector.

b) Developing a Wolverhampton City Strategy to deliver the vision of the BCF Adult Community Care workstream.

c) To ensure service planning takes account of the opportunities to provide truly integrated care to the local population by wrapping services around patients to deliver person centred, holistic care.

d) To ensure that services are commissioned based on evidence of need, including the complexity of conditions across the population.

e) Implementation of Personalised Care where appropriate into newly designed pathways and services.

f) People living with Frailty Programme:

- Review and redesign of current pathways to ensure services are meeting the needs of our aging population.

- A revised model of care will place a stronger focus on prevention, aging well with the delivery
of proactive care aiming to keep people living independently for longer.

- Recruitment and Deployment of a team of Healthy Ageing Co-ordinators to proactively work with patients and co-ordinate care between services.

g) Review and Redesign of community services programme:-

- In depth review of current Community Based services to establish effectiveness, efficiency and improve quality.

- To adopt a place based approach to the delivery of community based services ensuring where possible, persons are activated and encouraged to self-manage and remain In their usual place of residence where appropriate.

- Undertake a scoping exercise to identify acute based services that

could safely be delivered within a community setting to achieve care closer to home

- Co-production of detailed plan and the development of a robust business case based on opportunities identified.

- The Royal Wolverhampton Trust are undertaking a Community Transformation Programme and therefore this project will need to link with the transformation programme to avoid duplication and ensure that the two programmes are aligned.

h) Discharge to Assess Programme:

- The Discharge to Assess project is nearing completion. The Discharge to Assess process is now implemented across all Acute wards at RWT. A transition group has been set up to ensure BAU and the project aims to close by end of November 2019.

- A suite of information videos has been developed and is available to support patients, families, carers and staff in discussing the discharge pathways available to them.

- Supplementary information will be developed i.e. poster, leaflets, patient letters.

i) Review and Redesign of End of Life pathway

- The development of a Wolverhampton system wide End of Life model that provides effective, seamless, co-ordinated care for the people of Wolverhampton.

- Work with the ICA sub-groups to develop mechanisms to approve and resource a proposed model

j) GP Home Visiting Service

- Evaluation of a recent pilot and recommendations of future model of GP home visiting.

k) Multi-disciplinary teams

- Continuation of community locality based multi-disciplinary teams

- Rollout of Primary Care Based MDT meeting and the evolvement of the model to wrap around newly formed Primary Care Networks (PCNs)

l) Emergency Care Passport

- Scoping exercise to understand current usage and impact

- Exploration of crossover with Personalised Care Planning
- Further rollout plan
- Communication plan which encourages utilization, linking in with all agencies

m) Admission Avoidance

- Review and redesign of current Admission Avoidance teams if necessary i.e. further extended hours, linkages with WMAS Strategic Cell.
- Cross organizational, multi–disciplinary approach
- Review and development of established Admission Avoidance capability to identify opportunities to improve current performance and further promote services to partners and stakeholders.
- Undertake modelling with Primary Care to ensure alignment with new models of care emerging across the City.

n) Community Connections

- Profiling the WV10 area, understanding need and demand
- Analyse maps and identify areas of high need and demand
- Testing out ways of connecting people with each other and their communities
- Run a number of "Love your community" events
- Develop and establish regular Talking Points in a variety of settings
- Trial a scheme to reduce loneliness and social isolation

o) Telecare/Technology

- Evaluate the impact of new Telecare Response Service with SJA and its impact on admission avoidance
- Increase the number of referrals for Telecare (free for six weeks) within Discharge to Assess and Admission Avoidance Services
- Develop a digital Telecare service offer which does not relay on a landline telephone
- Scope the demand for urgent Telecare packages 'out of hours'
- Explore the possibility for a proactive telecare telephone welfare check call service to support Discharge to Assess
- Explore the benefits of using a connected care platform to support Discharge to Assess/re-ablement.

p) Red Bag

- Continued rollout out and evaluation of the Red Bag schemes.

6. COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 The Partners will act as Lead Commissioner for the Services within this

scheme as specified in the table set out at Appendix B to this schedule, below.

6.2 Contracting Arrangements

6.2.1 For the purposes of the integrated comm1ss1onmg process, either Partner can undertake commissioning on behalf of itself and the other Partner and hold a contract, based upon a best fit decision at the time. Each organisation agrees to brief the other Partner via the Partnership Board on issues relating to the core elements of each contract.

6.2.2 The following core elements will form the integrated contract management approach for the purposes of the agreement:

a) Contact Negotiation
b) Operational Provider Management
c) Contract Performance Management
d) Contract Review

6.2.3 These core elements will operate across the Adult Community Care Scheme in accordance with the following principles detailed below:

Workstream Area	Contract Responsibility 2019/20	Contract Negotiation 2019/20	Operational Provider Management 2019/20	Contract Performance Management 2019/20	Contract Review for 2020/21 preparation
Adult Community Care	Council & CCG Contract Leads	Council & CCG Contract Leads	Provider Workstream Lead Council Provider workstream lead	Council & CCG Contract Leads	Council Adult Community Social Care Commissioner CCG Commissioning Lead Council & CCG Contract leads

6.2.4 For the purposes of developing the integrated commissioning approach, procurement requirements and opportunities for 2020/21 will be reviewed in Quarter 4 of 2019/20. In 2019/2020 and future years, procurement delivery will take place in Quarters 1,2 & 3 with contract negotiation in Quarter 3 across each workstream.

6.2.5 The Contracts which will form part of this Scheme are set out at Appendix B - provided always that the parties acknowledge that this list will be amended as additional contracts are commissioned over the duration of this

Agreement.

6.3 Access

6.3.1 Access arrangements will be detailed across the individual work streams as pathways are redesigned

7. FINANCIAL CONTRIBUTIONS

7.1 Monies attributable to the Community and Primary Care Scheme are derived from the Better Care Pooled Fund as more particularly set out for this Scheme in Schedule 1 and include the ring fenced Disabilities Facilities Grants and the Social Care Capital Grants identified in the Better Care Pooled Fund for this Scheme.

7.2 Financial resources in subsequent years to be determined in accordance with the Agreement.

7.3 The financial governance arrangements for this Scheme are set out in Schedule 1.

8. GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

8.1 The Integrated commissioning governance arrangements specified in Schedule 3.

9. NON FINANCIAL RESOURCES

9.1 The commissioning arrangement for this Scheme will be supported by a separate agreement between the Council and the CCG setting out how non-financial arrangements (including staffing) will be dealt with. The Partners agree that, save as otherwise agreed, all staff shall, during the term of this Agreement, continue to be employed by their respective employers as at the Commencement Date and that there shall be no transfer of employees, but that employees employed by one Partner may second to the other Partner for fixed periods with specified expiry dates for the purpose facilitating the delivery of services under this Scheme.

10. ASSURANCE AND MONITORING

10.1 The Lead Officers will produce a report each Month of the performance of this Scheme against any Local Performance Metrics set out in Schedule 9 (Performance Measures).

10.2 The Lead Officers will produce a report each month of the performance of this Scheme against each of the Better Care Fund Metrics so that performance of the Better Care Fund Plan overall against the Better Care Fund Metrics may be established.

11. LEAD OFFICERS (SRO)

The SRO responsibility for each workstream will be reviewed with the merging of the BCF and ICA programmes.

Partner	Name of Lead Officer	Address	Telephone number	Email address
Council	David Watts	Civic Centre, Wolverhampton	01902 555310	David.Watts@wolverhampton.gov.uk

12. INTERNAL APPROVALS

12.1 This will be in line with each parties' powers delegated to their representatives on the partnership board, in line with their own scheme of reservation and delegation as set out in Schedule 3.

13. RISK AND BENEFIT SHARE ARRANGEMENTS

13.1 The risk and benefit sharing arrangements set out in Schedule 4 will operate.

14. REGULATORY REQUIREMENTS

14.1 To be confirmed

15. INFORMATION SHARING AND COMMUNICATION

15.1 The Information Governance arrangements set out in Schedule 8 will operate.

16. DURATION AND EXIT STRATEGY

16.1 The provisions of Clause 21 of this Agreement will operate.

17. OTHER PROVISIONS

17.1 None

Part 3 - Mental Health

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1. OVERVIEW OF INDIVIDUAL SERVICE

1.1 This Individual Scheme is the Mental Health Scheme

1.2 Monies attributable to the Mental Health Scheme are derived from the Better Care Pooled Fund as more particularly set out in for this Scheme in Schedule 1.

1.3 The Host Partner for the Better Care Pooled Fund is Wolverhampton City Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner, is the Better Care Fund Programme Director.

2. AIMS AND OUTCOMES

2.1 Mental Health

2.2 To improve the experience of people of all ages in Wolverhampton through the delivery of parity of esteem. This will include quality, sustainable, compassionate, seamless and effective mental health treatment. Prevention, early intervention, support and care including work with the crisis home treatment teams will be delivered in line with the City's existing Mental Health Strategy and Crisis Concordat agreements.

2.3 In light of the development of the Wolverhampton Integrated Care Alliance (ICA), and apparent overlaps between projects within this and within the BCF, a proposal has been agreed to bring together the two programmes of work during 2019/20. This will bring together the BCF Mental Health workstream with the ICA Mental Health workstream. This may result in some changes to the project management/support to the workstream in the future therefore the detail within this agreement is the “as is” position.

2.4 The merger of the BCF and ICA programmes will not impact on the Pooled Budget arrangements for 2019/20.

3. THE ARRANGEMENTS

3.1 The following applies in relation to the Mental Health Scheme:

- Lead Commissioning; and
- the allocation of monies from the Better Care Pooled Fund to Mental Health

3.2 This Individual Scheme will be supported by an integrated commissioning arrangement. This will set out how combined resources will be defined and their use will be planned to ensure the delivery of sustainable, demonstrable quality and best value services which will improve outcomes for the people of Wolverhampton. This will Involve:

- Developing integrated commissioning intentions for the population groups of Wolverhampton
- Developing a strategic commissioning plan which maximises the ability to achieve the identified outcomes required
- Development of an Integrated market strategy.

4. FUNCTIONS

4.1 NHS Functions

4.1.1 The functions of NHS bodies prescribed under regulation 5 of the Regulations subject of this Scheme are as follows:

a) The functions of arranging for the provision of services under section 117 of the Mental Health Act 1983;

b) The functions of providing services referred to in paragraph 1 pursuant to arrangements made by a clinical commissioning group or the Board;

c) The functions under Schedule A1 of the Mental Capacity Act 2005.

4.2 Health Related Functions

4.2.1 The Health Related Functions prescribed under regulation 6 of the Regulations subject of this Scheme are the health-related functions of local authorities specified in Schedule 1 of the Local Authority Social Services Act 1970 as referred to in paragraph 6(a) of the Regulations.

5. SERVICES

5.1 This Individual Scheme will deliver the following specific work:

a) Review of Preventative Services

- Identify and develop joint commissioning/integration opportunities that exist that may prevent escalation into more complex/acute services

b) Mapping of Current Services and Pathways

- To map out all current pathways and services for Mental Health in Wolverhampton with a view of a common understanding of services and to identify gaps

c) Review and Development of Discharge Planning and Pathways

- To review current Discharge policies / pathways and to produce an agreed Discharge pathway for patients with mental health needs

d) Develop New Model of Integrated Mental Health Services/Offer in Wolverhampton

- To identify and co-design opportunities for greater integration across partners

e) Interfaces between Primary and Secondary Care

- Development of pathways that define responsibilities between primary and secondary care, build relationships and develop seamless pathways for patients
- Wrapping services around Primary Care

f) Developing community based mental health services wrapped around Primary Care Networks (PCNs)

- Pathways for patients with Physical and Mental Health conditions
- Development of seamless care pathways for those patients with both physical and mental health conditions
- Defining responsibilities.

6. COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 The Partners will act as Lead Commissioner for the Services within this scheme as specified in the table set out at Appendix B to this schedule, below.

6.2 Contracting Arrangements

6.2.1 For the purposes of the integrated commissioning process, either Partner can undertake commissioning on behalf of itself and the other Partner and hold a contract, based upon a best fit decision at the time. Each organisation briefing the other Partner via the Partnership Board on issues relating to the core elements of each contract.

6.2.2 The following core elements will form the integrated contract management approach for the purposes of the agreement:

- Contact Negotiation

- Operational Provider Management
- Contract Performance Management
- Contract Review

6.2.3 These core elements will operate across Mental Health in accordance with the following principles detailed below:

Works tream	Contract respon sibility 2017/20 19	Contr act negoti ation 2017/ 2019	Operati onal Provid er Manag ement 2017/2 09	Contra ct Perfor mance Manag ement 2017/2 09	Contrac t Review for 219/202 0 preparat ion
Mental health	Council and CCG Contract Leads	Counc il and CCG Contra ct Leads	Council Social Care Mental Health Provide r Lead Mental Health Provide r Lead	Council and CCG Contrac t Leads	Council and CCG Contract Leads Council Social Care Mental Health Commis sioner CCG Commis sioning Lead

6.2.4 For the purposes of developing the integrated commissioning approach, procurement requirements and opportunities for 2020/21 will be reviewed in Quarter 4 of 2019/20. In 2019/20 and future years, procurement delivery will take place in Quarters 1,2 & 3 with contract negotiation in Quarter 3 across each workstream.

6.2.5 The Contracts which will form part of this Scheme are set out at Appendix B, provided always that the parties acknowledge that this list will be amended as additional contracts are commissioned over the duration of this Agreement.

6.3 Access

6.3.1 Access arrangements will be detailed across the individual work streams as pathways are redesigned

7. FINANCIAL CONTRIBUTIONS

7.1 Monies attributable to the Mental Health Scheme are derived from the Better Care Pooled Fund as more particularly set out for this Scheme in Schedule 1.

7.2 Financial resources in subsequent years to be determined in accordance with the Agreement.

7.3 The financial governance arrangements for this Scheme are set out In Schedule 1.

8. GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

8.1 The integrated commissioning governance arrangements specified in Schedule 3.

9. NON FINANCIAL RESOURCES

9.1 The commissioning arrangement for this Scheme will be supported by a separate agreement between the Council and the CCG setting out how non-financial arrangements (including staffing) will be dealt with. The Partners agree that, save as otherwise agreed, all staff shall, during the term of this Agreement, continue to be employed by their respective employers as at the Commencement Date and that there shall be no transfer of employees, but that employees employed by one Partner may second to the other Partner for fixed periods with specified expiry dates for the purpose facilitating the delivery of services under this Scheme.

10. ASSURANCE AND MONITORING

10.1 The Lead Officers will produce a report each month of the performance of this Scheme against any Local Performance Measures set out in Schedule 90 (Performance Measures).

10.2 The Lead Officers will produce a report each month of the performance of this Scheme against each of the Better Care Fund Metrics so that performance of the Better Care Fund Plan overall against the Better Care Fund Metrics may be established.

11. LEAD OFFICERS (SROs)

The SRO responsibility for each workstream will be reviewed with the merging of the BCF and ICA programmes.

Partner	Name of Lead	Address	Telephone Number	Email Address
CCG	Steven Marshall	Wolverhampton Science Park	01902 445797	Steven.Marshall3@nhs.net

12. INTERNAL APPROVALS

12.1 This will be in line with each party's powers delegated to their representatives on the partnership board, in line with their own scheme of reservation and delegation as set out in Schedule 3.

13. RISK AND BENEFIT SHARE ARRANGEMENTS

13.1 The risk and benefit sharing arrangements set out in Schedule 4 will operate.

14. REGULATORY REQUIREMENTS

14.1 To be confirmed

15. INFORMATION SHARING AND COMMUNICATION

15.1 The Information Governance arrangements set out in Schedule 8 will operate.

16. DURATION AND EXIT STRATEGY

16.1 The provisions of Clause 21 of this Agreement will operate.

17. OTHER PROVISIONS

17.1 None

Part 4 - Dementia

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1. OVERVIEW OF INDIVIDUAL SERVICE

1.1. This Individual Scheme is the Dementia Scheme

1.2. Monies attributable to the Dementia Scheme are derived from the Better Care Pooled Fund as more particularly set out in for the Scheme in Schedule 1.

1.3. The Host Partner for the Better Care Pooled Fund is Wolverhampton City Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2. AIMS AND OUTCOMES

2.1. **Dementia**

2.1.1 In line with the Wolverhampton Joint Dementia Strategy 2019-24 the BCF Dementia work stream has the remit to implement/deliver the elements of the Dementia strategy.

2.1.2 This includes the five elements of the Dementia Strategy; Preventing Well, Diagnosing Well, Living Well, Supporting Well and Dying Well.

2.1.3 The Workstream which includes representatives from multiple agencies; will also review existing dementia specific day services, education and awareness training and the health and social care pathway. The aim is to promote greater independence and choice for people with dementia, increasing their self-esteem and encouraging people to maintain good social and personal relationships.

3. THE ARRANGEMENTS

3.1. The following applies in relation to the Dementia Scheme:

3.1.1 Lead Commissioning; and

3.1.2 the allocation of monies from the Better Care Pooled Fund to Dementia.

3.2. This Dementia Scheme will be supported by an integrated commissioning arrangement. This will set out how combined resources will be defined and their use will be planned to ensure the delivery of sustainable, demonstrable quality and best value services which will improve outcomes for the people of Wolverhampton. This will involve:

3.2.1 Developing Integrated commissioning intentions for the population groups of Wolverhampton

3.2.2 Developing a strategic commissioning plan which maximises the ability to achieve the identified outcomes required

3.2.3 Development of an integrated market strategy

4. FUNCTIONS

4.1. NHS Functions

4.1.1 The functions of NHS bodies prescribed under regulation 5 of the Regulations subject of this Scheme are as follows:

- The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services;

- The functions of providing the services referred to in paragraph 1, pursuant to arrangements made by a clinical commissioning group or the National Health Service Commissioning Board (the "Board");

- The functions of making direct payments under:

  a. section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and

  b. the National Health Service (Direct Payments) Regulations 2013;

4.2. Health Related Functions

4.2.1 The Health Related Functions prescribed under regulation 6 of the Regulations subject of this Scheme are the health-related functions of local authorities set out in section 28 to the 2006 Act as referred to in paragraph 6(m) of the Regulations.

5. SERVICES

5.1. This Individual Scheme will deliver the following specific work:

- Implementation of the Dementia Strategy

- develop an Action plan

- Work with multiple organisations and teams to ensure delivery of the

Strategy.

6. COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 The Partners will act as Lead Commissioner for the Services within this scheme as specified in the table set out at Appendix B to this schedule, below.

6.2 Contracting Arrangements

6.2.1 For the purposes of the Integrated commissioning process, either Partner can undertake commissioning on behalf of itself and the other Partner and hold a contract, based upon a best fit decision at the time. Each organisation briefing the other Partner via the Partnership Board on issues relating to the core elements of each contract.

6.2.2 The following core elements will form the integrated contract management approach for the purposes of the agreement:

- Contact Negotiation
- Operational Provider Management
- Contract Performance Management
- Contract Review

6.2.3 These core elements will operate across Dementia in accordance with the following principles detailed below:

Workstream Area	Contract Responsibility 2017/19	Contract Negotiation 2017/19	Operational Provider Manageme	Contract Performance Manageme	Contract Review for 2019/20 preparation
Dementia	Council &CCG Contract Leads	Council& CCG Contract Leads	Provider Dementia Lead Council Dementia workstream lead	Council & CCG Contract Leads	CCG Commissioning Manager Council Social Care Commissioner - Dementia Council &CCG Contract Leads

For the purposes of developing the integrated commissioning approach, procurement requirements and opportunities for 2020/21 will be reviewed in Quarter 4 of 2019/20. In 2019/20 and future years,

procurement delivery will take place in Quarters 1,2 & 3 with contract negotiation in Quarter 3 across each workstream.

6.2.4 The Contracts which will form part of this Scheme are set out at Appendix B - provided always that the parties acknowledge that this list will be amended as additional contracts are commissioned over the duration of this Agreement.

6.3 Access

6.3.1 Access arrangements will be detailed across the Individual work streams as pathways are redesigned.

7. FINANCIAL CONTRIBUTIONS

7.1. Monies attributable to this Individual Scheme are derived from the Better Care Pooled Fund as more particularly set out for this Scheme in Schedule 1.

7.2. Financial resources in subsequent years to be determined in accordance with the Agreement.

7.3. The financial governance arrangements for this Scheme are set out in Schedule 1.

8. GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

8.1. The integrated commissioning governance arrangements specified in Schedule 3.

9. NON FINANCIAL RESOURCES

9.1 The commissioning arrangement for this Scheme will be supported by a separate agreement between the Council and the CCG setting out how non-financial arrangements (including staffing) will be dealt with. The Partners agree that, save as otherwise agreed, all staff shall, during the term of this Agreement, continue to be employed by their respective employers as at the Commencement Date and that there shall be no transfer of employees, but that employees employed by one Partner may second to the other Partner for fixed periods with specified expiry dates for the purpose facilitating the delivery of services under this Scheme.

10. ASSURANCE AND MONITORING

10.1. The Lead Officers will produce a report each month of the performance of this Scheme against any Local Performance Measures set out in Schedule 9 (Performance Measures).

10.2. The Lead Officers will produce a report each month of the performance of this Scheme against each of the Better Care Fund Metrics so that

performance of the Better Care Fund Plan overall against the Better Care Fund Metrics may be established.

11. LEAD OFFICERS (SROs)

The SRO responsibility for each workstream will be reviewed with the merging of the BCF and ICA programmes.

Partner	Name of Lead	Address	Telephone Number	Email Address
BCPFT	Steve Phillips	Delta House, Delta Point, Greets Green Road, West Bromwich, B70 9PL	0121 612 8689	steve.phillips@nhs.net

12. INTERNAL APPROVALS

12.1. This will be in line with each parties' powers delegated to their representatives on the partnership board, in line with their own scheme of reservation and delegation as set out in Schedule 3.

13. RISK AND BENEFIT SHARE ARRANGEMENTS

13.1. The risk and benefit sharing arrangements set out in Schedule 4 will operate.

14. REGULATORY REQUIREMENTS

14.1. To be confirmed

15. INFORMATION SHARING AND COMMUNICATION

15.1. The Information Governance arrangements set out in Schedule 8 will operate.

16. DURATION AND EXIT STRATEGY

16.1 The provisions of Clause 21 of this Agreement will operate.

17. OTHER PROVISIONS

17.1 None

Part 5 - CAMHS

SERVICE SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 This Individual Scheme is the CAMHS Scheme

1.2 Monies attributable to the CAMHS Scheme are derived from the Better Care Pooled Fund as more particularly set out in for this Scheme in Schedule 1.

1.3 The Host Partner for the Better Care Pooled Fund is Wolverhampton City Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

2 AIMS AND OUTCOMES

2.1 The aims of CAMHS transformation are to transform our local system by developing care pathways, services and Initiatives across health, education, criminal justice and social care with a unified set of values.

2.2 Funding received via Future in Mind has been committed to services with a clear vision as to how it will be spent in future years.

2.3 CWC and WCCG along with HeadStart have developed and commissioned an emotional Mental Health and Wellbeing service to plug the gap that currently exists at tier 2.

3 THE ARRANGEMENTS

3.1 The following applies in relation to the CAMHS Scheme:

- Lead Commissioning; and
- the allocation of monies from the Better Care Pooled Fund to CAMHS.

3.2 This CAMHS Scheme will be supported by an integrated commissioning arrangement. This will set out how combined resources will be defined and their use will be planned to ensure the delivery of sustainable, demonstrable quality and best value services which will improve outcomes for the people of Wolverhampton. This will involve:

- Developing integrated commissioning intentions for the population groups of Wolverhampton
- Developing a strategic commissioning plan which maximises the ability to

achieve the Identified outcomes required
- Development of an integrated market strategy.

4 THE FUNCTIONS

4.1 NHS Functions

4.1.1 The functions of NHS bodies prescribed under regulation 5 of the Regulations subject of this Scheme are as follows:

a) The functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the 2006 Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services;

b) The functions of providing the services referred to in paragraph 1, pursuant to arrangements made by a clinical commissioning group or the National Health Service Commissioning Board (the "Board");

c) The functions of making direct payments under:

- section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and

- the National Health Service (Direct Payments) Regulations 2013.

4.2 Health Related Functions

4.2.1 The Health Related Functions prescribed under regulation 6 of the Regulations subject of this Scheme are the health-related functions of local authorities set out in section 2B to the 2006 Act as referred to in paragraph 6(m) of the Regulations.

5 SERVICES

5.1 This Individual Scheme will deliver the following specific work:

- Transformation of CAMHS Service

- Following a review of the CAMHS services it was identified that the main gap was tier 2 services. Funding was identified from WCCG and CWC to procure a service to meet these needs – this service is in place until March 2020 when it will be subject to another procurement exercise. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.

6 COMMISSIONING, CONTRACTING, ACCESS

6.1 Commissioning Arrangements

6.1.1 The Partners will act as Lead Commissioner for the Services within this scheme as specified in the table set out at Appendix B to this schedule, below.

6.2 Contracting Arrangements

6.2.1 For the purposes of the integrated commissioning process, either Partner can undertake commissioning on behalf of itself and the other Partner and hold a contract, based upon a best fit decision at the time. Each organisation briefing the other Partner via the Partnership Board on issues relating to the core elements of each contract.

6.2.2 The following core elements will form the integrated contract management approach for the purposes of the agreement:

- Contact Negotiation
- Operational Provider Management
- Contract Performance Management
- Contract Review

6.2.3 These core elements will operate across CAMHS in accordance with the following principles detailed below:

Workstream Area	Contract Responsibility 2017/19	Contract Negotiation 2017/19	Operational Provider Management 2017/19	Contract Performance Management	Contract Review for 2019/20 preparation
CAMHS	Council and CCG Contract Leads	Council and CCG Contract Leads	Provider workstream lead Council workstream lead	Council and CCG Contract Leads	CCG Children's Commissioning Manager Council Lead Commissioner- Specialist and Targeted

For the purposes of developing the integrated commissioning approach, procurement requirements and opportunities for 2020/21 will be reviewed in Quarter 4 of 2019/20. In 2019/20 and future years, procurement delivery will take place in Quarters 1,2 and 3 with contract negotiation in Quarter 3 across each workstream.

6.2.4 The Contracts which will form part of this Scheme are set out at Appendix B - provided always that the parties acknowledge that this list will be amended as additional contracts are commissioned over the duration of this Agreement.

6.3 Access

6.3.1 Access arrangements will be detailed across the individual work streams as pathways are redesigned.

7 FINANCIAL CONTRIBUTIONS

7.1 Monies attributable to this Individual Scheme are derived from the Better Care Pooled Fund as more particularly set out for this Scheme in Schedule 1.

7.2 Financial resources in subsequent years to be determined in accordance with the Agreement

7.3 The financial governance arrangements for this Scheme are set out in Schedule 1.

8 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

8.1 The integrated commissioning governance arrangements specified in Schedule 3.

9 NON FINANCIAL RESOURCES

9.1 The commissioning arrangement for this Scheme will be supported by a separate agreement between the Council and the CCG setting out how non-financial arrangements (including staffing) will be dealt with. The Partners agree that, save as otherwise agreed, all staff shall, during the term of this Agreement , continue to be employed by their respective employers as at the Commencement Date and that there shall be no transfer of employees, but that employees employed by one Partner may second to the other Partner for fixed periods with specified expiry dates for the purpose facilitating the delivery of services under this Scheme.

10 ASSURANCE AND MONITORING

10.1 The Lead Officers will produce a report each month of the performance of this Scheme against any Local Performance Measures set out in Schedule 9 (Performance Measures).

10.2 The Lead Officers will produce a report each month of the performance of this Scheme against each of the Better Care Fund Metrics so that performance of the Better Care Fund Plan overall against the Better Care Fund Metrics may be established.

11 LEAD OFFICERS (SROs)

The SRO responsibility for each workstream will be reviewed with the merging of the BCF and ICA programmes.

Partner	Name of Lead	Address	Telephone Number	Email Address
CCG	Steven Marshall	Wolverhampton Science Park	01902 445797	Steven.Marshall3@nhs.net

12 INTERNAL APPROVALS

12.1 This will be in line with each party's powers delegated to their representatives on the partnership board, in line with their own scheme of reservation and delegation as set out in Schedule 3.

13 RISK AND BENEFIT SHARE ARRANGEMENTS

13.1 The risk and benefit sharing arrangements set out in Schedule 4 will operate.

14 REGULATORY REQUIREMENTS

14.1 To be confirmed

15 INFORMATION SHARING AND COMMUNICATION

15.1 The Information Governance arrangements set out in Schedule 8 will operate

16 DURATION AND EXIT STRATEGY

16.1 The provisions of Clause 21 of this Agreement will operate.

17 OTHER PROVISIONS

17.1 None

Appendix B – contract register

1. Adult Community Care Workstream

Service	Provider	Lead Commissioner/ Contract Lead CCG
District Nursing Community	Royal Wolverhampton NHS Trust	CCG
Community Matrons	Royal Wolverhampton NHS Trust	CCG
End of Life	Royal Wolverhampton NHS Trust	CCG
Falls Prevention team	Royal Wolverhampton NHS Trust	CCG
Older People Care Purchasing	Various Providers	Council
Palliative Care Consultants	Royal Wolverhampton NHS Trust	CCG
Hospice Services	Compton Hospice	CCG
Falls assessment team	Royal Wolverhampton NHS Trust	CCG
WUCTAS	Royal Wolverhampton NHS Trust	CCG
Physiotherapy	Royal Wolverhampton NHS Trust	CCG
Occupational Therapy	Royal Wolverhampton NHS Trust	CCG
Rapid Response Therapy Services	Royal Wolverhampton NHS Trust	CCG
Rapid Intervention Team	Royal Wolverhampton NHS Trust	CCG
CICT Hospital at Home	Royal Wolverhampton NHS Trust	CCG
CICT Rehab	Royal Wolverhampton NHS Trust	CCG
Stepdown	Royal Wolverhampton NHS Trust	CCG
Stepdown	Independent Provider	CCG
Re-ablement Team	Private Sector	CWC
Rehab outpatients	Royal Wolverhampton NHS Trust	CCG
Nursing and Residential Continuing Care	Individual placements with providers	CCG
Care of the Elderly Community Services	Royal Wolverhampton NHS Trust	CCG
Care of the Elderly in patient services	Royal Wolverhampton NHS Trust	CCG
Bradley Respite Centre	In House Service	Council
HIT/RIT	Royal Wolverhampton NHS Trust	CCG
Telecare	In House Service	Council
Adaptations	In House Service	Council
ILS	In House Service	Council
Behavior Change	In House Service	Council
Stroke Coordinators inc. TIA	Royal Wolverhampton NHS Trust	CCG
Acorns	Acorns Hospice	CCG
Frailty Co-ordinators	Primary Care Networks	CCG
MS Support	MS Support	CCG
Heantun Carers Support	Heantun	CCG
Generic carers	Various	CCG

2. Mental Health Workstream

Service	Provider	Lead Commissioner/ Contract Lead CCG
Referral and assessment	Black Country Partnership Trust	CCG
Crisis and home treatment	Black Country Partnership Trust	CCG
Mental Health Liaison	Black Country Partnership Trust	CCG
Victoria Court Nursing Home	Black Country Partnership Trust	CCG
African Caribbean and Dual Heritage Community Support Service	ACCI	Council
ACCI	ACCI	CCG
Outreach workers	Third sector providers	CCG
ACCI carers	ACCI	CCG
Mental Health NCAs	Various	CCG
Care purchasing	Various	Council

3. Dementia workstream

Service	Provider	Lead Commissioner/ Contract Lead CCG
Dementia cafes	Alzheimer's Society	Council
Blakenhall Resource Centre	In house service	Council
Community Mental Health Team	Black Country Partnership Trust	CCG
Memory Clinic	Black Country Partnership Trust	CCG

4. CAMHS

Service	Provider	Lead Commissioner/ Contract Lead CCG
CAMHS tier 1-3	BCPFT	CCG
CAMHS tier 1-3 key team	BCPFT	CCG
CAMHS tier 1-2 link worker	Headstart	CCG
CAMHS tier 1-2 EM/HW children's emotional health and wellbeing	Headstart	CCG
CAMHS tier 1-3	Inspire	Council
CAMHS tier 1-3 key team	Inspire	Council
CAMHS tier 1-2 EM/HW	Inspire	Council

SCHEDULE 3 - GOVERNANCE

1. Partnership Board

1.1 The membership of the Partnership Board will be as follows:

1.1.1 CCG:
Accountable Officer
Director of Strategy and Transformation
Head of Integrated Commissioning
Chief Finance Officer

or a deputy to be notified to the other members in advance of any meeting;

1.1.2 the Council:
Head of Strategic Commissioning
Director of Adult Services
Director of Children's Services
Director of Public Health
Finance Business Partner

or a deputy to be notified in writing to Chair in advance of any meeting;

1.1.3 The Chair of Wolverhampton Healthwatch shall be a non-voting observer.

1.1.4 Representation from Wolverhampton Voluntary Sector Council and Wolverhampton Homes.

2. Role of Partnership Board

2.1 The Partnership Board shall:

2.1.1 provide strategic direction on the individual schemes;

2.1.2 receive the financial and activity information, including the Quarterly reports of the Pooled Fund Manager for each Individual Scheme and ensure that such Individual Schemes are being developed to meet the requirements of the Better Care Fund Plan;

2.1.3 review and recommend the operation of this Agreement and performance manage the Individual Services;

2.1.4 agree such variations to this Agreement from time to time as it thinks fit, subject always to the governance arrangements of each Partner;

2.1.5 review and recommend annually a risk assessment and a Performance Payment protocol;

2.1.6 review and recommend annually revised Schedules as necessary;

2.1.7 request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Better Care Pooled Fund;

2.1.8 hold the Better Care Fund Programme Director to account for the delivery of the aims of the Agreement; and

2.1.9 provide regular reports to the Health and Well-Being Board on the operation of this Agreement.

3. Partnership Board Support

3.1 The Partnership Board will be supported by officers from the Partners from time to time. The BCF Project Support Officer will support the Partnership Board.

4. Meetings

4.1 The Partnership Board will meet monthly at a time to be agreed following receipt of each monthly report of the Pooled Fund Manager.

4.2 The quorum for meetings of the Partnership Board shall be a minimum of two representatives from each of the Partner organisations.

4.3 Decisions of the Partnership Board shall be made unanimously of those present and voting. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

4.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner In anyway.

4.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven days of every meeting.

5. Delegated Authority

5.1 The Partnership Board is authorised within the limits of the delegated authority given to' either Partner, exercising by its members (which is received through their respective organisation's own financial scheme of delegation) to:

5.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to the Better Care Pooled Fund in respect of any Individual Scheme only where responsibility for that overrun has been determined under the procedures set out in Schedule 4 (but not further or otherwise);

and

5.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme.

6. Information and Reports

6.1 Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

7. Post-termination

7.1 The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 4 - RISK SHARE AND OVERSPENDS

Pooled Fund Management

1. Variances on expenditure will be identified through monthly monitoring processes undertaken by Budget Managers in conjunction with the Host's Strategic Finance. Financial performance will be reported to the Partnership Board on a monthly basis

Overspend

2. The Partners agree that Overspends shall be apportioned in accordance with this Schedule 4.

3. The Partnership Board shall consider what action to take in respect of any actual or potential Overspends

4. The Partnership Board shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

4.1 whether there is any action that can be taken in order to contain expenditure;

4.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement.

5. A cap will set for each partner on the exposure to the other partners overspend in the pooled fund. The new iBCF monies, care act monies and capital expenditure (Disabilities Facilities Grant) Is excluded from this cap. The caps are as follows:

Cap on other partners overspend	CCG Cap (£000)	City Council Cap (£000)
	240	190

5.1 In the event that the overspend is below the total cap of £443,000, the overspend will be apportioned in accordance with their total revenue contribution to the pooled budget as detailed in the table below:

Workstream	CCG % Risk Share	City Council % Risk Share
Revenue contribution to Pooled Budget	56	44
Care Act	Capped*	
New iBCF monies/Winter pressures funding		100

Capital Grant		100

*the Care Act monies will be passed over to the City Council from the CCG. Any overspend in relation to Care Act responsibilities will be picked up by the City Council so risk sharing not applicable.

5.2 If the overspend exceeds the cap of £443,000, then each partner will pick up the overspend in relation to their schemes. Each partners exposure to the overspend in relation to the other partners schemes will be capped at the amounts detailed above.

5.3 The risk / benefit sharing arrangements in relation to the new iBCF monies will be held 100% by the City Council.

5.4 The risk / benefit sharing arrangements in relation to the Specific Capital Grant (Disabilities Facilities Grant) will be held 100% by the City Council.

6. The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

7. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides.

8. Each Partner will contribute to the demographic growth (£2,000,000) of the City Council. The split will be in line with the total revenue contribution to as detailed below.

Organisation	Percentage (%)	Contribution (£000)
CCG	56	1,120
CWC	44	880

This payment will be made to the Host Partner in the final payment (month 12) along with the Care Act. This will be reviewed on an annual basis.

SCHEDULE 5 - JOINT WORKING OBLIGATIONS

Part 1 - LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1. The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2. The Lead Commissioner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records;

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report.

3. The Lead Commissioner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4. The Lead Commissioner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

5. The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6. The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

7. The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports).

Part 2 - OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1. Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been

suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2. No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3. Each Partner (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

Schedule 6 – BCF Reporting Templates

BCF Planning Template 2019/20

BCF_201920_Planning_Template_v1.0.xls

BCF Quarterly Return Template

BCF_Q3_1920_Template_v1.1.xlsx

iBCF Return Template

BCF_Q2_1920_Template_v1.xlsx

Schedule 7 – Policy for the Management of Conflicts of Interest

1. Governance shall comply with the Nolan principles on public life, the relevant provisions of the Council's Code of Conduct for members and the CCG Code of Conduct for Governing Body Members and policies for managing conflicts of interest to the extent relevant.

2. No person may sit on the Partnership Board or otherwise be engaged in a decision with regard to the entering into of a Contract for Services where he / she has any personal / pecuniary interest, such as any financial or ownership interest in any body providing services in accordance with the definition of "Pecuniary Interest" within the constitution of the Council or the CCG's Policy for Declaring and Managing Interests.

3. Where it became apparent that an individual has such a personal or pecuniary interest, he / she will immediately disclose it to the Chair of the Partnership Board and take no further part in the discussions or determination of such item, except to the extent that this has been agreed by all other members of the Partnership Board in attendance.

Schedule 9 – Performance Measures

Performance shall be reported on a monthly basis in line with the requirements of Parts 2-5 of Schedule 2 in line with the metrics set out in the Better Care Fund Plan.

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 FEBRUARY 2020

Agenda item 9

TITLE OF REPORT:	Outcome of the 'Future Form of the Black Country and West Birmingham CCGs' Listening Exercise.
AUTHOR(s) OF REPORT:	Deborah Rossi, (former) Transition Director & Jayne Salter-Scott, Head of Engagement and Communications at SWBCCG.
MANAGEMENT LEAD:	Paul Maubach, Accountable Officer
PURPOSE OF REPORT:	This report has been composed to present to Governing Bodies of the 4 CCGs following the December Transition Board. Governing Bodies to receive the report on the outcome of the Listening Exercise for assurance relating the activities undertaken.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• A listening exercise has been conducted by the 4 CCGs in the Black Country & West Birmingham CCGs to involve stakeholders in the exploration of their future form. • The outcomes have been collated into the
RECOMMENDATION:	For the Governing Body to be assured of the extensive engagement activity undertaken; to be informed of the stakeholder feedback.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	The CCG has a duty to engage with patients and other stakeholders when considering significant changes either in services that have been commissioned or the way its commissioning functions will be delivered.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Transition Board established by the Governing Bodies of the four 4 Black Country and West Birmingham CCGs have undertaken a listening exercise on the future form of the CCGs as a Single Commissioning Voice in an Integrated Care System.

1.2. The outcome of the listening exercise was reported to the Transition Board in December 2019 and is presented to the Governing Body for consideration.

2. CLINICAL VIEW

2.1. The views of clinical stakeholders (including CCG Member practices) were gathered during the listening exercise and are detailed in the attached report.

3. PATIENT AND PUBLIC VIEW

3.1. Patient and public views were gathered during the listening exercise and are detailed in the attached report.

4. KEY RISKS AND MITIGATIONS

4.1. There are no specific risks associated with this assurance report.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. There are no financial implications arising from this report.

Quality and Safety Implications

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

Equality Implications

5.3. There are no specific equality implications arising from this report.

Legal and Policy Implications

5.4. There are no specific legal implications arising from this report.

Name	Deborah Rossi/	Jane Salter-Scott
Job Title	Transition Director	Head of Engagement and Communications (Sandwell and West Birmingham CCG)
Date:	December 2019	

ATTACHED:
Listening Exercise Outcome Report

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	See Appendix	December 2019
Public/ Patient View		
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)	**Deborah Rossi/ Jane Salter-Scott**	**December 2019**

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FUTURE FORM LISTENING EXERCISE

ENGAGEMENT FEEDBACK

October 2019

Contents Page

APPENDICES

1. Background

In January 2019, The NHS published their 10-year strategy called *The NHS Long Term Plan* www.longtermplan.nhs.uk this detailed a new model of care for the 21st century. The plan outlined how people would get more control over their own health and more personalised care when they need it, defining the priorities of care quality and outcomes improvement for the decade ahead.

The NHS plans to provide more joined up coordinated care and *The NHS Long Term plan* outlines how after 3 years of testing alternative care models through integrated care 'Vanguards' they are taking their learnings to redesign community services everywhere, to achieve person centred care supported by people managing their own health. A key element being community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices, resulting in fully integrated community-based healthcare.

As well as defining a more joined up community service, *The NHS Long Term Plan* defines how local NHS organisations will increasingly focus on population health, on prevention and health inequalities, and importantly moving to integrated care systems everywhere. NHS have stated that Integrated Care Systems (ICS) are central to the delivery of the long-term plan and define the role of an ICS is to bring together local organisations to redesign care and improve population health. The plan placed an emphasis on collaboration stating that Clinical Commissioning Groups (CCGs) will become more strategic, leaner organisations. And that typically there will be one CCG per Sustainability and Transformation Partnership (STP)/ Integrated Care System (ICS) area by March 2021.

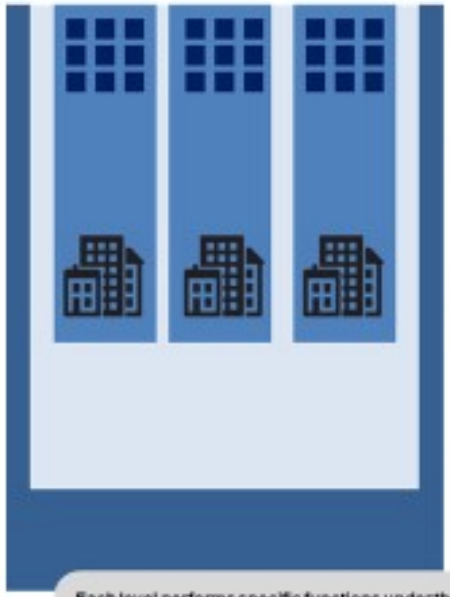
This new NHS strategy is significant to Clinical Commissioning Groups (CCGs). Locally four separate CCGs exist independently and collaborate with system partners across the Black Country and West Birmingham within a Black Country and West Birmingham Sustainability and Transformation Partnership (STP). In addition, for Sandwell and West Birmingham, who additionally partner within the Birmingham Solihull (BSOL) STP.

This new strategic direction from the NHS has necessitated that the leadership within the 4 Black Country and West Birmingham CCGs look at their own strategic direction. Importantly, to consider how they can work together to focus on collaborating to design care, to focus on the outcomes of improvements to population health, on prevention and health inequalities, with the aim being to enable the local population to live healthier for longer.

See table below – NHS England and NHS Improvement overview of the levels up to and including Region, with population sizes within an Integrated Care System (ICS)

Neighbourhood, Place, System, Region, and the purposes of what is carried out at each level.

ICSs carry out tasks at the appropriate geographical scale – NHS E & I



Level	Population size	Purpose
Neighbourhood	~50k	• Integrated multi-disciplinary teams • Strengthened primary care through Primary Care Networks – working across practices and health and social care enabled by Network Contract DES • Proactive role in population health and prevention
Place	~250-500k	• Typically council / borough level • Integrate hospital, council & primary care teams/services • Develop new provider models for 'anticipatory' care
System	1+m	• System strategy & planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources
Region	5-10m	• Agree system objectives • Hold systems to account • Support system development • Intervention and improvement

Each level performs specific functions under the following common headings

1. Leadership, engagement and workforce
2. Population health management
3. Accountability and performance management
4. Strategy and planning
5. Managing collective resources

Future Organisation of the Black Country and West Birmingham CCGs

In January 2019, a paper titled *'Future Organisation of the Black Country CCGs'* was written by the three Accountable Officers responsible for the 4 Clinical Commissioning Groups in the Black Country and West Birmingham.

The report acknowledged the following in relation to the longer-term position of the Black Country and West Birmingham CCGs

The general consensus of the group is that it will be necessary for our CCGs to formally come together in order to establish a single commissioner leadership, working on behalf of all the CCGs, within the future Black Country ICS.

We recognised that we must not lose the local work and local relationships that we have built up and that having commissioning which is both relevant and close to local provision in each of our areas will continue to be important in the Black Country. This is especially true for our place-based arrangements including our work to date with local authorities through the various Better Care Fund arrangements. However, on a STP/ICS footprint we will be increasingly required to take a strategic approach to the commissioning of acute services and to develop a role in assurance and oversight of the whole system.

As the STP/ICS develops, it will have an increasing need for management resources and many of the programmes of work that are being mandated by NHS England are being measured on an STP and not CCG footprint. We need to work with our teams to ensure that they are aligned to this new way of working and that the STP/ICS resources are as closely aligned to the shared CCG resources as possible. This will avoid duplication and keep administration costs to the minimum required.

Paul Maubach, Dr Helen Hibbs and Andy Williams, the Accountable Officers of the CCGs at the time, each submitted this paper to their respective CCGs Governing Body and requested approval for

- The three phased approach to improving collaboration between our CCGs, including the appointment of a single Accountable Officer and a single CCG team in 2020/21
- The establishment of a Black Country and West Birmingham Transition Board.

The following is the extract from their report setting out a **3-phase approach**:

Phase one:

During 2019/20 the CCGs will continue to prioritise the development of our local placed-based arrangements and our working in partnership in our local systems, local councils and providers. We will also need to collaborate with each other in order to ensure that there is alignment between the way in which our local systems develop where this both appropriate and possible; with a clear understanding of where there are significant differences and – if those differences are likely to present future difficulties – what mitigations might need to be developed to enable closer working in the future.

We will also continue to collaborate through our joint working with our Joint Commissioning Committee and as part of our Black Country and West Birmingham STP.

We will expect the Sandwell and West Birmingham review to reach a conclusion during this time as it clearly has a significant bearing on the future partnership arrangements between the CCGs in the Black Country.

Phase two:

During April 2020/21 we will strengthen our formal collaboration (between the 3 or 4 CCGs depending on the outcome of the Sandwell & West Birmingham position) by appointing a single Accountable Officer and a single CCG team working across the three/four CCGs.

This process will also incorporate the integration of STP resources and capabilities with the single CCG team to ensure full alignment and minimal duplication between the CCGs and the STP.

To be clear: our proposal for 2020/21 is to maintain four CCGs with one Accountable Officer and one CCG team because it is important to maintain our identity with our local places. It is not our proposal to establish a single Black Country CCG.

Phase three:

This will then enable the full working of a Black Country ICS incorporating a single commissioner from April 2021. As part of this, the four CCG Governing Bodies will have to agree the mechanism by which they collaborate to enable the Accountable Officer and CCG team to work as one, with one voice, on joint matters that relate to the Black Country ICS agenda and responsibilities.

This paper was duly considered within the private sessions of each of the four Black Country Governing Bodies, and in principle approved. This led to the formation of the Black Country & West Birmingham Transition Board in the early part of 2019.

Staff Communication

In order to keep staff appraised of what was happening an earlier communication was sent to all staff on Monday, 17 December 2018, which was followed up by staff briefings in each CCG, led by each Accountable Officer. The staff brief stated:

We are agreed that we want to achieve a shared vision of an Integrated Care System (ICS) for the Black Country by April 2021, and as a consequence we are developing a 3 phased approach working towards a single ICS and local place-based provider arrangements; with shadow arrangements in 2020/21; and with 2019/20 as our transition year. This vision of the ICS in 2021 is consistent with the timetable that has been agreed with Birmingham to work through the future of West Birmingham.
We recognise that one of our core strengths is the strength of our places, and the relationships which have been built between individual local authorities and CCGs. We affirm that even in the long-term we see a strong role for placed-based commissioning and joint-working with local authorities. However, we also recognise that in areas such as workforce, developing our digital capabilities, and improving our acute services, there is value in us working together as a system.

Over the next few months we will be establishing a Transition Board to lead this process, supported by a Programme Director and team. In line with this timeline, we will be engaging in a shared dialogue with all our partners, local communities and you, our staff, across our four places.

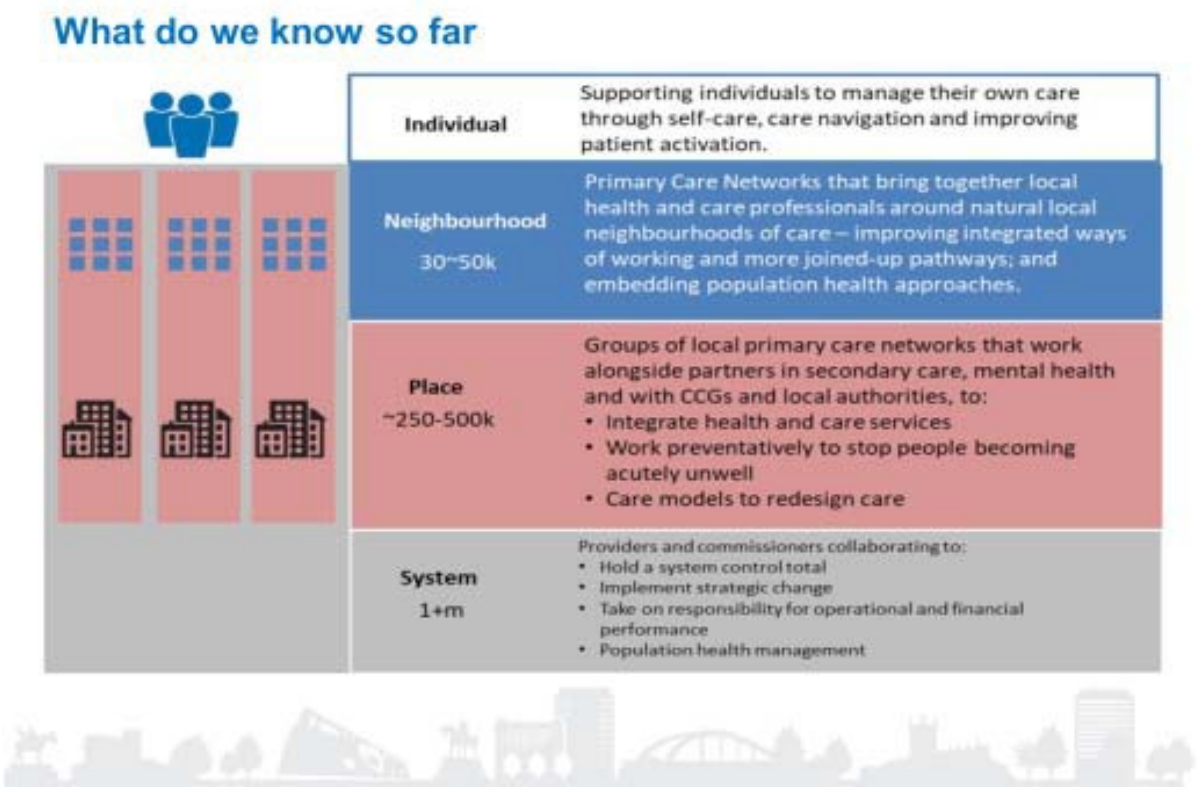
2. Introduction

Regulatory Context

The Long-Term Plan describes the activities that will take place at each of the 'levels'. CCG's collaborating at System level with Providers in an Integrated Care System. With system holding a system control total, implementing strategic change, taking on responsibility for operational and financial performance and population health management.

Understanding *The NHS Long Term Plan* and how the commissioning environment will continue to evolve is shaping the way that CCGs will operate in future.

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



The plan says that by 2020/21, individual CCG running cost allowances will be 20% lower in real terms than in 2017/18 and CCGs may therefore wish to explore the efficiency opportunities of merging with neighbouring CCGs. It is in this context that the Black Country and West Birmingham CCGs have taken steps to explore their future form. There are legal frameworks guiding these steps. Each CCG Constitution sets out the arrangements for seeking the views of GP Members in any decision of this nature including whether a vote is required. Section 14Z2 of the Health and Social Care Act 2012, places a requirement on CCGs to ensure stakeholder involvement in commissioning processes and decisions. It is also acknowledged that there are many other stakeholders who have an interest in

any CCG constitutional change of this nature and these were mapped out (See Appendix 1 – Stakeholder Map)

The latest NHSE Guidance states that CCGs must demonstrate how a merger would be in the best interests of the population that the new CCG would cover. The guidance details the steps which CCGs would need to take if they were considering a formal merger of CCGs and these include the extent to which the CCGs have sought the views of stakeholders and how they have been taken in to account. The Transition Board determined the starting point in this context would be to design a listening exercise

The Black Country and West Birmingham Transition Board

The Black Country and West Birmingham Transition Board was formed at the beginning of 2019. The membership at the beginning comprising of the 4 Chairs and the 3 Accountable Officers together with a Lay Representative of each CCG.

When the Transition Board first met, it was important to define the Terms of Reference, and to have each CCG Governing Body approve these.

The terms of Reference set out the purpose of the Transition Board as follows:

- *To support the CCG Governing Bodies in developing proposals for the establishment of a single CCG team from April 2020 to be agreed by the Governing Bodies.*

- *To develop and monitor the implementation of a milestone plan that will lead to the establishment of a single CCG team across the CCGs in line with proposals agreed by the Governing Bodies. This plan should be aligned to the timing of the production of the STP long-term plan and will include undertaking an options appraisal on whether a CCG merger would be beneficial.*

- *To reflect on comparative progress by each CCG in the development of their local placed-based arrangements with the intent of identifying any implications that may need to be taken account of in the plan for establishment of the single CCG team.*

- *To ensure that STP/ICS development is taken into account in the work of the transition board.*

- *To establish and enact a communications plan to ensure consistency of approach across all the CCGs in engaging with CCG staff and other stakeholders on the future plans for the CCGs*

The Terms of Reference (TOR) set out how the Transition Board would operate the meeting and chairing arrangements, which reflect that of the Joint Commissioning Committee; the voting rights being one for each member; and how it would make recommendation to the Governing Bodies.

Why a Listening Exercise? - To listen and understand before acting.

This was a focused exercise undertaken with the intention to listen to what people had to say, hence the name given to the engagement work. The listening exercise was designed to establish the views of stakeholders within each CCG around the future form of the CCGs within an ICS; it was not designed or intended to be a formal consultation with stakeholders. This engagement was not attempting to address the organisational design or development of the single CCG team. Equally, the listening exercise was not proposing to make changes to existing patient services. What the listening exercise has enabled is for all members of staff, public stakeholder groups and the entire GP Membership to engage with the CCG Governing Bodies.

It is a valuable piece of work and this report demonstrates the commitment of the Transition Board to be transparent and to share the insight gained from the Listening Exercise.

3. Engagement Approach and Methodology

It is important to ensure the correct people are involved at the right stage of any proposed changes. Stakeholder participants to the listening exercise were identified. (See Appendix 1 - Stakeholder Map). In addition, the reasons why these groups were selected, and the aims of the engagement were captured. (See Appendix 2 – Stakeholder Groups – Aims and Reasons)

The guiding principle of our messaging is to be straightforward with our dialogue, designed so that we are not overly simplistic, patronising or defensive, promoting respect and recognising the experience and importance of involvement of our audiences.

The knowledge and insight gained from the listening exercise is to be used to shape key messages in any future engagement that follows.

The key communication and engagement priorities we established were:

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

The 4 CCG's approach was the same. To facilitate the listening exercise a presentation was designed. The same content was shared with all groups, with each CCG contributing additional local information that explained the local and national context in which change is being considered. (See Appendix 3 – Listening Exercise Presentation)

The presentation covered an outline of the options that have been considered by The Transition Board, (See Appendix 4 – Options Future Form) what the case for change might include for a move towards a single CCG what some of the challenges might be in forming a single CCG.

To support the discussions held and enable us to report on the views of stakeholders, we asked 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?

Four Staff events were held, supported by Human Resource colleagues, staff were offered the opportunity to attend any of the locations regardless of their normal place of work. 355 staff

participated in one of the listening exercises. Staff were encouraged to share their views and concerns and as with all groups, provide any supplementary feedback within the sessions.

Five external stakeholder events were held in each 'Place' led by members of the Communications and Engagement Teams, with a total number of 74 attendees from across a range of representative groups.

The groups invited to attend the external stakeholder events were as follows:

- Patient representatives
- Representative from governors at local acute, community, mental health trusts
- Health and Well Being Board colleagues
- Health and Adult Social Care colleagues
- Overview and Scrutiny Committee colleagues
- Healthwatch colleagues
- Voluntary and Community Sector colleagues
- Local ward Councillors
- Statutory Sector Partners e.g. local councils, other CCGs
- GP colleagues from other CCGs
- Other key influential partners in place

Seven Members events were held for GP members led by Primary Care colleagues across the whole footprint of the Black Country and West Birmingham CCGs, with 155 individuals contributing their insight and concerns.

Each individual piece of feedback has been collated using a feedback form. (See Appendix 5 – Feedback Template Forms). The responses are grouped by stakeholder and by CCG location. (See Appendix 6 – Individual Feedback by CCG / Stakeholder Group.

4. Engagement Feedback

Table depicting the number of attendees at each event

	Dudley	Walsall	Wolverhampton	Sandwell & West Birmingham	Total number of attendees by Stakeholder Group
Staff	50	45	80	180	355
GP Members	70	46	30	9	155
Stakeholders	8	5	10	51	74
Total number of Attendees at each CCG event	128	96	120	240	584 Attendees in Total

Common Themes across the CCG's

The shared common themes across the groups are that relationships have taken time to nurture and need to be retained and that a local voice and presence is very important.

GP members are enthusiastic about keeping the financial envelope with their CCG and retaining a voice and influence. They would like to protect the progress they have made with their Primary Care Networks (PCN's) and want to keep their local Primary Care commissioning arrangements that they have helped develop for their local population.

GP members in Dudley feel especially supported by their CCG and SWB members are passionate about holding onto West Birmingham.

As well as local relationships, CCG staff value their culture, identity and organisational heritage. There are concerns regarding job security, office location and staff benefits. Dudley staff thought loss of morale and the stability of the MCP were risks.

Local relationships and local voice were a concern for stakeholders and patients. They did not want to lose what they did well as a local healthcare economy and wanted to be engaged with at every step of the way.

CCG Staff	
Similar Themes	
• We have good team relationships within the CCG's, and we do not want to lose them • Keep the identity and culture of the CCG's • Keep the relationships with local providers, parents, carers, voluntary sector • Hold onto the organisational intelligence & memory • CCG's reputation (which has taken years to build) may be lost • Confusion on what is meant by a single management team • Worry about redundancy, changes of role, pay banding and the 20% cut • Location of offices (everyone wants to stay where they are) • Keeping staff benefits (training, development, flexible working and progression opportunities) • Every CCG is proud of their achievements and see other CCG's as performing less well	
Differing themes	
Dudley	• Morale and the existing relationship and roles with the MCP

GP members
Similar Themes
• Want to keep the staff that have a relationship with (We know who to contact) • Keep the CCG as it is, we like things the way they are • Merging will dilute our success • We do not want to lose the 7 years of relationships we have built with partners as a CCG

• Keeping the funding within the CCG – there is a fear across the board that other CCG's do not manage their finances as good as "we" do • Fears of losing influence, voice and control • These changes are a threat to the emerging PCN's • A feeling by all CCG's that "we" are unique • Want to keep their local LES/DES/ Primary care commissioning arrangements

Differing themes	
Dudley	• Do not want to lose good support for GP members from the CCG
SWB	• Merger/reorganisation is a big distraction and unproductive • A strong feeling that we want to keep West Birmingham

Of the GP Membership events held, Walsall utilised Locality Events, holding one in each – North, South, East and West. This resulted in a high level of attendance with 39 different GP Practices of their 52 Practices represented, and 46 people in total. This represents 75% of their GP Voting Membership

Dudley achieved a 63% member representation with GPs from 27 different practices of their total 43 Member Practices

Wolverhampton had 30 people attend, representing 13 different Practices, from their total of 40 Member Practices, this equates to 32%

Sandwell and West Birmingham (SWB) reported a very high level of engagement despite the low number of attendees with 10% of their Practices present at the Members event. 9 GPs present from 8 different Practices, from a total Membership of 81. It should be noted that different circumstances surround the SWB cohort of GPs, and interestingly all 5 West Birmingham PCN's attended.

Stakeholders and Patients
Similar Themes
• We value our relationships and trust locally that has taken time and effort to build - and want to keep these • Keep communicating with us • Keep the CCG finances for our CCG • Listen to the voice of the patient/public • Keep good relations with Local Authority and the VCS • Do not want to prop up other CCGs who haven't managed so well in terms of finance and performance • Concerned we will lose influence • Bigger is not seen as better • Resources need to be protected.
Differing themes
None

Of those Public stakeholders invited, 10 attended in Wolverhampton, 8 in Dudley, 5 in Walsall and 51 in Sandwell and West Birmingham. From the comments made within the Public groups, there was confusion that any change in future form would mean a change in service provision, and that this could directly affect patients.

Following the events held with external stakeholders, two written pieces of communications were received within the CCGs. In each case, the individual concerns and questions raised were discussed at Executive level and individually responded to by the CCG involved.

Paul Maubach met with the senior representatives of the organisations who had raised concerns to Sandwell and West Birmingham CCG, to listen to their concerns and provide a response to the issues raised. Clarity was given around the purpose and context of the engagement events held and confirmation provided that these were part of a listening exercise and not a formal consultation.

Wolverhampton CCG received a letter from a member of the public involved with public participation groups, concerned that a proposed merger of CCGs was taking shape without the involvement of the public. It was confirmed that city council representatives, local patient participation groups and disease specific groups had been invited to the listening exercise. With members from some of these groups attending and contributing to the external stakeholder event. Clarity was provided on why the events had been held; confirming that the engagement exercise was designed to listen to local voices around the future form of the CCGs and was not an element of formal consultation about a merger.

5. Findings and Sample Comments

Measurement of communications and engagement outcomes took place throughout the process to ensure that we remained aligned to the delivery to our goals. Evaluation allows us to: improve the effectiveness of our activities, adapt our approach as situations change, and allocate our resources appropriately. This evaluation can then be summarised in to findings.

Effectiveness of the communications and engagement activities were measured by:

- The number of stakeholders who engage in the events/ submit views
- The overall number and range of responses;
- The number of survey response aligned to the demographic profile of the Black Country and West Birmingham

Across all CCGs in all groups, there was a strong and recurring emphasis on local identity, including relationships, reputation, organisational culture and intelligence, knowing who to go to and a focus on the local population. There has been a real sense of pride in what has been achieved locally which people are keen not to lose sight of. *'recognise CCGs plus points and bring others up to the same level rather than bring everyone down one level, e.g. performance currently each CCG specialising in one area'*. Strongly expressed was a feeling that 'their own' CCGs could end up taking on baggage from other CCGs who were perceived as failing financially or lacking in performance or standards. *'why should we prop up CCGs who haven't managed so well?'*

Again, all groups thought there was uncertainty around a single CCG. The terms single management team and single management structure have been used interchangeably, *'what do we mean by single management team'* and people are asking for clarity on what a new vision could look and feel like and what it would mean for all concerned. Asking how would it work and what is the vision? The options that were presented as part of the paper were seen as mostly already discounted with only a couple of viable ones. *'what are the risks and benefits of the options – we need more information'*

A solution for this could be the desire for strong, clear and visible leadership. Many citied this as being key to success with concerns that a smaller leadership team could be diluted and almost invisible. *'Importance of leadership visibility and access – will leaders in a single management team know all of their team members – staff are more than just a number'.*

It was acknowledged that change could offer opportunities for better collaboration, staff engagement and provide training, development and possibly promotion.

Timing was also an issue. How quickly would changes be taking place and how would this affect staff that were already earmarked for other organisations such as the MCP? *'are the timeframes realistic and will timescales be communicated at each stage'* and *'how will the MCP affect the change process'*

Some staff also felt that the listening exercise was just lip service. What decisions were they being asked to make, what could they influence, and would it make a difference anyway because ultimately the vote would be with members if it went to a formal consultation? *'concern I don't really have any influence over decisions'*

Stakeholder groups focussed on ensuring that they are given a voice *'be clear on structures and where patients have influenced local service design'* and listened to and it was clear that they valued their relationships locally. They felt they were held in high esteem and had spent time building networks and relationships. It was felt that if the CCG became too big it could lose sight of what mattered locally and there could be a disconnect. *'too big loses focus'*

Members recognised that they not only worked differently within all CCGs but localities in some areas also had different ways of working. There were concerns over diluting their voice and the influence they had but also recognition that as a wider voice they could have more influence over secondary care. There was concern that GP could become even more disenfranchised and disenchanted and this would lead to an increase in GPs retiring early when we already have a diminishing workforce. Members also appreciated good clinical leadership.

Questions were raised around the voting process, power and influence being taken from local stakeholders and the importance of the local relationship.

6. Conclusion

Engagement and feedback within the Listening Exercise was well received and appreciated and from this viewpoint, it can be judged as a successful program of engagement. Meetings were held in good

and therefore, any formal engagement process will be well served from the information this exercise provides.

It is worth noting that although the same message has been delivered to all stakeholders, that there is a requirement to tailor future content for the relevant audience, providing the right overview with level of context and detail of information to reflect the needs of the stakeholder groups. Different groups have mixed the messaging within the listening exercise with other issues they are currently focused on. Answering the all-important 'why' is different for each stakeholder group.

There is no single overwhelming preference for any one single option, from the discussions held within many groups, a definite interest was expressed in exploring those options that achieved a single commissioning voice, through exploration of a streamlined governance structure and a single operational management team, but did not create a single CCG. The strong concerns expressed over locality, led contributors to seek a solution where local identity and 'Place' would be retained, but with the benefits of close collaboration.

Whilst it is evident that with all 4 CCGs performing well it is also clear from comments made within the meetings that there is an acknowledgement and acceptance that the CCGs would be better served in the future through closer collaboration and a clear interest exists in what this might look like and how it can be achieved.

7. Next Steps

Since the agreement to proceed with the plans outlined in the *'Future Organisation of the Black Country CCGs'* paper and the formation of the Transition Board, the four CCGs have been working more closely together, supporting the work of the Transition Board, enabling the progression of the aims set out in the *'Future Organisation of the Black Country CCGs'* paper.

Following the appointment of a Single Accountable Officer, Paul Maubach, work is now being undertaken to develop the plans to create a single CCG team. This work will be developed and undertaken by the Human Resources Team supporting the Accountable Officer. It is accepted that this can only happen after the appointment of a Deputy Accountable Officer and a single HR Director for the whole of the Black Country and West Birmingham is in place. It is recognised by The Transition Board how important effective communication is, and staff and relevant stakeholders will be kept informed during this period of change.

Work to support the development of the 3-phase plan set out by the Accountable Officers in their paper *(Future Organisation of the Black Country CCGs)* is on-going.

The 4 Governance teams are working together exploring options around the future governance arrangements. The work supported by Lay Members will ensure the CCGs align committee structures to effectively deliver on their statutory duties whilst supporting the operational requirements of the organisations to work closely as a single CCG team.

The Directors of Commissioning in the 4 CCGs are carrying out a detailed evaluation of the local models of care. The intent being to identify those areas of commissioning that potentially would be suited to commission singularly and strategically across the whole Black Country and West Birmingham footprint. This evaluation work will include looking at how commissioning can effectively deliver the health and care needs of the local population through the placed-based commissioning arrangements.

This work supports the overarching goals of focusing on the outcomes of improvements to population health, on prevention and health inequalities.

Senior leaders of Communications & Public Insight designed a detailed communications and engagement plan, to support and inform the Transition Board with the best approach to communicate with stakeholders. All Governing Bodies agreed the approach proposed in the plan, to undertake informal engagement in the form of a 'Listening Exercise'.

The CCGs take their statutory responsibility to involve seriously. Ensuring that we feedback on the outcome of the Listening Exercise is an essential part of the process and our statutory duty. The table below, highlighted by type of partner sets out how we intend to assure ourselves and our stakeholders that we have listened and heard what they choose to share with us and how we will us the insight gathered to prepare for the next steps.

It was agreed at Transition Board that a single feedback report be created and that this shared with all stakeholders, regardless of which group they represented, so each of the participants and invitees are seeing the whole picture and the same information.

Table of how we will share the Listening Exercise Feedback Report across 4 CCGs

Type of Partner	Dudley	Sandwell & WB	Walsall	Wolverhampton
Staff	Direct Email/Members News	Staff News / Intranet	Staff Newsletter / Intranet	Staff News
GP Members	Members News	Members News	GP Newsletter	GP Bulletin
Wider Stakeholders	Stakeholder Bulletin/ Direct Email/Website	Stakeholder Bulletin/ Direct Email/Website	Direct email / Website / Patient Participation Liaison Group	Direct Email/Website

The Transition Board recognise the need for on-going dialogue and engagement with the stakeholders of the CCGs. A report will be provided to Governing Bodies from the Transition Board for them to determine the next steps. The commitment to engage is shared across all 4 CCGs and future plans will be designed to involve audiences. This will take many forms and might include:

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

Glossary of Terms

Better Care Fund (BCF) - The Better Care Fund is a pooled budget announced by the Government back in 2013. The initiation of the Better Care Fund is to shift resources into social care and community services from the NHS budget in England, to keep people out of hospital.

Clinical Commissioning Group (CCG) – Clinical Commissioning Groups are NHS organisations set up by the Health and social Care Act 2012 to organise the delivery of NHS services in England.

Commissioning – Commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health outcomes.

Integrated Care System (ICS) – Integrated Care Systems bring together providers and commissioners to help break down the barriers between primary care, secondary care and social care

Mutually Agreed Resignation Scheme (MARS) - Mutually Agreed Resignation Scheme is a form of voluntary severance and has been developed with the aim of increasing the flexibility to organisations as they need to address periods of change and service redesign, considering the financial circumstances in which they operate.

Multispecialty Community Provider (MCP) – A Multispecialty Community Provider is a new approach to out of hospital health and care services. It is a way of the health and care system works together to meet the future needs of the local population and deliver the effective, seamless care.

Primary Care – Primary Care is usually the first-place people go to when they have a health problem and includes a wide range of professionals such as, GPs, Pharmacists.

Primary Care Networks (PCNs) – Primary Care Networks were introduced as part of *The NHS Long Term Plan*. GPs can join up to form local networks, each with between 30'000 and 50'000 patients. The stated aim is to create fully integrated community-based health services for their local population.

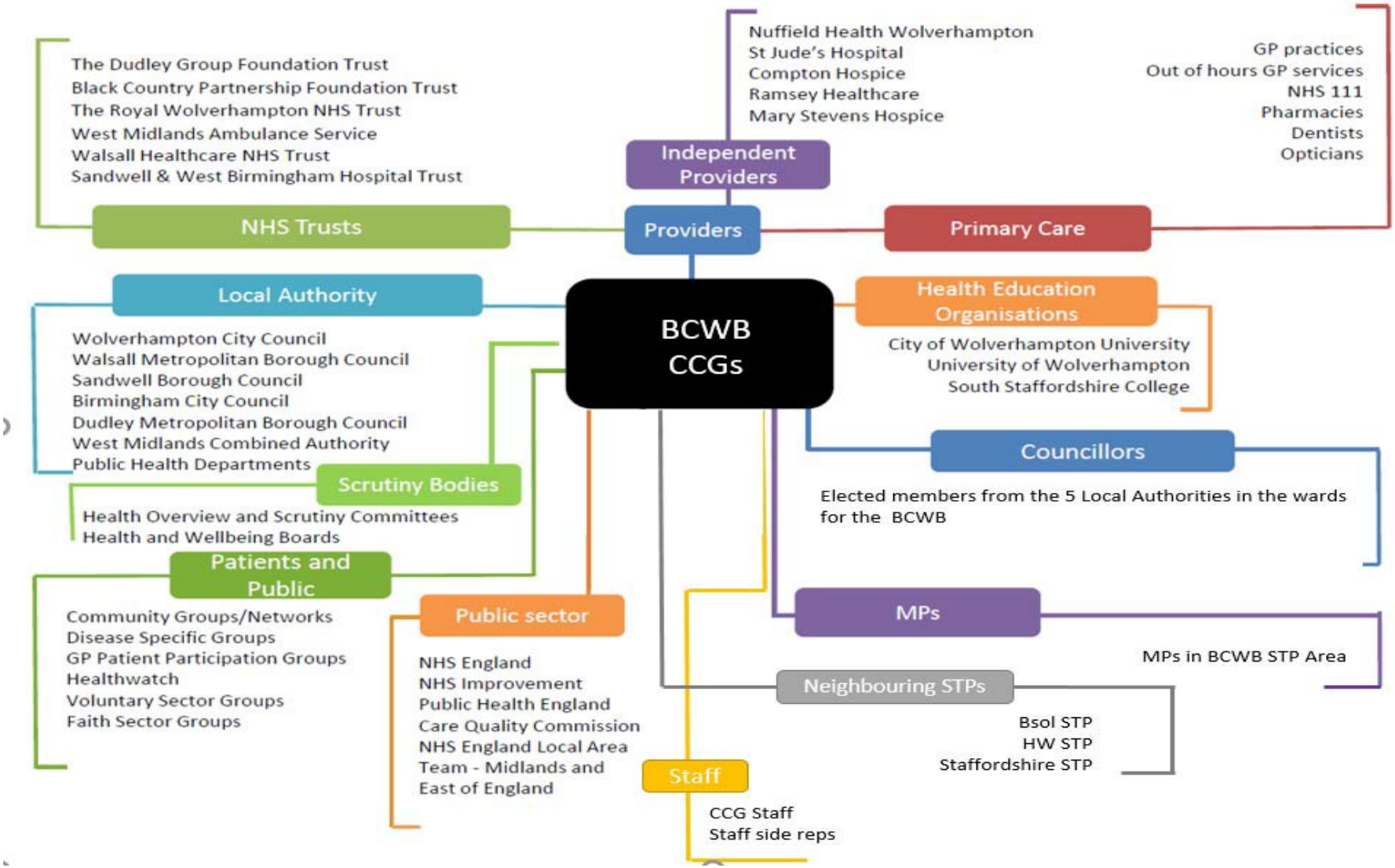
Secondary Care – Secondary Care simply means being care of by someone who has expertise in whatever the problem might be. It is where most people go when they have a health problem that cannot be dealt with in primary care because it needs more specialist knowledge, skills or equipment than a GP has. It is often provided in a hospital setting.

Sustainability and Transformation Partnership (STP) - Sustainability and Transformation Partnerships are areas covering England, where local NHS organisations, local councils drew up shared proposals to improve health and care in the area they serve.

The NHS Long Term Plan (LTP) - *The NHS Long Term Plan*, also known as the NHS 10 Year Plan, is a document published by NHS England early this year, which sets out its priorities for healthcare over the next 10 years and shows how NHS funding will be used.

Vanguards – In 2015, NHS England set up a 'Vanguard Programme' to lead the development of new ways of working, known as models of care. It was a way of transforming and integrating health and social care.

Appendix 1- Stakeholder Map



Appendix 2 – Stakeholder Groups - Aims and Reasons

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

The future for CCGs in the Black Country and West Birmingham

Listening Exercise

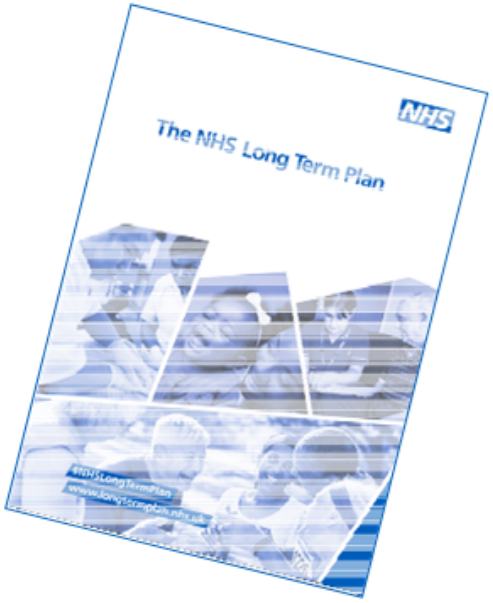
Insert presenter name and title

Current position

- We currently have 4 CCGs in the Black Country and West Birmingham serving 1.2 million people
  - NHS Dudley Clinical Commissioning Group (320,000 population)
  - NHS Sandwell and West Birmingham Clinical Commissioning Group (574,690 population)
  - NHS Walsall Clinical Commissioning Group (274,000 population)
  - NHS Wolverhampton Clinical Commissioning Group (285,000 population)
- A collective budget of over £2 billion
- The 4 CCGs manage contracts with our main Hospital, Community, Mental Health and Primary Care providers
- There are 5 Local Authorities
  - Dudley Metropolitan Borough Council
  - Walsall Metropolitan Borough Council
  - Sandwell Borough Council
  - Wolverhampton City Council
  - Birmingham City Council
- We have 1 Sustainability and Transformation Partnership with 18 partner organisations

Background and context

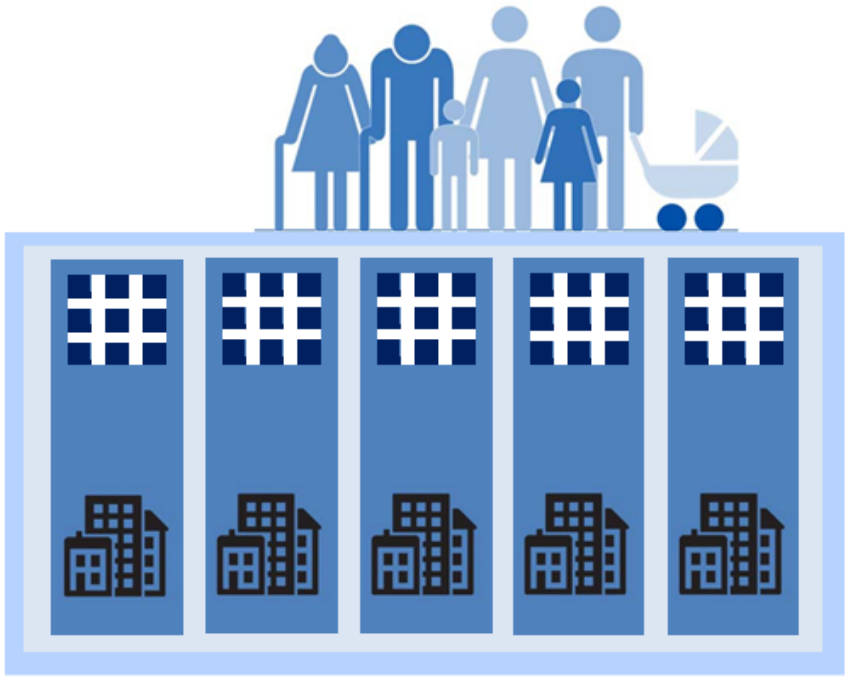
- NHS **Long Term Plan** published January 2019
- Real focus on **collaboration**, moving away from market, competition and transacting
- *'…CCGs will become more **strategic, leaner organisations**…'*
- *'… **Typically** there will be **one CCG** per STP/ICS area by March 2021…'*
- **Integrated Care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



Changes to commissioning

- Greater **commissioning influence** created through a larger scale organisation
- **Population health management** principles
- Continue to promote **partnership working** with local Government, NHS providers and other partners
- Support **Primary Care Networks** to develop
- Refocus **clinical leadership and input**
- Develop **place based models of care** to focus on improving health outcomes for people in each of the 5 places

Future model for the system



People	People empowered to look after their own health and each other.
Neighbourhood	Services wrapped around 30-50,000 GP neighbourhoods
Place	Our five places support the integration of health and care services focussed around the patient. This includes: acute, community mental health, local authority and voluntary sector services.
System	Partnership sets the vision, strategy and pace of system wide development. It will oversea the delivery of the Partnership and ensures effective collaborative working. Working as a system to tackle the health, quality and experience gaps.
Region	NHS England & NHS Improvement working together to directly commission some services at a national and regional level, including most specialised services. (Midlands)

Place Based Care

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

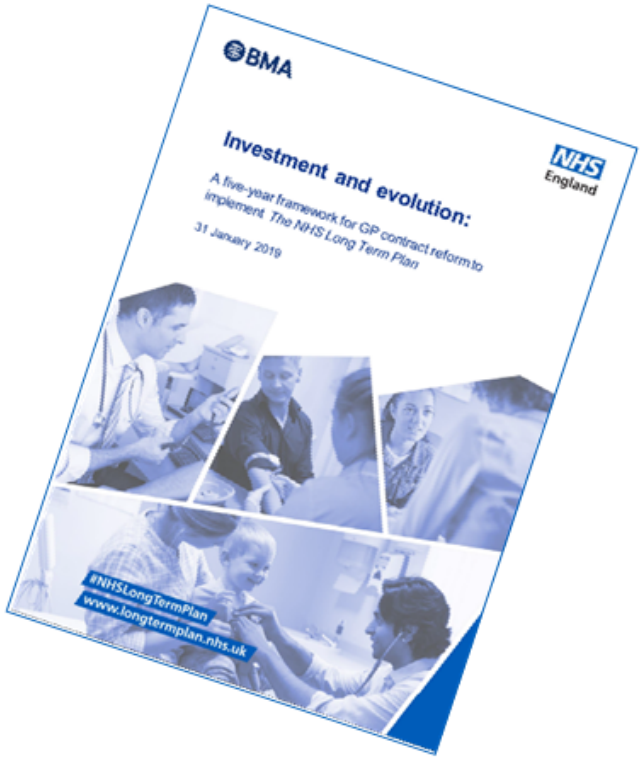
Place Based Care

This slide outlined the local place based care unique to each CCG to describe how local accountability will work in each place

Each CCG to add own slide

Primary Care Networks

- Also published in January, **£4.5 billion extra** (nationally) for primary care over 5 years to fund 20,000 additional staff.
- Two main aims –
  - **bringing GP Practices together** in networks so they can support each other and increase resilience
  - **Create an infrastructure** for the alignment of community health resources
- In the Black Country and West Birmingham we have **34 Primary Care Neighbourhood Teams**
- In **xxxx** we have **xx** of these PCNs which serve a population of around **xx,000** each.



The position (Oct 2019)

- The 4 CCGs have already determined that they will have a single Accountable Officer and a single Management Team
- The option we have considered are:
  - Option 1 - No change to current status – Individual SMT and Governing Bodies with separate management and governance structures maintained, JCC formed with no delegated authority and no joint commissioning decisions
  - Option 2 - Joint Committee with Delegated responsibilities and decisions taken at a Black Country/West Birmingham level with individual management teams remaining in place i.e. each Governing Body delegate's decision making to the Joint Committee
  - Option 3 - Form a shared Executive Management Team but Not a Joint Committee i.e. each CCG maintains separate governance structures
  - Option 4 - Joint Committee with delegated responsibilities from all CCGs with a shared Executive Management Team, individual governance and sub-committees
  - Option 5 - Form a Federation – continue with separate CCG's but establish shared management team, governance and decision making.
  - Option 6 - Full Merger of all CCGs and Creation of Single Black Country CCG able to maintain 'Place/Localities'
  - Option 7- Merger of Dudley CCG & Walsall CCG - variation of Option 6- merge the two CCG's who currently share AO and CFO

We now need to determine if we stay as 4 CCGs with more collaboration, merge the 4 CCGs or look at any other arrangement

Key Question for CCGs…

- The questions that we are now exploring, with regard to future CCG arrangements are,
  - 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 you give us during this listening period will be considered by the CCG Governing Bodies and the Transition Board which brings representatives from each CCG together
- The Governing Bodies of the 4 CCGs want to hear your views to inform their decision on whether to move to a formal consultation process

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

Patients:

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

Staff:

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

CCG Organisations:

- Increased **financial resilience**
- 20% **reduction in management costs** spend

Partners:

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

Member Practices:

- **Consistency** of offer for patients in terms of **Access** to Primary Care
- **Consistency** of **policy position** for patients
- Consistency of **training, development and support** for practices

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

- How would we ensure any change doesn't negatively impact on 'business as usual' performance?
- How would we retain local knowledge and insight to best serve local population need?
- How would we work with partners in each of the 5 places?
- How would we support our GP Membership in each place?
- How would we support staff through any changes?
- How would we ensure public accountability, openness and influence of decisions taken?
- How would we ensure that people still know who to contact (relationships)?
- How would it impact on local outcomes and priorities for each community?

Options and Processes

- There is **predefined national policy**
- Your views now will **inform** whether a **consultation happens**
- **This is your opportunity to tell us:**
  - What do you value from the current CCGs?
  - What would good look like to you in terms of future CCG arrangements?
  - 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?
- Decision to merge CCGs is for **NHS England**
- **Help us to respond to your questions/ concerns/ issues**

Questions

Appendix 4 - Summary of Options – Future Form

The Transition Board has so far considered several options these are as follows:

- Option 1

No change to current status – Individual SMT and Governing Bodies with separate management and governance structures maintained, JCC formed with no delegated authority and no joint commissioning decisions

- Option 2

Joint Committee with Delegated responsibilities and decisions taken at a Black Country and West Birmingham level with individual management teams remaining in place i.e. each Governing Body delegate's decision making to the Joint Committee

- Option 3

Form a shared Executive Management Team but Not a Joint Committee i.e. each CCG maintains separate governance structures

- Option 4

Joint Committee with delegated responsibilities from all CCGs with a shared Executive Management Team, individual governance and sub- committees

- Option 5

Form a Federation – continue with separate CCG's but establish shared management team, governance and decision-making

- Option 6

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

- Option 7

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

Appendix 5 - Feedback Responses Template

Future of CCGs Listening Events - Feedback Capture Form

Please record feedback, comments and questions raised at each session and return the completed forms to deborah.rossi@nhs.net and laura.broster@nhs.net where possible within 2 days of the event, and no later than 9am on the 25th October 2019 for inclusion in the final report for Board/Governing Bodies.

Meeting (Name of Group)		**Date of Meeting**		**Location:**	
Number of People Attending		**Target Audience**		**Form completed by:**	

Question	**Feedback given**
• 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?	
Please record any key questions asked and summary responses given	

Appendix 6 - Individual Feedback by CCG / Stakeholder Group

	Dudley	Walsall	Wolverhampton	Sandwell & West Birmingham	Total number of responses
Staff	50	45	80	180	355
GP Members	70	46	30	9	155
Stakeholders	8	5	10	51	74
Total number of responses	128	96	120	240	584

Common Themes – Dudley

Relationships/Communication	Supported & Valued	Place Based	Governance/ Finance	Influence	Job Security
STAFF					
Team relationships Relationships with local providers, parents, carers, voluntary sector Relationships with patient groups	Atmosphere & culture Good working conditions Need accessible and visible senior leadership support Could lose morale if another restructure Staff need to feel supported	Relationships Huge organisational intelligence & memory	Providers acting in an autocratic manner How much will the change cost? What are the risks of being a single CCG? What do we mean by a single management team?	Regular staff engagement Concerned I don't really have any influence over decisions	Worry about redundancy Could be more job opportunities Need consistency in HR processes Formal consultation if goes ahead needs to be meaningful and demonstrate it has already taken on board comments and be open to influence Needs to fair and transparent Flexibility around working arrangements if bases are moved

					Consistency in pay banding Training & development Being slotted into jobs that don't match our skills
	GP MEMBERS				
Like that staff have stayed the same We know who to contact We like our CCG 7 years of relationship we have built We like the familiarity and reliability Good communication We like the weekly newsletter appreciate keeping us informed Value their knowledge and experience Don't want to lose staff in Dudley Maintain a local team – it's important Digital issues, It's ok GP's will work to the letter of their contract not the spirit. That will bring the system to standstill	Respect members meetings they arrange Supportive Trust and respect Dudley CCG Forward thinking Good support for GPs Good clinical leadership Don't dilute our success Stay the same Leave things as they are Keep listening If GP's feel disenfranchised by a distant CCG I guess another 10% will retire early. This happened with the transition from PCT to CCG in 2013	Reputation exceeds beyond Dudley boundary Work well together with practices Forward thinking for Dudley people There are some positives to a bigger footprint but we like things the way they are We like having one CCG and Trust Local knowledge and responsiveness and awareness of local needs Loss of Dudley identity Flexibility would be lost MCP needs to form first Differences in culture Impact on local patients	Keeping Dudley funding in Dudley Share some functions like HR and management etc. Losing control of finances Will there be less people but the same amount of work Joining neighbouring failing CCGs Loss of saving and budget Finances and efficiencies Funding What's in it for GPs as members? We need to keep a CCG in each area Merged CCG not for me. When can we vote	Would we have more power Need fair and effective representation Better influence over secondary care Reduction in local influence CCG in each area. Vote is a must We need a referendum!	Would see an increase in GPs leaving if no local arrangements We need security over finances

STAKEHOLDERS					
We value our relationship and want our voice to be heard Keep communicating with us Efficient communication between providers	Don't lose sight of what the patient wants and use patient experience		Keep the Dudley pound in Dudley Need transparent and accountable governance What is the role of the CCG if there is a local remit If centralised this could have negative impact on services/providers	We want our voice listened to	

Common Themes – Walsall

Relationships/Communication	Supported & Valued	Place Based	Governance/ Finance	Influence	Job Security
STAFF					
Strong internal relationships String external relationships Knowing your teams and who to go to Keep communicating with us – even if nothing to say Importance of sitting with and being with team members Opportunity to diversify workforce Strong leadership exhibiting strong values	Visibility and accessibility senior leaders Open and transparent process for change Workforce happy and resilient and resourced Development opportunities Shared values and behaviours Support goodwill and working together	Location of office Local knowledge Organisational intelligence Local reputation – we've worked hard for it Free/plentiful parking Practice based commissioning works well	Local processes that work well Concentrate on quality outcomes Outstanding CCG/IAF Decrease repetition CSU agreements vary across the 4 CCGs Consistency in applying banding and A4C as varies greatly across the 4 CCGs	Access to leaders for decision making – single team will make this harder Will our relationship with NHSE be better as one organisation – or have we lost 3 voices? Balance of power with acute and others to be maintained Don't mask failure of other CCGs	Role changes need to be appropriate and staff need to be supported Going into a role that you have no skills for and be used as a basis for no redundancy Fear of losing job Will MARS be available Will terms and conditions of employment be harmonised

Behaviours/values displayed during periods of change	Career development Promotion opportunities Achieving work/life balance	Local pharmacy works well Consider impact on patients How do we maintain our sense of pride	Need to define management structure and roles and responsibilities Financial situation of other CCGs	We are not the decision makers What are risks/benefits – we need more information What are the real options	What do we mean by 20% reduction Other CCGs pay differently for same role How will you manage the job process Keep my job at my grade Being forced into roles I don't want
	GP MEMBERS				
Need full engagement of public health How do we develop relationships with a distant CCG Value local relationships How will this benefit patients Patient care must be a priority	PCN system is good – GPs feel more informed	Place based care Need strong resources locally Like the local aspect of everything – skills, control and knowledge Local primary care office is important Different populations have different needs and demands	Just a cost saving exercise Need clarity over Walsall Together – how will it work and it seems to be going ahead without GP involvement This will cost money to set up How do we protect budgets Need more information on what the structure could look like What is the governance around voting	Don't dilute our voice What are other GP member saying across the CCGs We feel we have a strong presence at the moment Local GP voice in the Black Country structure Need a proper consultation and the same across the 5 areas Need autonomy at a local level	

STAKEHOLDERS					
Use the right language when communicating with people Don't lose sight of individual care	Appreciate the value of the voluntary sector	Population centred – focus on Walsall Appreciate local staff Volunteers don't get paid travel expenses so beware if you move meetings to other locations	Potential impact of general election CCG could grow too big and lose sight of local people Is it cost saving or working smarter	Make sure everyone is involved in decision making Listen to the voice of the patient/public Clearly articulate how one organisation will link into each of the 5 places	
Common Themes – Wolverhampton					
Relationships/Communication	**Supported & Valued**	**Place Based**	**Governance/ Finance**	**Influence**	**Job Security**
STAFF					
Fantastic working relationships and trust between staff. Want staff to be listened to.	Staff are valued and supported – do not want to lose this.	Value our community and partnerships locally. Potential to learn some good practice from other CCG's. Need to keep local knowledge and organisational memory.	Keep to retain knowledge Outstanding rating as a CCG.	Direct access to approachable leadership is valued.	Concerns about job security and pay banding. Like the car parking and location in Wolverhampton.
GP MEMBERS					
We have good local relationships with the Trust and partners.		Want to keep local relationships	Need to keep our strong financial position and clinical leadership.		

Need good communication to the members.			Want to keep our Outstanding rating.		
STAKEHOLDERS					
Good partnership working Good relations with Local Authority Key player in management of behaviour and relationships Accessible and visible leadership Good clinical leadership Don't dilute local relationships	Volunteers are valued Innovation Opportunities with collaboration Sharing best practice	Local focus which is good for the patient Expertise and local knowledge Organisational intelligence Might be difficult to get a grasp across larger footprint	Propping up other CCGs who haven't managed so well	Influence is very important Wider patient engagement Concerned we will lose influence	

Common Themes – Sandwell & West Birmingham

Relationships/Communication	Supported & Valued	Place Based	Governance/ Finance	Influence	Job Security
STAFF					
Visible and approachable leadership. Transparent and open communications. Involving and listening to staff.	Staff team feel valued and recognised. Staff feel invested in e.g. training opportunities. A culture of positivity and "family".	Relationships with GP members, partners and patients. Threat of losing local variation; one size does not fit all. Loss of local culture is a risk. Will BSOL swallow up West Bham?	Will the EXEC team reflect all four CCG's?	Will staff be listened to and retain the Staff Council? Opportunities to discuss change.	Concerns over job security and retaining pay bands. Location of the workplace was also a concern. Favouritism to known staff. Fairness to all staff. What is the process for moving staff around? E.g. slot and match?

GP MEMBERS					
We would like the same staff who we have a relationship with.		We want to keep West Birmingham. We want to keep a local team; staff who we know and have a relationship with. What does place based mean? (what stays in place?) We need to retain local knowledge. We want to keep our Primary Care Commissioning Framework.	If it's not broke, don't fix it. Bringing CCG's together will cut down on management costs. A merger is a big distraction and unproductive. Some functions can be delivered at scale e.g. HR, strategic commissioning, finance, contracting. We don't want to take on the debts of other CCG's.		
STAKEHOLDERS					
Patient communication and engagement is very important- A clear strategy is needed. Important to keep communicating during change and keeping stakeholders in the loop.		View from Birmingham representatives that West Birmingham should be part of Birmingham. Want to keep local focus and trusted relationships which may be lost in a bigger structure. Bigger is not seen as better.	Collaboration between Public Health, Social Care etc. needs to be strengthened. Resources need to be protected. How do we maintain governance through the changes?		

End of Report

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 FEBRUARY 2020

Agenda item 10

TITLE OF REPORT:	**Governing Body Assurance Framework and Risk Register**
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide assurance to the Committee on the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain. Any confidential information relating to any risks has been redacted.
KEY POINTS:	• This report outlines the current work underway to support risk management across the CCG, including the work of the Governing Body Committees. • The latest updated version of the GBAF and Strategic risk register, is appended following consideration at the Audit and Governance Committee in November 2019. • The Governing Body are asked to consider whether the risk ratings for each domain remain appropriate.
RECOMMENDATION:	That the Governing Body • Considers the report and updated risk profile for the CCG • Comments on any matters relating to risk management.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	This report details progress with developing the overall Board Assurance Framework and is therefore relevant to all of the aims and objectives.

1. BACKGROUND AND CURRENT SITUATION

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

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

2. ASSURANCE FRAMEWORK UPDATE

2.1. The Audit and Governance Committee considered the latest version of the GBAF at its November meeting following a review by the Executive and Senior Management Team. This includes an indicative score from the management team to identify the risk to the achievement of each objective based on the updated risk profile, including the identified Corporate Risks which impact on each domain. The committee were assured that the scoring was appropriate and the Governing Body are asked to make their own assessment based on the assurance provided.

2.2. A key support for the development of the GBAF is the CCG's Strategic Risk Register, which includes an update on each of the identified risks, including those reviewed by the Governing Body Committees, which take place at each meeting. The committee were advised that, following management review, risk CR14 - Development of the Integrated Care Alliance (ICA) is recommended for closure and a new risk associated with the implementation of the ICA contract has been identified following a deep dive. Subsequently, following the regular reviews by management and committees, the score for risk CR21 – Impact of Funding reduction from City of Wolverhampton Council has been reduced and risk CR22 – Leaving the European Union is recommended for closure.

3. COMMITTEE RISK REVIEWS

3.1. In addition to supporting the Governing Body with their review of the Strategic Risk Register, Committees have also continued to review their own assigned risk registers at each meeting. These discussions are supported by work in CCG teams to identify operational risks and discussion at team meetings to escalate risks as appropriate to committees.

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

Committee	Number of Risks				
	Red	Amber	Yellow	Green	TOTAL
Commissioning Committee	1 (1)	1 (2)	0 (0)	0 (0)	2 (3)
Finance and Performance Committee	0 (0)	3 (2)	5 (6)	0 (0)	8 (8)
Primary Care Commissioning Committee	0 (0)	3 (5)	1 (0)	0 (0)	4 (5)
Quality and Safety Committee	1 (2)	1 (4)	4 (1)	0 (0)	6 (7)
TOTAL	**2 (3)**	**8 (13)**	**10 (7)**	**0 (0)**	**20 (23)**

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

4. RISK MANAGEMENT ARRANGEMENTS

4.1. The Audit and Governance committee were advised that a deep dive into Domain 2b – Build on our Primary Care Networks wrapping Community, Social Care and Mental Health Services around them had taken place. Following this review, it was determined that the risk scoring was appropriate, with a number of actions identified:-

- A further review of the risk associated with the Integrated Care Alliance. This review has led to the closure of the original risk and the identification of a new risk associated with the contract.
- Further work is required to identify any risks associated with the development of Primary Care Networks.

4.2. The Committee have agreed an indicative programme of future deep dive reviews across the remaining domains. This will remain under review as the CCG's transition programme continues.

4.3. Following the meeting of the four Black Country and West Birmingham CCGs' Governing Bodies in Common on 21 January 2020 work is underway to develop a revised Governance structure. This will include further meetings of the Governing

Bodies in common to support the development of a common strategy and objectives across the four CCGs as they work together to become a Single Commissioning Voice in the developing Integrated Care System. As this work progresses, the CCGs will be developing mechanisms to understand and manage the risks to achieving these shared objectives. The Governance and Risk Team continue to be engaged in this developing agenda.

5. CLINICAL VIEW

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

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable for the purpose of this report.

7. KEY RISKS AND MITIGATIONS

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

8. IMPACT ASSESFSMENT

Financial and Resource Implications

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

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

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

Other Implications

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

Name	Peter McKenzie
Job Title	Corporate Operations Manager
Date:	January 2020

ATTACHED

Draft GBAF and Risk Register.

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	Not Applicable	
Public/ Patient View	Not Applicable	
Finance Implications discussed with Finance Team	Not Applicable	
Quality Implications discussed with Quality and Risk Team	Not Applicable	
Equality Implications discussed with CSU Equality and Inclusion Service	Not Applicable	
Information Governance implications discussed with IG Support Officer	Not Applicable	
Legal/ Policy implications discussed with Corporate Operations Manager	Report Owner	January 2020
Other Implications (Medicines management, estates, HR, IM&T etc.)	Not Applicable	
Any relevant data requirements discussed with CSU Business Intelligence	Not Applicable	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**31/01/2020**

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Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Sources of Assurance	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation	Previous Rating (September 2019)	Trend
1. Improving the quality and safety of the services we commission									
a. Continue to commission high quality, safe healthcare services Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions	CR02 - Cyber Attacks CR03 - NHS Constitutional Targets CR15 - CCG Staff Capacity Challenges CR19 - Transforming Care Partnership CR22 - Exiting the European Union	There are a number of high level risks associated with provider safety concerns listed on the Risk Register. In particular, cancer outcomes at RWT and mortality statistics have the potential to have a significant impact. In addition there is an underlying risk that mitigating action to address these concerns may divert resources from overall systemic improvement.	No new strategic risks have been identified. The Quality and Safety Committee are managing risks associated with cancer performance at RWT, for which system level action plans have been put in place, and performance is beginning to improve. The risk managed by the committee in relation to mortality figures is also reducing.	The CCG continues to actively monitor the quality of provision at all its providers. The CCG is engaged with a multiagency improvement board to support improvements at the Urgent Care Centre and is working with other CCGs across the STP to ensure a system level approach is taken to issues with Maternity services. Existing monitoring systems are in place to ensure that concerns about Quality are addressed at the earliest possible opportunity and to ensure that appropriate contractual levers can be used if necessary	Monthly Quality Reporting via QSC CQRM Meetings with main providers Quality Monitoring Visits Information from Regulators (CQC, NHSE/NHSI, Ofsted etc.)	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 3 Impact - 4 12 High	Likelihood - 3 Impact - 4 12 High	⇔
b. Ensure that services perform effectively so that the CCG can continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality physical and mental health and care services for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework	CR03 - NHS Constitutional Targets CR05 - Mass Casualty Planning CR15 - CCG Staff Capacity Challenges CR22 - Exiting the European Union	In a period of change across the health service, it is important that the CCG is able to maintain a focus on delivering its core duties and responsibilities within the available capacity. This includes meeting our corporate responsibilities in law for areas such as Equality and Diversity, Data Protection and Health and Safety. In particular, the CCG must ensure that it works to ensure our local providers deliver on commitments in the NHS Constitution in the face of considerable national and local challenges, including rising demand for services and the need to respond to unforeseen or unpredictable events.	No new strategic risks have been identified. Paul Maubach has been appointed as the Accountable Officer for the Black Country and West Birmingham CCGs and is now leading the next phase of the CCG's Transition Programme. Risks associated with this programme will continue to be identified, including ensuring that the CCG continues to meet its statutory duties during the transition period. To support this, the role of Deputy Accountable Officer which will play a key role in the CCGs' relationships with the regulator has been identified as a priority for recruitment. Risks associated with key performance areas continue to be managed.	The CCG has clear accountability mechanisms in place for the delivery of statutory duties and uses robust performance management frameworks to ensure that providers are meeting their statutory responsibilities, particularly those relating to the NHS Constitution. This includes the use of a range of contractual mechanisms when appropriate.	NHS England CCG Improvement and Assessment Framework Monthly Performance reporting via F&PC Internal and External Audit work Contract Review mechanisms Statutory and Regulatory reporting (e.g. Data Security and Protection Toolkit, Workforce Race Equality Standards)	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 3 Impact - 4 12 High	Likelihood - 3 Impact - 4 12 High	⇔
2.Reducing health inequalities in Wolverhampton									
a. Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions Work with partners across the City to support the development and delivery of the emerging vision for transformation towards services wrapped around the patient that will lead to improved outcomes.	CR09 - Better Care Fund CR14 - Developing Local Accountable Care Models CR17 - Failure to secure appropriate estates and infrastructure funding CR20 - Governance for Insight Shared Care record CR21 - Impact of potential funding withdrawal by City of Wolverhampton Council	The CCG is working with partners in the City to support the development of an Integrated Care Alliance for Wolverhampton. This creates a number of significant risks as each organisation needs to balances their own priorities and challenges to deliver systemic change and understand the interface between the local programme of work and its contribution to the Black Country and West Birmingham STP becoming and integrated Care System. In particular, there is a risk that relationships between partners may become strained as differing priorities are encountered. There are also significant challenges for CCG staff delivering these changes in addition to their existing responsibilities, particularly as they need to build their understanding of the impact of new models.	A new strategic risk associated with enacting the Integrated Care Alliance has been identified. This supersedes the risk associated with the development of the alliance which is recommended for closure. The risk associated with the Better Care Fund has also been closed. Proposals are now being developed to formalise the governance arrangements for the ICA, supported by clear outcome measures and new approaches to contracting.	The CCG is working in partnership with the other organisations and is ensuring all work on new models is done collaboratively. Clear lines of responsibility for developing clinical and governance workstreams to support these priorities have been developed. Communication lines with staff are prioritised to ensure that all staff are briefed on the trajectory of work and that there are opportunities for questions to be raised to allay any concerns.	Better Care Fund performance and assurance reports to Governing Body and Health and Wellbeing Board Developing ICA governance framework Risk Share Arrangement with RWT	Likelihood - 4 Impact - 3 **12** High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 2 Impact - 3 6 Moderate	⇔

Governing Body Assurance Framework

BAF Objectives	Relevant Corporate Risks	Description	Change in risk profile	Key Controls in place	Sources of Assurance	Initial Risk to objective being achieved (Pre-mitigation)	Residual Risk to objective being achieved post mitigation	Previous Rating (September 2019)	Trend
b. Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them Working with our members and other key partners to ensure that primary care and the developing PCNs are at the heart of improving how local healthcare services are delivered, including encouraging innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.	CR12 - New Ways of Working in Primary Care CR14 - Developing Local Accountable Care Models	The CCG's Primary Care strategy sets an ambitious programme in partnership with GP practices and Primary Care Networks to deliver significant improvements in care for patients in primary care in Wolverhampton. The scale of change itself has a number of inherent risks as it involves CCG Staff, GPs and practice staff considering significant changes to their ways of working. This comes on top of existing high demand for services and a recognised workforce challenge in Wolverhampton. The most significant risks identified relate to the ongoing transition into networks able to deliver new services, at scale.	As highlighted above, a new strategic risk associated with the implementation of the ICA has been identified, superseding the risk related to its development. This followed a deep dive into this domain at SMT which recognised further information is required to fully understand a number of risk areas associated with the next stage of Primary Care Network Development. The new Primary Care Strategy has been approved and implementation is being managed through the milestone review board. PCNs are now established and working through programmes of development tailored to their individual needs, supported by regular meetings with Clinical Directors.	The CCG continues to support the development of PSNs with staff in the Primary Care team providing direct support. Progress with the Primary Care Strategy is being measured by a milestone plan through monthly checks and quarterly review meetings now reported to the Primary Care Committee. Significant work continues to take place both locally and at an STP level to ensure that workforce challenges are addressed through both recruitment and upskilling of the existing workforce.	Primary Care Contracts Primary Care Network Directed Enhanced Service NHSE PCN assurance framework Primary Care Strategy Milestone Review	Likelihood - 3 Impact - 4 **12** High	Likelihood - 2 Impact - 4 **8** High	Likelihood - 2 Impact - 4 **8** High	⇔
3. System effectiveness delivered within our financial envelope									
a. Proactively drive our contribution to the Black Country and West Birmingham STP Aligning our Clinical Priorities, as appropriate, to STP/ ICS plans to ensure resources are used to deliver material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country and West Birmingham footprint.	CR08 - New Ways of Working across the STP CR14 - Developing Local Accountable Care Models CR15 - CCG Staff Capacity Challenges CR19 - Transforming Care Partnership	As the STP seeks to transition to become an Integrated Care System (ICS), a number of risks emerge. In particular, as highlighted above, there is the potential for tensions in relation to the interface between efforts to develop locally appropriate models of care and strategic commissioning across the wider footprint, which could create risks associated with the relationships between organisations within the system. In addition, the transition to become an ICS involves a programme of closer collaboration across the CCGs in order to form a single commissioning voice, this has a significant impact on the overall risk related to CCG staff capacity in an uncertain environment.	No new strategic risks have been identified. As highlighted above, recruitment has been completed for the Accountable Officer for the 4 CCGs. The transition programme to implement a single team across the four CCGs will now continue and include assessment of the CCGs' role in the developing ICS. Further risks associated with the impact on staff will continue to be monitored as the Transition Programme continues to develop.	The CCG is ensuring that it remains fully engaged with the STP process as it continues to develop. CCG staff contribute to strategic leadership groups and all staff are briefed as part of ongoing internal communication plans. The STP has developed an MOU and governance framework to provide clarity about the aims and objectives of the STP and how it links into other ongoing work streams. Proposals for the development of an ICS and closer working between the CCGs are being developed via the CCG's Governing Body	STP Governance Framework and Assurance reporting Transition Board Assurance Reports	Likelihood - 4 Impact - 4 **16** Very High	Likelihood - 4 Impact - 3 12 High	Likelihood - 4 Impact - 3 12 High	⇔
b. Ensuring our services are cost effective and sustainable Working across all of the services we commission to ensure that the CCG meets its financial duties and responsibilities and achieves the best possible value for the money it spends.	CR01 - Failure to meet QIPP targets CR07 - Failure to meet overall financial targets CR18 - Long Term Financial Strategy	The CCG faces, in common with other health service organisations, a number of financial challenges. This includes continuing to meet QIPP targets and planned reductions in running costs whilst managing the challenges of maintaining performance and quality in the face of increasing demand. In addition, as financial planning increasingly moves to the STP footprint with shared control totals , work to deliver these targets will need to be based on closer collaboration, both between CCGs and commissioners and providers.	No new strategic risks have been identified. The risks associated with QIPP delivery plans continue to be managed at the Finance and Performance Committee, informed by the development of a STP Operational plan in response to NHSE/I financial improvement Trajectories. The CCG's robust programme process continues to monitor in year QIPP performance and develop an approach to delivery in future years.	The CCG has a robust financial planning process in place, supported by PMO processes to manage key areas including QIPP delivery. Financial performance is monitored through the F&P Committee on a monthly basis. The CCG is a core and key participant in STP financial planning processes	Financial reporting mechanisms Internal and External Audit work	Likelihood - 3 Impact - 4 12 High	Likelihood - 2 Impact - 3 6 Moderate	Likelihood - 2 Impact - 3 6 Moderate	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR01	PCPB14 - QIPP: Delivery of Targeted GP Peer Review Scheme	**Failure to meet QIPP Targets** QIPP Delivery is vital to ensuring that the CCG meets its financial targets. A challenging QIPP target of 3.5% has been set equivalent to £14m in 2018-19	Robust QIPP Process is in place, progress is being made towards identifying new schemes to deliver QIPP targets. **Update** QIPP Plans in place for 2019/20 following NHSE Scrutiny of Planning Process. The CCG has fully identified QIPP schemes to meet the revised target. An initial assessment of deliverability risk has been undertaken and the consequences of which can be met through reserves - this will continue to be the focus of close scrutiny in collaboration with partners across the system in line with the STP planning process.	12/08/2016	Jan-20	3b - Ensuring our services are cost effective and sustainable	Finance and Performance	Tony Gallagher	12	High	12	High	⇔
CR02		**Cyber Attacks** Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.	Robust SLA in place with RWT for IT systems Proactive approach to Cyber Security with consequent investment in cyber security approaches CCG EPPR and Business Continuity plans in place to address any issues should they arise **Update** Internal audit is currently underway and once completed the Audit and Governance Committee will be reviewing the risk level in line with national best practice around the top ten identified risks	31/01/2014	Nov-19	1a - Continue to commission high quality, safe, healthcare services	Executives	Mike Hastings	4	Moderate	4	Moderate	⇔
CR03	FP04 - Increased Activity at RWT FP11 - System Pressures A&E Performance QS06 - Cancer Target	**NHS Constitutional Targets** There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes	CCG Performance Management Framework ensures robust monitoring of Constitutional Targets through meetings with providers, analysis of performance data and rigorous reporting through the Committee structures). Contract Management applied when necessary Whilst providers are not yet meeting all targets, performance is improving on key indicators **Update** Cancer performance continues to be scrutinised by NHS England, Recovery Action Plan is in place and is being monitored by NHSE and the Cancer Alliance via weekly assurance calls and monthly face to face meetings. Recent impact of month on month increase in breast referrals on to the Urgent (2WW) referral pathway has impacted on performance. High levels of scrutiny remain in place with support from IST and NHSE. Coordinated approach involving Quality, Commissioning, Contracting and Performance team are driving CCG approach. Finance and Performance Committee have assessed the risk associated with RTT targets	28/02/2017	Nov-19	1a - Continue to commission high quality, safe, healthcare services	Finance and Performance	Mike Hastings	8	High	12	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR05		**EPPR Support** There is a risk that effective plans will not be in place for CCG and other agencies will not be in place	CCG is working in conjunction with other CCGs to ensure that there is regional capacity sharing and resilience. WCCG has been working closely internally and with all stakeholders on EU Exit preparations. **Update** Public Health staffing resource has reduced. However meetings with PH continue to take place locally. Work continues with Public Health and other partners to ensure key work is prioritised regionally.	01/05/2014	Sep-19	1b - Ensure that services perform effectively so that the CCG can continue to meet our Statutory Duties and responsibilities	Quality and Safety	Mike Hastings	8	High	6	Moderate	⇔
CR08	Execs	**New Ways of Working across the STP** The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system	Relationships across the STP continue to develop, an MOU is being put into place and clear leadership for individual work streams are being identified and put into place. **Update** New Accountable Officer now appointed across four CCGs and transition programme will continue to develop single CCG team, Transition Board continues to monitor this process on behalf of the CCG Governing Bodies. STP plan in development and Dr Helen Hibbs will continue as SRO for the STP until April 2020.	21/06/2017	Nov-19	3a - Proactively drive the CCG's Contribution to the Black Country STP	Governing Body	Helen Hibbs	16	Very High	9	High	⇔
CR10		**BCF Programme Success** The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes	Programmes are being put into place and work continues to ensure that the impact of this work can be measured in an efficient and effective way. **Update** Section 75 for 19/20 has now been signed and we continue to develop and put in place full plans and actions in line with national planning guidance. Work is also taking place to align governance and programme support for the ICA with linked BCF programmes.	12/09/2017	Jul-19	2a - Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions	Commissioning Committee	Steven Marshall	12	High	9	High	⇔
CR12		**New Ways of Working in Primary Care** There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change	Substantive appointments now made in the Primary Care Team to support group working. Milestone plans developed to support the overall delivery of the Primary Care Strategy. Primary Care groups are actively involved in discussions to develop accountable care models in Wolverhampton. **Update** New Primary Care Strategy is now in place with implementation being monitored via the Milestone Review Board. PCNs are moving forward with tailored development programmes and regular meetings have been established with Clinical Directors to support their role in system change.		Nov-19	2b - Build on our Primary Care Networks (PCN's), wrapping community, social care and mental health services around them	Primary Care Commissioning Committee	Steven Marshall	12	High	8	High	⇔
CR14	Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	**Developing Local Accountable Care Models** The potential complexity of the developing new models locally will mean having to balance competing priorities for different organisations and against other drivers in the system to clearly articulate the rationale for change and the direction of travel. This means that there is a risk that the objectives of improving patient care and delivering financial stability across the system will not be realised	The CCG is working collaboratively with partners in the system to develop plans to ensure that they are produced in an open and constructive way. Ernst Young are supporting the development of clear plans and proposals for discussion. **Update** Risk share agreement contract is signed. Clinical priorities pathways are being finalised. Agreement has been reached with regard to IG and shared data governance processes. Outcomes framework is still under development and there remains much work to be done on the 'shared' virtual contract concept. ****Risk Recommended for closure and now to be superseded by Risk CR23****	12/09/2017	Nov-19	3a - Proactively drive the CCG's Contribution to the Black Country STP	Commissioning Committee	Steven Marshall	16	Very High	12	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR15	Workload pressures of STP Workload pressures - Black Country Joint Commissioning Committee Impact of unexpected events on overall workload CSU Capacity	**CCG Staff Capacity Challenges** The level of change across the system means that existing staff resources are stretched to contribute to change based work streams including Black Country Joint Commissioning, STP and local models of care in addition to existing responsibilities. This creates a risk that gaps will be created as well as the existing risk of recruiting sufficiently skilled staff to fill any vacancies that arise in an uncertain environment.	Open lines of communication are being provided to staff through regular updates from STP and Joint Commissioning Committee meetings and through CCG staff briefings **Update** Following Deep Dive discussion meetings with staff, including a workshop with team managers and Director lead meetings with all staff have taken place. This continues to allow staff issues to be raised and understood as they arise. ICS development proposals will continue to have an impact as more details emerge, including the CCG's approach to meeting the planning requirement to achieve a 20% reduction in its running costs. The transition board established by the Governing Bodies across the 4 CCGs is developing proposals for the development of a single management team.	12/09/2017	Jul-19	3a - Proactively drive the CCG's Contribution to the Black Country STP	Executives	Helen Hibbs	12	High	9	High	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR17	Primary Care estate improvements	**Failure to secure appropriate Estates Infrastructure Funding** Much of the plans to improve services, particularly in Primary Care, is dependent on securing improvements in the facilities across Wolverhampton. There are a number of possible avenues for funding these improvements but there is a risk that the complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk	The CCG is working with partners across the local health economy to develop collaborative and strategic plans for estates developments. GP practices are key partners and the CCG is working with a number of individual practices with identified needs to address these issues in a targeted manner. **Update** Funding sources have been identified for a number of proposed improvements in GP practices and the CCG continues to work with other partners to identify alternative sources of funding. Strategic plans are developing in conjunction with relevant practices in key areas. Two improvement schemes have been approved and work has begun on those schemes. Further work is being carried out across w'ton following a number of practice mergers. WCCG continue to support hub working across multi-provider setting and a number of funding sources around proposals are being explored.	12/09/2017	Dec-18	2a - Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions	Primary Care Commissioning Committee	Mike Hastings	8	High	8	High	⇔
CR18	FP05 - Over Performance Acute Contract FP06 - Prescribing Budget FP07 - CHC Budget	**Failure to Deliver Long Term Financial Strategy** Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years	Proactive approach to identifying QIPP schemes and embedding them in contracts has been developed. The CCG has submitted initial plans for 20/21 to 23/24 to NHSE for consideration and there remains a significant QIPP challenge in excess of 5.2% of the CCG's allocation which will be the subject of detailed scrutiny. Work with partners to support alliance working with risk/ gain share. Proactive approach to financial planning to identify potential gaps and develop mitigating actions **Update** Financial Plan for 19/20 had risks of approximately £6.3m following the requirement to identify additional QIPP of £3.1m to support the Regional financial control total. Mitigations have been identified but the plan included a significant revised QIPP target of £16.7m (equivalent to 4.1%) and the use of nonrecurrent contingencies to meet financial targets There is an expectation that the Black Country CCG Risk share arrangements will be enacted to provide additional mitigation as a consequence of Wolverhampton CCG meeting a disproportionate share of the overall Black Country requirement of £8.4m . The CCG in accordance with national guidance will produce a revised long term financial plan for the period 2019-20 to 2024-25 to inform the STP financial plan for consideration by the Governing Body prior to September. This will need to reflect the requirement for the CCG to achieve a 20% reduction in its running costs.	31/03/2019	Jan-20	3b - Ensuring our services are cost effective and sustainable	Finance and Performance	Tony Gallagher	20	Very High	12	High	⇔
CR19	FP14 - Transforming Care - Financial Impact	**Transforming Care Partnership** There are a number of risks to the delivery of the Black Country Transforming Care Partnership's programme of work that cause result in a failure to deliver improvements in the quality of service for patients with Learning Disabilities	Black Country Joint Commissioning Committee has delegated authority for oversight of the programme of work across the four CCGs Programme Management for the partnership resourced by Sandwell and West Birmingham CCG with Wolverhampton AO acting as SRO Collaborative work underway to understand patient cohort and their needs Joint finance work to understand financial impacts on CCG. **Update** The risk sharing agreement with partners to support the funding transfer arrangement has been finalised. The financial risk is fully mitigated through the application of non-recurrent reserves in 2019-20	27/02/2018	Jan-20	3a - Proactively drive the CCG's Contribution to the Black Country STP	Finance and Performance	Tony Gallagher	16	Very High	6	Moderate	⇔

Corporate - Organisational Risks

New ID	Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary	Latest Update and Key mitigations	Opened	Latest Update	Principal GBAF Objective	Responsible Committee	Responsible Director	Rating (initial)	Risk level (initial)	Rating (current)	Residual Risk Level	Change/ Trend
CR20		**Insight Shared Care Record – Governance Arrangements** If robust governance arrangements are not put in place to support the implementation of the Insight Shared Care record then it may not be possible to deliver the intended benefits of the programme to support direct care for patients and improved population health planning in order to support overall strategic aims across the health economy.	Technical Project Group in place discussing the implementation. ICA Sub-group established to support developing governance arrangements. Clear project mandate and timelines being developed. **Update** ICA IG & BI Sub-group has been established to support the work going forward including developing DSA and DPIA for all Data controllers. Project resource has been identified to support the development of the project which will continue to require input from all parties.	19/07/2018	Jul-19	2a - Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions	Executives	Mike Hastings	12	High	12	High	⇔
CR21	BICPB - Reduction in funding to BCPFT as a result of City of Wolverhampton council withdrawing their current funding to specialist CAMHS.	**Impact of potential funding withdrawal by City of Wolverhampton Council (CWC) following consultation process.** As CWC formally consult on budgets for 2019/20 the CCG must consider the quality, safety, and financial impact of funding withdrawal for the delivery of statutory & specialist services across Wolverhampton for service users.	Reduction in funding to BCPFT as a result of City of Wolverhampton council withdrawing their current funding to specialist CAMHS. Potential for impact if a similar approach is taken to other services. CWC have been asked to look to reduce budgets across the services which are not impacting on statutory provision and as a result it may be that no actions undertaken by the CCG will result in funding not being removed from BCPFT. • Meetings to be arranged with CWC to discuss funding • Alternative method for funding EPP has potentially been agreed with CWC and this funding could be used to support the gap in funding from CWC. **Update** Funding has been agreed to fill the gap as a result of the removal of funding by the City of Wolverhampton Council. This is a temporary measure with work to be completed on development of service specifications to ensure that the service being provided meets the health needs which is required from a CCG point of view.	20/11/2018	Jan-20	2a - Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions	Commissioning Committee	Steven Marshall	12	High	9	High	⇩
CR22		**Leaving the European Union (EU-Exit)** A No-Deal Brexit scenario could impact Primary care services including GPs, Pharmacies, Ambulance service and Hospital trusts. Medical/non-medical supplies, medicine/vaccine and workforce could all potentially not be available at business as usual levels posing a risk to service delivery.	Regular communication with all relevant organisations have taken place and assurance calls are regularly taking place in line with national guidance. Work with Primary Care providers, Acute trust and other stakeholders to ensure appropriate actions and planning for eventualities continues. **Update** Following the ratification of the Withdrawal agreement, the United Kingdom has now left the European Union. *****Risk Recommended for Closure*****	25/03/2019	Jan-20	1a - Monitoring ongoing safety and performance in the system	Executives	Mike Hastings	9	High	3	Low	⇩
CR23		**Enacting the Wolverhampton ICA Contract** If the enacting of the Wolverhampton ICA contract is not fulfilled then there is a risk of reverting to PbR which will lead to: • A potentially unaffordable contract and a difficult collaborative relationship. • A lack of traction in the ICA in the absence of a contract.	The CCG continues to work collaboratively with partners in the system ensuring the enactment of the Wolverhampton ICA contract.	06/11/2019	****NEW****	2a - Deliver the Integrated Care Alliance for Wolverhampton to support preventative care closer to home and improve management of Long Term Conditions	Commissioning Committee	Steven Marshall	12	High	12	High	*

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12th November 2019

Agenda item 11

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

2. MAIN BODY OF REPORT – November 2019

2.1 Medicines of Limited Clinical Value

The Committee were presented with a report for approval to NHS guidance on 7 new additional items which should not be routinely prescribed in Primary Care. This is an addition to the presentation of a report in June 2019.

An engagement exercise took place in October 2019 via survey monkey. The results show that patients agreed that reviews should be conducted by a health care professional for these medicines. A defined communication programme is planned

The Committee noted the contents and gave approval

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

2.2 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

Activity/ Performance

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

Contract Performance

- Referral to Treatment –performance continues to deteriorate. a recovery action plan has been put in place with a focus departmental actions. This is overseen weekly by a newly appointed oversight group within the Trust and reviewed monthly by the CCG during contracting meetings.

- Diagnostics - The service failed to achieve targets in August and September 2019 due to an increase in referrals for Endoscopy service. Performance deterioration was also compounded by compounded additionally by capacity issues in the Neurophysiology department.

- Cancer – Performance has improved Breast Cancer area as a result of the STP referral diversion programme. Additionally, a recovery plan is

addressing a number of additional factors, main one being workforce recruitment in radiology.

RWT Planning Round for 2020/21

The planning round has now commenced with first meeting on the 24th October 2019, the CCG has expressed the desire to continue with the approach of an open and collaborative process

Other Contractual issues

Dermatology – the CCG has agreed with the current provider to continue services from the 1 December 2019 to 31 March 2020 by extended contract, the new service will take over from 1 March 2020. The additional contractual month will include the scope of minor surgery to continue for patient referred prior to the end of the extended contract.

Phoenix Walk in Centre – investment has been provided for the migration to an Urgent Treatment Centre.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

- Improving Access to IAPT – This service has shown a decline in the month of August. The Trust has advised that July was an usually successful month and also there were a high number of appointment cancelations in August

Nuffield

Contractual Issues

This service is currently running under plan at month 6 period in Orthopaedics. A new pathway has been introduced for MSK referrals requiring patients access the service via single point of access to Connect.

Contract negotiations and intentions are currently ongoing with the first meeting taking place on the 15 November 2019.

Urgent Care/Ambulance/ Patient Transport

Non-Emergency Patient Transport Service (NEPTS)

This contract has been awarded to WMAS for 5 years with an option to extend for a further 2 years and will commence April 2020.

111 Service

This integration transferred on the 5 November 2019 to WMAS. With the associated planned reduction in conveyances, there exists a potential for a significant saving for the CCG.

Other contracts

- Termination of Pregnancy Service– The drafting/finalising of the contract with the new provider is now being completed. The new provider service will commence on 1 January 2020.

- Assisted Conception Service – Invites to tender for this service have been issues for re-procurement and evaluation will commence on the 20 November 2019.

Resolved: The Committee noted the contents of the update

Action - The Governing Body notes the updates provided

2.3 Review of Risks

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

The Committee noted the update 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: **28th November 2019**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
11th February 2020

Agenda item 11

TITLE OF REPORT:	**Commissioning Committee – February 2020**
AUTHOR(s) OF REPORT:	Dr Manjit Kainth
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in February 2020
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:	
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 February 2020 meeting.

2. MAIN BODY OF REPORT – February 2020

2.1 Ophthalmology – Cataract Provision

The Committee was presented with a report for approval to consider the impact of SpaMedica establishing a hospital location in Wolverhampton, and the contractual implications for Wolverhampton CCG. The Committee is asked to approve the recommendation to enter into a contract with SpaMedica for Wolverhampton CCG patients.

Entering into a contract will enable the CCG to monitor activity with SpaMedica and ensure that they follow required policies.

The Committee noted the contents and agreed a Contract Directly option with 6 monthly reviews and lessons to be learnt from Sandwell & West Birmingham CCG current contracting.

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

2.2 Contracting Update Report

Royal Wolverhampton NHS Trust (RWT)

Activity/ Performance

The Committee was updated on the overview and key contractual areas for January 2020.

Contract Performance

The main Points of Delivery (PODs) contributing to over-performance at RWT in month are A&E, Drugs and Devices and Planned Same Day. It is however that despite the levels of over-performance, outpatient first attendances are significantly under-plan.

- Referral to Treatment – overall performance continues to deteriorate despite a marginal improvement in October 19 (to 83.34%), recorded at 83.18% in November 19. To meet the aspirations of the planning guidance, RWT has undertaken further work to reduce the number of patients on the incomplete waiting list. This has been incorporated into the existing recovery action plan with a new trajectory along with specific departmental actions.

- Diagnostics –The November reported position is 97.21%. This indicator continues to be a challenge for RWT, largely due to a marked increase in referrals into the Endoscopy Department with an increased demand of Fast Track patients taking precedence over routine tests.
- Cancer – Performance has failed on a number of 8 out of the 9 cancer indicators in September 19. However since this period performance has improved, and during October to December 19 three indicators are meeting the target:
  - 31Days subsequent treatment is surgery
  - 31Days subsequent treatment is anti-cancer drug regime
  - 31Days subsequent is a course of radiotherapy

RWT Planning Round for 2020/21

The planning round process continues with executive meetings taking place. A significant financial gap still exists with the Trust due the acceptance of only 50% value of the CCG's QIPP projects at this present time. The forecast outturn for 2019/20 is also yet to be agreed, with the Trust expecting to reset the value of non-electives.

Other Contractual issues

Dermatology – A contract variation has been drafted to amend activity levels with the Trust, which apply particularly to 2020/21 rather than the current year.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

Improving Access to IAPT – Performance is improving and the service are confident of achieving targets by year end. A final meeting in January with Primary Care colleagues will take place to ensure that the alignment to Primary Care Networks is working efficiently. The presence of IAPT staff in PCNs has had a positive impact on increasing access rates and this will continue to be monitored.

Transfer of the Non Contract Activity funding to the Provider

Following the decision to move management of out of area Non Contract Activity to the trust, discussions are underway to ensure that services do not become disjointed by removing inpatients out of the main contract as arrangements move to a single contract across the four CCGs. Discussions are on-going with all CCGs.

Data Quality Improvement Plan

The Trust has now implemented advice and guidance with GPs via a secure email address, which should improve communication and may reduce the number of referrals into the Trust.

The Graphnet system has also been implemented and there is a plan to train staff across the Trust using a phased approach. The system has been uploaded with patient data which will allow clinicians to see GP records and share patient records with Primary Care.

The CCG has a target for quarter 2 of 55%, for Physical Health Checks carried out on patients with a Serious Mental Illness. Currently the CCG is at 47% at the end of quarter 2 and is working closely with Primary Care and the Trust to ensure that the data is uploaded accurately and that the checks are being offered to patients.

The CCG are still working with the Trust to establish which patients would be best suited to receiving Personal Health Budgets and staff training.

Nuffield

Contractual Issues

The Contract Planning Round is currently underway with the first draft proposed 2020/21 Finance and Activity Model shared and feedback received from Nuffield. The model will be updated in line with discussion and the consultation tariff that has now been published.

Nuffield has approached the CCG with regards to them putting in place a service level agreement with Primary Eye Care Services Ltd to carry out a post-operative cataract service following day case cataract surgery at Nuffield. Following discussion and Nuffield sharing the draft Service Level Agreement, the CCG has agreed to support the change in pathway.

Urgent Care/Ambulance/ Patient Transport

Non-Emergency Patient Transport Service (NEPTS)

This contract has been awarded to WMAS for 5 years with an option to extend for a further 2 years and will commence April 2020.

Vocare - Urgent Care Contract

Vocare are presently meeting the majority of their performance standards with one exception being Friends and Family Test, which is a recurrent theme across may providers.

Other contracts

- Assisted Conception Service – re-procurement of this service is currently underway. Walsall CCG is the lead commissioner on this, working with CSU Procurement. The moderation stage of the procurement was planned to take place during December 2019 and January 2020.

- Social Prescribing - A Contract Variation has been completed for the Social Prescribing Contract, to reflect what has been agreed in the Memorandum of Understanding for the delivery of a Social Prescribing Service to Wolverhampton Primary Care Networks.

Resolved: The Committee noted the contents of the update

Action - The Governing Body notes the updates provided

2.3 Review of Risks

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

The Committee noted the contents of the update

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: **30th January 2020**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body Meeting
Tuesday 11th February 2020

Agenda item 12

TITLE OF REPORT:	**Quality and Safety Assurance Report**
AUTHOR(s) OF REPORT:	Sally Roberts, Chief Nurse Yvonne Higgins, Deputy Chief Nurse
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse & Director of Quality
PURPOSE OF REPORT:	To provide the Governing Body with detailed information collected via the clinical quality monitoring framework pertaining to provider services. Including performance against key clinical indicators (reported by exception) September/October/November 2019 data.
ANY EMERGING RISKS OR AREAS OF CONCERN FOR ESCALATION:	**Transforming care Programme –** Wolverhampton continues to have more inpatients than the national identified trajectory, despite the significant reduction achieved. Wolverhampton has not had an admission to an inpatient bed for 16 months. BCWB CCGs remain on national escalation for this performance. **Planned merger of Black Country Partnership Trust and Dudley Walsall Mental Health Trust –** To seek assurance from the provider that any emerging clinical and governance risks identified during transition process are effectively and adequately mitigated and that there are effective processes and plans are in place to ensure continued mitigation and management of these risks post-transition. An update has been requested from BCPFT for the February, 2020 CQRM. The CCG is developing integrated assurance arrangements to ensure mechanisms are in place to effectively gain assurance relating to the quality and safety of the merged provider across the Black Country footprint. Strengthened reporting mechanisms have already been embedded and further work is ongoing.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail.

RECOMMENDATION:	• GB to seek assurance through this report on those areas of highest risk and to receive assurance that the current arrangements for assuring Q&S of the local system are in place and that the mitigation provided is robust. • GB to be assured on the quality and safety of care, and compliance with CCG constitutional standards ongoing.
KEY HIGHLIGHTS:	The main areas for focus identified in this report are: • Cancer performance at Royal Wolverhampton Hospital Trust against 62 and 104 day cancer pathways, although improving, remains below trajectory. No reports of harm for patients waiting for treatment. • Referral to treatment time incomplete pathway performance at Royal Wolverhampton Hospital Trust has not achieved the 92% target. There are no reported waits over 52 weeks and the referral backlog is reducing. • Standardised Hospital Mortality Index for Royal Wolverhampton Hospital Trust has now returned to 'within expected' range. • On-going workforce challenges, in line with national picture, in relation to the retention and recruitment of clinical staff at the Black Country Partnership NHS trust remain. • Mental health bed capacity is running at above 95% consecutively at Black Country Partnership NHS trust. • Report contains updates on the Quality and Safety issues raised through Q&S committee. • Report contains summary of assurance and update on the reports received by Q&S committee for this reporting period.

1. Introduction

This report details the key activities of the oversight and improvement actions taken within the WCCG and the associated providers in relation to quality, safety and performance assurance. The report summarises information received at the Quality and Safety Meeting held for this reporting period.

2. Provider Key Issues

2.1 The Royal Wolverhampton NHS Trust

Cancer performance at Royal Wolverhampton Hospital Trust against 62 and 104 day cancer pathways, although improving, remains challenging. The trust has failed 5 out of the 9 indicators against the 2 week wait-breast symptomatic referrals, 31 days to first treatment, 62 day wait for the first treatment, 62 day wait-screening and 62 day wait - consultant upgrade. Assurance continues to be received relating to the actual or potential impact of harm to patients as a result of the delay, to date there have been no serious incidents reported relating to delays in cancer treatment. Key areas of concern remain urology and colorectal patients due to a number of late tertiary referrals and capacity to meet demands within these specialties.

Risk mitigation:

Significant improvements for Breast symptomatic patients have been sustained and patients are now being booked within the standard and currently, there is no backlog. The system wide approach to improving performance delivered on the initial part of this improvement, and further improvements relating to increased capacity initiatives have embedded and sustained improvements. Daily monitoring of waiting times for this pathway across providers continues to ensure consistency. In addition, there is an increased focus on patient throughput in breast imaging and an Advanced Nurse Practitioner has been successfully recruited and commenced in post in December 2019.

A key focus for improvement remains on the 62-day target. This is challenging due to the number of late tertiary referrals and capacity to meet demand within specialty services such as urology. Colorectal referral numbers are increasing due to the high level of demand. A Nurse-led triage process for gastro referrals will commence in January 2020.

For September 2019, 21 patients and for October 2019, 17 patients over 104 days were treated on a cancer pathway, all of these patients had a harm review and no harm was identified. The main reasons identified for these breaches were internal issues (capacity), patient choice, the clinical complexity of cases and delays in receiving tertiary referrals.

- **Referral to treatment time incomplete pathway performance has not achieved the 92% target**

  An additional performance risk which may impact on the quality of patient care has been identified in relation to referral to treatment time. No patients have currently waited over 52 weeks; performance has improved against the 95% standard to 83.30% for November 2019 and thereby, reversing the trend of deteriorating performance from previous months. Assurance is required relating to the actual or potential impact of harm to patients as a result of the delay.

  Risk Mitigation

  The Trust has undertaken further work to reduce the number of patients on the incomplete waiting list. This work has been incorporated into the existing recovery action plan and a new trajectory has been agreed with specific departmental actions to aid improvement of compliance for this indicator. This is being monitored on a fortnightly basis and is showing signs of improvement. A return to standard is anticipated by March 2020.

  The Trust is undertaking additional list validation, increasing capacity along with pathway cleansing and targeted in-depth training.

  The Trust is continually experiencing high levels of referrals into the Endoscopy Department and capacity constraints in neurophysiology have been identified. Additional sessions have been sourced in endoscopy at the weekends throughout December 2019 and January 2020 with an aim of improving this performance as quickly as possible. For neurophysiology, capacity has been sourced elsewhere.

  There have been no 52 week breaches for any patients on RTT pathway reported for this period.

  For the month of November the trust maintained the performance and thereby is continuing to reverse the trend of deteriorating performance from previous months.

- **Mortality: Standardised Hospital Mortality Index was above national expected rates**

  RWT was reporting higher than expected Standardised Hospital Mortality Index rates. RWT had a high percentage of in-hospital deaths for the local health economy compared with the national mean.

  Risk Mitigation

  The latest published SHMI has further reduced from 1.14 to 1.12 (period August 2018 to July 2019) and the trust has now moved inside the national SHMI funnel plot and is now classed as within the 'expected' range. The rate of SJR completion is showing improvement, with the backlog previously reported having reduced. A thematic review of SJR 2 cases has been shared with clinical colleagues. No further CQC or Dr Foster mortality alerts have been received.

- **Concerns around sepsis pathways within RWT**

  Following the CQC mortality outlier alert in relation to sepsis and sepsis CQUIN performance in 2018-19, the CCG requires further assurance in relation to sepsis pathways.

  Data identifies that for the month of November 2019, 100% of patients who met the sepsis screening criteria in ED were appropriately screened and 90% of these received IV antibiotics within the hour. Within in patient areas 79.9% of patients who met the sepsis criteria were appropriately screened and 52.8 % of these received IV antibiotics within the hour.

  Risk Mitigation

  The sepsis indicators continued to be achieved in the Emergency Department and improvements sustained. In terms of inpatient areas, the indicators remained rated as amber or red. The Trust continues to drive improvements via the established sepsis improvement plan.

  The trust has raised concern with System C (electronic observations and sepsis module provider) in regards to the accuracy of the reports produced via the system. Compliance is higher from paper audit than the electronic ones generated. Therefore, the trust has arranged a meeting with System C. The trust will review their approach in term of reporting after this meeting.

  The trust has achieved slight improvement for the late observations for this reporting period, however, this still remains a challenge. The trust is continually working on delivering Continual Quality Improvement (CQI) projects on a variety of wards to drive improvements.

- **Maternity Services**

Maternity services at RWT continue to engage positively with the Local Maternity System (LMS) and embedding the saving babies V2 care bundle and continuity of carer initiatives.

Risk Mitigation

The percentage of mothers where breast feeding has been initiated has improved and has exceeded target of 65% for the last 5 months. Smoking at the time of delivery has reduced significantly to 12% from 17.7%. The trust are reporting that these improvements are as a direct consequence of implementation of improvements with continuity of carer and saving babies lives care bundle V2.

The number of bookings has increased in October and November 2019. There are small numbers coming from Shropshire and may be in relation to the current publicity relating to maternity services within Shropshire. Maternity workforce indicators are closely monitored by the CCG. The vacancy rate is currently 0.5% and Birth to Midwife ratio is in line with birth rate plus at 1:27.

2.2 Black Country Partnership Foundation Trust

- **Workforce issues which may impact on the quality and safety of care provided**

In line with the national picture, BCP have identified workforce challenges in terms of retention and recruitment of clinical staff.

Risk Mitigation

The Trust continue to work with Health Education England to recruit nurses to the learning disability nursing apprenticeship programme at Coventry University in March 2020 and further work is taking place regarding the nurse fellowship programme with Wolverhampton University in relation to overseas recruitment of nurses.

The Trust is looking at the roll-out of the safe care tool alongside the Mental Health Optimal Staffing Tool (MHOST) which calculates clinical staffing requirements in mental health based wards based on patient needs (acuity and dependency) alongside clinical judgement. The trust is currently liaising externally to allocate a roster management system to develop an implementation plan.

The Trust sickness absence rate has reduced slightly to 5.93% compared to 5.96% in October but still remains amber rated against a threshold of 4.5%. The vacancy rate has increased to 12.91% which is slightly higher compared to 11.33% in October and remains red rated against the trust target. Staff turnover rate also increased to 13.33% compared to 12.95% in October and remains within the target range.

- **BCP adult MH beds capacity issues which may impact on the experience, quality and safety of care provided to patients**

  Issues identified in relation to capacity of adult mental health beds. From April 2019 RWT to December 2019 there has been six 12-hours ED breaches reported and all these breaches relate to mental health patients. A local system wide table top review was led by CCG and identified the common themes as MH bed capacity issues, transport delays and unavailability of section 12 approved social worker.

  Risk Mitigation

  An initiative to implement an enhanced Bed Management function to support capacity has been agreed. A collaborative approach to bed management with Dudley & Walsall Mental Health Trust is also been explored, to ensure good practice is shared and the STP out of area placement plan ambition of zero out of area patients by April 2021 is achieved.

  The system wide 12 hour mental health breach action plan has been revised to include more measurable outcomes. This will be monitored through the Urgent Care Delivery Board.

- **Planned merger of Black Country Partnership Trust and Dudley Walsall Mental Health Trust**

  On 1st April 2020, it is planned that Black Country Partnership Trust and Dudley Walsall Mental Health Trust will merge to become one organisation -Black Country Healthcare NHS Foundation Trust; which will provide Mental Health and Learning Disability services across the Black Country.

  Risk Mitigation

  The two organisations have been working collaboratively over a number of months to align governance processes, structures and systems in preparation for the proposed merger.

  The CCG is developing integrated assurance arrangements to ensure mechanisms are in place to effectively gain assurance relating to the quality and safety of the merged provider across the Black Country footprint. Strengthened reporting mechanisms have already been embedded and further work is ongoing.

- **Transforming Care Partnership (TCP)**

  Although the Black Country and West Birmingham system has achieved significant discharges over the lifetime of the Transforming Care Programme, it is recognised that there a significant number of adults with learning disabilities and/or autism who are currently inpatients in mental health or learning disabilities services. Wolverhampton has not had an admission to an inpatient bed for 16 months.

  Risk Mitigation

  Transformation work continues in relation to commissioning and service provision for adults with learning disabilities and/or autism, and in particular support for cases that require legal frameworks to enable discharge from inpatient services.

  Further external reviews have been commissioned for clients who do not have an estimated discharge date before March 2020, to ensure that all actions are in place to effectively support discharge if appropriate.

  A revised strengthened governance framework has been embedded across the TCP, with a key focus on quality. This includes changes to leadership arrangements across the TCP.

  A revised detailed action plan, with a focus on high-level actions, was agreed by the TCP Board on 21st November. The action plan will be managed through the Delivery Group on a monthly basis, with a report to the TCP Board and through the CCG Governing Bodies.

3. Wolverhampton Nursing Homes

Two of the Wolverhampton nursing homes were rated “Inadequate” by CQC earlier this year; however, both of these homes have since been re-inspected by CQC and have been rated as “Requires Improvement”. Both homes have made significant improvements against robust action plans, supported by the CCG Quality Nurse Advisors (QNA) and Local Authority quality teams. The WCCG QNA team will continue to provide advice and support to the homes to improve the quality of care of the residents and to assist with the on-going Quality Improvement initiatives identified. An enhanced ward round has recently been commissioned by WCCG and is currently live in two nursing homes, with full roll out planned shortly to all Wolverhampton Nursing homes.

4. Primary Care

The vast majority of Wolverhampton practices have been rated "Good" by CQC with no practice rated as "Inadequate"; however, one practice has been rated as “Requires Improvement”. The practice rated as Requires Improvement has a comprehensive action plan in place, which is progressing well. The improvement plan is closely monitored and supported by WCCG. No serious incidents have been reported by Wolverhampton practices for this reporting period.

5. Safeguarding Arrangements

Adult Safeguarding

WCCG’s Designated Adult Safeguarding Lead is leading the STP Safeguarding Assurance Framework and Dashboard Work Stream. A report was presented to the ICA End of Life Sub Group to update the group on the progress and learning from the LeDeR Programme (Learning Disabilities Mortality Review) in Wolverhampton, which indicates Wolverhampton is achieving its local LeDeR trajectory.

Planning is under way to arrange a Black Country and West Birmingham LeDeR Learning event in March 2020 at Walsall Football club. The first planning meeting took place in November. Learning from local Domestic Homicide Reviews, Safeguarding Adult Reviews and Serious Case Reviews event was held in November at Wolverhampton Race Course. The event was opened by WCCG Chief Nurse and Director of Quality in her capacity as chair of the executive WST and was facilitated by WST members. The event was well attended by Multi Agency Colleagues, including staff from WCCG Commissioned Services. The Safeguarding Commissioning Assurance Toolkit (S-CAT) was successfully submitted to NHSE at the end of November. This is part of a pilot, and has replaced the SAT (Safeguarding Assurance Toolkit). The United Nations Orange the World Campaign started on 26th November. This is 16 days of action to end violence against women and girls. The Safeguarding team promoted staff to wear orange ribbons and held a display in the Lockside Coffee shop in support of the campaign.

As part of the new statutory safeguarding arrangements (Wolverhampton Safeguarding Together), a workshop was held to plan how the proposed ‘One Panel’ will function. This will panel will replace the previous Safeguarding Adult Review Committee, the Serious Case Review Committee and the Domestic Homicide Review Panel. The first meeting of the One Panel is planned for spring 2020. A draft of the DHR 11 Report was shared at the DHR panel meeting on 29th November, prior to the Practitioners Learning Event planned for 5th December. Level 3 Safeguarding Adults training was provided for Primary Care and WCCG staff in November. The next session will be held in March 2020.

Children’s Safeguarding

As part of the assurance work of the Wolverhampton Safeguarding Together partnership, the Deputy Designated Nurse (DDN) carried out a frontline practitioner visit alongside the police to the Multi-agency Safeguarding Hub (MASH), the ‘front door’ service that

manages early help and safeguarding concerns. A group of professionals, from different agencies were involved in the workshop session where questions were asked in relation to a variety of aspects in relation safeguarding children practices, policies and procedures. The DDN completed feedback documentation which has been submitted to WST for the Executive Group to review WST had recommenced the JTAI (Joint targeted area inspection programmes where Ofsted, Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS), the Care Quality Commission (CQC) and HMI Probation jointly inspect and report on the impact of local multi-agency safeguarding arrangements on children) preparation meetings which the DDN attended this month.

The current theme that is being inspected nationally is Children's mental health, where they are reviewing cases of children aged between 10-15, who are living with a mental health diagnosis. Self-evaluations in regards to mental health provision within services have been circulated for all agencies to complete. DDN led a meeting with BCPFT, RWT and MASH to review the audit tool used within health to review safeguarding practice. A generic audit tool was compiled with the agreement for the tool to be piloted in an audit, to be completed by June 2020 in RWT, BCPFT, MASH and CCG, in relation to domestic abuse in both adults and children's services.

6. LeDeR Update

The LeDeR Programme in Wolverhampton continues to progress well. There are no unallocated reviews in Wolverhampton; however, there are 24 unallocated across the rest of the Black Country. The LeDeR Administrator and LeDeR Co-ordinator posts have been recruited to, and will be supporting the allocation of unallocated reviews to agency reviewers. NHSE/I are providing the funding for this. A Black Country LeDeR Learning Event is planned for spring 2020.

7. Medicines Optimisation Update

The key highlights from the Medicines Optimisation reports received for this reporting period are as below:

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 the best value for medicines, it has been very successful.

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 is 'good' in this area. It also showed that there was an inappropriate prescribing of Co-Amoxiclav in ED. The CCG offered a Prescribing Incentive Scheme, which was very successful last year.

8. SEND Update

The key highlights from the SEND reports received for this reporting period are as below:

- The SEND Health Local Offer review completed.
- The SEND Health Strategy drafted and at consultation stage.
- CCG colleagues took part in a SEND listening and engagement event and are actively working with young people and parents/carers to ensure the co-production of health work for this agenda.
- A three year Delivery Plan following the recommendations arising from the health review has been developed and shared with all stakeholder colleagues.

9. CHC Update

The key highlights from the CHC reports received for this reporting period are as below:

- WCCG continues to meet requirements of the National Framework and Quality Premium.
- The service has adopted a number of process changes to improve efficiency and delivery of CHC.
- CHC has now fully committed to QA database.
- The Total Funded Care Budget is at present forecast to break even.

10. Health and Safety Update

R G Wilbrey (Consultants) Limited currently provides advice on Health and Safety for Wolverhampton CCG. A Quarter 3 Health & Safety audit has been undertaken. The action plan has been updated to reflect the considerable amount of work undertaken following R G Wilbrey's initial audit in March 2019. Six items remain amber, there are no significant risks reported with work either in hand or awaiting quotes. There are no red risks/issues. Plans are currently in place to reconfigure the CHC office to provide a safer working environment for staff. It is intended for this work to be completed by the end of March 2020.

11. Appendices

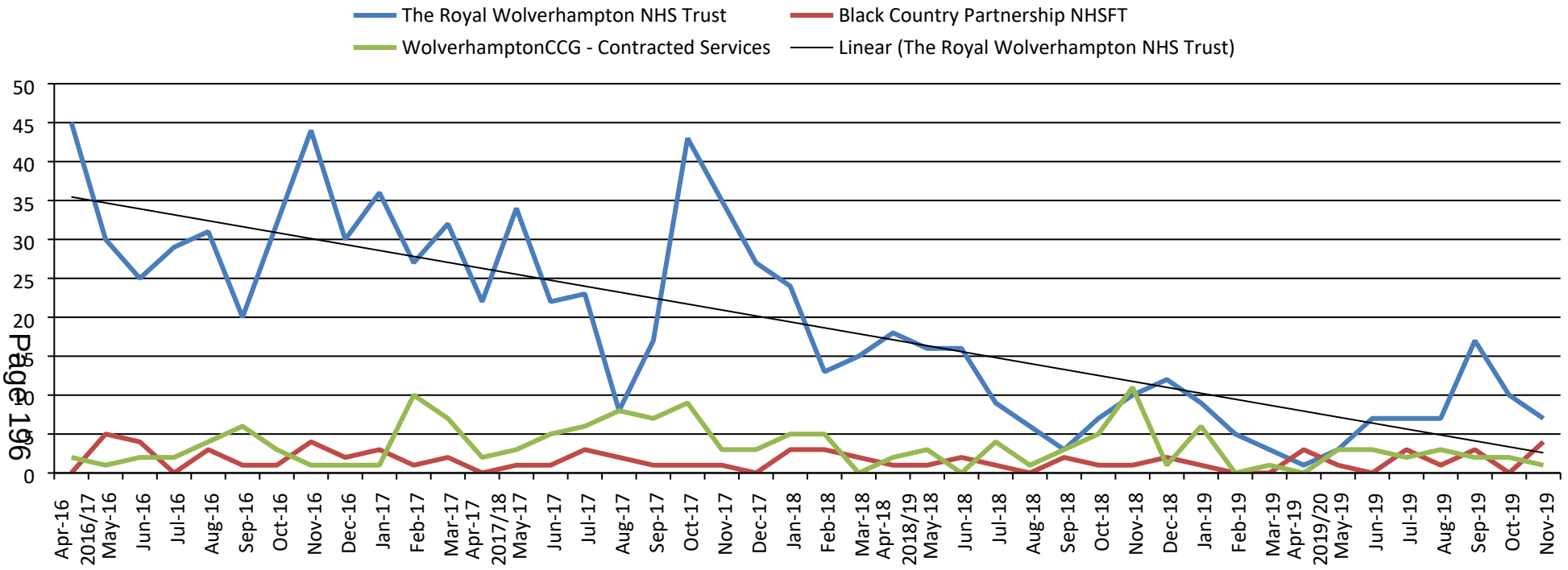
Appendix 1 - Serious Incidents Summary

Appendix 2 – Acute and Mental Health Providers' Quality & Safety Dashboard

Appendix 3 – Primary Care Quality Dashboard

Appendix 1 - Serious Incidents Summary

Chart 1: Serious Incidents Reported by Month



In total, 12 Serious Incidents (SIs) were reported in November 2019. Of these seven related to RWT, four incidents were attributable to BCPFT, and one for WCCG.

Chart 2: Serious Incident Types Reported November 2019

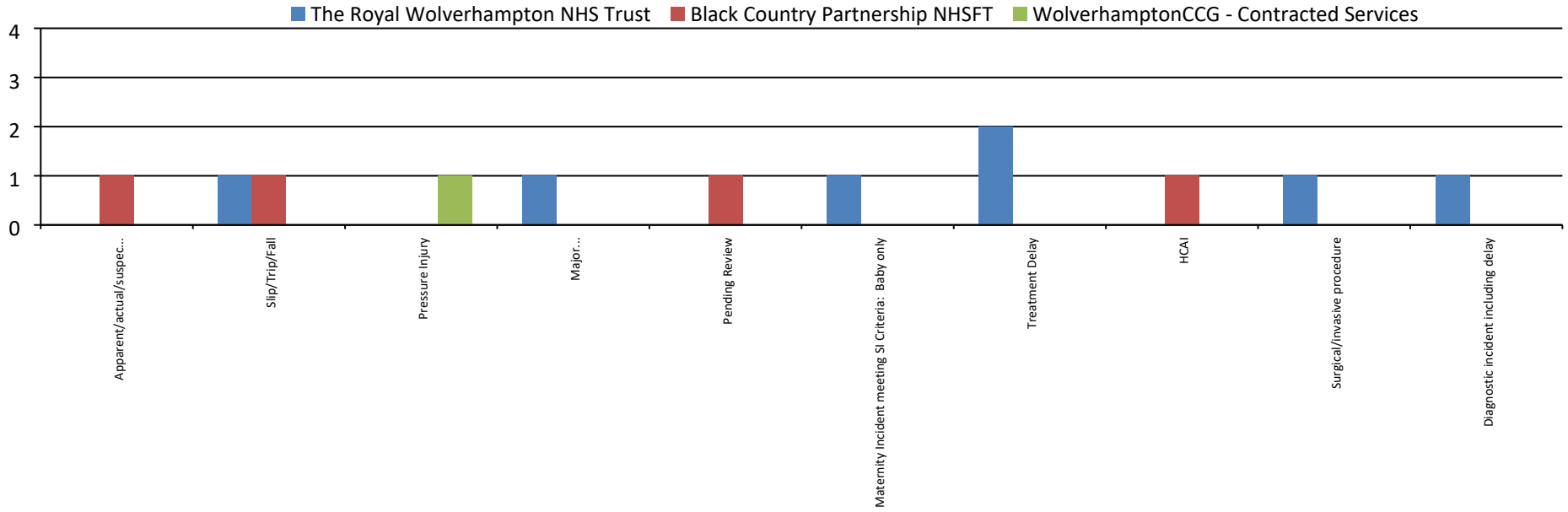


Chart 2 shows the breakdown of serious incident types reported by each provider for November 2019.

RWT Pressure Ulcer incidents: There is an increased prevalence in the number of pressure ulcers reported (non-STEIS) mainly in the community care settings. In acute settings, the pressure ulcers are mostly reported from 2-3 clinical areas and the trust is doing further correlation to identify any common themes or trends, however, initial findings suggest that staffing may be a contributing factor. In community settings, there are number of pressure ulcer incidents reported by north-east team and delays in escalation and risk assessments have been identified as a common theme. The trust has developed comprehensive action plans to maintain and improve their position on achieving a reduction in pressure ulcers across the trust.

Chart 3: Never Events

Reported Never Events

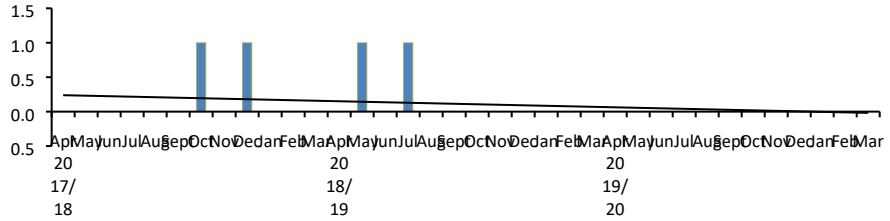
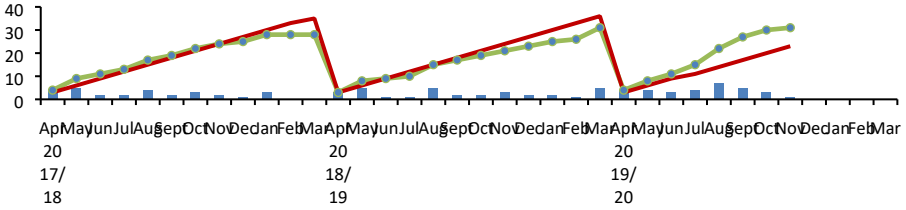
	Yr. 16-17	Yr. 17-18	Yr. 18-19	April 19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Yr. to date
Royal Wolverhampton	**5**	**4**	**4**	1	0	1	0	0	0	0	0					2
Black Country Partnership	**0**	**0**	**0**	0	0	0	0	0	0	0	0					0
Other providers	**0**	**1**	**0**	0	0	0	0	0	0	0	0					0
Total Reported	**5**	**5**	**4**	1	0	1	0	0	0	0	0					2

No new never events reported for November 2019.

Appendix 2 –Quality & Safety Dashboard

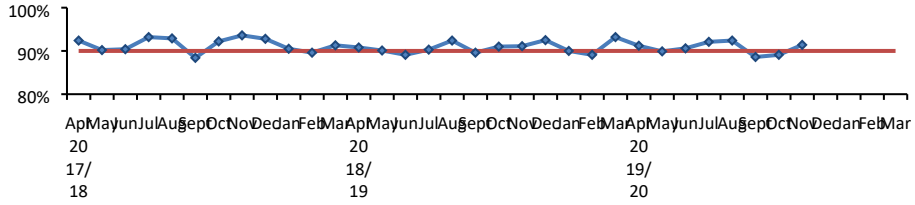
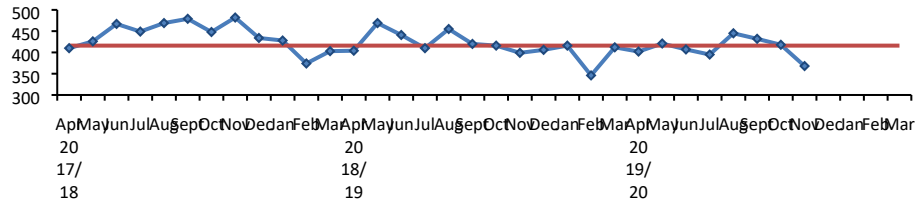
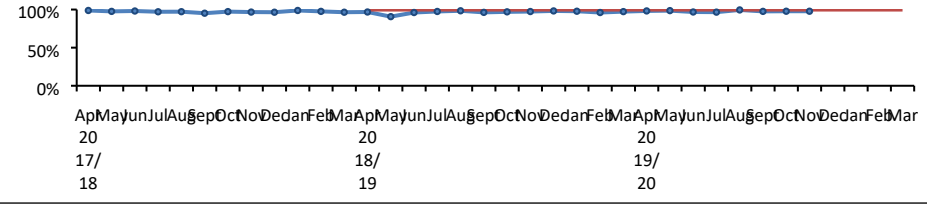
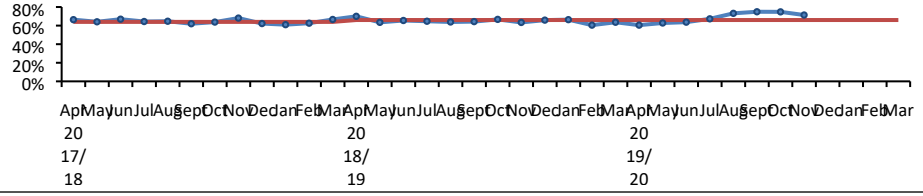
Royal Wolverhampton Hospitals NHS Trust

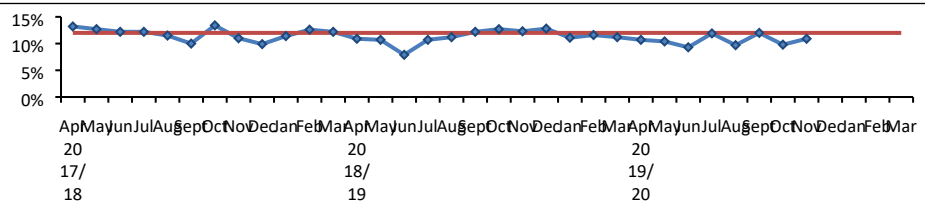
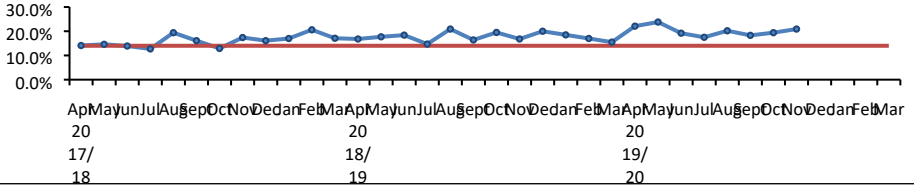
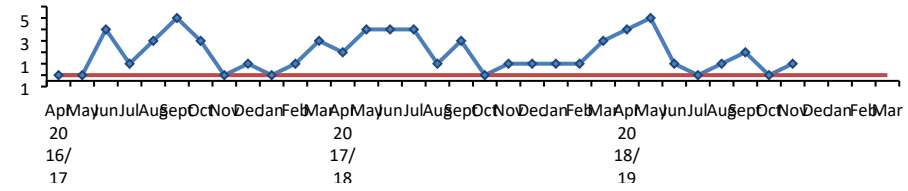
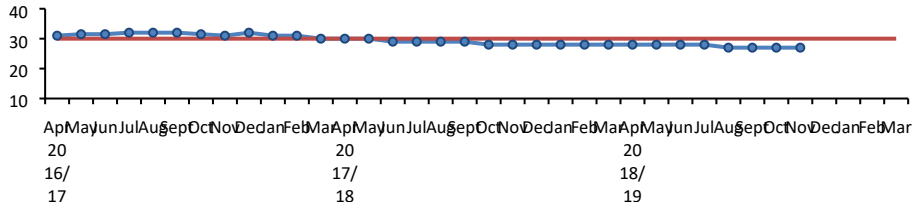
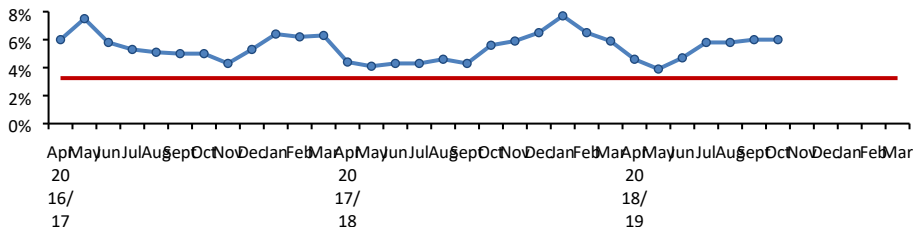
1. Infection Prevention

Measure	Trend	Target	Assurance/Analysis
MRSA		**0**	No new MRSA cases reported in November 2019. Trust has reported one MRSA Bacteraemia incident which has been attributed to the WCCG because the bacteraemia was identified within 48 hours of admission to the trust. A table-top meeting identified no omissions in care and treatment Therefore, this incident did not meet the criteria to be reported as a serious incident. Trust has completed the PIR (Post Infection Review) for this incident and all relevant data was inputted on the DCS (Data capture system) as per the national guidance. Incident has been logged onto WCCG local incident reporting system. Any learning identified from this incident will be shared across the system.
C.Diff		**<35**	The Trust reported one case in November 2019. The cumulative figure for 2019/20 is 31 and above trajectory. 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 underway to address this. Deep clean programme for 2019/20 underway. Further analysis required to identify if any additional actions are required. Trust currently undertaking a deep dive into the recent increase of Cdiff cases. Initial findings suggest that in all 11 cases reviewed patients were given Intra Venous Antibiotics but it was clinically appropriate. 6/11 patients were identified to be on Proton Pump inhibitors which may have been a contributing factor.

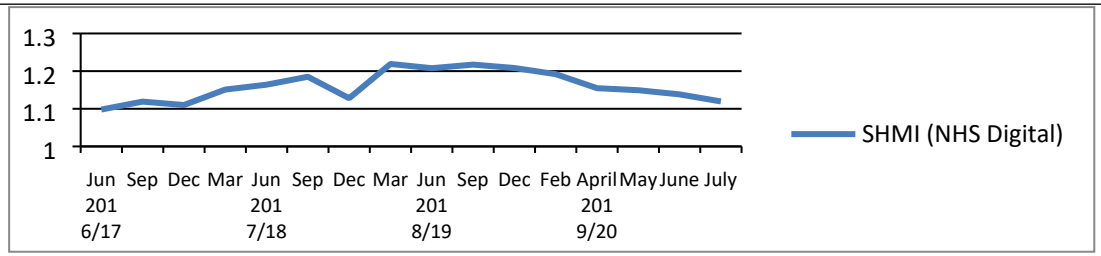
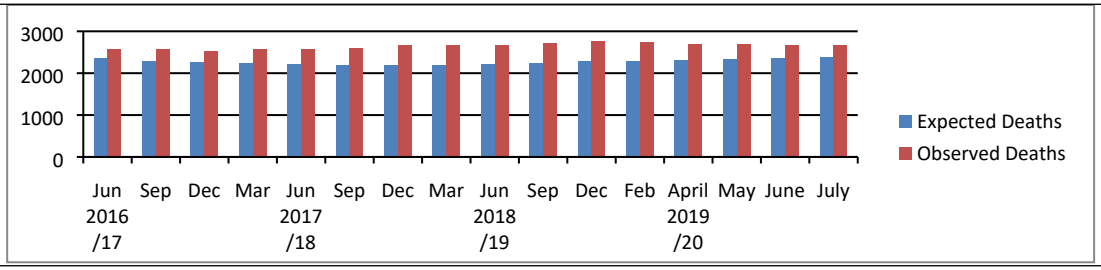
2. Maternity

Maternity services at RWT continue to engage positively with the Local Maternity System (LMS) and embedding the saving babies V2 care bundle and continuity of carer initiatives.

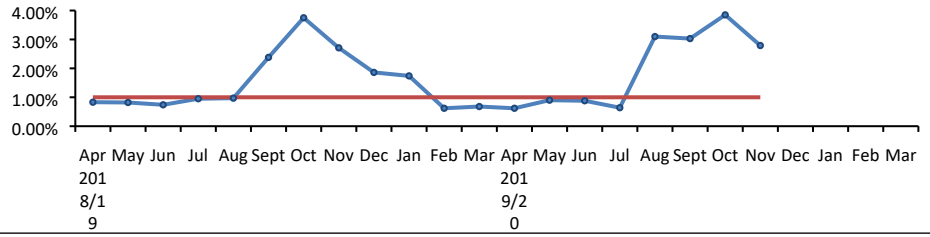
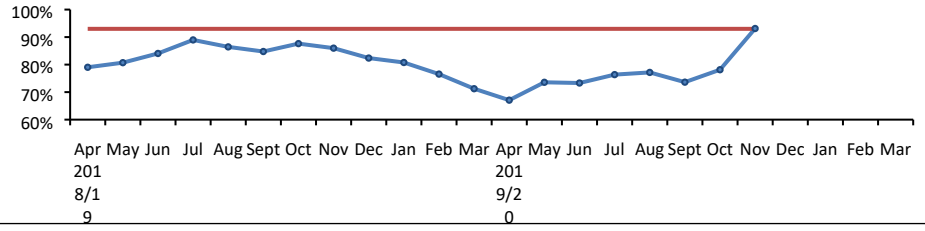
Measure	Trend	Target	Assurance/Analysis
Bookings at 12+6 weeks		>90%	The number of bookings has increased in October and November 2019. This may be in relation to the current publicity relating to maternity services within Shropshire.
Number of Deliveries (mothers delivered)		<416	Number of mothers delivered decreased substantially to 368 in November from 416 in October.
One to One care in established labour		100%	November's figure remains steady at 97.8%.
Breastfeeding (initiated within 48 hours)		>=66%	The percentage of mothers where breast feeding has been initiated has exceeded the target of 65% for the last 5 months. Smoking at the time of delivery has also reduced significantly to 12% from 17.7%. The trust are reporting that these improvements are as a direct consequence of implementation of improvements with continuity of carer and saving babies lives care bundle V2.
C-Section – Elective (Births)		<12%	The rate for elective C-Sections has fluctuated since June. November's figure shows an increase back up to 12% from 9.8% in October.

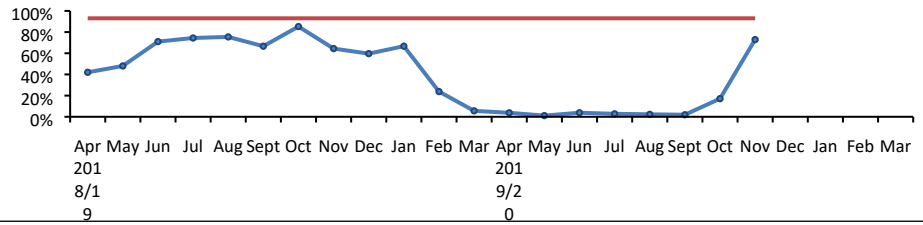
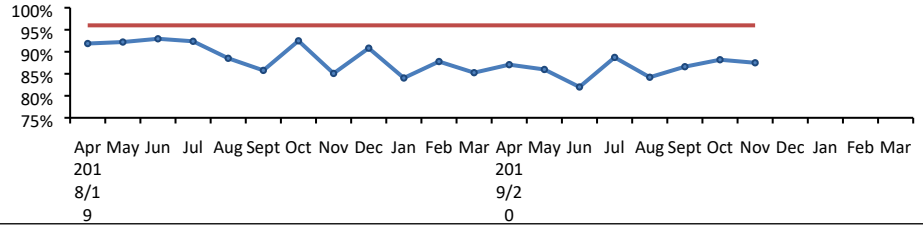
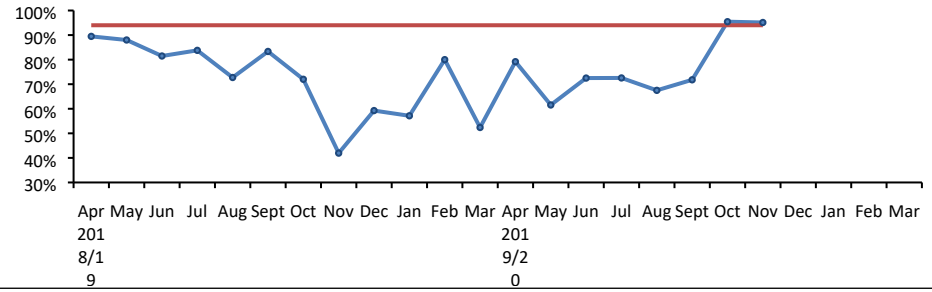
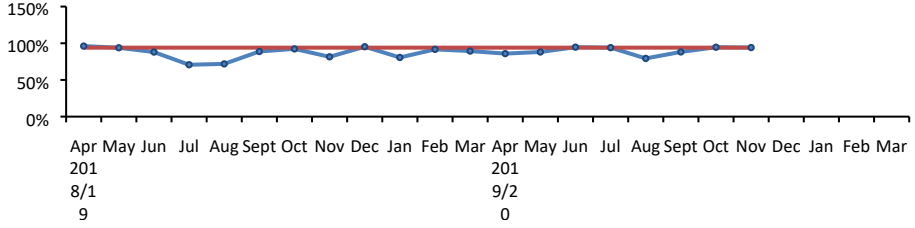
Measure	Trend	Target	Assurance/Analysis
			
C-Section – Emergency (Births)		<14%	Emergency C-section case rate saw another slight increase in November to 20.9%, up from 19.4% in October, and 18.3% in September.
Admission of full term babies to Neonatal Unit		0	One neonatal unit admissions during November 2019.
Midwife to Birth Ratio (Worked)		<=30	Maternity workforce indicators are closely monitored by the CCG. The vacancy rate is currently 0.5% and Birth to Midwife ratio is in line with birth rate plus at 1:27.
Maternity – Sickness Absence		<3.25%	Maternity sickness rates remained stable again in October at 6% (reported one month behind).

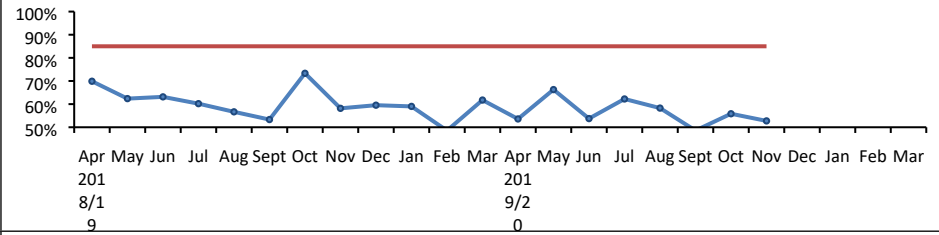
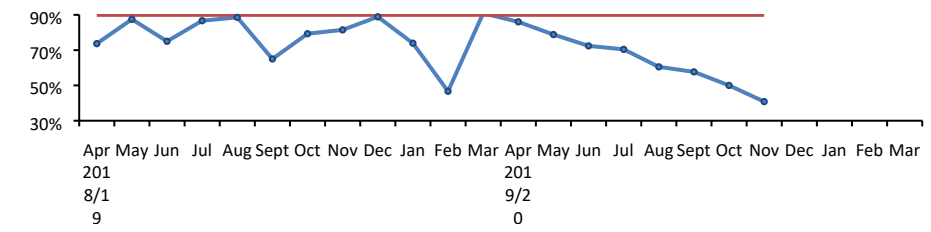
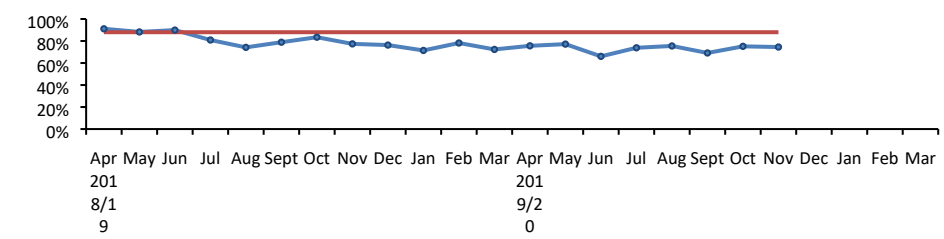
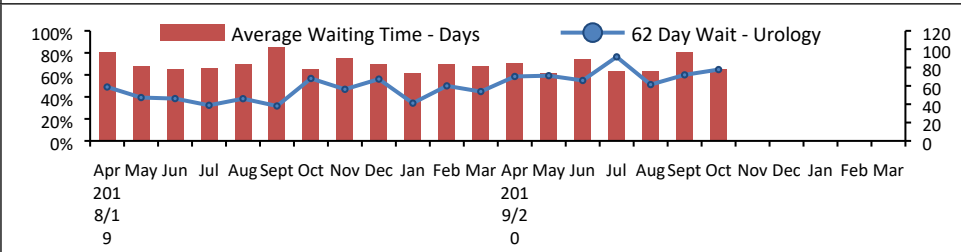
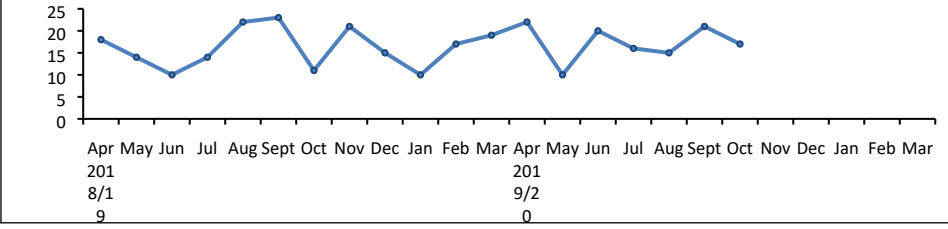
3. Mortality

Measure	Trend	Target	Assurance/Analysis
Mortality – SHMI (NHS Digital)		**N/A**	The SHMI for August 2018 to July 2019 is 1.1195. Expected deaths 2,375. Observed deaths 2,660. 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**	

4. Cancer Waiting Times

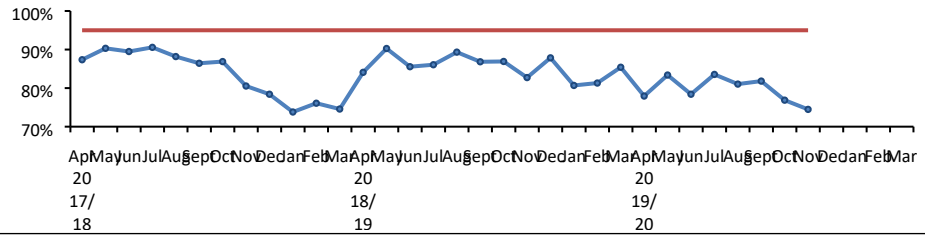
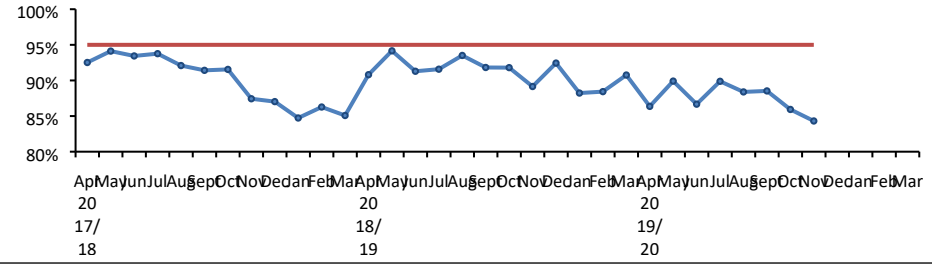
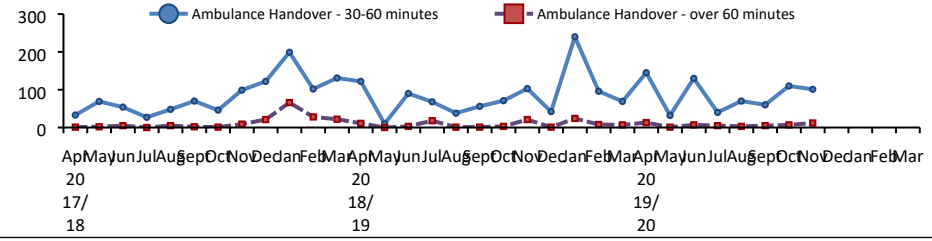
Measure	Trend	Target	Assurance/Analysis
6 Week Diagnostic Test		**<1%**	November's figure showed a decrease to 2.79% from 3.85% in October.
2 Week Wait Cancer		**93%**	The 2 week wait cancer performance position in November was 93.12% against a target of 93%.

Measure	Trend	Target	Assurance/Analysis
2 Week Wait Breast Symptomatic		**93%**	November's figure showed significant increase to 72.92% up from 17.11% in October and September's figure at 1.92%.
31 Day to First Treatment		**96%**	November data shows a very slight decrease at 87.5% compared to 88.19% in October.
31 Day Sub Treatment - Surgery		**94%**	Data for November 2019 shows November figure of 95.12% against a target of 95% and the target has now been achieved for two consecutive months.
31 Day Sub Treatment - Radiotherapy		**94%**	31 day sub treatment radiotherapy shows 94.12% in November, achieving the target of 94% for the second month in succession.

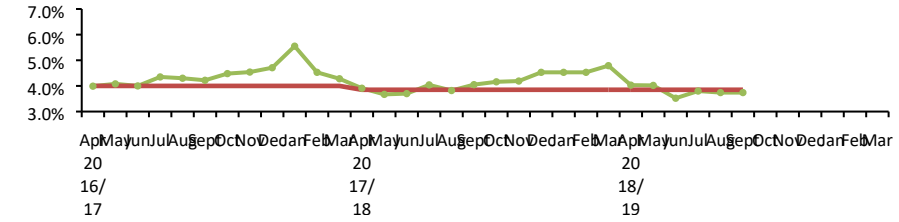
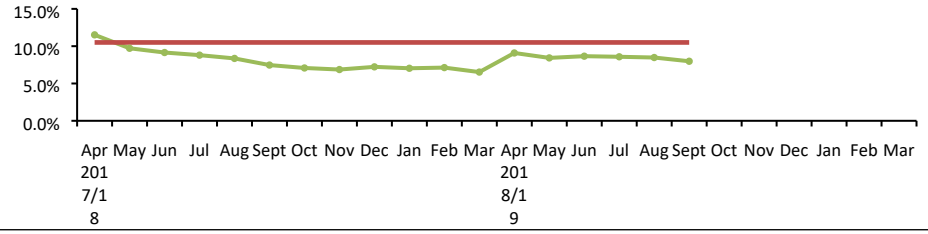
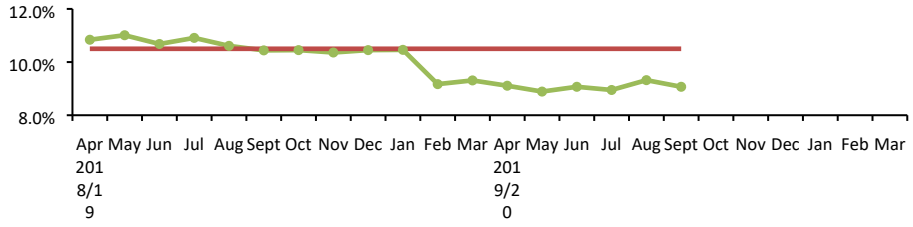
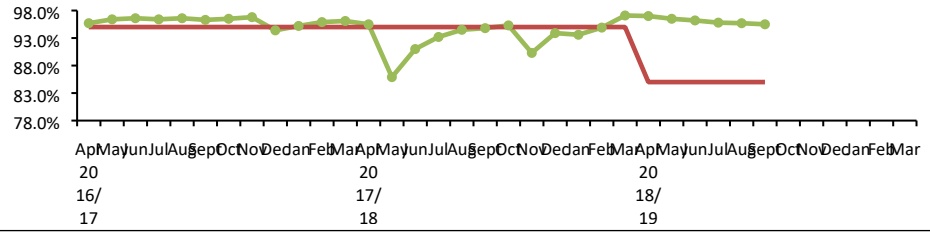
Measure	Trend	Target	Assurance/Analysis
62 Day Wait for First Treatment		**85%**	Performance continues to fluctuate. Figure for November has decreased slightly to 52.75% compared to October at 55.84%. September figure was 48.59%.
62 Day Wait - Screening		**90%**	62-day wait showed a further decline in November to 40.82% from 50% in October, with September at 57.69%.
62 Day Wait - Consultant Upgrade (local target)		**88%**	The 62-day wait consultant upgrade (local target) performance was 74.53% in November compared to 75.15% in October.
62 Day Wait - Urology		**85%**	The average waiting time in October decreased to 78 compared to September at 96 days (reported one month behind). Performance for Urology in October increased to 64.81%, up from 60% in September (reported one month behind).
Patients over 104 days		**N/A**	17 patients identified over 104 days in October 2019 compared to 21 in September 2019 (reported one month behind).

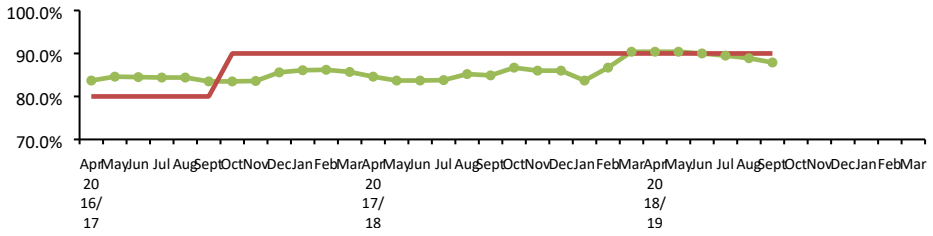
5. Total Time Spent in Emergency Department (4 hours)

In January 2020 to date, 13 patients have spent over 12 hours within the Emergency Department from the time when a decision to admit was decided. These breaches were as a result of capacity within the Trust. A full RCA will be undertaken and further analysis and learning reported in subsequent reports.

Measure	Trend	Target	Assurance/Analysis
Time Spent in ED (4 hours) - New Cross		**92%**	November performance decreased further compared to the previous month, down to 74.48% compared to 76.87% in October and 81.82% in September.
Time Spent in ED (4 hours) - Combined		**95%**	Performance for November declined slightly to 84.31% compared to October's figure of 85.93%.
Ambulance Handover		**N/A**	101 ambulances breached the 30-60 minute ambulance handover target during November, a slight decrease on the October figure of 110. 12 ambulances breached the >60 minutes handover target during November (7 in October).

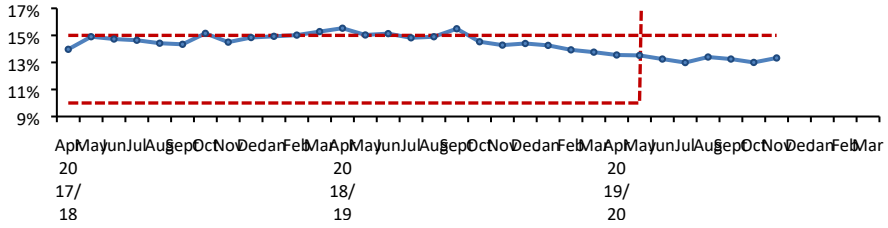
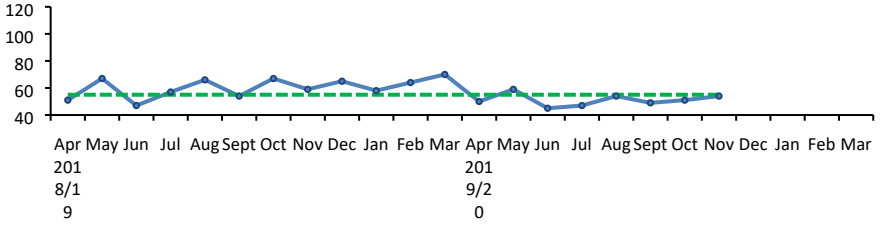
6. Workforce and Staffing

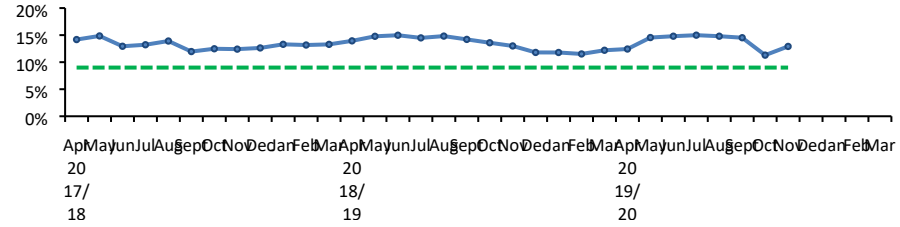
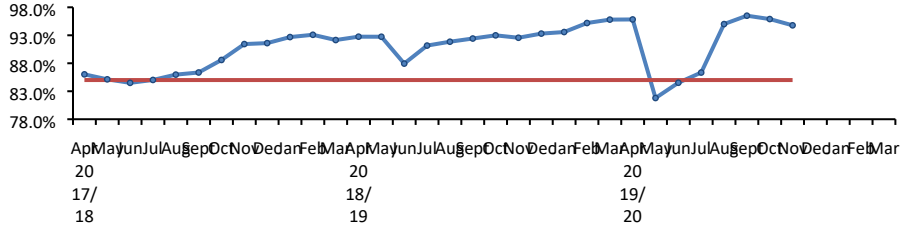
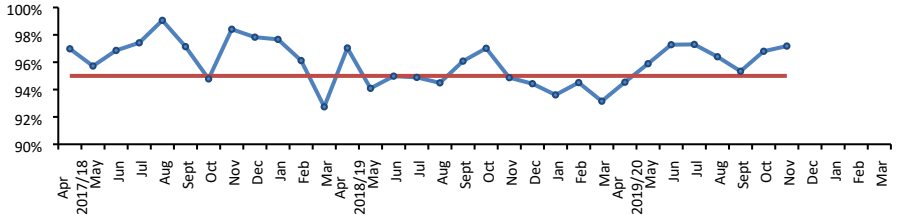
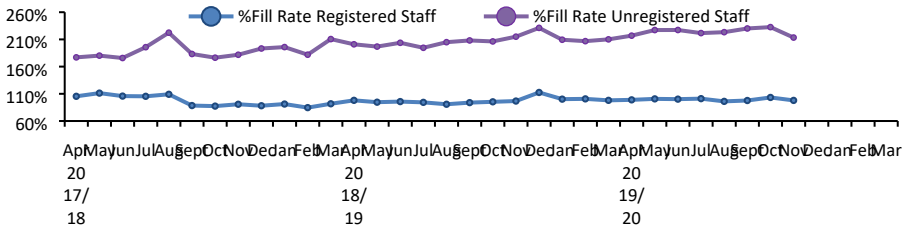
Measure	Trend	Target	Assurance/Analysis
Staff Sickness Absence Rates (%)		**3.85%**	Staff sickness absence rates remained steady during August and September at 3.74%, slightly under target. Further Data is awaited.
Vacancy Rates (%)		**10.5%**	The vacancy rate has reduced and remains within target at 7.98% in September (reported one month behind). This is driven by a net increase of almost 25 WTE trained nurses and a further 11.53 WTE awaiting their pin in September. October data waited.
Staff Turnover Rates (%)		**10.5%**	Staff turnover rate reduced to 9.07% in September (reported one month behind). Turnover performance is meeting the standard in all but unregistered clinical staff groups where it is at, or slightly over, target. Reports are now available at a granular level in respect of vacancies and these have been circulated to divisional nurses and other leaders. Reports have also been introduced in nursing areas which provide vacancy forecasts, taking into account anticipated leavers and known starters. October data waited.
Mandatory Training Rate (%)		**85%**	Mandatory training (generic) compliance rates have remained steady in September (95.5%) and continue to meet the 85% target which changed from April 2019 (reported one month behind). October data waited.

Measure	Trend	Target	Assurance/Analysis
Appraisal Rate (%)		**90%**	Performance decreased slightly in September to 87.9% compared to August at 88.9%. Appraisal compliance is not meeting the Trust target. The Trust is undertaking work to improve the position (reported one month behind). October data waited.

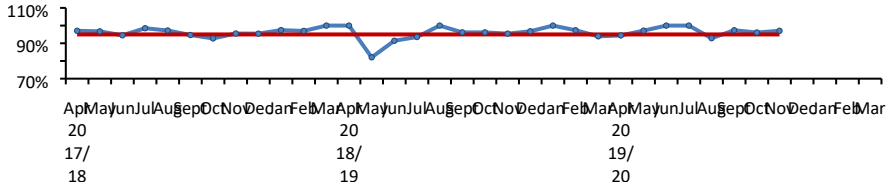
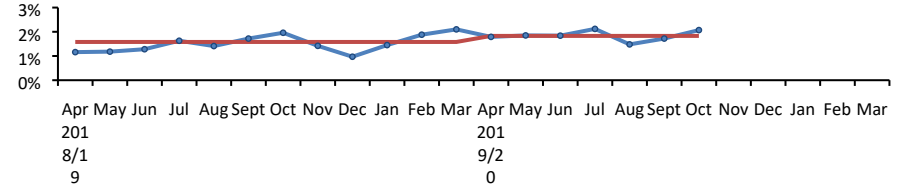
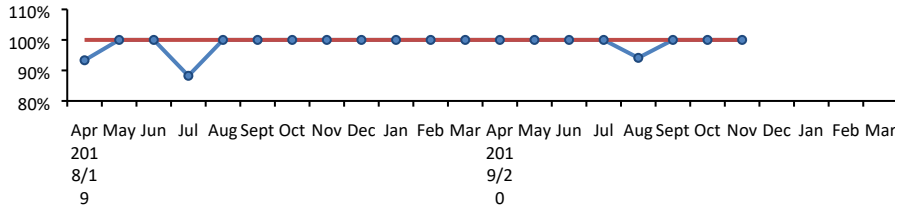
BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

1. Workforce and Staffing

Measure	Trend	Target	Assurance/Analysis
Staff Turnover Rates (%)		**10-15%**	Turnover rate in November increased slightly to 13.33% but remains within the target range.
Average Time to Recruit		**55**	Average time to recruit KPI increased slightly to 54 working days in November but remains within the 55 working day target

Measure	Trend	Target	Assurance/Analysis
Overall vacancy rate		**<9%**	Vacancy rate increased in November to 12.91% up from 11.33% in October and remains red rated against the target.
Mandatory Training Rate (%)		**85%**	Performance against annual mandatory training and 3 yearly specialist mandatory training were all on target at the end of November.
% of Shifts filled (Bank and Rostered)		**95%**	The overall figure has increased slightly in November to 97.18%.
Safe Staffing - %Fill Rate Registered Staff		**N/A**	The registered fill rate for November has decreased slightly to 97.9% compared to October at 103.3%. The unregistered fill rate also decreased to 213.4% from 232% in October.

2. Quality Performance Indicators

Measure	Trend	Target	Assurance/Analysis
CPA % of Service Users followed up within 7 days of discharge		**95%**	This KPI remains steady at 97.06%.
% of people with anxiety or depression entering treatment		**1.83%**	October data shows a further increase to 1.83% and has achieved target (reported one month behind).
% of inpatients with Crisis Management plan on discharge from secondary care		**100%**	November data remains on target at 100%.

Appendix 3

PRIMARY CARE QUALITY DASHBOARD

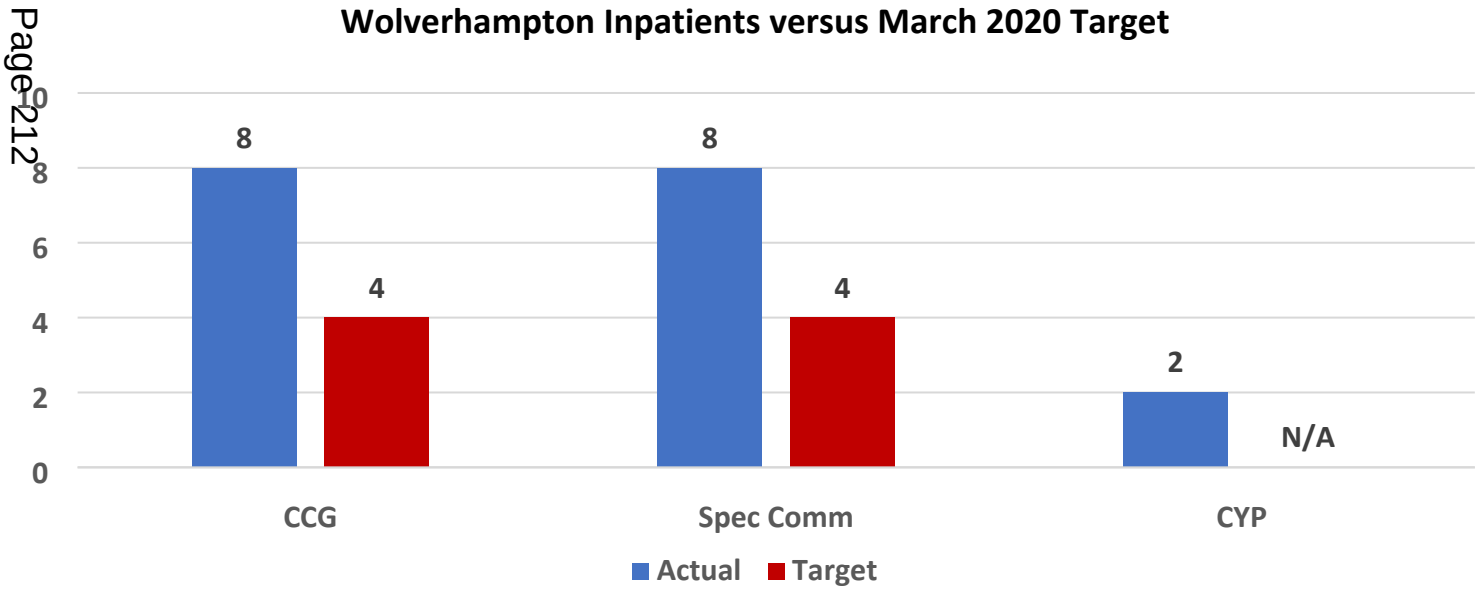
RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

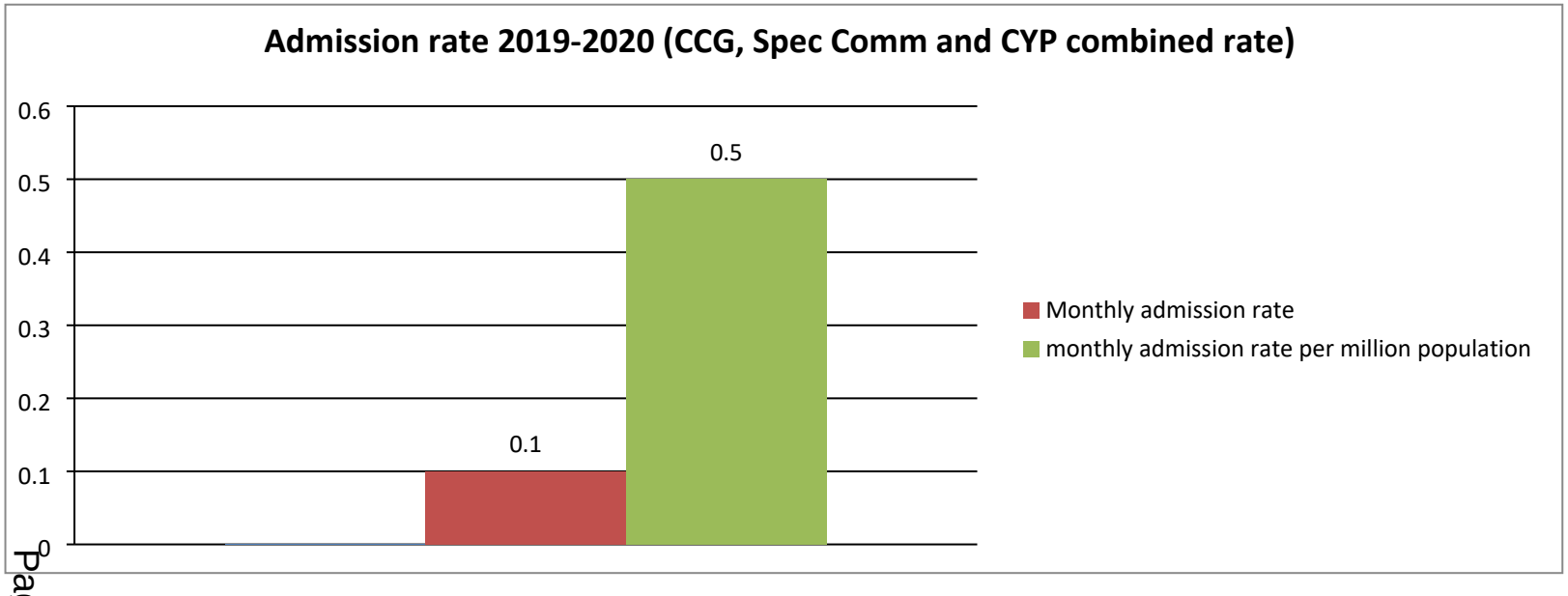
Issue	Comments	Highlights for November 2019	Mitigation for December 2019	Date of expected achievement of performance	RAG rating
Serious Incidents	All RCAs are reviewed at SISG and escalated to PPIGG if appropriate.	Awaiting further information before referring into PPIGG following Quality Matters referral	One practice has recently had a vaccine fridge failure – being managed at practice level	31st January 2020	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	13 open Quality Matters 10 of these are new 3 are continuing 2 QM are overdue 7 QMs closed	12 open Quality Matters 3 QM is overdue 0 QM closed	31st January 2020	1b
Escalation to NHSE	Four incidents due to be reviewed at PPIGG from Quality Matters	Awaiting further information before referring into PPIGG for two incidents	PPIGG referrals awaiting further information	31st January 2020	1b
Infection Prevention	IP audit cycle has recommenced for 2019/20	Average IP rating 95% Audits continue	Average IP rating 95% Audits continue Plans to support IP improvements in practice being scoped	On going	1a
Flu Programme	Flu planning meetings have recommenced for 2019/20 flu season	LAIV child vaccine ordering has reopened following issue Uptake: 51.5% Over 65s 18.5% Under 65s at risk 18.3% Pregnant women	Current adult uptake for week 49 (w/c 9th December 2019): 64.3% Over 65s 33.6% Under 65s at risk 32.6% Pregnant women	31st March 2020	1a
Vaccination Programme	Vaccination programmes continue to be monitored	Uptake for 2018/19 66.4% Work to increase uptake continues with Public Health	Work continues as previously	On-going	1a
Sepsis/ECOLI	Planning continues around training for practices in reduction of gram negative infection – collaboration with	Training was undertaken on 14th November – work to increase awareness of programme continues	Work continues as previously	On-going	1a

	IP team, prescribing and continence teams. Some practices have still not identified a sepsis lead and this is being chased.				
MHRA	No issues at present.	No issues at present	No issues at present	None at present	1a
Complaints	No issues at present – quarterly report due July 2019	No new complaint data at present	No new complaint data at present	On going	1a
FFT	Slightly lower uptake in July, most probably due to summer holidays	In October 2019 (September data): • 3 practices did not submit • Uptake was 2.2% compared with 0.7% regionally and 0.9% nationally	In November 2019 (October data): • 8 practices did not submit • Uptake was 1.9% compared with 1.1% regionally and 0.8% nationally	On-going	1a
NICE Assurance	No actions at present	Awaiting information	New NICE guidance available	None at present	1a
Collaborative Contracting visits	All practices now complete new cycle to commence in November 2019	One visit undertaken Four visits booked in up to March 2020	Two visits undertaken Three further visits booked up to March 2020	On going	1a
CQC	Monitoring of practices and support continues.	Two practices now have requires improvement ratings and support continues Annual reviews and inspections continue	Two practices now have requires improvement ratings and support continues Annual reviews and inspections continue	On going	1b
Workforce Activity	Work continues to promote primary care as a desirable place to work and to promote current programmes	GP and GPN retention work continues at STP level	GP and GPN retention work continues at STP level	On-going	1a
Workforce Numbers	Awaiting NHS Digital workforce data release.	Data available via new workforce dashboard tool	Data available via new workforce dashboard tool	On-going	1a
Training and Development	None flagged at present	GP and GPN retention work continues Practice nurse education continues with 2020 programme under	GPN Speciality Training programme bid successful at STP level – 10 places available across patch	On-going	1a

		development Training Hub continue to support extra sessions NMP funding available Apprenticeship offers continue Pharmacist network continues Non-clinical training continues			
Training Hub/HEE/HEI update	To continue monitoring, risk reduced and closed.	Training Hub coordinator now embedded in CCG	No further updates	On-going	1a

Transforming Care data




Admission rate 2019-2020 (CCG, Spec Comm and CYP combined rate)
0.6
0.5
0.4
0.3
0.2
0.1
0
0.1
0.5
Monthly admission rate
monthly admission rate per million population

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WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 26th November 2019**
Report of:	Tony Gallagher – Director of Finance
Contact:	Tony Gallagher – Director of Finance
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	• **Receive** and **note** the information provided in this report.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The organisation has a number of finance and performance related statutory obligations including delivery of a robust financial position and adherence with NHS Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG must secure the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best

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

1. FINANCE POSITION

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

Financial Targets				
Statutory Duties	**Target**	**Out turn**	**Variance o(u)**	**RAG**
Expenditure not to exceed income	£13.178m surplus	£13.178m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£450.942m	£437.764m	(£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	£300k	(£101k)	G
Maximum closing cash balance %	1.25%	0.96%	(0.29%)	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 *	£251,325k	£253,077k	£1,752k	G
Reserves *	£1,636k	£0k	(£1,636k)	G
Running Cost *	£3,217k	£3,101k	(£117k)	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 M07							In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o/(u)
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)			
Acute Services	210,606	122,853	123,982	1,129	0.9%	212,356	1,750	0.8%		0	1,750
Mental Health Services	44,353	25,873	26,310	437	1.7%	45,241	887	2.0%		0	887
Community Services	45,624	26,614	26,675	62	0.2%	45,303	(320)	(0.7%)		0	(320)
Continuing Care	16,072	9,375	9,384	9	0.1%	16,110	38	0.2%		0	38
Primary Care Services	58,025	33,848	33,899	51	0.2%	58,143	118	0.2%		0	118
Delegated Primary Care	37,573	21,918	22,251	334	1.5%	37,573	0	0.0%		0	0
Other Programme	17,191	10,844	10,575	(269)	(2.5%)	17,150	(41)	(0.2%)		0	(41)
Total Programme	**429,444**	**251,325**	**253,077**	**1,752**	**0.7%**	**431,876**	**2,432**	**0.6%**		**0**	**2,432**
Running Costs	5,516	3,217	3,101	(117)	(3.6%)	5,316	(200)	(3.6%)		(200)	0
Reserves	2,804	1,636	0	(1,636)	(100.0%)	572	(2,232)	(79.6%)		0	(2,232)
Total Mandate	**437,764**	**256,178**	**256,178**	**0**	0.0%	**437,764**	**0**	**0.0%**		**(200)**	**200**
Target Surplus	13,178	7,687	0	(7,687)	(100.0%)	0	(13,178)	(100.0%)		0	(13,178)
Total	**450,942**	**263,865**	**256,178**	**(7,687)**	(2.9%)	**437,764**	**(13,178)**	(2.9%)		**(200)**	**(13,178)**

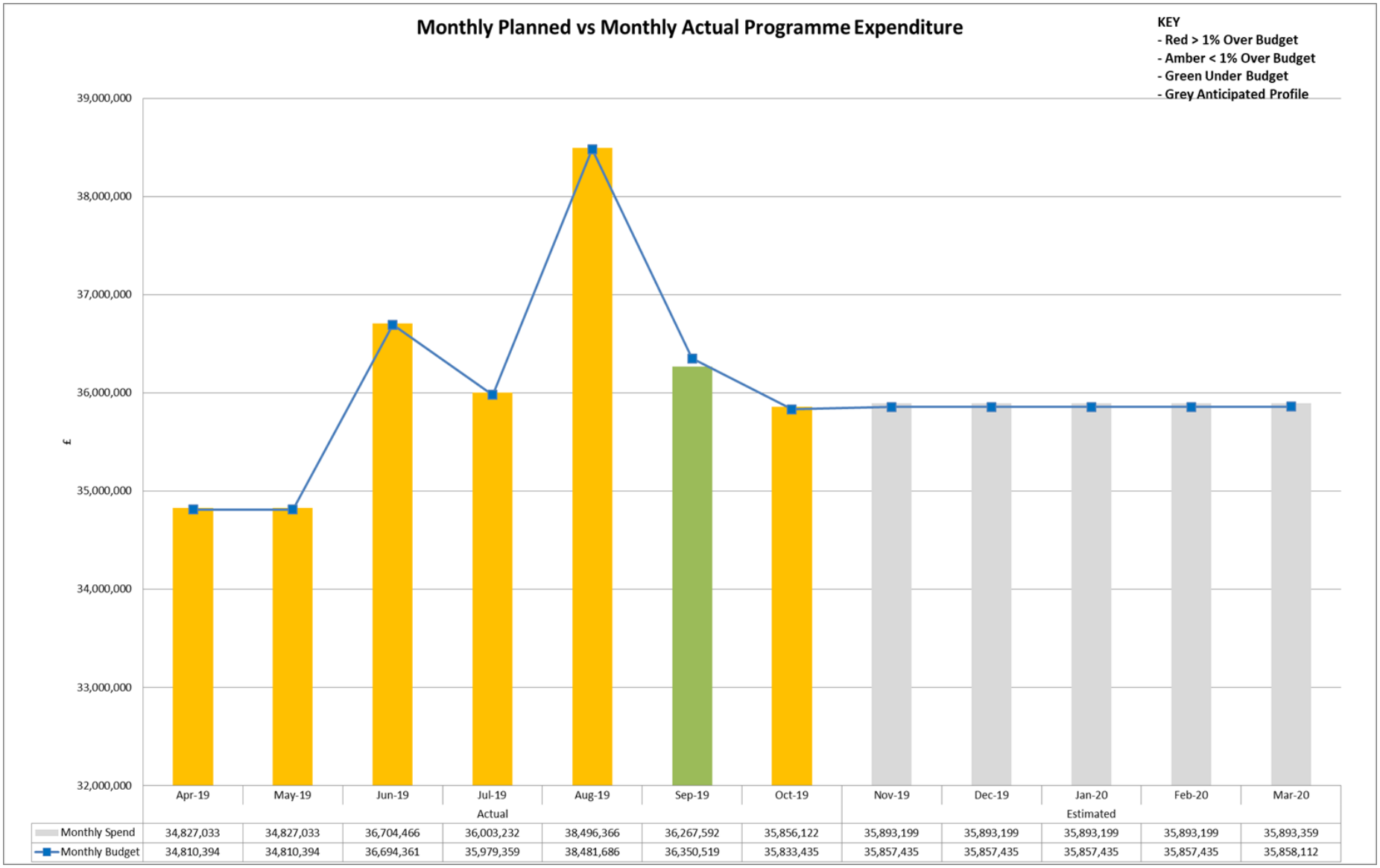
- The Acute over performance relates in the main to RWT. Having received Month 6 data the CCG has considered the level of performance reported and has reflected a level of over performance which it considers to be appropriate based on historic activity patterns.

- 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.

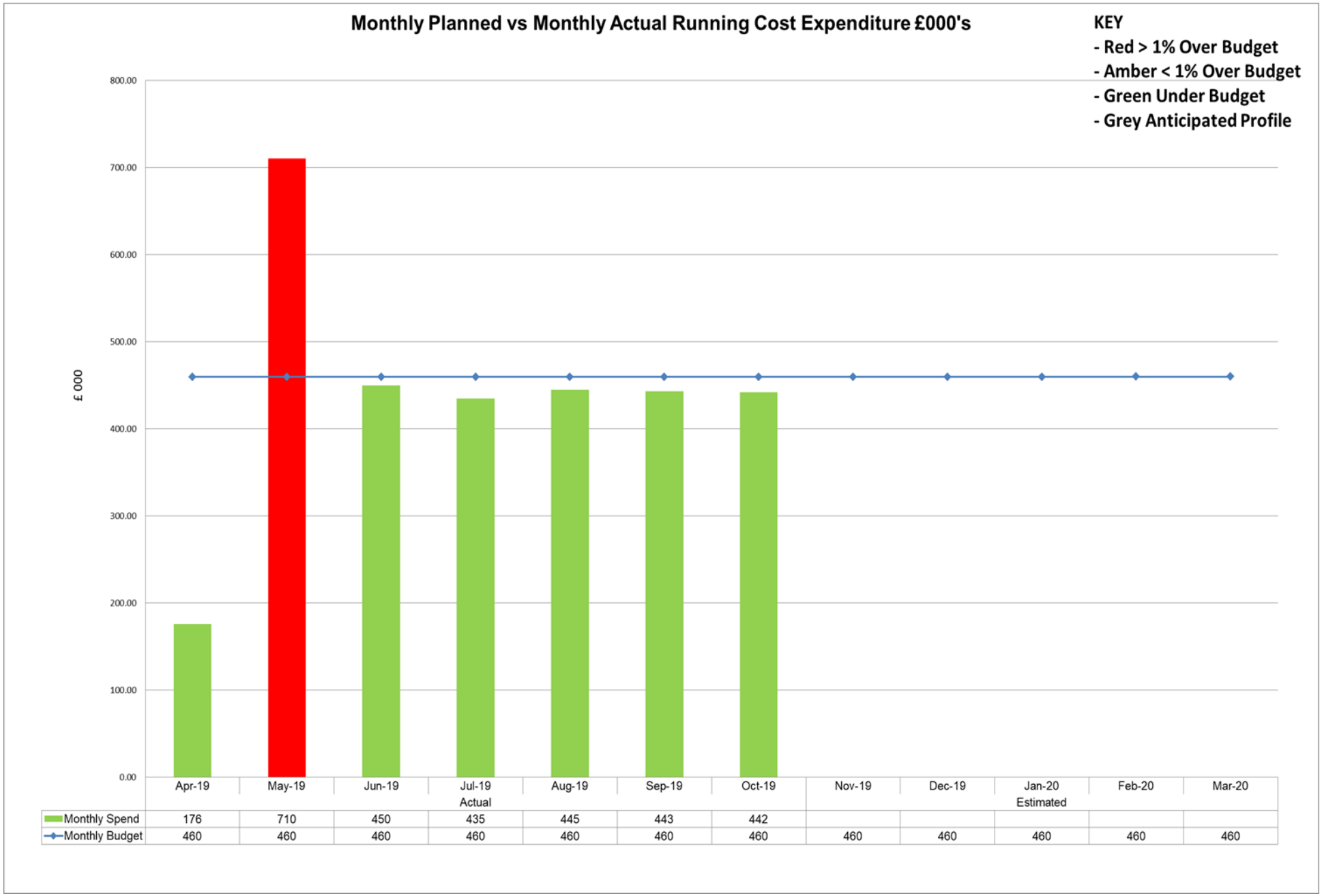
- The extract from the M7 non ISFE demonstrates the CCG is meeting its plan, achieving 1.0% recurrent underlying surplus after adjusting for Co Commissioning

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)	**440.914**				(14.522)							426.392
Acute Services	**210.606**	**212.356**	**(1.750)**	**(0.8%)**	(2.691)	1.110		(2.795)				207.980
Mental Health Services	**44.353**	**45.241**	**(0.887)**	**(2.0%)**	(3.904)	-		(0.581)				40.756
Community Health Services	**45.624**	**45.303**	**0.320**	**0.7%**	(0.162)	-		0.782				45.923
Continuing Care Services	**16.072**	**16.110**	**(0.038)**	**(0.2%)**	-	-		0.122				16.232
Primary Care Services	**58.025**	**58.143**	**(0.118)**	**(0.2%)**	(4.186)	0.500		0.374				54.831
Primary Care Co-Commissioning	**38.145**	**38.145**	**-**	**0.0%**	-	-	(0.191)	0.191				38.145
Other Programme Services	**19.423**	**17.150**	**2.273**	**11.7%**	(3.579)	1.540	(2.132)	0.411				13.390
Commissioning Services Total	**432.248**	**432.448**	**(0.200)**	**(0.0%)**	**(14.522)**	**3.150**	**(2.323)**	**(1.496)**		-	-	**417.257**
Running Costs	**5.516**	**5.316**	**0.200**	**3.6%**	-	-						5.316
TOTAL CCG NET EXPENDITURE	**437.764**	**437.764**	**(0.000)**	**(0.0%)**	**(14.522)**	**3.150**	**(2.323)**	**(1.496)**		-	-	**422.573**
IN YEAR UNDERSPEND / (DEFICIT)	**3.150**	**3.150**	**0.000**	**0.0%**					**Underlying Underspend / (Deficit)**			**3.819**
									% RRL			**0.9 %**



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Actual							Estimated				
Monthly Spend	34,827,033	34,827,033	36,704,466	36,003,232	38,496,366	36,267,592	35,856,122	35,893,199	35,893,199	35,893,199	35,893,199	35,893,359
Monthly Budget	34,810,394	34,810,394	36,694,361	35,979,359	38,481,686	36,350,519	35,833,435	35,857,435	35,857,435	35,857,435	35,857,435	35,858,112

- The graph details the monthly and cumulative budgeted and actual expenditure in 2019/20.


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 176 710 450 435 445 443 442
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 is £38.145m. At M7 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.

- The table below shows the outturn for month 7:

	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	13,137	13,092	(45)	22,521	22,521	0		0	0
General Practice PMS	847	847	(0)	1,452	1,452	0		0	0
Other List Based Services APMS incl	1,641	1,601	(41)	2,814	2,814	0		0	0
Premises	1,396	1,403	8	2,393	2,393	0		0	0
Premises Other	49	34	(15)	83	83	0		0	0
Enhanced services Delegated	1,106	1,119	13	1,896	1,896	0		0	0
QOF	2,142	2,142	0	3,672	3,672	0		0	0
Other GP Services	1,600	2,014	414	2,743	2,743	0		0	0
Delegated Contingency reserve	111	0	(111)	191	191	0		0	0
Delegated Primary Care 1% reserve	222	0	(222)	381	381	0		0	0
Total	**22,251**	**22,251**	**0**	**38,145**	**38,145**	**0**		**0**	**0**

2019/20 forecast figures have been updated on quarter 3 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.

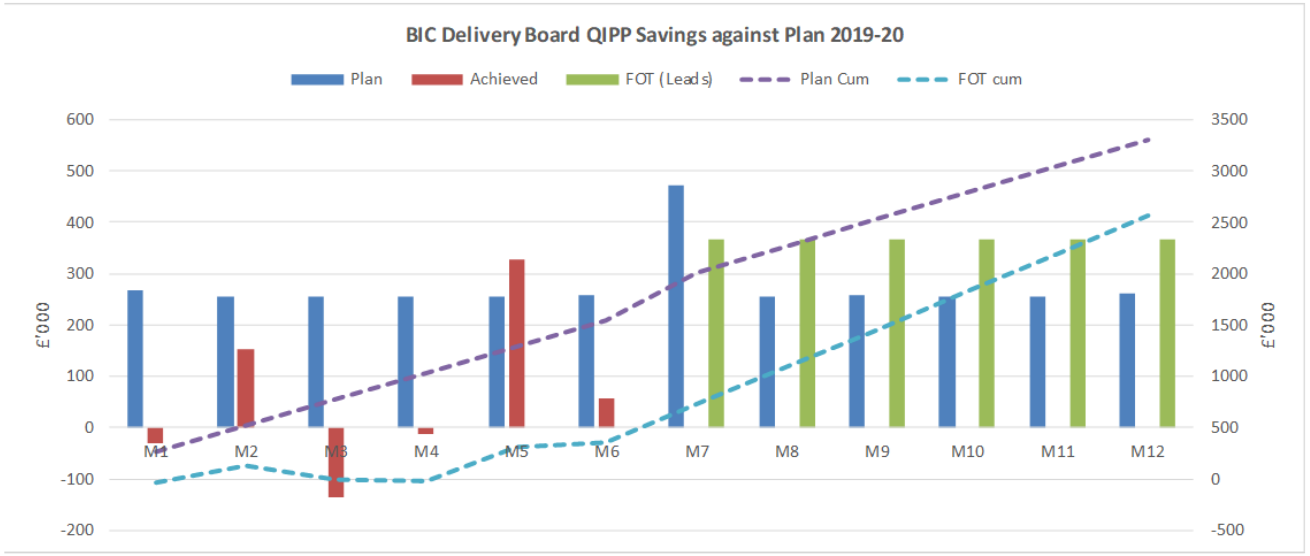
2. QIPP

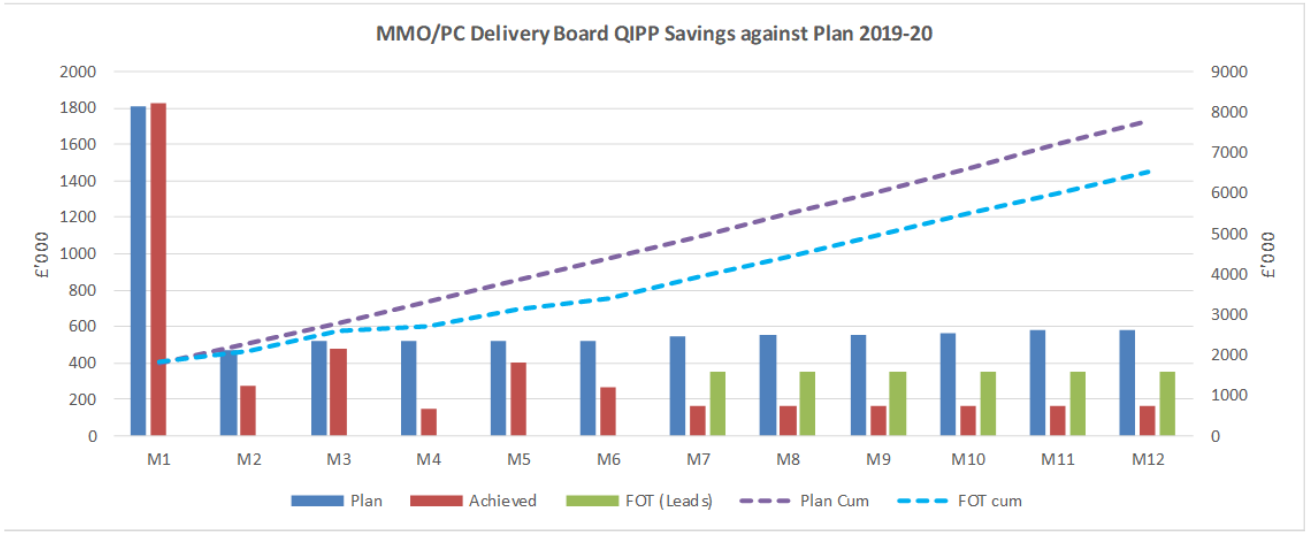
The key points to note are as follows:

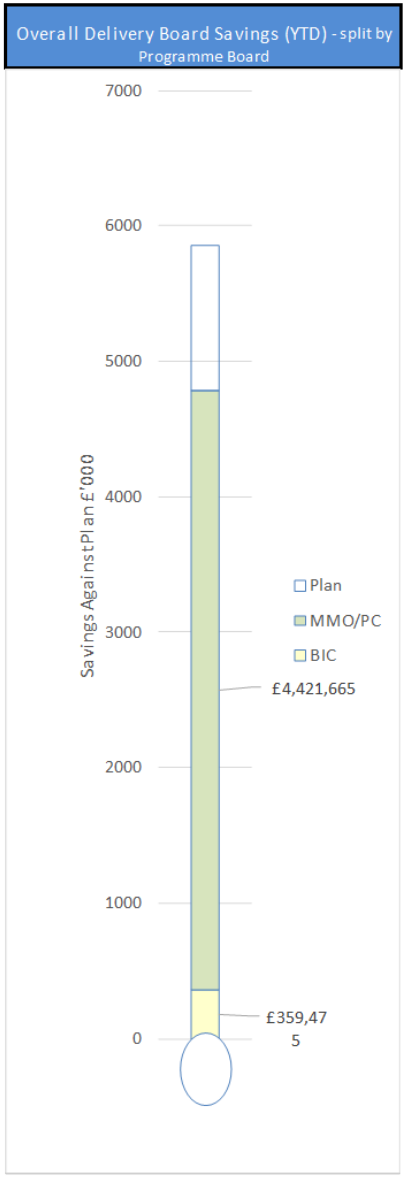
- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686m,(4.1%) the additional QIPP being identified at a high level as follows :

    - 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 M7 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 M7 QIPP delivery is behind plan ytd.


BIC Delivery Board QIPP Savings against Plan 2019-20
Plan
Achieved
FOT (Leads)
Plan Cum
FOT cum
£'000
£'000
600
500
400
300
200
100
0
-100
-200
3500
3000
2500
2000
1500
1000
500
0
-500
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12


MMO/PC Delivery Board QIPP Savings against Plan 2019-20
£'000
£'000
2000
1800
1600
1400
1200
1000
800
600
400
200
0
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12
Plan
Achieved
FOT (Leads)
Plan Cum
FOT cum


Overall Delivery Board Savings (YTD) - split by Programme Board
Savings Against Plan £'000
7000
6000
5000
4000
3000
2000
1000
0
Plan
MMO/PC
BIC
£4,421,665
£359,475

3. STATEMENT OF FINANCIAL POSITION

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

	31 October '19 £'000		30 September '19 £'000	Note	Change In Month £'000
Non Current Assets					
Assets	0		0	1	0
Accumulated Depreciation	0		0	2	0
	0		0		
Current Assets					
Trade and Other Receivables	1,747		1,770	3	-23
Cash and Cash Equivalents	264		175	4	89
	2,011		1,945		
Total Assets	**2,011**		**1,945**		
Current Liabilities					
Trade and Other Payables	-45,664		-44,405	5	-1,260
	-45,664		-44,405		
Total Assets less Current Liabilities	**-43,653**		**-42,460**		
TOTAL ASSETS EMPLOYED	**-43,653**		**-42,460**		
Financed by:					
TAXPAYERS EQUITY					
General Fund	43,653		42,460	6	1,193
TOTAL	**43,653**		**42,460**		

Key points to note from the SoFP are:

- The cash target for month 7 has been achieved.

- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days.

- **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 (September 19):

- WCCG 84.7%, England 84.8%, STP 89.0%
- 92% WCCG patients started treatment within 22.6 weeks at any provider in England against the standard of 18 weeks which is the same as the previous month (England was 23.9 which was up from 23.7).
- There were no WCCG patients waiting over 52 weeks to start treatment during September.
- 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 is 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.
- Queries have been raised regarding the performance of the Nuffield Hospital Wolverhampton, for which the CCG acts as lead commissioner. This is due to variances in locally reported SQPR figures and the nationally published data. September performance has been confirmed as 94.58%.
- Diagnostic performance for September remains above the 1% threshold (RWT = 3.03%, WCCG = 2.56%). The Trust has confirmed that expected recovery has moved from October to December 2019 with increases in Endoscopy referrals remaining the main issue against recovery. The Trust continues to investigate support from the private sector to alleviate pressure on the service. The CCG have requested an updated exception report with updated actions and recovery timescales.

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.

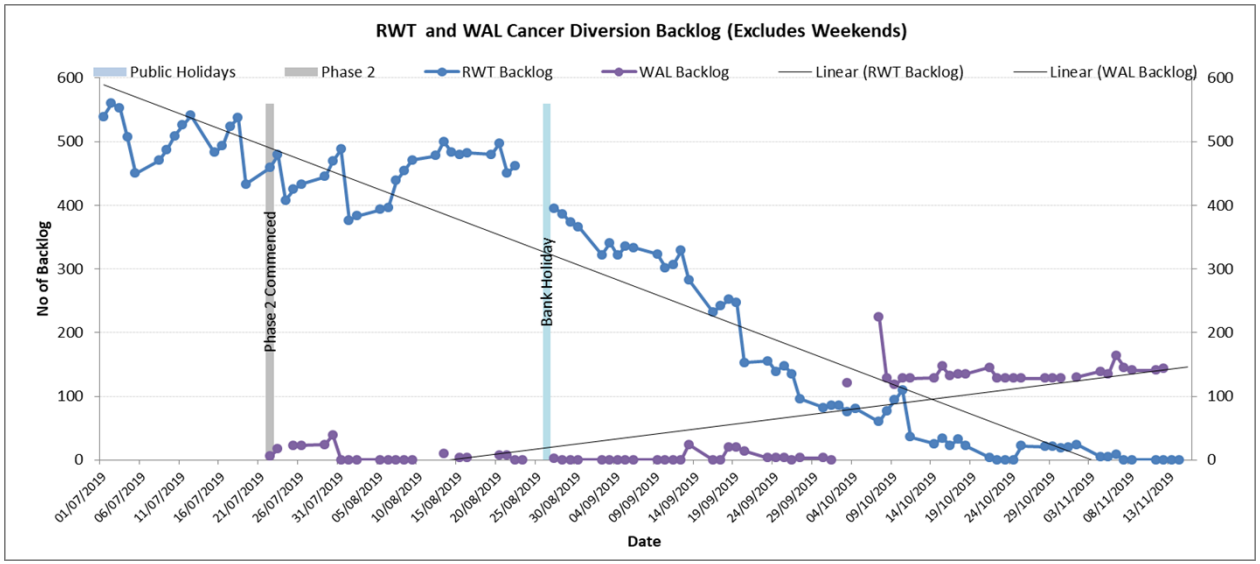
- 85.93% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in October.
- The Trust was ranked at 44th out of 121 Acute Trusts in October; 5 Trusts achieved the national standard of 95% (2 of which did not have a Type 1 A&E Department).
- Performance remains challenged across the country with England at 75.34% and the Black Country STP at 81.43%.
- Delayed Transfer of Care (DToC) rates for September have been reported at 1.84% (excluding Social Care) 3.57% (total including Social Care) which is the first month that rates have risen above the national ambition of 3.5%.
- Out of area DToC particularly to Staffordshire remains challenging, the Trust have sent an escalation letter regarding increasing DToCs.
- MADE events continue.
- 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.
- 110 ambulances breached the 30-60 minute A&E ambulance handover target during September and 7 breached the >60 minutes. *Please note that the September handover breaches were reported as 160 (30-60 min) however, have been confirmed as 60.*
- Winter Pressures reporting continues for 19/20, with the Trust submitting their first exception report (since April 2019) due to increased system pressures across the region on 12th November. Attendances on the 12th were confirmed as the 3rd highest on record for the Trust combined with high numbers of ambulance conveyances. Requests for divert support from neighbouring Providers were declined.
- There was one breach of the 12 hr standard in October and related to the availability of a Mental Health bed. This brings the total year to date to 7.

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:***
  - September nationally published (provisional) performance has improved for the CCG at 10.3%.
  - RWT performance has declined as predicted 1.44% however early indications are that the Trust's is likely to be achieving a performance in the region 75% for November.
  - STP performance is 66.8% and England is 88.0%.
  - 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.
  - From 9th September STP agreed diversion at source for RWT receiving referrals from practices in the scheme to refer directly to Walsall/Dudley.
  - Trust running "Super Clinics" through September and October.
  - Wolverhampton CCG Breast Pain pathway commenced in August.
  - As at the time of reporting (18/11/19) RWT has now ceased diverting patients and is currently booking new referrals at day 14.
  - RWT's backlog position which has reduced from 539 at 1st July to 0.
  - Recovery to standard is currently on track, as 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 backlog of patients waiting over 62 day is remaining relatively steady with the largest cohorts of patients being on the Urology and Colorectal pathways.
  - 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 have successfully recruited to the Consultant Radiologist post and are now running regular Saturday morning lists which overall will see more patients than a mega clinic (15 per session).
  - 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.
  - In the summer of 2019 Faecal Immunochemical Test (FIT) replaced guaiac Faecal Occult Blood testing (gFOBt) as the test for bowel screening in England. Initial referral numbers were low in July and August, however are now up to 130 in a month in September and October which is over the anticipated referrals from the pilot. The increase has driven the waiting time up to 6 weeks and appears to be reflected nationally. Concerns have been flagged to NHSE and The Cancer Alliance as the actual demand on resources (clinics) is much greater than the pilot estimated.

Cancer performance data for September 19

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	76.30%	74.83%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	1.44%	10.28%
EB8	31 Day (1st Treatment)	96%	87.15%	94.17%
EB9	31 Day (Surgery)	94%	86.84%	100%
EB10	31 Day (anti-cancer drug)	98%	100.0%	100%
EB11	31 Day (radiotherapy)	94%	88.37%	82.76%
EB12	62 Day (1st Treatment)	85%	53.85%	61.70%
EB13	62 Day (Screening)	90%	60.38%	57.14%
EB14	62 Day (Consultant Upgrade)	No Standard	70.93%	67.39%

3.1.4. E.A.S4 and E.A.S5 – MRSA and Clostridium Difficile (C.Diff)

- The were no MRSA cases report for the CCG during September, however the breach in June has already taken the CCG over the zero threshold for the year.
- The September C.Diff Public Health data confirms :
  - CCG = 4 cases (against threshold of 4), 25 YTD
  - RWT = 5 cases (against threshold of 3), 27 YTD
- The RWT figures are for healthcare associated cases only; with all cases (including community associated) total cases for August was 7, 42 YTD.

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

3.2.1. Mental Health

3.2.2. E.A.S.2: IAPT Recover Rate (Moving to Recovery

- The Moving to Recovery indicator has been reported as achieving the 50% target each month locally, however the National NHS Digital monthly extracts based on the Mental Health Minimum Data Set (MHMDS) show performance against a rolling 3 month calculation and has failed to meet target since May 2019.
- The MHMDS publications are subject to data lags with the latest data for August performance confirming as 48.72% in month and 46.02% for the 3 rolling months.

- The Wolverhampton performance has been flagged with the Trust at the Data Quality Improvements Process (DQIP) due to the variation in reporting.
  .

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

- The validated published figures for September 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 Wolverhampton and Sandwell CCG, all the CCGs within the Black Country STP were able to achieve standard. Performance is affected by small number variation; the total number of patients for September within the STP starting treatment within 2 weeks totalling 3 (out of 5 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 August 19 performance as 5.47% and above the Q3 target of 5.13%.
- 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.11 – CYP Eating Disorder (Routine and Urgent)

- Q2 performance achieved 93.75% against a planned trajectory of 95% for routine cases seen within 4 weeks of referral.
- Local performance is affected by small number variation; the total number of patients for September at CCG level was 15 starting treatment within 4 weeks (out of 16). The STP performance was 89.22% based on 91 (out of 102 patients).
- The performance for urgent cases within 1 week achieved 100% against 95% target at CCG level, 90.01% at the Black Country Partnership and 88.89% at STP level.

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

- Q2 performance achieved 42.07% against a planned trajectory of 50%.
- Locally refreshed information puts November performance at 43.9% against an in year trajectory for Q3 as 55%.
- 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.

4. RISK and MITIGATION

In reviewing the financial position of the CCG as at Month 7, the CCG has been able to reduce the level of risk as additional expenditure has been assigned to programme areas particularly in relation to Mental Health. This is demonstrated in the table below.

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)	440.914																		
REVENUE RESOURCE LIMIT (CUMULATIVE)	450.942																		
Acute Services	210.606	212.356	(1.750)	(0.8%)	(0.500)	-				(0.500)	0.500			-					0.500
Mental Health Services	44.353	45.241	(0.887)	(2.0%)		-				-				-					-
Community Health Services	45.624	45.303	0.320	0.7%		-				-				-					-
Continuing Care Services	16.072	16.110	(0.038)	(0.2%)		-				-				-					-
Primary Care Services	58.025	58.143	(0.118)	(0.2%)		-		(0.500)		(0.500)	0.500			-					0.500
Primary Care Co-Commissioning	38.145	38.145	-	0.0%		-				-				-					-
Other Programme Services	19.423	17.150	2.273	11.7%		-			(1.600)	(1.600)				-	1.600				1.600
Commissioning Services Total	432.248	432.448	(0.200)	(0.0%)	(0.500)	-	-	(0.500)	(1.600)	(2.600)	1.000	-	-	-	1.600	-	-	-	2.600
Running Costs	5.516	5.316	0.200	3.6%		-				-				-					-
Unidentified QIPP						-				-				-					-
TOTAL CCG NET EXPENDITURE	437.764	437.764	(0.000)	(0.0%)	(0.500)	-	-	(0.500)	(1.600)	(2.600)	1.000	-	-	-	1.600	-	-	-	2.600
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	0.000	0.0%															
CUMULATIVE UNDERSPEND / (DEFICIT)	13.178	13.178	0.000	0.0%															

- Utilisation of Contingency
-

In summary the CCG is reporting.

	£m Surplus(deficit)	
Most Likely	£13.178	No risks or mitigations, **achieves** control total
Best Case	£15.778	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	£10.578	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. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **27.11.19**

Wolverhampton CCG Performance against the NHS Constitution Standards

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

Current Month: Sep-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	Sep	92.0%	84.65%	↓	↓	86.99%													
		CCG Validated		**Sep**	**92.0%**	**84.65%**	↓	↓	**86.99%**	R	R	R	R	R	R							R
		RWT		Sep	92.0%	83.01%	↓	↓	85.56%													
		Black Country STP		Sep	92.0%	89.02%	↓	↓	91.16%													
		National		Sep	92.0%	84.76%	↓	↓	85.85%													
EB4	Diagnostic Waits (6wks)	CCG Provisional	Mth	Sep	1.0%	2.56%	↑	↓	1.37%													
		CCG Validated		**Sep**	**1.0%**	**2.56%**	↑	↓	**1.37%**	G	G	G	G	R	R							R
		RWT		Sep	1.0%	3.03%	↑	↓	1.49%													
		Black Country STP		Sep	1.0%	1.48%	↑	↓	1.51%													
		National		Sep	1.0%	3.80%	↑	↓	3.84%													
EB5	A&E (Waits Within 4hrs)	CCG Provisional	Mth	No Data	95.0%	-			-													-
		CCG Validated		**No Data**	**95.0%**	-			-													-
		RWT		Oct	95.0%	85.93%	↓	↓	87.94%													
		Black Country STP		Oct	95.0%	81.43%	↓	↓	83.98%													
		National		Oct	95.0%	75.34%	↓	↓	83.14%													
EB6	Two Week Waits (2WW)	CCG Provisional	Mth	No Data	93.0%	66.85%			66.85%													
		CCG Validated		**Sep**	**93.0%**	**74.83%**	↓	↑	**72.98%**	R	R	R	R	R	R							R
		RWT		Sep	93.0%	76.30%	↓	↑	74.83%													
		Black Country STP		Sep	93.0%	88.30%	↑	↓	89.19%													
		National		Sep	93.0%	90.10%	↑	↑	90.20%													
EB7	Two Week Waits (2WW) Breast Symptoms	CCG Provisional	Mth	No Data	93.0%	-			-													-
		CCG Validated		**Sep**	**93.0%**	**10.28%**	↑	↑	**6.83%**	R	R	R	R	R	R							R
		RWT		Sep	93.0%	1.44%	↓	↓	2.56%													
		Black Country STP		Sep	93.0%	66.76%	↑	↓	69.94%													
		National		Sep	93.0%	88.02%	↑	↑	81.15%													
EB8	31 Day Cancer Treatment	CCG Provisional	Mth	No Data	96.0%	-			-													
		CCG Validated		**Sep**	**96.0%**	**94.17%**	↑	↑	**92.18%**	R	R	R	G	R	R							R
		RWT		Sep	96.0%	87.15%	↓	↑	87.33%													
		Black Country STP		Sep	96.0%	95.36%	↑	↑	94.43%													
		National		Sep	96.0%	95.50%	↓	↓	96.07%													
EB9	31 Day Cancer Treatment (Surgery)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		**Sep**	**94.0%**	**100.00%**	↑	↑	**88.07%**	R	G	R	R	R	G							R
		RWT		Sep	94.0%	86.84%	↑	↑	77.06%													
		Black Country STP		Sep	94.0%	95.92%	↑	↑	91.53%													
		National		Sep	94.0%	90.18%	↓	↓	91.43%													
EB10	31 Day Cancer Treatment (anti cancer drug)	CCG Provisional	Mth	No Data	98.0%	-			-													
		CCG Validated		**Sep**	**98.0%**	**100.00%**	→	↑	**99.38%**	G	G	G	R	G	G							G
		RWT		Sep	98.0%	100.00%	→	↑	99.66%													
		Black Country STP		Sep	98.0%	100.00%	→	↑	98.97%													
		National		Sep	98.0%	99.08%	↓	↓	99.19%													
EB11	31 Day Cancer Treatment (Radiotherapy)	CCG Provisional	Mth	No Data	94.0%	-			-													
		CCG Validated		**Sep**	**94.0%**	**82.76%**	↓	↓	**89.55%**	R	R	G	G	R	R							R
		RWT		Sep	94.0%	88.37%	↑	↓	89.11%													
		Black Country STP		Sep	94.0%	93.85%	↑	↓	86.20%													
		National		Sep	94.0%	95.06%	↓	↓	96.37%													
EB12	62 Day Cancer Treatment 1st Definitive Treatment	CCG Provisional	Mth	No Data	85.2%	-			-													
		CCG Validated		**Sep**	**85.2%**	**61.70%**	↑	↑	**64.00%**	R	R	R	R	R	R							R
		RWT		Sep	85.2%	53.85%	↓	↓	59.90%													
		Black Country STP		Sep	85.2%	72.62%	↑	↓	75.08%													
		National		Sep	85.2%	76.89%	↓	↑	77.76%													

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		No Data	90.0%	-			-													
		CCG Validated		**Sep**	**90.0%**	**57.14%**	↑	↓	**67.21%**	R	R	R	R	R	R							R
		RWT	Mth	Sep	90.0%	60.38%	↑	↓	70.43%													
		Black Country STP		Sep	90.0%	82.50%	↓	↓	88.26%													
		National		Sep	90.0%	86.95%	↓	↑	87.07%													
EB14	62 Day Cancer Treatment (Consultant Upgrade)	CCG Provisional		No Data	0.0%	-			-													
		CCG Validated		**Sep**	**0.0%**	67.39%	↓	↓	75.37%	G	G	G	G	G	G							G
		RWT	Mth	Sep	0.0%	70.93%	↓	↑	73.64%													
		Black Country STP		Sep	0.0%	78.10%	↓	↓	80.69%													
		National		Sep	0.0%	81.01%	↓	↓	82.72%													
EB18	52 Week Waiters (RTT)	CCG Provisional		Sep	0.0%	0	→	→	0													
		CCG Validated		**Sep**	**0.0%**	0	→	→	0	G	G	G	G	G	G							G
		RWT	Mth	Sep	0.0%	0	→		0													
		Black Country STP		Sep	0.0%	0	↑	↑	11													
		National		Sep	0.0%	1474	↓	↓	7176													
EH1	IAPT Programme: Treated within 6 wks	CCG Provisional		No Data	75.0%	-																
		CCG Validated		**Aug**	**75.0%**	90.00%	↑	↑	84.78%	G	G	G	G	G								G
		BCPFT	Mth	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		No Data	95.0%	-																
		CCG Validated		**Aug**	**95.0%**	100.00%	↑	↑	98.37%	G	G	G	G	G								G
		BCPFT	Mth	Jul	95.0%	98.88%	↑	↑	98.60%													
		Black Country STP		Jul	95.0%	97.84%	↓	↑	97.78%													
		National		No Data	95.0%	-																
EH4	EIP 1st Episode (within 2 wks)	CCG Provisional		Sep	56.0%	0.00%	↓	↓	66.67%													
		CCG Validated		**Sep**	**56.0%**	0.00%	↓	↓	66.67%	G	G	G	G	R	R							G
		BCPFT	Mth	Sep	56.0%	0.00%	→	↓	42.86%													
		Black Country STP		Aug	56.0%	60.00%	↑	↑	56.00%													
		National		Jul	56.0%	77.42%	↑	↑	76.06%													
EH9	CYP Access Rates	CCG Provisional		Aug	34% Full Yr	1.94%	↓		22.81%													
		CCG Validated		**Aug**	**34% Full Yr**	4.21%	↑		22.89%	G	G	G	G									G
		BCPFT	Mth	Aug	34% Full Yr	-			-													
		Black Country STP		Aug	34% Full Yr	3.29%	↑		16.16%													
		National		No Data	34% Full Yr	-																
EAS1	Dementia Diagnosis (65+)	CCG Provisional		No Data	71.4%	-			-													
		CCG Validated		**Sep**	**71.4%**	73.10%	↓	↑	72.96%	G	G	G	G	G	G							G
		Primary Care	Mth	No Data	71.4%	-			-													
		Black Country STP		Sep	71.4%	66.59%	↓	↑	66.50%													
		National		No Data	71.4%	-			-													
EAS2	IAPT Recovery Rate (Moving to Recovery)	CCG Provisional		No Data	50.0%	-			-													
		CCG Validated		**Aug**	**50.0%**	48.72%	↑	↓	48.31%	G	G	R	R	R								R
		BCPFT	Mth	Aug	50.0%	52.63%	↓	↓	54.52%													
		Black Country STP		Aug	50.0%	48.26%	↓	↓	52.06%													
		National		No Data	50.0%	-			-													
EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	CCG Provisional		No Data	0.0%	-			-													
		CCG Validated		**Aug**	**0.0%**	0	→	↑	1	G	G	R	G	G	G							R
		RWT	Mth	Sep	0.0%	0	→	→	0													
		Black Country STP		Sep	0.0%	2	↓	→	6													
		National		No Data	0.0%	-			-													
EAS5	Minimise rates of Clostridium Difficile	CCG Provisional		No Data	CCG: 48 Full Yr	-																
		CCG Validated		**Sep**	**CCG: 48 Full Yr**	4	↑	↑	25	R	R	G	G	G	R							G
		RWT	Mth	Sep	RWT: 40 Full Yr	5	↑	↓	27													
		Black Country STP		Sep	STP: 288 Full Year	22	↓	↓	137													
		National		No Data	TBC	-			-													

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
EBS1	MSA Breaches	CCG Provisional	Mth	Aug	0.0%	0			1													
		CCG Validated		**Sep**	**0.0%**	**0**			**1**	G	G	R	G	G	G							R
		RWT		Sep	0.0%	0			0													
		BCPFT		Sep	0.0%	0			0													
		Black Country STP		Sep	0.0%	24			132													
		National		Sep	0.0%	1595			8232													
EBS5	12 hr Trolley Waits	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		**No Data**	**0.0%**	**-**			**-**													
		RWT		Oct	0.0%	1	⇨	⇩	7													
		Black Country STP		No Data	0.0%	-			-													
		National		No Data	0.0%	-			-													
EBS6	No urgent operation should be cancelled for a second time	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		**No Data**	**0.0%**	**-**			**-**													
		RWT		Sep	0.0%	0	⇨	⇨	0													
		Black Country STP		No Data	0.0%	-			-													
		National		No Data	0.0%	-			-													
EBS3	CPA Follow Up within 7 days from Discharge	CCG Provisional	Mth	No Data	95.0%	-			-													
		CCG Validated		**Sep**	**95.0%**	**96.91%**			**97.93%**			G			G							G
		BCPFT		Jun	95.0%	98.21%			98.21%													
		Black Country STP		Sep	95.0%	96.11%			96.70%													
		National		Sep	95.0%	94.54%			94.79%													
EH10	CYP Eating Disorder (Urgent within 1 wk) - 12 Rolling Mths	CCG Provisional	Mth	Sep	95.0%	100.00%			100.00%													
		CCG Validated		**Sep**	**95.0%**	**100.00%**			**100.00%**			G			G							G
		BCPFT		Sep	95.0%	90.91%			96.00%													
		Black Country STP		Sep	95.0%	88.89%			90.24%													
		National		Sep	95.0%	75.08%			76.36%													
EH11	CYP Eating Disorder (Routine within 4 wks) - 12 Rolling Mths	CCG Provisional	Mth	Sep	95.0%	93.75%			91.67%													
		CCG Validated		**Sep**	**95.0%**	**93.75%**			**91.67%**			R			R							R
		BCPFT		Sep	95.0%	93.02%			92.13%													
		Black Country STP		Sep	95.0%	89.22%			89.86%													
		National		Sep	95.0%	85.98%			84.66%													
EH13	Physical Health Checks for People with a Severe Mental Illness	CCG Provisional	Mth	No Data	60% by Yr End	-																
		CCG Validated		**Sep**	**60% by Yr End**	**42.07%**			**40.68%**			R			R							R
		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	**CCG : Q1 = 4.94%, Q2 = 5.13%, Q3 = 5.31%, Q4 = 5.50%**	-																
		CCG Validated		**Aug**		**5.47%**	⇩	⇩	**28.33%**	G	G	G	G	G								G
		BCPFT		Aug		-																
		Black Country STP		Aug		5.93%	⇩	⇩	35.73%													
		National		No Data		-																
EH12	OoAPs - Out of Area Placements (STP target)	CCG Provisional	Mth	Sep		265	⇩		1345													
		CCG Validated		Aug		265	⇧	⇧	1665	R	R	G	R	G								R
		Black Country STP		Aug	STP Wide Traj 978 by Yr End	888	⇧		4017													
		National		No Data		-																
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	-																

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
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	92.5%	-			-													
		CCG Validated		**Sep**	**92.5%**	**97.87%**			**98.86%**			G			G							G
		Black Country STP		Jun	92.5%	95.79%			95.79%													
		National		No Data	92.5%	-																
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%**			**46.51%**						G							G
		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**			**262**			G			G							G
		Black Country STP		Sep	STP tbc	1143			1143													
		National		Sep	TBC	70990			70990													

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

Current Month: Sep-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	Sep	Seasonal Variation	7508	⇧	⇧	44873													
		CCG Validated		Sep	Seasonal Variation	7508	⇧	⇧	45483													
EM8	Consultant Led First Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Sep	Seasonal Variation	8474	⇧	⇧	49109													
		CCG Validated		Sep	Seasonal Variation	8474	⇧	⇧	49145													
EM9	Consultant Led Follow-Up Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Sep	Seasonal Variation	14877	⇧	⇧	87587													
		CCG Validated		Sep	Seasonal Variation	14877	⇧	⇧	87743													
EM10	Total Elective Spells (Specific Acute)	CCG Provisional	Mth	Sep	Seasonal Variation	2674	⇧	⇧	16472													
		CCG Validated		Sep	Seasonal Variation	2674	⇧	⇧	16473													
EM11	Total Non-Elective Spells (Specific Acute)	CCG Provisional	Mth	Sep	Seasonal Variation	2407	⇧	⇩	14462													
		CCG Validated		Sep	Seasonal Variation	2407	⇧	⇩	14459													
EM12	Total A&E Attendances (Excl. Planned Follow Up Attendances) *Awaiting confirmation of Vocare submissions	CCG Provisional	Mth	Sep	Seasonal Variation	15052	⇧	⇧	67727													
		CCG Validated		Sep	Seasonal Variation	15052	⇧	⇧	92582													
EM12a	Type 1 A&E Attendances (Excluding Planned Follow Up Attendances)	CCG Provisional	Mth	Sep	Seasonal Variation	8178	⇧	⇧	48832													
		CCG Validated		Sep	Seasonal Variation	8178	⇧	⇧	48862													
EM18	Number of completed admitted RTT pathways	CCG Provisional	Mth	Sep	Seasonal Variation	1128	⇧	⇧	6629													
		CCG Validated		Sep	Seasonal Variation	1128	⇧	⇧	6629													
EM19	Number of completed non-admitted RTT pathways	CCG Provisional	Mth	Sep	Seasonal Variation	5114	⇧	⇩	31414													
		CCG Validated		Sep	Seasonal Variation	5114	⇧	⇩	31414													
EM20	Number of new RTT pathways (clock starts)	CCG Provisional	Mth	Sep	Seasonal Variation	8226	⇧	⇧	49836													
		CCG Validated		Sep	Seasonal Variation	8226	⇧	⇧	49835													
EM21	Consultant Led Outpatient Attendances with Procedures (Specific Acute)	CCG Provisional	Mth	Sep	Seasonal Variation	1949	⇧	⇧	12422													
		CCG Validated		Sep	Seasonal Variation	1949	⇩	⇩	12434													
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

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 28th January 2020**
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	£453.191m	£4340.013m	(£13.178m)	G
Revenue Administration Resource not exceeded	£5.516m	£5.194m	(£0.322m)	G

Non Statuory Duties	**YTD Target**	**YTD Actual**	**Variance o(u)**	**RAG**
Maximum closing cash balance	£521k	£231k	(£290k)	G
Maximum closing cash balance %	1.25%	0.55%	(0.70%)	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 *	£324,438k	£326,754k	£2,317k	G
Reserves *	£2,076k	£0k	(£2,076k)	G
Running Cost *	£4,137k	£3,896k	(£241k)	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 an 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 M09							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	211,032	158,274	159,324	1,050	0.7%	212,348	1,317	0.6%		8	1,308
Mental Health Services	45,312	33,984	34,388	403	1.2%	45,917	604	1.3%		136	468
Community Services	45,624	34,218	33,868	(349)	(1.0%)	45,197	(427)	(0.9%)		150	(576)
Continuing Care	16,072	12,054	12,174	120	1.0%	16,362	290	1.8%		21	269
Primary Care Services	57,786	43,339	43,147	(192)	(0.4%)	57,618	(168)	(0.3%)		(267)	98
Delegated Primary Care	37,573	28,180	28,609	429	1.5%	37,573	0	0.0%		0	0
Other Programme	18,330	14,389	15,245	856	5.9%	19,232	902	4.9%		(49)	950
Total Programme	**431,729**	**324,438**	**326,754**	**2,317**	**0.7%**	**434,247**	**2,518**	**0.6%**		**0**	**2,518**
Running Costs	5,516	4,137	3,896	(241)	(5.8%)	5,194	(322)	(5.8%)		0	(322)
Reserves	2,768	2,076	0	(2,076)	(100.0%)	572	(2,196)	(79.3%)		0	(2,196)
Total Mandate	**440,013**	**330,650**	**330,650**	**(0)**	(0.0%)	**440,013**	**(0)**	**(0.0%)**		**0**	**(0)**
Target Surplus	13,178	9,883	0	(9,883)	(100.0%)	0	(13,178)	(100.0%)		0	(13,178)
Total	**453,191**	**340,534**	**330,650**	**(9,883)**	(2.9%)	**440,013**	**(13,178)**	(2.9%)		**0**	**(13,178)**

The Acute over performance relates in the main to RWT. Having received Month 8 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.

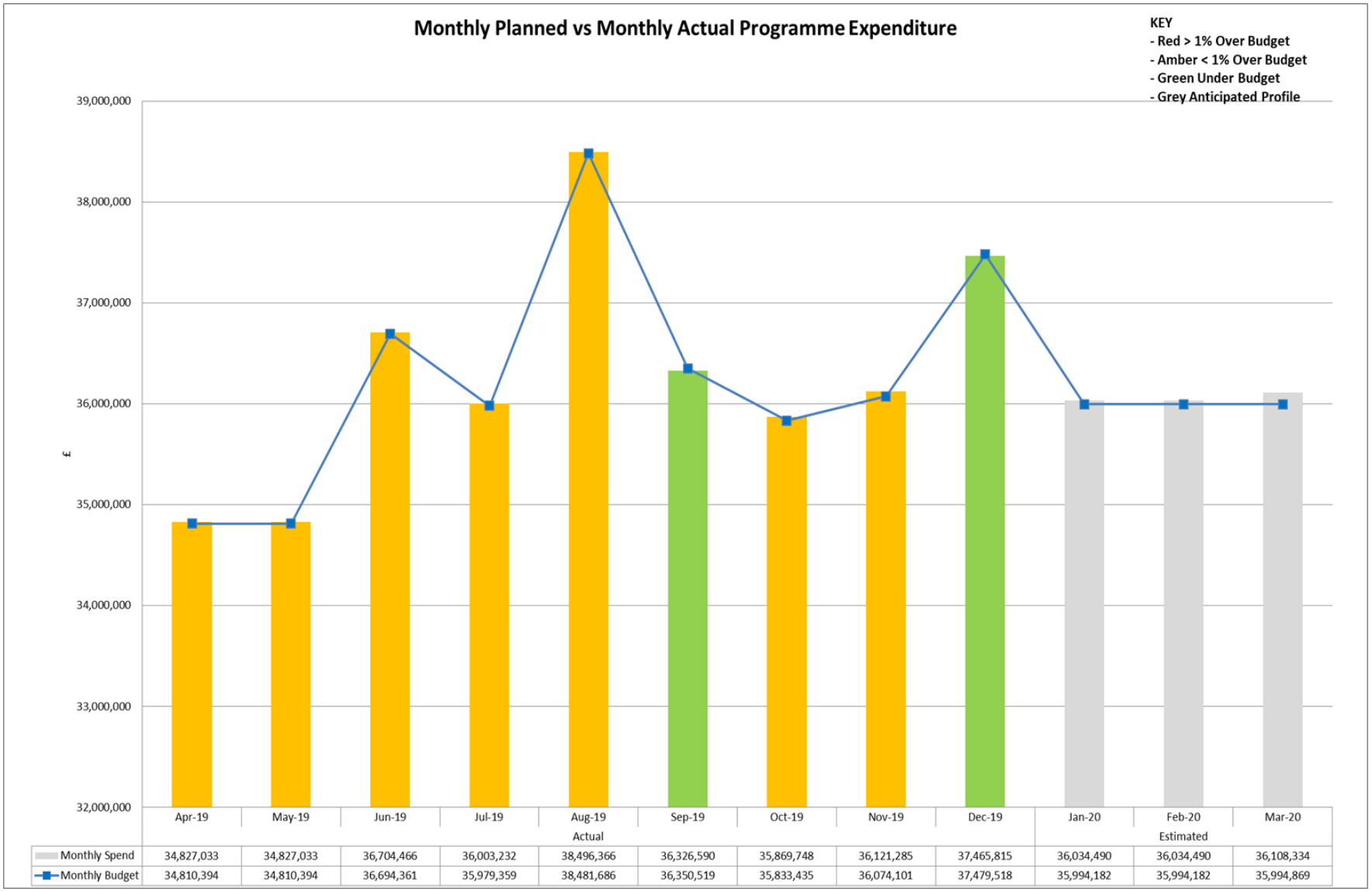
The level of over-performance faced by the CCG is potentially recurrent in nature and is mitigated through the utilisation of non-recurrent flexibilities. This could present a recurrent challenge for 20-21 of approximately £2-£2.5m which will need to addressed in the financial plan

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 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 M9 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)	443.163				(16.771)						426.392
Acute Services	211.032	212.348	(1.317)	(0.6%)	(3.081)	1.110		(2.455)			207.923
Mental Health Services	45.312	45.917	(0.604)	(1.3%)	(4.863)	-		0.010			41.064
Community Health Services	45.624	45.197	0.427	0.9%	(0.162)	-		0.796			45.831
Continuing Care Services	16.072	16.362	(0.290)	(1.8%)	(0.191)	-		0.212			16.384
Primary Care Services	57.786	57.618	0.168	0.3%	(3.766)	0.500		0.479			54.831
Primary Care Co-Commissioning	38.145	38.145	-	0.0%	-	-	(0.191)	(5.811)			32.143
Other Programme Services	20.526	19.232	1.294	6.3%	(4.663)	1.540	(2.132)	5.255			19.232
Commissioning Services Total	434.497	434.819	(0.322)	(0.1%)	(16.726)	3.150	(2.323)	(1.513)	-	-	417.407
Running Costs	5.516	5.194	0.322	5.8%	(0.055)	-					5.139
TOTAL CCG NET EXPENDITURE	440.013	440.013	(0.000)	(0.0%)	(16.781)	3.150	(2.323)	(1.513)	-	-	422.546
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	0.000	0.0%					**Underlying Underspend / (Deficit)**		3.846
									% RRL		0.9 %



- The graph details the monthly and cumulative budgeted and actual expenditure in 2019/20.


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 Actual
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20 Estimated
Mar-20
Monthly Spend 176 710 450 435 445 443 442 322 473
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 M9 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 9:

	YTD budget £'000	YTD spend £'000	YTD Variance £'000 o/(u)	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
General Practice GMS	16,832	16,832	0	22,521	22,521	0		0	0
General Practice PMS	1,089	1,089	(0)	1,452	1,452	0		0	0
Other List Based Services APMS incl	2,058	2,058	(0)	2,814	2,814	0		0	0
Premises	1,804	1,804	0	2,393	2,393	0		0	0
Premises Other	43	43	0	83	83	0		0	0
Enhanced services Delegated	1,439	1,439	0	1,896	1,896	0		0	0
QOF	2,754	2,754	0	3,672	3,672	0		0	0
Other GP Services	2,160	2,589	429	2,743	2,743	0		0	0
Delegated Contingency reserve	143	0	(143)	191	191	0		0	0
Delegated Primary Care 1% reserve	286	0	(286)	381	381	0		0	0
Total	**28,609**	**28,609**	**0**	**38,145**	**38,145**	**0**		**0**	**0**

2019/20 forecast figures have been updated on quarter 3 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 .

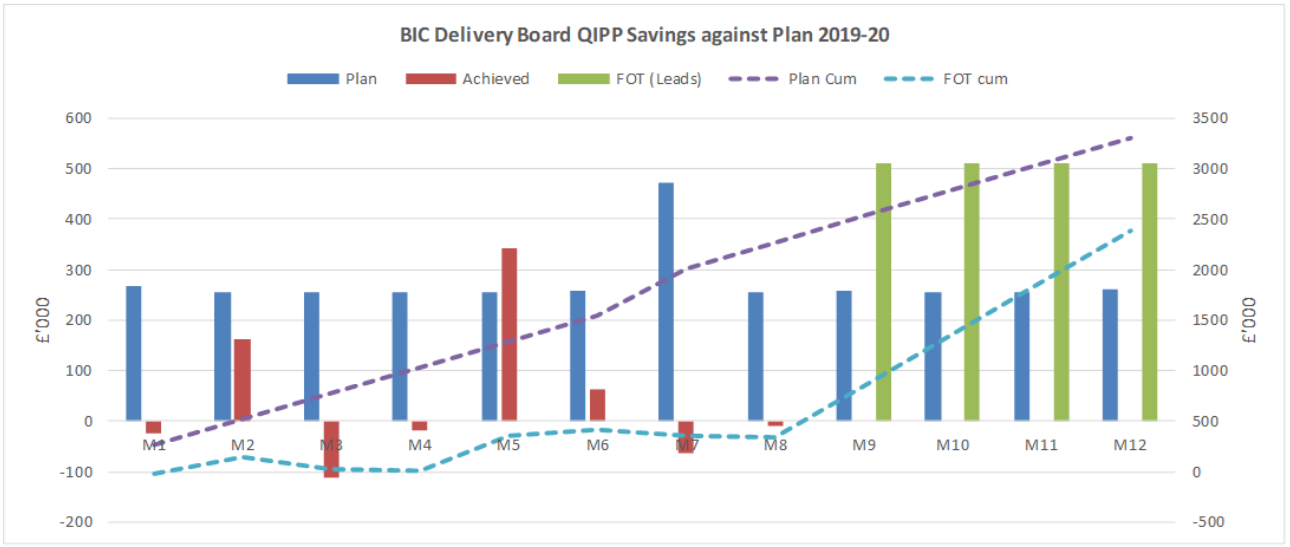
The CCG continues to identify flexibilities within the Delegated budget and a paper will be taken to the Primary Care Commissioning Committee detailing flexibilities and agreed plans for expenditure to ensure the best possible use of resources.

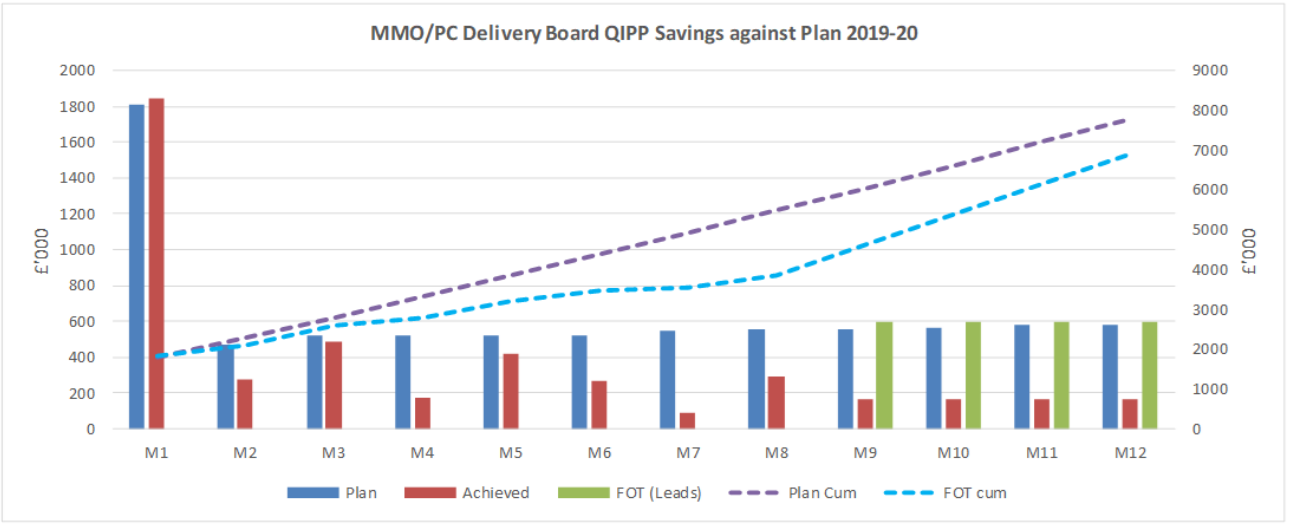
2. QIPP

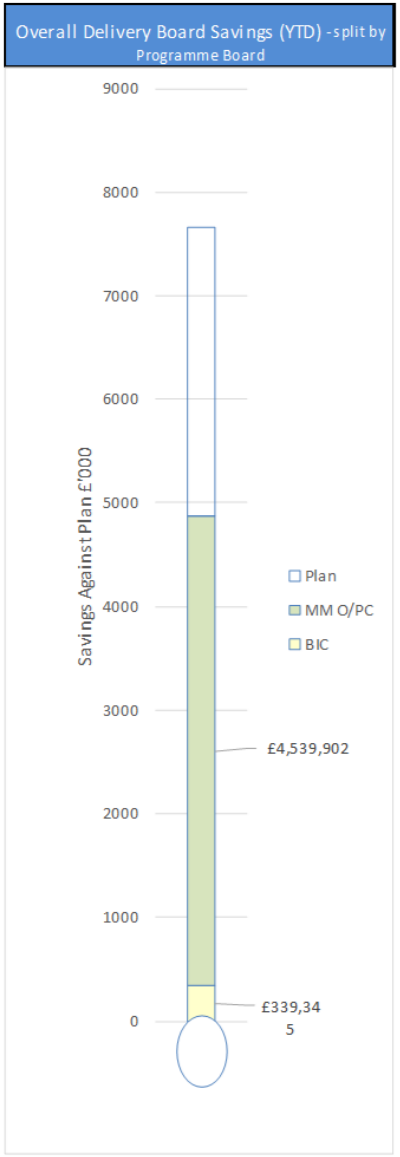
- The submitted financial plan, prior to the request to increase the control total,required a QIPP of £13.536m or 3.5% of allocation.
- The revised financial plan reflecting the increase in the control total requires a QIPP of £16.686m,(4.1%) the additional QIPP being identified at a high level as follows :

    - 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 supported by the planned use of reserves and the CCG continues to meet its financial metrics.
- There is no real movement in QIPP for both BIC and MMO.


BIC Delivery Board QIPP Savings against Plan 2019-20
Plan
Achieved
FOT (Leads)
Plan Cum
FOT cum
£'000
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12


MMO/PC Delivery Board QIPP Savings against Plan 2019-20
£'000
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12
Plan
Achieved
FOT (Leads)
Plan Cum
FOT cum


Overall Delivery Board Savings (YTD) - split by Programme Board
Savings Against Plan £'000
Plan
MM O/PC
BIC
£4,539,902
£339,345

3. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st December 2020 is shown below:

	31 December '19 £'000	30 November '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	1,868	2,095	-228
Cash and Cash Equivalents	231	53	178
	2,098	2,148	
Total Assets	**2,098**	**2,148**	
Current Liabilities			
Trade and Other Payables	-38,704	-46,447	7,743
	-38,704	-46,447	
Total Assets less Current Liabilities	**-36,606**	**-44,299**	
TOTAL ASSETS EMPLOYED	**-36,606**	**-44,299**	
Financed by:			
TAXPAYERS EQUITY			
General Fund	36,606	44,299	-7,694
TOTAL	**36,606**	**44,299**	

Key points to note from the SoFP are:

- The cash target for month 9 has been achieved.
- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days.

- **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 (November 19):

- WCCG 84.9%, England 84.4%, STP 88.3%
- 92% WCCG patients started treatment within 22.4 weeks of referral at any provider in England against the standard of 18 weeks (England was also down from 25.8 to 23.9).
- A Recovery Action Plan (RAP) was agreed with the Trust, in October, to support recovery of Trust performance which will in turn improve the performance of the CCG.
- The RAP is being monitored and managed via the monthly Contract Review Meeting.
- The Trust performance indicates a sustained performance for the third consecutive month however has not achieved the recovery trajectory of 88.5% for November.
- The Trust RTT waiting list has also been sustained in November, down from the peak of 42,229 in August to 41,668 in November. Unvalidated performance indicates a further reduction in December to 40,510 making progress towards the ambition to not exceed the levels of the waiting list as at March 2019 (37,598).
- As the waiting list is decreased it is the expectation that this will enable the Trust to see more patients within standard, however will take some time to impact on the monthly performance figures.

- Dermatology – Staffordshire patients have now been transferred to new provider, transition arrangements have been agreed with Wolverhampton CCG and new referrals turned off.
- There were no WCCG patients waiting over 52 weeks to start treatment during November.
- Diagnostic performance for November remains above the ≤1% threshold (WCCG = 2.1%, RWT 2.8%).
- Performance has been impacted by high levels of referrals into the Endoscopy Department (with increased demand of Fast Track patients taking precedence over routine tests) and capacity constraints in neurophysiology.
- Additional sessions continue to be undertaken in endoscopy at the weekends throughout December 2019 and January 2020 to improve performance as quickly as possible however capacity has been limited due unavailability of Endoscopy Consultants due to sickness during this period.
- The Trust has contracted with a 3rd party supplier to provide additional capacity for Neurophysiology however capacity has been limited in December.
- The Trust is now forecasting a delay in recovery to March 2020.

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.

- 82.8% of A&E attendances were admitted, transferred or discharged within 4 hours from arrival in December.
- The Trust was ranked at 36th out of 121 Acute Trusts in November; once again only 3 Trusts achieved the national standard of 95% (only 1 of which has Type 1 A&E activity).
- Performance was extremely challenged across the country in December with England at 79.8% and the Black Country STP at 79.5%.
- DToC rates for November have been reported at 1.16% (excluding Social Care) 3.00% (total including Social Care).
- Out of area DToC particularly for Staffordshire remains challenging, with just over 40% of RWT delays, this has been escalated by both the Trust and the CCG.
- 241 ambulances breached the 30-60 minute ambulance handover target during December 2019 compared with 42 for the same period last year. 45 ambulances breached the >60 minutes handover target during the month compared with 1 for the same period last year.
- The longest waiting ambulance during the month was recorded at 4 hours and 11 minutes; this was on 30th of the month when there were 169 ambulance conveyances and a total of 477 attendances on the day. The average daily number over the rest of the month was 154 ambulances and 387 attendances.

There was one breach of the 12 hr standard in December which was due to bed capacity on the 30/31st December (see previous comments re high levels of activity over these days). This brings the total year to date to 9.

3.1.3. Cancer – All Standards

- ***2WW Breast Symptomatic specific issues and actions:***
  - November nationally published (provisional) performance has improved for the CCG from 31.3% to 68.9% and RWT from 18.4% to 76.9%.
  - STP performance has declined from 63.6% to 53.9% and England has also dropped from 89.9% to 87.5%.
  - RWT's backlog position has reduced from 539 at 1st July to 0 in October and has been sustained in to November.
  - Wolverhampton CCG Breast Pain pathway commenced in August.
  - RWT ceased diversion of patients to Walsall and Dudley at the end of November as was achieving the 14 booking day. However, as the Walsall waiting times have deteriorated, RWT is working with the Trust to flex capacity as required to equalise waiting times across the patch. At time of reporting (23/01/19), new referrals are being booked at day 14.
  - Trust unvalidated performance is expected to be in the region of 80% for December and is not currently expected to achieve the national standard whilst the flexing of activity with Walsall continues, however this does ensure parity of service and better overall outcomes for patients.

- ***All Cancer standards – issues and actions:***
  - Remedial action plan is in place and reviewed monthly with revised improvement trajectories agreed.
  - The main backlog of patients waiting over 62 days remains in Urology awaiting Robotic Surgery.
  - Performance against the 62 Day standard has improved 59.6% for the CCG and 57% for RWT, however will not achieve the national standard of 85% before year end.
  - 62 Day performance now included in the RAP by pathway.
  - The Trust has appointed a new Cancer lead who is concentrating on tumour site including those who require Faster Diagnosis Standard (28FDS).
  - The Trust has successfully recruited to the Consultant Radiologist post and is now running regular Saturday morning lists which overall will see more patients than a mega clinic (15 per session).
  - The Intensive Support Team (IST) continues to support the Trust and is scheduled to return to review previously identified actions (and progress against the 18/19 plan) in January 2020.

- The Trust continues to achieve standard for the 3 sub specialities.
- The Trust has also now achieved the national standard for 2WW in November and is forecasting to continue to do so apart from an expected drop in performance in January due to capacity over December.

Cancer performance data for November 2019

Ref	Indicator	Standard	RWT	WCCG
EB6	2 Week Wait (2WW)	93%	93.05%	87.76%
EB7	2 Week Wait (2WW) Breast Symptoms)	93%	76.92%	68.91%
EB8	31 Day (1st Treatment)	96%	88.57%	91.18%
EB9	31 Day (Surgery)	94%	95.12%	92.31%
EB10	31 Day (anti-cancer drug)	98%	100.0%	100%
EB11	31 Day (radiotherapy)	94%	94.40%	89.19%
EB12	62 Day (1st Treatment)	85%	57.00%	59.62%
EB13	62 Day (Screening)	90%	44.23%	33.33%
EB14	62 Day (Consultant Upgrade)	No Standard	75.43%	78.38%

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

- One additional MRSA case was reported for the CCG during November, bringing the total to 2 cases. The CCG has already breached the zero thresholds for the year. Local data has confirmed the breach was not at either main provider (RWT/BCPFT); further information is awaited regarding the breach.
- The number of C.Diff cases has seen a decrease and is within threshold for the CCG, RWT and STP for November 2019.
- October C.Diff Public Health data confirms :
  - CCG = 1 case (against threshold of 4), 30 YTD
  - STP = 8 cases (against threshold of 25),166 YTD
  - RWT = 1 case (against threshold of 3), 31 YTD
- RWT figures are for healthcare associated cases only; total cases (including community associated) for November was 2, 55 YTD.

3.2. Mental Health (BCPFT) and Primary Care

3.2.1. IAPT Recovery Rate (Moving to Recovery) E.A.S.2

- Previously the CCG's performance had improved for September to achieve the 50% standard however October performance has dipped to 39.5% giving a rolling 3 month performance of 46.2%. This will also impact on the Q3 performance.
- The validated performance using the National NHS Digital monthly extracts based on the Mental Health Minimum Data Set (MHMDS) is showing variation between local and national data. The difference is marginal however has a significant impact on performance against the national standard. The difference has been flagged via the DQIP and is currently being investigated by the Trust.
- IAPT Access Rates and Waiting Times (6 and 18wk) standards are all being achieved by the CCG.

3.2.2. Psychosis treated with a NICE approved care package within two weeks of referral (E.H.4)

- NHS E&I have confirmed that the EIP data will no longer be available from the SEFT collation system from the September data collection. As the EIP data is a mandatory element of the Mental Health Minimum Data Set (MHMDS), this will be used to measure performance of the referral to treatment element of the EIP standard going forward, however publication of the MHMDS extracts will now be subject to a month data lag. Therefore, the October data is currently unavailable.
- Local data from the Black Country Partnership Foundation Trust confirms that performance has consistently met the target with the exception of August 2019.

3.2.3. Out of Area Placements STP Target (E.H.12)

- STP wide Out of Area Placements (OAPs) Reduction Plan has been submitted and the STP is working with Providers on implementation. The plan's focus is upon improved patient flow, improving access to crisis resolution home treatment and enhancing the community mental health offer to prevent / reduce relapse whilst exploring options to improve step up / step down provision across the STP.
- Commissioners are to adopt a single contract for commissioning of inpatient beds across the Black Country in 202/21, with the number of beds being sized to demand.
- Development of Single 24/7 Bed Management function across the Black Country. Enhancing BCPFT Bed Management team to include embedding of Discharge Co-ordinator Roles within the Bed Management Team.
- Effective 24/7 community based Crisis Response and crisis alternatives (Crisis Café) is expected to improve referral to assessment times, reduce inpatient admissions and provide more effective pathways between services.

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

- The SMI Health Check indicator relates to 6 individual tests which patients with a Severe Mental Illness need to receive. All 6 tests are required within a 12 month rolling period in order to achieve the performance standard.
- The Q3 CCG performance is currently reporting at 47.2% against the Q3 trajectory of 50%.
- A review of the information flow (between Black Country Partnership and GP Practices) has taken place as health checks provided by the Mental Health Trust may not have been transferred back to patients' records in a consistent and coded manner. Although the patient's computer record is updated in Primary Care, health check data has to be coded to be included as part of the CCG's overall performance.
- Primary Care facilitators (in cooperation with Contracting teams and Primary Care Commissioning) are investigating a submission template for the Mental Health Trust which will enable GP Practices to receive and upload data to systems and enable inclusion and therefore improvement in performance.
- Proactive practice identification of patients who are missing 1 or 2 checks which will also have a direct effect on CCG performance.

3.2.5. % of Population that the UCC (NHS111) can directly book (E.D.18)

- Performance for the CCG is currently zero (against a 100% target).
- The CCG have practice test sites ready to roll out, however are unable to action due to NHS111 software issues that prevent the system to differentiate between branch surgeries under the same practice code.

3.2.6. Dementia Diagnosis Rate - 65+ (E.A.S.1)

- As at November CCG performance is 70.95% against a national standard 66.7%; however the CCG was required to set a target of 71.4% in 2019/20 due to previously achieving the national standard in 2018/19.Reminders for training and dementia friendly sessions have been sent via the GP Practice Communications.
- Dementia has been included at the Team W (CCG GP Learning Event) agenda for March.

Development of a STP wide specification for memory assessment services which will form part of commissioning intentions in September and align with the Dementia Strategy implementation of each CCG.

4. RISK and MITIGATION

In reviewing the financial position of the CCG as at Month 9, the CCG has adjusted the risk profile as well as reducing the level of risk not reflected in the reported position.

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)	443.163																		
REVENUE RESOURCE LIMIT (CUMULATIVE)	453.191																		
Acute Services	211.032	212.348	(1.317)	(0.6%)	(0.800)	-				(0.800)	0.800			-					0.800
Mental Health Services	45.312	45.917	(0.604)	(1.3%)		-				-				-					-
Community Health Services	45.624	45.197	0.427	0.9%		-				-				-					-
Continuing Care Services	16.072	16.362	(0.290)	(1.8%)		-				-				-					-
Primary Care Services	57.786	57.618	0.168	0.3%		-		(0.200)		(0.200)	0.200			-					0.200
Primary Care Co-Commissioning	38.145	38.145	-	0.0%		-				-				-					-
Other Programme Services	20.526	19.232	1.294	6.3%		-				-				-					-
Commissioning Services Total	434.497	434.819	(0.322)	(0.1%)	(0.800)	-	-	(0.200)	-	(1.000)	1.000	-	-	-	-	-	-	-	1.000
Running Costs	5.516	5.194	0.322	5.8%		-				-				-					-
Unidentified QIPP						-				-				-					-
TOTAL CCG NET EXPENDITURE	440.013	440.013	(0.000)	(0.0%)	(0.800)	-	-	(0.200)	-	(1.000)	1.000	-	-	-	-	-	-	-	1.000
IN YEAR UNDERSPEND / (DEFICIT)	3.150	3.150	0.000	0.0%															
CUMULATIVE UNDERSPEND / (DEFICIT)	13.178	13.178	0.000	0.0%															

In summary the CCG is reporting:

	£m Surplus(deficit)	
Most Likely	£13.178	No risks or mitigations, **achieves** control total
Best Case	£14.178	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	£12.178	Adjusted risks and no mitigations occur. CCG **misses** revised control total

5. Contract and Procurement Report

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

6. RISK REPORT

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

7. PRIMARY CARE COMMISSIONING COMMITTEE REPORT – Q3 FINANCE POSITION

The Committee received for information the Q3 Finance position report due to go to the February meeting of the Primary Care Commissioning Committee.

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: **29th January 2020**

Wolverhampton CCG Performance against the NHS Constitution Standards

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

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

Current Month: Nov-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
		CCG Provisional		Nov	92.0%	84.92%	↓	↓	86.50%													
		CCG Validated		**Nov**	**92.0%**	**84.92%**	↓	↓	**86.50%**	R	R	R	R	R	R	R	R					R
EB3	Referral to Treatment (18 Wks)	RWT	Mth	Nov	92.0%	83.18%	↓	↓	84.97%													
		Black Country STP		Nov	92.0%	88.26%	↓	↓	90.49%													
		National		Nov	92.0%	84.35%	↓	↓	85.51%													
		CCG Provisional		Nov	1.0%	2.10%	↑	↑	1.71%													
		CCG Validated		**Nov**	**1.0%**	**2.10%**	↑	↑	**1.71%**	G	G	G	G	R	R	R	R					R
EB4	Diagnostic Waits (6wks)	RWT	Mth	Nov	1.0%	2.79%	↑	↑	1.95%													
		Black Country STP		Nov	1.0%	2.01%	↓	↓	1.60%													
		National		Nov	1.0%	2.95%	↑	↑	3.63%													
		CCG Provisional		No Data	95.0%	-			-													-
		CCG Validated		**No Data**	**95.0%**	**-**			**-**													**-**
EB5	A&E (Waits Within 4hrs)	RWT	Mth	Dec	95.0%	82.78%	↓	↓	86.92%													
		Black Country STP		Dec	95.0%	79.50%	↓	↓	83.02%													
		National		Dec	95.0%	71.79%	↓	↓	80.67%													
		CCG Provisional		No Data	93.0%	66.85%			66.85%													
		CCG Validated		**Nov**	**93.0%**	**87.76%**	↑	↑	**74.94%**	R	R	R	R	R	R	R	R					R
EB6	Two Week Waits (2WW)	RWT	Mth	Nov	93.0%	93.05%	↑	↑	77.61%													
		Black Country STP		Nov	93.0%	81.98%	↑	↓	87.00%													
		National		Nov	93.0%	91.33%	↓	↑	90.50%													
		CCG Provisional		No Data	93.0%	-			-													-
		CCG Validated		**Nov**	**93.0%**	**68.91%**	↑	↑	**19.03%**	R	R	R	R	R	R	R	R					R
EB7	Two Week Waits (2WW) Breast Symptoms	RWT	Mth	Nov	93.0%	76.92%	↑	↑	15.25%													
		Black Country STP		Nov	93.0%	53.93%	↓	↓	66.95%													
		National		Nov	93.0%	87.50%	↓	↑	83.12%													
		CCG Provisional		No Data	96.0%	-			-													
		CCG Validated		**Nov**	**96.0%**	**91.18%**	↓	↓	**92.11%**	R	R	R	G	R	R	R	R					R
EB8	31 Day Cancer Treatment	RWT	Mth	Nov	96.0%	88.57%	↓	↑	87.80%													
		Black Country STP		Nov	96.0%	92.78%	↓	↓	94.25%													
		National		Nov	96.0%	95.94%	↓	↓	96.06%													
		CCG Provisional		No Data	94.0%	-			-													
		CCG Validated		**Nov**	**94.0%**	**92.31%**	↓	↑	**90.45%**	R	G	R	R	R	G	G	R					R
EB9	31 Day Cancer Treatment (Surgery)	RWT	Mth	Nov	94.0%	95.12%	↓	↑	82.24%													
		Black Country STP		Nov	94.0%	93.90%	↓	↑	92.60%													
		National		Nov	94.0%	91.59%	↑	↑	91.40%													
		CCG Provisional		No Data	98.0%	-			-													
		CCG Validated		**Nov**	**98.0%**	**100.00%**	→	→	**99.52%**	G	G	G	R	G	G	G	G					G
EB10	31 Day Cancer Treatment (anti cancer drug)	RWT	Mth	Nov	98.0%	100.00%	→	→	99.73%													
		Black Country STP		Nov	98.0%	100.00%	→	→	99.15%													
		National		Nov	98.0%	99.37%	↑	↓	99.22%													
		CCG Provisional		No Data	94.0%	-			-													
		CCG Validated		**Nov**	**94.0%**	**89.19%**	↓	↓	**90.73%**	R	R	G	G	R	R	G	R					R
EB11	31 Day Cancer Treatment (Radiotherapy)	RWT	Mth	Nov	94.0%	94.40%	↓	↑	90.61%													
		Black Country STP		Nov	94.0%	92.86%	↓	↑	88.19%													
		National		Nov	94.0%	96.87%	↑	↑	96.45%													

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

Current Month: Nov-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
EB12	62 Day Cancer Treatment 1st Definitive Treatment	CCG Provisional		No Data	85.2%	-			-													
		CCG Validated		**Nov**	**85.2%**	**59.62%**	↑	↑	**62.84%**	R	R	R	R	R	R	R	R					R
		RWT	Mth	Nov	85.2%	57.00%	↑	↓	59.17%													
		Black Country STP		Nov	85.2%	72.40%	↑	↑	74.13%													
		National		Nov	85.2%	77.38%	↑	↓	77.63%													
EB13	62 Day Cancer Treatment (NHS Screening)	CCG Provisional		No Data	90.0%	-			-													
		CCG Validated		**Nov**	**90.0%**	**33.33%**	↓	↓	**61.04%**	R	R	R	R	R	R	R	R					R
		RWT	Mth	Nov	90.0%	44.23%	↓	↓	63.94%													
		Black Country STP		Nov	90.0%	84.62%	↑	↓	86.19%													
		National		Nov	90.0%	83.84%	↑	↓	86.10%													
EB14	62 Day Cancer Treatment (Consultant Upgrade)	CCG Provisional		No Data	0.0%	-			-													
		CCG Validated		**Nov**	**0.0%**	**78.38%**	↓	↓	**76.58%**	G	G	G	G	G	G	G	G					G
		RWT	Mth	Nov	0.0%	75.43%	↓	↓	74.36%													
		Black Country STP		Nov	0.0%	79.43%	↑	↓	80.05%													
		National		Nov	0.0%	81.98%	↑	↑	94.51%													
EB18	52 Week Waiters (RTT)	CCG Provisional		Nov	0.0%	0	→	→	0													
		CCG Validated		**Nov**	**0.0%**	**0**	→	→	**0**	G	G	G	G	G	G	G	G					G
		RWT	Mth	Nov	0.0%	0	→		0													
		Black Country STP		Nov	0.0%	0	→	↑	11													
		National		Nov	0.0%	1570	↓	↓	10246													
EH1	IAPT Programme: Treated within 6 wks	CCG Provisional		Oct	75.0%	90.00%	↑	↑	85.82%													
		CCG Validated		**Oct**	**75.0%**	**90.00%**	↑	↑	**85.82%**	G	G	G	G	G	G	G						G
		BCPFT	Mth	Oct	75.0%	93.58%	↑	↑	90.67%													
		Black Country STP		Oct	75.0%	92.65%	↑	↑	88.16%													
		National		No Data	75.0%	-																
EH2	IAPT Programme Referral to Treatment (18wks)	CCG Provisional		Oct	95.0%	95.00%	↓	↓	97.76%													
		CCG Validated		**Oct**	**95.0%**	**95.00%**	↓	↓	**97.76%**	G	G	G	G	G	G	G						G
		BCPFT	Mth	Oct	95.0%	98.17%	↓	↓	98.77%													
		Black Country STP		Oct	95.0%	98.53%	↓	↑	98.07%													
		National		No Data	95.0%	-																
EH4	EIP 1st Episode (within 2 wks)	CCG Provisional		Sep	56.0%	0.00%	↓	↓	66.67%													
		CCG Validated		**Sep**	**56.0%**	**0.00%**	↓	↓	**66.67%**	G	G	G	G	R	R							G
		BCPFT	Mth	Sep	56.0%	0.00%	→	↓	42.86%													
		Black Country STP		Sep	56.0%	60.00%	↑	↑	56.00%													
		National		Jul	56.0%	77.42%	↑	↑	76.06%													
EH9	CYP Access Rates	CCG Provisional		Nov	34% Full Yr	3.15%	↑		26.93%													
		CCG Validated		**Oct**	**34% Full Yr**	**4.21%**	↑		**24.67%**	G	G	G	G									R
		BCPFT	Mth	Oct	34% Full Yr	-			-													
		Black Country STP		Nov	34% Full Yr	2.29%	↑		20.42%													
		National		No Data	34% Full Yr	-																
EAS1	Dementia Diagnosis (65+)	CCG Provisional		No Data	71.4%	-			-													
		CCG Validated		**Nov**	**71.4%**	**70.95%**	↑	↓	**72.45%**	G	G	G	G	G	G	R	R					G
		Primary Care	Mth	No Data	71.4%	-			-													
		Black Country STP		Oct	71.4%	65.33%	↓	↓	66.33%													
		National		No Data	71.4%	-			-													
EAS2	IAPT Recovery Rate (Moving to Recovery)	CCG Provisional		Sep	50.0%	50.00%	↑	↑	-													
		CCG Validated		**Oct**	**50.0%**	**39.47%**	↓	↓	**47.29%**	G	G	R	R	R	G	R						R
		BCPFT	Mth	Oct	50.0%	49.06%	↓	↓	52.97%													
		Black Country STP		Sep	50.0%	51.33%	↑	↑	51.92%													
		National		No Data	50.0%	-			-													
EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	CCG Provisional		No Data	0.0%	-			-													
		CCG Validated		**Aug**	**0.0%**	**1**	↓	↓	**2**	G	G	R	G	G	G	G	R					R
		RWT	Mth	Nov	0.0%	0	→	→	0													
		Black Country STP		Nov	0.0%	1	↓	↓	6													
		National		Nov	0.0%	75	↑	↓	535													

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		**Nov**	**CCG: 48 Full Yr**	1	⇧	⇧	30	R	R	G	G	G	R	R	R					R
		RWT		Nov	RWT: 40 Full Yr	1	⇧	⇧	31													
		Black Country STP		Nov	STP: 288 Full Year	8	⇧	⇧	166													
		National		Nov	TBC	1027	⇧	⇧	9048													
EBS1	MSA Breaches	CCG Provisional	Mth	Oct	0.0%	0			1													
		CCG Validated		**Nov**	**0.0%**	0			1	G	G	R	G	G	G	G	G					R
		RWT		Nov	0.0%	0			0													
		BCPFT		Nov	0.0%	0			0													
		Black Country STP		Nov	0.0%	15			170													
		National		Nov	0.0%	1968			12040													
EBS5	12 hr Trolley Waits	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		**No Data**	**0.0%**	-			-													
		RWT		Dec	0.0%	1	⇨	⇨	9													
		Black Country STP		No Data	0.0%	-			-													
		National		No Data	0.0%	-			-													
EBS6	No urgent operation should be cancelled for a second time	CCG Provisional	Mth	No Data	0.0%	-			-													
		CCG Validated		**No Data**	**0.0%**	-			-													
		RWT		Dec	0.0%	0	⇨	⇨	0													
		Black Country STP		No Data	0.0%	-			-													
		National		No Data	0.0%	-			-													
EBS3	CPA Follow Up within 7 days from Discharge	CCG Provisional	Mth	No Data	95.0%	-			-													
		CCG Validated		**Sep**	**95.0%**	96.91%			97.93%			G			G							G
		BCPFT		Sep	95.0%	97.74%			97.97%													
		Black Country STP		Sep	95.0%	96.11%			96.70%													
		National		Sep	95.0%	94.54%			94.79%													
EH10	CYP Eating Disorder (Urgent within 1 wk) - 12 Rolling Mths	CCG Provisional	Mth	Sep	95.0%	100.00%			100.00%													
		CCG Validated		**Sep**	**95.0%**	100.00%			100.00%			G			G							G
		BCPFT		Sep	95.0%	90.91%			96.00%													
		Black Country STP		Sep	95.0%	88.89%			90.24%													
		National		Sep	95.0%	75.08%			76.36%													
EH11	CYP Eating Disorder (Routine within 4 wks) - 12 Rolling Mths	CCG Provisional	Mth	Sep	95.0%	93.75%			91.67%													
		CCG Validated		**Sep**	**95.0%**	93.75%			91.67%			R			R							R
		BCPFT		Sep	95.0%	93.02%			92.13%													
		Black Country STP		Sep	95.0%	89.22%			89.86%													
		National		Sep	95.0%	85.98%			84.66%													
EH13	Physical Health Checks for People with a Severe Mental Illness	CCG Provisional	Mth	No Data	60% by Yr End	-																
		CCG Validated		**Dec**	**60% by Yr End**	47.23%			42.83%			R			R			R				R
		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	**CCG :**	-																
		CCG Validated		**Oct**	**Q1 = 4.94%,**	5.27%	⇩	⇩	38.94%	G	G	G	G	G	G	R						G
		BCPFT		Oct	**Q2 = 5.13%,**	3.62%	⇧	⇧	2.90%													
		Black Country STP		Oct	**Q3 = 5.31%,**	6.73%	⇧	⇩	48.81%													
		National		No Data	**Q4 = 5.50%**	-																
EH12	OoAPs - Out of Area Placements (STP target)	CCG Provisional	Mth	Sep		265	⇩		1345													
		CCG Validated		Oct		360	⇩	⇧	2255	R	R	G	R	G	G	R						R
		Black Country STP		Oct	STP Wide Traj 978 by Yr End	965	⇩		5874													
		National		No Data		-																
ED16	% of the population with access to online consultations	CCG Provisional	Mth	No Data	75.2% Yr End	-																
		CCG Validated		**Dec**	**75.2% Yr End**	96.61%	⇧		96.61%	G	G	G	G	G	G	G	G	G				G
		Black Country STP		No Data	75.2% Yr End	-																
		National		No Data	75.2% Yr End	-																
ED17	% Extended Access Appointment Utilisation	CCG Provisional	Mth	Oct	85% Yr End	69.82%	⇩	⇧	66.16%													
		CCG Validated		**No Data**	**85% Yr End**	-																
		Black Country STP		No Data	85% Yr End	-																
		National		No Data	85% 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
ED18	% population that the Urgent Care System (NHS111) can directly book appointments for in contracted extended hours	CCG Provisional	Mth	Oct	100% Yr End	0.00%	⇨	⇨	0.00%													
		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	Dec	20.02 by Yr End	40.03			40.03													
		CCG Validated		**Dec**	**20.02 by Yr End**	**40.03**		⇧	**40.03**			R			R			R				R
		Black Country STP		Dec	18.31 by Yr End	36.62			36.62													
		National		No Data	-	-																
EK1b	Rate (per million GP Registered Population) Inpatient Care for People with LD or Autism (NHSE Commissioned)	CCG Provisional	Mth	Dec	20.02 by Yr End	40.03			40.03													
		CCG Validated		**Dec**	**20.02 by Yr End**	**40.03**		⇨	**40.03**			G			R			R				R
		Black Country STP		Dec	18.31 by Yr End	26.98			26.98													
		National		No Data	-	-																
EO1	% of Children Waiting more than 18 weeks for a Wheelchair	CCG Provisional	Qtr	No Data	92.5%	-			-													
		CCG Validated		**Dec**	**92.5%**	100.00%			99.24%			G			G			G				G
		Black Country STP		Sep	92.5%	92.82%			94.38%													
		National		Sep	92.5%	84%																
EK3	AHCs delivered by GPs for patients on the Learning Disability Register	CCG Provisional	Mth	No Data	75.0%	-																
		CCG Validated		**Jan**	**75.0%**	47.45%	⇧		47.00%						R			R	R			R
		Black Country STP		No Data	75.0%	-																
		National		No Data	75.0%	-			-													
EN1	Cumulative number of Personal Health Budgets (PHBs)	CCG Provisional	Mth	No Data	320 Yr End	-																
		CCG Validated		**Dec**	**320 Yr End**	373			373			G			G			G				G
		Black Country STP		Sep	STP tbc	1143			1143													
		National		Sep	TBC	70990			70990													

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

Current Month: Nov-19

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

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

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

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	Nov	Seasonal Variation	7295	⇩	⇧	60509													
		CCG Validated		Nov	Seasonal Variation	7295	⇩	⇧	61119													
EM8	Consultant Led First Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Nov	Seasonal Variation	8879	⇧	⇧	66863													
		CCG Validated		Nov	Seasonal Variation	8879	⇩	⇧	66915													
EM9	Consultant Led Follow-Up Outpatient Attendances (Specific Acute)	CCG Provisional	Mth	Nov	Seasonal Variation	14961	⇩	⇧	118579													
		CCG Validated		Nov	Seasonal Variation	14961	⇩	⇧	118852													
EM10	Total Elective Spells (Specific Acute)	CCG Provisional	Mth	Nov	Seasonal Variation	2870	⇩	⇧	22408													
		CCG Validated		Nov	Seasonal Variation	2870	⇩	⇧	22402													
EM11	Total Non-Elective Spells (Specific Acute)	CCG Provisional	Mth	Nov	Seasonal Variation	2565	⇩	⇧	19675													
		CCG Validated		Nov	Seasonal Variation	2565	⇩	⇧	19666													
EM12	Total A&E Attendances (Excl. Planned Follow Up Attendances) *Awaiting confirmation of Vocare submissions	CCG Provisional	Mth	Nov	Seasonal Variation	15762	⇧	⇧	98071													
		CCG Validated		Nov	Seasonal Variation	15762	⇧	⇧	122959													
EM12a	Type 1 A&E Attendances (Excluding Planned Follow Up Attendances)	CCG Provisional	Mth	Nov	Seasonal Variation	7963	⇩	⇧	65005													
		CCG Validated		Nov	Seasonal Variation	7963	⇩	⇧	65064													
EM18	Number of completed admitted RTT pathways	CCG Provisional	Mth	Oct	Seasonal Variation	1208	⇧	⇩	7837													
		CCG Validated		Nov	Seasonal Variation	1141	⇩	⇧	8978													
EM19	Number of completed non-admitted RTT pathways	CCG Provisional	Mth	Oct	Seasonal Variation	5791	⇧	⇩	37205													
		CCG Validated		Nov	Seasonal Variation	5845	⇧	⇧	43050													
EM20	Number of new RTT pathways (clock starts)	CCG Provisional	Mth	Oct	Seasonal Variation	9437	⇧	⇧	59273													
		CCG Validated		Nov	Seasonal Variation	8141	⇩	⇧	67413													
EM21	Consultant Led Outpatient Attendances with Procedures (Specific Acute)	CCG Provisional	Mth	Oct	Seasonal Variation	2213	⇩	⇧	16897													
		CCG Validated		Nov	Seasonal Variation	2213	⇩	⇧	17060													
EM22	Average number of G&A beds open per day (specific acute)	RWT	Mth	Sep	Seasonal Variation	117		⇧	117													

NHS
Wolverhampton
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WOLVERHAMPTON CCG

GOVERNING BODY
11 February 2020

Agenda item 14

TITLE OF REPORT:	Summary – Wolverhampton Clinical Commissioning Group Audit and Governance Committee – 3 December 2019
AUTHOR(s) OF REPORT:	Peter Price – Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Director of Finance
PURPOSE OF REPORT:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• To provide an update of the WCCG Audit and Governance Committee to the WCCG Governing Body.
RECOMMENDATION:	• That the Governing Body **receive** and **note** the actions taken by the Audit and Governance Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	

1. BACKGROUND AND CURRENT SITUATION

1.1 Appointment of Committee Member

The Committee approved the reappointment of the Independent Member of the Audit and Governance Committee for a further three year term in office.

1.2 Internal Audit Progress Report

The progress report gave updates on each area and which quarter the delivery included in the plan. The areas identified were:

1. Corporate Governance – Equality and Diversity
2. Finance
3. Delegated Commissioning
4. Cybersecurity
5. Continuing Healthcare
6. Brexit Planning
7. Conflicts of Interest
8. Information Governance
9. HR/Restructuring
10. Audit Follow Up

Cybersecurity was highlighted as a red rated item and that it had been particularly difficult to obtain the contract held by Wolverhampton CCG and The Royal Wolverhampton Hospitals Trust. The report now contained information regarding outstanding actions which had been requested previously by the Committee. The Committee noted and accepted the report.

1.3 Wolverhampton CCG – Equality and Diversity – Final Report Nov 2019

The Equality and Diversity Report had been given a 'low' risk rating. Completion of Equality and Analysis forms and Equality Analysis forms are not centrally stored had been given 'advisory' ratings. The Committee noted the report.

1.4 Primary Care Commissioning Final Report Nov 2019

The Primary Care Commissioning Report identified 1 medium risk relating to Urgent Contracts and 1 low risk relating to the Outdated procurement policy. The Committee noted the report.

1.5 Wolverhampton CCG – Stakeholder engagement – Final Internal Audit Report 29 July 20189

The Stakeholder Engagement Final Report was shared with the committee for information and Mr Price felt that it would be a good idea to share this with the Accountable Officer for the Black Country and West Birmingham for information.

1.6 Local Security Management Update

The Local Security Management Update was presented to the Audit and Governance Committee.

The biggest piece of work was around CHC and going into CCGs to remind them about adhering to polices, lone working, use of technology etc. The Committee were also advised that there had been no incidents reported by Wolverhampton CCG.

1.7 External Audit Progress Report

The External Audit Progress Report and Report on the Mental Health Investment Standard Compliance Statement were presented to the Committee

External Audit had concluded their work on compliance with the Mental Health Investment Standard and signed their independent assurance report on 1 October 2019. The opinion given was the that Wolverhampton CCG's Mental Health Investment Standard compliance statement was properly prepared, in all material respects, in accordance with guidance published by NHS England.

1.8 Governance Statement

The Governance Statement was presented to the committee to give an early view of the likely themes and content for the year.

The Committee discussed how this year's statement may need to be in a different format in order to comply with that of the other CCGs.

1.9 Risk Register Reporting/Board Assurance Framework

A report on the Risk Register and Board Assurance Framework was shared with the Committee to update them on what had happened since the last meeting. The report also contained the table for Deep Dives which had been requested previously by the committee.

Risks continued to be embedded and discussed at committees. A full report would be taken to the Governing Body in February and a further update would be given at the next committee meeting. The Committee accepted and approved the Deep Dive plan.

1.10 Losses and Compensation Payments – Quarter 2 2019/20
There were no recorded losses or special payments recorded for the Q2 period ended September 2019. The Committee noted the report.

1.11 Feedback to and from the Audit and Governance Committee/Update on Transition Governance Programme
An update was given to the Committee on the Governance implications of the Transition Programme for the Black Country and West Birmingham CCGs. The Committee accepted the report for information.

1.12 Suspensions, Waiver and Breaches of SO/PFPS
There were 15 suspensions raised in quarter 2 of 2019/20. During this period there were 17 waivers and 40 non-healthcare invoices paid without a purchase order.

The Committee were informed that there was a new process in place regarding the completion of waivers and would be shared with them for information.

1.13 Receivable/Payable Greater than £10,000 and over 6 months
The Committee noted that as at September 2019, there were 4 receivables and 7 payables over £10,000 and greater than 6 months old.

It was noted that there was currently an invoice that was in dispute with Walsall CCG regarding the payment of a patient's section 117 aftercare. Legal advice had been sought by each organisation and each had come back to advise that they were not liable for payment. The Committee felt that this should now be referred to the Accountable Officer for the Black Country and West Birmingham CCGs to advise.

1.14 Counter Fraud Progress Report
This paper was received for information.

2. CLINICAL VIEW

2.1. N/A

3. PATIENT AND PUBLIC VIEW

3.1. N/A

4. KEY RISKS AND MITIGATIONS

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

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. N/A

Quality and Safety Implications

5.2. N/A

Equality Implications

5.3. N/A

Legal and Policy Implications

5.4. N/A

Other Implications

5.5. N/A.

Name	Tony Gallagher
Job Title	Director of Finance
Date:	23 December 2019

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Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/a**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/a**	
Signed off by Report Owner (Must be completed)	**Peter Price**	**December 2019**

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Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
11 FEBRUARY 2020

Agenda item 15

TITLE OF REPORT:	Summary – Remuneration Committee – 15 October 2019 & 26 November 2019
AUTHOR(s) OF REPORT:	Peter Price – Remuneration Committee Chairman
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	To provide an update of key discussions and decisions made at the Remuneration Committee to the Governing Body.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The Committee met in Common with the Remuneration Committees of Dudley, Sandwell and West Birmingham and Walsall CCGs on 15 October to discuss matters relating to the Single Executive Team. • The Committee met on 26 November 2019 to discuss matters relating to the Remuneration of the CCG's Senior Team.
RECOMMENDATION:	That the Governing Body receive and note the contents of this report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Remuneration Committee is responsible for ensuring that the CCG has appropriate Human Resources Policies and Procedures in place to deliver statutory responsibilities as an employer.

1. BACKGROUND AND CURRENT SITUATION

1.1 This report gives details of the issues discussed and decisions made at the meetings of the Remuneration Committee on 15 October and 26 November 2019.

2. 15 OCTOBER MEETING IN COMMON

2.1. Accountable Officer Remuneration Arrangements

The committee discussed and made recommendations to the Governing Body in respect of Remuneration arrangements for the Accountable Officer.

2.2. Single Executive Team

The Committee discussed and made recommendations to the Governing Body in respect of the remuneration for the new position of Deputy Accountable Officer. The committee also noted the recruitment a Director of HR.

3. 26 NOVEMBER MEETING

3.1. Accountable Officer Update

The committee received an update on the arrangements for the transfer of responsibilities to the new Accountable Officer.

4. CLINICAL VIEW

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

5. PATIENT AND PUBLIC VIEW

5.1. Not applicable.

6. KEY RISKS AND MITIGATIONS

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

7. IMPACT ASSESSMENT

Financial and Resource Implications

7.1. Not applicable.

Quality and Safety Implications

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

Equality Implications

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

Legal and Policy Implications

7.4. There are no additional legal or policy implications arising from this report.

Other Implications

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

Name	Peter Price
Job Title	Remuneration Committee Chair
Date:	January 2020

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REPORT SIGN-OFF CHECKLIST

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

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WOLVERHAMPTON CCG

GOVERNING BODY MEETING
11 February 2020

Agenda item 16

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 5 November 2019 and 3 December 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 5 November 2019 and 3 December 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• The Committee approved the proposal from Tettenhall Medical Practice to reduce the number of sessions provided at Wood Road Surgery from 7 to 4.
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 5 November 2019 and 3 December 2019. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Commissioning Committee – 5 November 2019 - Extraordinary Meeting

2.1 A series of documents were presented to an Extraordinary Committee meeting around Tettenhall Medical Practice's intentions to reduce the number of clinical sessions offered at the branch surgery at Wood Road from 7 to 4 sessions per week. In doing so, the Practice felt this would enable them to continue to provide quality primary medical services to their patient population without compromising services offered to patients local to Wood Road who have difficulties accessing the Lower Green site.

2.2 Following consideration of the proposal, including the views of patients from Tettenhall Medical Practice, the Committee approved the proposal to reduce the number of sessions provided at Wood Road Surgery from 7 to 4.

Primary Care Commissioning Committee – 3 December 2019

2.3 Quarterly Finance Report Q2 July – September 2019

2.3.1 The Director of Finance (WCCG), Tony Gallagher, provided a summary of the finance report for the period ending September 2019. It was noted that the delegated commissioning element of primary care was forecast to breakeven this year. An overspend of £487,000 was forecast which was largely attributable to prescribing and NHS111 services. An amount of £1m was identified for Primary Care development. Due to the proximity of the year end it may not be possible to identify schemes to the full amount.

2.4 Primary Care Quality Report

2.4.1 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:

- Infection prevention audits continued and practices were doing well with average ratings slightly improved from last year.

- The Quality Team were working closely with Public Health on the flu vaccine programme. All practices now have access to the vaccines. The over 65s update at the beginning of November was 51.5% and for under 65s 18.5%.
- The MMR vaccination programme uptake is slightly down on both the rest of the region and nationally but was being picked up at the collaborative contract review visits.
- Wolverhampton remains the best in England at an average of 2.2% for Friends and Family Test returns.

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

2.5.1 The Head of Primary Care, Sarah Southall, advised that she had chaired the meeting and that no major issues were reported.

2.6 **STP Primary Care Programme Board Actions and Decisions**

2.6.1 The Head of Primary Care provided an overview of the discussions that took place at the STP Primary Care Programme Board. It was noted that funding proposals were considered and approved by the Board for a GP mid-career scheme due to commence in March 2020 which affords GPs the opportunity to be part of a network and take part in a learning development programme. A scheme was also approved for welcoming back GPs into General Practice and a legacy scheme to help retain skills, knowledge and experience.

2.6.2 The Board received an update on the PCN development and the opportunity to share approaches taken to social prescribing and the leadership development programmes.

2.7 **Milestone Review Board (Q2 2019/20) Report**

2.7.1 The Head of Primary Care advised that the Milestone Review Board met in October and the report provided a summary of that meeting along with a copy of the assurance pack shared at the meeting. The Board gave recognition to the progress that had been made in relation to the work programme and a communication and engagement plan that had been requested. Approval was also given to address some of the gaps in public knowledge and to ensure that practices were actively publicising the new roles to patients.

2.8 **Social Prescribing**

2.8.1 The Head of Primary Care updated the Committee on the progress of the Social Prescribing Service and the new roles that Primary Care Networks were able to recruit to. It was noted that Social Prescribing Link workers are funded as part of the role reimbursement scheme. All six Primary Care Networks now had an allocated Link Worker based within practices to provide a social prescribing service at neighbourhood level.

2.9 **Primary Care Contracting Update**

2.9.1 The Primary Care Contracts Manager, Gill Shelley, presented a report to Committee outlining any relevant issues with regards to primary care contracting in Wolverhampton. It was noted that an internal audit on effectiveness on commissioning and procurement of primary medical services had been undertaken where one medium and one low risk recommendation identified.

2.9.2 The Committee were informed that the practice merger of Parkfields Medical Centre and Grove Medical Centre which took place in November had gone smoothly from a clinical system perspective. A further monitoring meeting between the CCG and the new providers will take place in the new year.

2.9.3 It was noted that a contract monitoring review was undertaken at MGS Medical Practice in early November, which proved successful. When the previous contract review meeting was undertaken in September 2017, there had been 34 actions to complete but the recent visit highlighted only 3 actions which represented a massive improvement.

Primary Care Commissioning Committee (Private) – 3 December 2019

2.10.1 The Committee met in private to receive updates including feedback following Local Medical Committee Meeting, PCN Patient Stakeholder Specification and Post Payment Verification – Enhanced Services.

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: 28 January 2020

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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**	**28/01/20**

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WOLVERHAMPTON CCG

Governing Body
11 February 2020

Agenda item 17

TITLE OF REPORT:	**Communication and Participation update**
AUTHOR(s) OF REPORT:	Sue McKie, Patient and Public Involvement Lay Member Helen Cook, Communications, Marketing & Engagement Manager
MANAGEMENT LEAD:	Mike Hastings – Director of Operations
PURPOSE OF REPORT:	This report updates the Governing Body on the key communications and participation activities during November, December 2019 and January 2020
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the **public** domain
KEY POINTS:	The key points to note from the report are: 2.1.2 **Christmas and New Year opening** 4.1 **Engagement on NHS services**
RECOMMENDATION:	• **Receive** and **discuss** this report • **Note** the action being taken
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework.

1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place November, December 2019 and January 2020, 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 **Winter campaign – Help Us to Help You**
January saw the start of the **Help Us Help You: Get it seen to** pharmacy advice phase of the winter campaign.

The campaign aims to increase people's use of community pharmacy services by encouraging them to access clinical advice and support for minor illnesses. Activity is aimed at all members of the public and also targets parents and carers of children aged 5 – 12 years old.

The campaign is advertised using a range of media including press releases, social media, online and printed materials.

2.1.2 **Christmas and New Year opening**

During December we advertised the GP hubs and Pharmacy Christmas and New Year opening times online, in newspapers, via social media, press releases and with printed materials delivered to GP surgeries across the city.

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

January 2020

- Call to combat obesity in Wolverhampton
- Plea for more men to donate blood in Wolverhampton
- Can you go dry for January?

December 2019

- Plan ahead for Christmas and New Year
- Flu Fighters campaign wins prestigious communications award
- Extended Access to GP Appointments in the Black Country and West Birmingham
- GP and Pharmacy Opening Times over Christmas 2019 and New Year 2020

November 2019

- Newly released figures prompt local NHS to reach out to unpaid carers
- Be aware of Norovirus
- Breathe easier and seek treatment on World COPD Day
- Help Us, Help You - Before it gets worse
- Think self-care this winter and for life
- Do you know the signs of Diabetes or if you are at risk?
- Enjoy Bonfire Night safely

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:

- Phoenix UTC extended opening hours
- Wolverhampton CCG revise Primary Care Strategy
- Introducing Liz Corrigan GPN Professional Lead for the STP
- Wolverhampton women sought for maternity services study
- Referrals to New Diabetes Prevention Programme (NDPP) provider
- Primary human papillomavirus (pHPV) Electronic results guidance
- Tell us about your experience of hospital eye service
- 100,000 more people set to benefit from personal health budgets
- Study into knowledge, attitudes and practices of practice nurses in the West Midlands relating to Female Genital Mutilation
- Fibromyalgia survey
- Safer Wolverhampton Partnership is seeking your views
- Black Country and West Birmingham Primary Care (BPWB) workforce retention programme newsletter
- New healthcare professionals feedback form to provide views on NHS 111
- Latest news from the Black Country and West Birmingham STP
- Grants available for boilers, radiators and heating systems
- Training & Events and Vacancies

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

Phase II of the listening exercise has begun with a meeting in January with GP members and meetings with staff and stakeholders planned for February.

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 Engagement on NHS services

Children and young people

In January we carried out targeted engagement with parents of 0-5s, as we know this age group are the most frequent attendees at A&E, to inform them of NHS services available and when to access them. We attended three parent and toddler groups across the city and spoke to 26 parents/carers. Six parents said they have attended the urgent treatment centre/A&E because they either: experienced difficulty getting an appointment with their GP; wanted their child to be seen quickly; were left waiting too long for NHS 111 to call back. The engagement team gave information on the extended access hub appointments available on evenings and weekends, and information on how to book appointments online which was well received.

To support this engagement, the team have produced a leaflet that informs patients and members of the public about different services to access if they become unwell. Leaflets will also be delivered to GP practice sites.

Seldom heard groups

Throughout December and January planning also took place to reach seldom heard groups to carry out engagement with them on services they have accessed, their experiences and areas for improvement. The communications and engagement team have met with the Refugee and Migrant Centre and P3 homeless charity to discuss engagement opportunities. We are looking to carry out engagement with these groups during February and continue to approach other seldom heard groups for opportunities to engage.

4.2 **PPG Chairs and Citizen Forum**

PPG Chair meetings are now conducted at Primary Care Network (PCN) level with improving but 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 proving to be very informative to the PPG Chairs that attend. Discussions at these meetings continue to centre on how to reach the seldom heard members of our community and that the reliance on electronic methods of communication will not engage certain communities.

The engagement officer is out meeting with some of the organisations that can support the delivery of information to harder to reach individuals such as the Refugee and Migrant Centre.

The production of a newsletter to inform our Citizens Forum representatives and a wider range of stakeholders is in its final stages. It has become evident that the contact details we hold are now out of date and we are working to produce a more comprehensive list of which organisations and agencies might benefit from the newsletter.

5 Lay Member meetings attended:

5.1 Primary Care Commissioning Committees (Public and Private)
CCG Governing Body
CCG Governing Body Development
Quality and Safety
Strategic communications
1:1 meetings with CCG Officers
1:1 meeting with Patient representative
Engagement Cycle
Black Country CCG Joint development meeting
Wolverhampton Total Health PPG Chairs PCN
Wolverhampton North Network PPG Chairs PCN
Unity PPG Chairs PCN
VI PPG Chairs PCN
Black Country Governing Body in common
Listening Exercise – phase I
Royal Wolverhampton Hospital Council of Members 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: 31 January 2020

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**	**31 January 2020**
Finance Implications discussed with Finance Team	**n/a**	
Quality Implications discussed with Quality and Risk Team	**n/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**n/a**	
Information Governance implications discussed with IG Support Officer	**n/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**n/a**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**n/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**n/a**	
Signed off by Report Owner (Must be completed)	**Sue McKie**	**31 January 2020**

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NHS
Wolverhampton
Clinical Commissioning Group

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

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Mike Hastings – Director of Operations, WCCG
Yvonne Higgins – Deputy Chief Nurse, WCCG

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
Peter McKenzie – Corporate Operations Manager, WCCG
Phil Strickland - Governance & Risk Coordinator, WCCG

APOLOGIES:
Sue McKie – Patient/Public Involvement – Lay Member
Ankush Mittal – Public Health, Wolverhampton Council
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Sally Roberts – Chief Nurse, Director of Quality, WCCG

QSC/19/095 Apologies and Introductions

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

QSC/19/096 Declarations of Interest

No declarations of interest.

QSC/19/097 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/097.1 Minutes from the meeting held on 13th August 2019 (Item 3.1)

Dr Rajcholan commented on the harm reviews (page 3) and commented that she thought that the one incident that had caused harm didn't lead to harm in the end.

Ms Higgins confirmed this.

QSC/19/088.1: Quality Report **- Cancer (Red rated)** – Mrs Roberts attended the first Cancer Board meeting in August. Harm reviews are continuing and there has still only been one patient where harm has been identified as a result of waits.

Mr Hastings advised that with regards to the section about Digital First (page 7) Babylon in Hand is in fact Babylon GP at Hand.

QSC/19/088.2: Primary Care Report **-** 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 GP at Hand* is being used in Birmingham; this is capped with how many patients they can register.

With these two amendments the minutes from the last meeting were read and agreed as a true record.

QSC/19/097.2 Action Log from meeting held on 13th August 2019 (Item 3.2)

QSC/19/088.1 - Quality Report: CQC **Mortality Outlier Alerts** – 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.

Mrs Hough advised that this information was available on the trust's intranet; therefore the link could not be shared with the Committee.

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

QSC/19/088.2 - Primary Care Report **-** With regards to Digital First need to consider the access issues and asked if we could get something here and/or Governing Body.

Mr Hastings advised that this was due last Friday but had not been received as yet. As part of the STP review, a meeting had taken place with Clinical Directors of the Primary Care Networks and they need to decide the vision regarding video consultations.

Mr Oatridge asked for more detail with regards to what it was about.

Mr Hastings explained the video consultations in more detail.

Mr Oatridge commented that it was more about patient's expectations.

Mr Hastings confirmed that that was the key question. The national consultation has now closed and he advised that there was an executive summary which was worth looking at.

Mr Hastings stated that Wolverhampton had installed video links in the practices and there were 16 practices enabled so far. He added that it needs to be a joint venture across the City. There are more practices in Birmingham that have this now.

Mr Hastings stated that a digital solution is ready and available and the IM&T team are ready to support it.

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

QSC/19/091.2 - Public Health Data - 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.

A meeting has taken place regarding the public health dashboard reporting to discuss formatting, data requirements and agreed to provide some data at the November Quality and Safety meeting to present to the group.

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 is being identified around A&E breaches.

Mr Hastings advised that there were some Mental Health actions which went to the A&E Delivery Board.

Ms Higgins advised that Mrs Roberts had chaired a subsequent meeting and Cygnet is cover until 10pm now and that beds can now be sought from them out of hours. There are plans in place to secure more beds.

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.

This was shared with Ms Henriques-Dillon on 24th September 2019.

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 advised that she hadn't received any feedback as yet.

Mr Hastings added that CSU provide the services for this.

Dr Rajcholan agreed to close this action.

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

QSC/19/098 Matters Arising

There were no matters arising.

QSC/19/099 Performance and Assurance Reports

QSC/19/099.1 Quality Report (Item 5.1)

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

Cancer (Red rated) – With regards to the two week wait breast cancer pathway the trust performance has seen an improvement. Wolverhampton is currently working against 9 days, Walsall was booking at 27 and Dudley was 14. The backlog has gone from 560 to less than 50.

Mr Hastings added that they need to get back to a manageable level with RWT continuing to divert patients to an alternative provider. Walsall has taken the main impact of this. Wolverhampton are looking at reducing the number going to Walsall; this was ratified at the meeting on Thursday with NHSE/I. They have agreed to step down to a two mile radius and then a one mile in November. They will continue to refer to Dudley. This is not taking into account any sick leave or other absence.

Mr Price asked about maintaining the level.

Mr Hastings advised that at the meeting with NHSE/I on Thursday they discussed when they will be at a point where they can maintain as they can't continue to rely on other providers. Sustainability for this is to maintain capacity and they are looking at December for this.

Ms Higgins stated that plans for this are moving forward. With regards to 104 days they are still having late tertiary referrals.

NEW - Referral to treatment time incomplete pathway performance has not achieved the 92% target and is deteriorating (Red rated) – The CCG have received the recovery action plan for the trust and at CQRM the trust identified that there was an action plan for ophthalmology too. They will follow the same harm review process as for the 104 days cancer patients.

Mortality: Standardised Hospital Mortality Index (SHMI) (Amber rated) – This is going in a positive direction; it is currently at 1.16. There is ongoing work taking place with Sepsis and Deteriorating Patient. There have been four Serious Incidents relating to late diagnostics lately and 3 of these were with children, 1 was a Walsall patient; RWT are reviewing this incident. There were no themes and trends identified.

Escalating Concerns Regarding Position of a Nursing Home (Amber rated) – There are two Nursing Homes rated as inadequate by the CQC. One of the homes are having a revisit in November 2019; their issues were more to do with Health and Safety issues rather than quality of care. There was a 'Whose Shoes' event with the other home; there are clear actions. There are less Safeguarding issues now and more GP support is needed for the homes.

Concerns around Sepsis Pathways (Amber rated) – The inpatient pathway has been updated and the team have increased their presence within in patient areas.

Dr Rajcholan asked if there was any update on the pre-mixed anti-biotics.

Ms Higgins replied they are still having discussions in relation to this

BCP Workforce issues including 12 hour breaches and MH capacity (Amber rated). There has been an issue with a patient in the last week.

The CCG have undertaken a deep dive review of suicide and self-harm SIs and referred the Committee to page 49 of the papers. It was noted that the number of suicides have decreased year on year in Wolverhampton and the statistics e.g. age and gender correlate with national picture. Mr Parvez had pulled out some key issues for the trust; training, communication; those accessing drug and alcohol services and risk assessments.

Dr Rajcholan referred to page 53 of the papers and the key points identified that 77% of self-harm or suicide were in patients who had been in contact with mental health services in the previous 10 days and wondered how many had been in Primary Care setting.

Ms Higgins replied that the RCA wouldn't identify this and added that they would need to go to GPs to ask them, but thought that would be difficult. She has looked at some of the RCAs and the added difficulty of how people pass through multiple services as well.

Mr Price asked about the deep dive and wondered why they had concentrated on suicides.

Ms Higgins replied that the team had seen an increase in the suicide numbers and added that they also see Sandwell suicides as well and the figures were increasing; this was from dashboard intelligence. The plan will be to do the same with diagnostics at RWT as well. With regards to staffing at BCP it is static.

Reduced CQC rating of Wolverhampton Nursing Home (Amber rated) – This has been reviewed and there are Wolverhampton residents in the home, there is a robust action plan and hopefully the home will have a revisit in November.

Mortality – This is still on track; hopefully see an improved SHMI in November 2019.

Breast Cancer – Hopefully see an improvement in November 2019; RAP predicted February 2020.

Ms Higgins asked for comments on the rest of the report.

Mr Price commented on the concerns around the sepsis pathway as it was expected to return to performance in June 2019.

Ms Higgins replied that sepsis has been delayed; there had been an IT provider delay to install e-sepsis by six months and advised that the old system for sepsis and deteriorating patient wasn't capturing the real picture. There was an issue with the 15 minute window to repeat observations and if it was repeated within the time then the patient would be removed off the system. She added that she has asked for improvement plan and trajectory in relation to late observations.

Ms Higgins agreed and added that sepsis has been achieved in the Emergency Department but not the inpatient services and stated that she could split the table to show this.

Mr Oatridge commented on Mental Health for the Black Country and the transition stage as they are merging again; it had been mentioned that their boards were sighted on the issues they had got. Their board will now look at other issues and asked how we will look at this going forward.

Ms Higgins replied that Mrs Roberts is now chairing the Joint CQRM and that she has regular meetings with the Deputy Chief Nurse and Mrs Roberts has meetings with the chief nurse; they have improved reporting following CCG challenge. CQC are due to go in and the trusts are asking for a delay to after the merge.

Ms Higgins agreed and advised that one of the attachments with the report is the report from the Duty of Candour review visit that took place at Black Country Partnership Foundation Trust on 17th June 2019 and the synopsis gave some assurance. The team will revisit in the middle of October 2019.

There has been an increase in the C *Diff* numbers for the Royal Wolverhampton Trust and the trust is looking at undertaking a deep dive into this but the rules for reporting has also changed.

The Maternity unit at the Royal Wolverhampton Trust has reduced their booking cap and Walsall has also removed their cap.

Mr Oatridge noted that there had been an increase in bookings in August.

Ms Higgins replied that the staffing is really good now in maternity. With regards to smoking at delivery this has decreased and it is thought that there is a link with Continuity of Care this is a positive with the LMS work and Saving Babies Lives. She added that the trust has also won an award for their work around workforce.

Dr Rajcholan referred the Committee to page 64 of the papers and the Compton Care visit and asked if they had they gone to EMIS and if they are able to see patients' notes from GPs yet.

Mr Hastings replied that Compton Care has gone to EMIS but there is no shared agreement as yet. He added that he had offered his team to help and support them and that he is meeting them very soon.

Ms Higgins advised that there is a new chief nurse at Compton Care.
The Committee **received** and **noted** the content of the report for assurance.

Mrs Corrigan joined the meeting.

QSC/19/099.2 Cancer and End of Life Update (Item 5.3)

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

Ms Higgins advised that Mrs Thorpe is doing lots of work with residential homes and especially the roll out of the Swan boxes as well as offering help to families. She will continue to support End of Life and support with the ICS. Mrs Thorpe is also supporting the roll out of the FREED document. With regards to FREED there is some good news that they have received £150k from HEE who had seen the booklet and got in touch to ask about working with this.

The Committee **received** and **noted** the content of the report.

QSC/19/099.3 Primary Care Report (Item 5.2)

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

Serious Incidents – One incident was referred to PPIGG around an Information Governance breach and they are awaiting some further information from the practice.

Quality Matters – Received quite a lot of activity over the last few months but were mainly incidents.

Ms Higgins stated that it is not for incident reporting and advised that they reviewing this process.

Practice Issues – There has been an issue with safeguarding reports, the response had been low; GPs are asked to provide reports. Mrs Corrigan and Ms Janavicius (Contracting) have been going to practices as they are not sending reports and apparently they are not sure they had to and when practices do sent them back they are not acknowledged. Mrs Corrigan and Lorraine Millard are going to practices to see what is happening; it appears that DOCMAN have told practices not to review the inbox.

Dr Rajcholan stated that the response time is a short reporting window.

Infection Prevention – There has been an improvement seen on last year.

Flu Programme – This is now up and running; there has been a delay for the under 65 years vaccines and some of them are ready for delivery a bit earlier than expected, as the delivery schedule was middle to then end of October.

Complaints – No data; expected at the end of the month.

FFT – There is an additional report which will be shared via Mrs Hough. This has been reviewed this month and there has been a good response. There a few practices that have got a low satisfaction rate; this may be due to more people responding, they have looked at low satisfaction and they are the same on the GP satisfactory survey and the triangulated data. There are no surprises from GPs as they are where there are issues. There is no qualitative data from FFT; this is only available at the individual practices, which is usually shared with their PPG.

ACTION: Mrs Corrigan/Mrs Hough

Collaborative Contracting Visits – There is a new cycle due to commence next month in collaboration with Public Health. The team will be taking intelligence from other areas such as FFT, CQC, Healthwatch etc.

Mrs Corrigan replied that they that they are undertaking check to see how they are doing and gets them prepared for CQC visits, which gives them a heads up if there are any concerns.

Dr Rajcholan asked how much notice is given to practices.

Mrs Corrigan replied that it is about one month as the practices need to do some pre-work first e.g. collecting policies, practice leaflets etc.

Mr Oatridge commented that in effect the team have a checklist to review; he asked if he could see a copy of the checklist.

ACTION: Mrs Corrigan

Mr McKenzie joined the meeting.

Ms Higgins stated that recently there had been a launch of the STP GPN strategy and advised that Mrs Corrigan had been instrumental with this from beginning to end.

Mrs Corrigan advised that she would share this document with the Committee and added that good feedback was received from attendees.

Ms Higgins added that there is not another GPN Strategy in the Country.

Mr Hastings enquired if Mrs Corrigan is putting it and herself forward for any awards.

Ms Higgins replied that Mrs Corrigan is having some dedicated time to evaluate the work undertaken.

The Committee **received** and **noted** the content of the report for assurance.

Mrs Corrigan left the meeting.

QSC/19/099.4 Information Governance Report (Item 5.4)

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

Mr McKenzie presented the Information Governance Report on behalf of Ms Huckvale.

Information Governance Work Plan 2019 – 2020 - The work plan that the Committee approved at the beginning of the year is being worked through.

Information Governance Incidents - There have been no IG incidents reported during quarter two. Ms Huckvale continues to support the CCG.

Quality Impact Assessments – These continue to be embedded in the processes.

Subject Access Requests - There was one Subject Access Request for information in quarter one and none in quarter two.

General Practice Information Governance Service: Summary of Uptake - Summary of support from Arden and Gem CSU. They are working through the work to be ready for the toolkit to be in place by the end of the year. The CCG has to submit a baseline assessment for the first time this year and has to be done by next month. This is an indication to say we have started the work and the final assessments are to be submitted at the end of the year.

Dr Rajcholan commented that there are two training sessions for general practices and queried if they were on line.

Mr McKenzie replied that they were face-to-face sessions; he was unsure if Arden and Gem are working with Lancashire or not.

The Committee **received** and **noted** the content of the report.

Mr Strickland joined the meeting.

QSC/19/099.5 FOI Report (Item 5.5)

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

Mr McKenzie presented the FOI report and advised that he pleased to share that they are 100% compliant with responding to FOI requests within the statutory 20 working days. The requests are generally made by the media and health service trade journals as well as private providers of health services, charities and pressure groups and students and researchers; they are usually the same subjects that are in the news.

Ms Higgins left the meeting.

Mr McKenzie stated that there are currently no concerns.

The Committee **received** the report and **noted** the details of requests received and dealt with during the quarter.

Mr McKenzie and Mr Oatridge left the meeting.

QSC/19/099.6 Business Continuity Report (Item 5.6)

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

NHSE Submission – The Core Standards submission requirement was met for Wolverhampton CCG and a rating of 'substantially compliant' had been approved by NHSE; Mr Hastings stated that he was happy with that rating. The CCG has worked on preparedness with the local providers too.

Ms Higgins and Ms Danks joined the meeting.

EU Exit – Mr Hastings advised that he had received a link this morning and have to complete daily SIT REPS starting next week; this is about our preparedness (attached in appendices). He stated that he had been to events around this and was due to present at JCC this week. He referred the Committee to Appendix 2 'Detailed EU Exit Information' which identified progress so far. He felt we were as prepared as we could be for the EU Exit on 31st October 2019.

The Committee **received** and **noted** the content of the report for assurance.

QSC/19/099.7 Quality Assurance in CHC Report (Item 5.7)

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

Ms Danks gave an update on NHS Funded Care Provision and advised that it is not too bad at the moment. Information has been received from Future Forums; the web site shows like for like; for eligibility the CCG are not the highest nor the lowest and our spend is low. The team are currently up to date with assessments and reviews. They are meeting with reviews in hospital as necessary and seeing patients within 28 days and there were no breaches in the last quarter. The forecast currently shows a slight underspend with an overspend on funding care and an overspend on CHC. The allocated QIPP of £375,000 has already been delivered.

Fast Track Tool - About a year ago they changed the fast track system with information being shared; the team is still getting fast tracks, there is still ongoing training on a rolling programme.

Mr Oatridge re-joined the meeting.

Fast tracks – Nearly 80% of patients received care at home, the others are placed within a placement.

Dr Rajcholan commented that GPs are not trained in fast track and advised that she was asked last week to sign a fast track form by a nurse.

Ms Danks stated that we don't normally accept the fast track if it is signed by somebody who has not been trained.

Dr Rajcholan offered to share the information about who this was with Ms Danks.

ACTION: Dr Rajcholan

Ms Danks stated that there is a lot of lack of understanding around the fast track process.

Ms Higgins suggested that maybe they could put some detail in the GP newsletter.

Ms Danks advised that the fast track is only needed if there are complex needs; it is getting more appropriate now. Compton Care are now filling in a lot of forms. The team are happy to provide more training and put a flow-chart with summary for newsletter.

Dr Rajcholan asked if the GP newsletter was also shared with District Nurses.

Ms Higgins replied that it is a GP newsletter and added that she is having 6 weekly meetings with the Community lead nurse.

Personal Health Budget (PHB) – This is slowly increasing; the system is working now with Public Health and there is a comprehensive joint shared plan, which is working well.

Mr Oatridge commented that you continue to transition all care packages and asked if people have to go through that route.

Ms Danks replied that yes they do have to go through that route but they don't have to manage it all; they can have direct payment and do it themselves or shared or manageable budget. We are in the process of moving over to PHB systems; it is working well with team; have shared detail and a good audit tool, we can now see money coming off balance and this is in place now.

Step down – The number of patients in step down is between 25 and 30 per week at the most. If there are issues they are coming through quality matters and if there are themes they can be shared with the provider. The QA system is delayed; the new system should be in place by the end of December 2019. This will be a paper free system and will be live and people can amend it themselves.

Complaints – The team receive very taxing complaints and they are being assessed through the appropriate channels; this has been flagged with NHSE/I with types of defamation of character which becomes personal even though it goes through the Ombudsman; NHSE need to assess them.

Decision Support Tools (DST) – The number of DST assessments has slightly decreased since the change to complete checklists in the community rather than acute care.

Staffing - The team is up to compliment with staff now; although there are currently two members of staff on sick leave.

STP Wide Work – There is a meeting this afternoon. The second market engagement event went very well on 13th September 2019. This was a positive event and the feedback allows concerns to be addressed, prior to the procurement going live in December 2019.

Mr Oatridge commented on the appeals process and asked if there was any independence involved.

Ms Danks replied that yes there is an independent chair involved.

Mr Oatridge asked if the chair was consistent.

Ms Danks replied that yes the chair is consistent. She added that they don't have to have it locally, but they do. If a case goes to an independent review; this takes place in Birmingham and then there are lots of independent reviewers. She stated that she is doing one a month at the moment.

Mr Oatridge asked if Ms Danks was seeing some themes.

Ms Danks replied that yes they are seeing themes as she has been involved in doing it for a long time now. The appeal process is now a half hour meeting.

The Committee **received** and **noted** the content of the report for assurance.

Ms Danks left the meeting.

QSC/19/100 Risk Review

QSC/19/100.1 Risk Register (Item 6.1)

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

Mr Strickland advised that he has received two updates since the distribution of the papers.

Committee Risks:

QS09: Royal Wolverhampton Trust (RWT) are currently not meeting NHS constitutional standards for Breast 2 week wait (2ww) cancer (16) – It was agreed that this could be reduced to 12 and is also picked up on the quality report as well.

The other Committee risks were:

- **QS06**: Royal Wolverhampton Trust (RWT) are currently not meeting NHS constitutional standards for 62 and 104 day cancer pathways (16)
- **QS13**: Supply of quadrivalent influenza vaccine (QIV) for 2019/20 influenza season from Sanofi (12)
- **QS07**: The Royal Wolverhampton Hospital (RWT) has higher than expected Summary Hospital-level Mortality Indicator (SHMI) (9)
- **QS11**: Safeguarding Transition from LSCB to MASA (8)
- **QS10**: Methods of transfer of data between non-GP provider and GP provider needs to be timely in line with the NHS England flu vaccination contractual requirements (6)

The Governing Body risks have been reviewed and have been reflected on the risk register.

Ms Higgins asked if RTT should be a risk.

Mr Hastings replied that we were awaiting the list cleansing at the moment; he was hopeful they would be able to remove around 2000 patients.

The Committee **received** and **noted** the corporate and committee risks.

QSC/19/100.2 Tolerate or Treat Risk Review (Item 6.2)

Mr Strickland advised that this was to be reviewed on a quarterly basis and it was to treat all risks on the committee agenda, to ensure that the Committee are happy with the risks. He stated that the Committee is treating all risks at the moment.

Ms Higgins advised that we will await the SHMI data as it is further decreasing.

Mr Oatridge enquired as to whether there were any items of our work covered by Shropshire and Telford NHS Trust (SaTH).

Mr Hastings replied that the biggest impact to us was ambulances and the modelling they didn't do was consider about the Royal Wolverhampton NHS Trust.

Ms Higgins added that with regards to the maternity capping, the trust might see an influx from SaTH.

Mr Hastings stated that they will also need to keep an eye on A&E.

Mr Strickland left the meeting.

QSC/19/101 Any Other Business

QSC/19/101.1 NOF – NHS Oversight Framework (Formerly IAF) (Item 7.1)

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

Mr Hastings advised that Mrs Moon is pulling this together and added that the detail within the report has moved on slightly; this originally went through the Finance and Performance Committee and some information from NHSE needs to be discussed at this meeting. The original Improvement and Assessment Framework (IAF) has been replaced with this, the NHS Oversight Framework (NOF) which reviews the improvement in performance. This is more about having a balance score card which reviews the balance against what is in our control. He referred the Committee to page 157 of the papers (Appendix 1) and advised that for all areas, we are balancing; the question is will it affect our rating we can look at the performance figures and see what our influence is. It has been back to the Finance and Performance Committee and they were happy to continue to work with us. He added that they have now been able to put a 'Quality' column in. Mrs Moon will meet with Mrs Roberts and Ms Higgins to progress with this. If anything is raised via CQRM or quality premium it will be added to this document. High scores are to be at the top of the document and will be monitored with the Senior Management Team (SMT).

Ms Higgins commented that this was a really good piece of work.

Mr Hastings stated that Mrs Moon has put a lot of work into this. We can look at areas where there is an issue and where we can influence. The report will be presented to the Finance and Performance Committee on a quarterly basis and will also come here on a quarterly basis too and will go to every SMT meeting which is on a fortnightly basis.

The Committee **agreed** this.

Mr Oatridge enquired as to when the STP move to an ICS will it be a scrutiny document.

Mr Hastings replied that yes it would, we have got our eyes on the dashboard information and added that we can look at other areas outside of the dashboard too.

Ms Higgins commented on smoking at delivery and advised that it was on here now which is really good.

Mr Hastings stated that it was a working document and is therefore not static.

Dr Rajcholan commented that there were seven ticks in the 'New' column and referred to number 21 'Evidence-based interventions' and asked what this was.

Mr Hastings replied that he would check this and get back to Dr Rajcholan.

ACTION: Mr Hastings

Dr Rajcholan commented on the score card and asked if that would get updated and come back here with an overall rating.

Mr Hastings replied that yes it would and added that things will change on a near daily basis.

The Committee **received** and **noted** the content of the report for recommendations to impact on performance.

QSC/19/102 Feedback from Associated Forums

QSC/19/102.1 Commissioning Committee (Item 8.1)

The Commissioning Committee minutes from 29th August 2019 were received for information/assurance.

QSC/19/102.2 CCG Governing Body (Item 8.2)

The CCG Governing Body minutes from 9th July 2019 were received for information/assurance.

QSC/19/102.3 NICE Group (Item 8.3)

The NICE Group minutes from 4th September 2019 were received for information/assurance.

QSC/19/102.4 Area Prescribing Committee Virtual Meeting (July 2019)

The Area Prescribing Committee Virtual Meeting minutes from July 2019 were received for information/assurance.

QSC/19/102.5 Quality Surveillance Group Quality Data Pack (Item 7.2)

The Quality Surveillance Group Quality Data Pack from the August 2019 meeting was received for information/assurance.

QSC/19/103 Items for Escalation/Feedback to CCG Governing Body

- EU Exit update

QSC/19/104 **Date of Next Meeting:** Tuesday 12th November 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.30pm

Apologies received from Dr Rajcholan for the next meeting.

Signed: …… **Date**: ……
Chair

NHS
Wolverhampton
Clinical Commissioning Group

Minutes of the Quality & Safety Committee
Tuesday 12th November 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Mike Hastings – Director of Operations, WCCG
Yvonne Higgins – Deputy Chief Nurse, WCCG
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:
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG

APOLOGIES:
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Sue McKie – Patient/Public Involvement – Lay Member
Ankush Mittal – Public Health, Wolverhampton Council
Dr R Rajcholan – WCCG Board Member

QSC/19/105 Apologies and Introductions

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

Mr Oatridge commented on the membership of the Committee and asked about lay clinical representation.

Mrs Roberts replied that there was somebody who was interested but has since withdrawn their interest and she thought it was probably best to wait until further decisions are made around shared Committees.

QSC/19/106 Declarations of Interest

No declarations of interest.

QSC/19/107 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/107.1 Minutes from the meeting held on 8th October 2019 (Item 3.1)

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

QSC/19/107.2 Action Log from meeting held on 8th October 2019 (Item 3.2)

QSC/19/088.1: Quality Report: Pressure Ulcers - Mrs Roberts advised that full RCAs are always undertaken and in care homes; an update next month will provide more data as to on the origin of PU.

It was agreed that this would be included in the Care Home report in December.

QSC/19/099.3: Primary Care Report: FFT – There is an additional report which will be shared via Mrs Hough.

This was sent by e-mail on 4th November 2019 and was also attached as item 3.2a

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

QSC/19/099.3: Primary Care Report: Collaborative Contracting Visits – Mr Oatridge commented that in effect the team have a checklist to review; he asked if he could see a copy of the checklist.

This was sent by e-mail on 4th November 2019 and was also attached as item 3.2b.

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

QSC/19/101.1: NOF – NHS Oversight Framework (Formerly IAF) – To find further information about 'Evidence-based interventions' and get back to Dr Rajcholan.

It has been confirmed that this is the national version of POLCV. This was sent by e-mail on 4th November 2019 and was also attached as item 3.2c

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

Mrs Roberts advised that Ms Gillian Shelley was planning to retire and she has got lots of knowledge and understanding on the primary care agenda.

Mr Hastings advised that Ms Jane Worton is working alongside Ms Shelley.

Mr Oatridge wondered if there should be some discussion at Governing Body around corporate memory.

Mr Hastings advised that this could be a Governing Body development session.

Mr Price wondered if this should be raised at Transition Board.

Mr Price advised that he would raise this at the Transition Board.

ACTION: Mr Price

QSC/19/108 Matters Arising

There were no matters arising.

QSC/19/109 Performance and Assurance Reports

QSC/19/109.1 Quality Report (Item 5.1)

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

Cancer Performance (Red rated) – With regards to the breast two week wait performance; RWT are in an ever improving position and as of last Thursday they were booking on day 12, Walsall and Dudley were both day 29. RWT have put on some 'Super Saturday Clinics' which has had an impact on their performance.

Mr Oatridge enquired about a one stop clinic.

Mrs Roberts replied that Walsall and RWT are offering a one stop clinic. Dudley are operating a 14 day pathway. The three mile radius rule has now been reduced with Walsall practices being removed.

Ms Higgins added that this was in line with the improvement plan.

Mr Oatridge enquired if there had been any reaction from the patients.

Mrs Roberts replied that she was aware that two people had refused to go to another hospital; one changed their mind and the other was seen by RWT.

Referral to treatment time incomplete pathway performance has not achieved the 92% target and is deteriorating (Red rated) – The trust is still not meeting the trajectory, an action plan is in place. There has been one harm review and there was no harm identified to the patient. Clinic capacity is being reviewed and waiting lists cleansed.

Mr Hastings added that this should impact by early November.

Ms Higgins advised that they will continue to monitor this.

Mr Price commented that this action was still red on the Quality Report and wondered if it was still on the risk register.

Ms Higgins replied that they will keep them on for now.

Mortality: Standardised Hospital Mortality Index (SHMI) (Amber rated) – This is showing an improving picture; it currently stands at 1.14 and thought they would also maintain this for next month. Coding at the trust has improved and co-morbidity coding had also improved. A lot of work has been and is still being done around the recognition of the deteriorating patient. The trust is re-launching and strengthening the critical care outreach team.

Some emerging concerns regarding nursing home being able to deliver to the Step Down Contract (Amber rated) – This was with regards to Primrose Hill; quality issues have decreased and they are no longer having safeguarding issues. Ms Higgins and Mrs Roberts visited the home last week and have received assurance.

Concerns around Sepsis Pathways (Amber rated) – There has been improved performance across the trust; ED has improved and have maintained their performance; work is now to be done on the in-patient services. The trust has now got a dashboard and it is expected to see improvement very soon.

Mr Oatridge asked if there were any specific wards/areas.

Ms Higgins replied that the sepsis team are looking into this; AMU will have a lot of sepsis triggers, they have got more real time data now and the sepsis team are identifying issues and they will go out to the wards to help staff.

Ms Higgins stated that work is being undertaken around the deteriorating patient. She added that she attended the mortality review meeting at the trust last week and assurance was received as work is being completed.

Mr Oatridge wondered if this will increase as we get closer to Christmas/winter.

Ms Higgins replied that the trust has recognised this and are revisiting training all staff. The hospital at night service is also being reviewed.

Mr Hastings commented on winter pressures and that they have normally had extra funding by now but noted that he hadn't seen anything.

Mrs Roberts agreed that there was nothing as yet.

Mr Oatridge commented on the winter pressure monies and asked where our vulnerability was.

Mrs Roberts advised that social work was an issue and there are two hot spots around domiciliary care and care homes. Flow and front door activity for RWT is the main issue. The trusts had a couple of ambulance diverts this weekend and need to monitor

Shropshire vulnerability.

Ms Higgins commented that there is a delay of care going to Staffordshire and there are weekly calls to help flow and pathway.

Mr Hastings stated that the A&E delivery board have allocated some monies through the year.

Mr Oatridge commented that with regards to winter monies he thought that it should be mentioned to the Governing Body this afternoon.

Mr Price advised that he thought the winter monies were given out at the beginning of the year.

Mrs Roberts commented on preparation for winter and advised that it is on the agenda for CQRM (RWT) with an update being provided next month.

BCP Workforce issues including 12 hour breaches and MH capacity (Amber rated) – A further visit took place in October 2019 to seek assurance from the provider around the Duty of Candour application and SI reporting process. It was a positive and assurance visit and it was pleasing to see that they had implemented feedback from us. Work continues with other private providers for access to beds to prevent 12 hour breaches and an action plan is to go to the A&E Delivery Board.

Reduced CQC rating of Wolverhampton Nursing Home (Amber rated) –

Mr Price commented that although good progress is being made wondered if they were still keeping it rated as amber and not changing it to green.

Ms Higgins replied that although it was thought it could go green in January/February 2020 CQC need to change the rating to Requires Improvement from inadequate before it changes. The QNAs have done brilliantly with supporting the homes during this time.

Mr Oatridge commented on the access to neurology consultants and wondered if Wolverhampton has any issues. Some GP referrals are taking 12-18 months. Some consultants are writing back to say that they are not ill enough to see them.

Mrs Roberts replied that this was not flagging through RTT; but was not surprised that there were issues as neurologists are small in numbers; UHT have been flagging for five years now. She added that head and neck have some issues but they are sighted on that and advised that she would review this.

ACTION: Mrs Roberts

C *Diff* – This is one to observe; reporting has changed this year. RWT is the only provider in the local area that are over trajectory and the only trend is PPI. A deep dive has been undertaken.

Mr Hastings asked when the maternity cap was removed.

Mrs Roberts replied that she thought it was August and added that Walsall lifted their cap earlier in the year; would need to keep an eye on the Shifnal numbers.

Ms Higgins added that RWT have more midwives now and they are meeting the birth-rate plus ratio.

Mr Price stated that this was really good to see there was lots of positive work being done and added that there has been no never events for three months and there were low numbers of complaints.

Mr Oatridge agreed that it had been a long time since the Committee had discussions about Never Events.

Ms Higgins stated that there is a really good electronic learning system now at the trust and added that they have done some really good work on this.

Mr Price wondered if the Committee could report back to Governing Body about the positives around Never Events etc.

Mrs Roberts replied that the CQC report should have come in now and they were expecting a positive report; Mental Health was an issue as well as a few issues with their medical wards and their staffing.

The Committee **received** the Quality Report for **assurance** purposes.

QSC/19/109.2 Primary Care Report (Item 5.2)

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

Flu Programme – The under 65 flu vaccines are now available; there are no national campaigns taking place. Healthwatch had a pop up shop in the Mander Centre and there was an issue with the trivalent last year which was then withdrawn.

There have been some batches of nasal flu vaccines which require further testing. This may impact on stock availability going forward.

Mr Oatridge asked about the over 65 flu vaccines issues.

Ms Higgins replied that we were OK with this.

Vaccination Programme – MMR screening will now form part of the practice visits.

Sepsis/E Coli – Training delivered on 14th November 2019.

FFT – There has been a lower response rate than normal but is still above national rates.

Ms Higgins advised that there was some good news that Mrs Corrigan had been successful in obtaining a STP Practice Nurse role.

Mrs Roberts stated that Mrs Corrigan has done some outstanding work and is leading nationally on Practice Nursing especially the work she has led with the Practice Nursing strategy it is the first STP policy across the country.

Mr Price commented on the 'Escalation to NHSE' and noted that there were two incidents and wondered if the CCG got feedback from these.

Ms Higgins replied no we don't get feedback it is discussed at PPIGG group and is treated confidentially.

Mr Price stated that there is no learning from it then.

Mrs Roberts asked Ms Higgins to raise it at Quality Surveillance Group.

ACTION: Ms Higgins

The Committee **received** the Primary Care Report for **assurance** purposes.

QSC/19/109.3 Health and Safety Performance Report (Item 5.3)

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

Mr Parvez advised that there had been an inspection from the external provider; there a couple of reds outstanding from the original action plan; these are mainly for the CHC area. A meeting is taking place today; there is some Health and Safety internal champions

and offered to provide an update in January for progress made. He referred the Committee to the Health and Safety Management Plan on page 81 of the papers and advised that it was at 'draft' stage and any comments on the plan are welcome.

Mrs Roberts advised that there are champions in each area; this was an outlier for a while but is now sorted.

Mr Oatridge commented on the current issues linking to key risks and the action plan assessment and asked if it was sufficiently acute and wondered if they should flag it on the risk register.

Mrs Roberts advised that the risks for CHC are on their team risk register and didn't think it should be on the main risk register.

Mr Hastings stated that the work is planned for two weekend's time and it will include some cable work.

Mr Oatridge confirmed that there would be feedback provided in January 2020.

The Committee received and **noted** the report and asked for feedback in January 2020.

QSC/19/109.4 E-Coli Report (Item 5.4)

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

Ms Higgins presented the E-Coli report and advised that some really good work has been done around this. In November 2018 the CCG was contacted by NHSI as Wolverhampton were in the bottom 30 CCGs for Gram Negative Bacteraemia; there has been lots of positive joint system working.

Dip or Not to dip – This focuses on stopping the inappropriate use of urine dipsticks for older and catheterised patients and focussing instead on number and type of symptoms as per NICE guidance. Mr Hemant Patel is leading on this. The project was originally intended to involve four homes with full roll out in 2020. A support group has been set up and all homes will be visited in 2019. Ms Higgins referred the Committee to appendix 3 and advised that they had adapted an assessment tool which was really helpful to guide people through the process. For Nursing Homes and Residential Homes it shows where they should go for help.

Hydration – This work is being led by Public Health.

Catheter Management - RWT have been leading on catheter management and are reviewing indwelling catheter time; there is now an improvement plan. The trust has now got a dashboard (Appendix 5); the bottom graph showed urinary catheter per occupied bed days; discharge information for people with catheters will be improved.

Project Impact – Ms Higgins advised that page 5 showed where we started in November 2018 and it is showing the work is having an impact. There is a real good system wide approach.

Ms Higgins advised that the catheter quality improvement project originally focussed on the acute setting and is now going to focus on the community.

The Committee **received** the update on progress with the reduction of E-Coli rates and the assurance provided relating to the Quality and Safety of the population.

Mr Strickland joined the meeting.

QSC/19/110 Risk Review

QSC/19/110.1 Risk Register (Item 6.1)

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

Mr Strickland advised that there were no new risks or updates apart from the SHMI; which was updated on Friday and was requested to be reduced to six if the committee was in agreement. Last month, the register didn't have the two week wait but is now reflected on the risk register.

RTT – The question was raised if this was a risk now.

Mr Hastings advised that the trust won't hit the target but it was acknowledged that the target was difficult to hit.

Mr Hastings commented that there might be a risk relating to corporate memory and advised that this would be discussed at Governing Body.

Mr Oatridge added that this was broader than just Quality and Safety.

Mr Hastings wondered how we would get this on a STP level risk register.

Mr Oatridge advised that this would be discussed at Governing Body today.

The Committee **received** and **noted** the corporate and committee risks.

Mr Strickland left the meeting.

QSC/19/111 Any Other Business

QSC/19/111.1 Cygnet, Coventry (Inadequate)

The CCG has one person within this provision but they have been reviewed by the case manager and assurance gained in relation to the environment and progress. This will be continued to be closely monitored.

QSC/19/112 Feedback from Associated Forums

QSC/19/112.1 Commissioning Committee Minutes (Item 8.1)

The Commissioning Committee minutes from 26th September 2019 were received for information/assurance.

QSC/19/112.2 Primary Care Operational Management Group Minutes (Item 8.2)

The Primary Care Operational Management Group minutes from 11th September 2019 were received for information/assurance.

QSC/19/113 Items for Escalation/Feedback to CCG Governing Body

- Winter monies
- Share positive issues
- Nasal flu
- Corporate memory

QSC/19/114 Date of Next Meeting: Tuesday 10th December 2019 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12:10pm

Signed: …… **Date**: ……
Chair

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Minutes of the Quality & Safety Committee
Tuesday 10th December 2019 at 10.30am in the CCG Main Meeting Room

PRESENT:
Dr R Rajcholan – WCCG Board Member (Chair)
Yvonne Higgins – Deputy Chief Nurse, WCCG
Sukhdip Parvez - Patient Quality and Safety Manager, WCCG
Sally Roberts – Chief Nurse, Director of Quality, WCCG

Lay Members:
Sue McKie – Patient/Public Involvement – Lay Member
Jim Oatridge – Lay Member

Patient Members:
Marlene Lambeth – Patient Representative

In attendance:
Liz Corrigan – Primary Care Quality Assurance Coordinator, WCCG
Mavis Foya – Quality Team, WCCG
Nicola Hough – PA to Chief Nurse, Director of Quality, WCCG
David King – EIHR Manager, WCCG
Matt Leak – Public Health, Wolverhampton Council
Peter McKenzie – Corporate Operations Manager, WCCG
Lorraine Millard – Designated Nurse Safeguarding Children, WCCG
Hemant Patel - Head of Medicines Optimisation, WCCG
Matt Reid – Acting Head of Nursing - Corporate Support Services
Ravi Seehra - Public Health, Wolverhampton Council
Lesley Thorpe – Primary Care Macmillan Nurse Facilitator, WCCG

APOLOGIES:
Mike Hastings – Director of Operations, WCCG
Annette Lawrence - Designated Adult Safeguarding Lead
Katrina McCormick – Children's SEND Programme Officer, WCCG
Ankush Mittal – Public Health, Wolverhampton Council
Peter Price – Independent Member – Lay Member
Phil Strickland - Governance & Risk Coordinator, WCCG

QSC/19/115 Apologies and Introductions

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

QSC/19/116 Declarations of Interest

No declarations of interest.

QSC/19/117 Minutes, Actions and Matters Arising from Previous Meeting

QSC/19/117.1 Minutes from the meeting held on 12th November 2019 (Item 3.1)

The minutes from the last meeting were read and agreed as a true record with a couple of minor amendments:

Apologies were received from Sue McKie

QSC/19/112.2 - Primary Care Operational Management Group Minutes

The Primary Care Operational Management Group minutes from 11th September 2019 were received for information/assurance.

QSC/19/117.2 Action Log from meeting held on 12th November 2019 (Item 3.2)

QSC/19/107.2: Corporate Memory - To raise this at the Transition Board.

This was discussed at Governing Body and it was agreed to take it to the Transition Board.

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

QSC/19/109.1: Quality Report - To review if there are any issues with regards to access to neurology consultants at RWT.

There were no delays, concerns at RWT.

Dr Rajcholan advised that a patient was referred in October and was offered an appointment for June.

Mr Oatridge commented that he had heard that some neuro-specialist at another trust had declined the referral as they thought the patients were not ill enough.

Mrs Roberts stated that all four Black Country CCGs are working on pathways and added that neurology will be one of them.

Mr Parvez informed the Committee that referrals are being seen between 9.4 weeks and a maximum of 20 weeks.

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

QSC/19/109.2: Primary Care Report - To raise at the Quality Surveillance Group (QSG) regarding incidents that are referred to NHSE for escalation and the feedback from them.

Ms Higgins advised that she had raised this issue and NHSE had said that they couldn't feedback on any individual performance queries raised.

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

QSC/19/099.7: Quality Assurance in CHC Report: Fast tracks – To share information about who asked Dr Rajcholan to sign a fast track form by a nurse.

Dr Rajcholan advised that this was for a COPD patient and would let Ms Danks know which nurse had asked her to sign the form.

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

QSC/19/088.1: Quality Report: Pressure Ulcers - 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.

Mrs Roberts advised that this information was in the report in item 5.4.

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

QSC/19/118 Matters Arising

There were no matters arising.

QSC/19/119 Performance and Assurance Reports

QSC/19/119.1 Quality Report (Item 5.1)

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

Cancer Performance (Red rated) – This was showing an improving picture and for the two week wait for breast, RWT was best in the Black Country at the moment; Walsall was working on day 27 and Dudley was on day 23 and the backlog had been reduced. RWT is

still having late tertiary referrals; Harm reviews continue to be conducted and no harm has been identified as yet. This still needs to stay as a red risk at the moment.

Referral to treatment time incomplete pathway performance has not achieved the 92% target and is deteriorating (Red rated) – An update has been provided and there was a slight improvement in October; a robust remedial action plan is in place. There are still issues in endoscopy and neurophysiology; there are no 52 week breaches but if there are they will go through a harm review process.

Mortality: Standardised Hospital Mortality Index (SHMI) (Amber rated) – This is showing an improving picture with the latest SHMI being at 1.14. PWC developed a tracker to show where they should be and they were hoping the trust will be within the funnel plot on the next data release.

Mrs Roberts added that RWT haven't been in the funnel plot in two years.

Ms Higgins stated that RWT was 122 out of 132 trusts across the Country. Work continues around End of Life pathways and the recognition and response of deteriorating patient; the trust is receiving fewer Dr Foster alerts.

Mr Oatridge asked if the tracker shows where they expect it to be.

Ms Higgins replied that it generates an expected SHMI; so far it has been quite accurate.

Mrs Roberts advised that she feels quite assured, the front door activity is good and patient flow is also good the trust is admitting the right patients with higher acuity of patients; however, there is still more work to do in the Community.

Concerns around Sepsis Pathways (Amber rated) – ED has shown sustained improvement. ED data is prevalence data. Inpatient areas data still remains concerning, although some improvement is apparent.

Dr Rajcholan stated that the report says that the PGDs are due to be in place by November 2019 and added that it would be good to mention it at CQRM.

C *Diff* Numbers – Ms Higgins advised that the trust is over trajectory for C *Diff* and added that the new reporting is being given as an issue.

Mr Parvez added that there was a spike in the number of cases in September and the trust are reviewing staff training.

BCP Workforce issues including 12 hour breaches and MH capacity (Amber rated) – CQC have inspected and the Trust are awaiting the report; workforce issues remain as amber; sickness rates have reduced. Challenge continues regarding improved reporting to CQRM; Wolverhampton CCG presented the suicide themed review they had undertaken and BCP thanked the CCG for it; the trust response to the review will be presented in January. There was a 12 hour breach recently, but this was due to them awaiting bariatric transport.

Mrs Roberts advised that the 12 hour breaches have improved.

Mr Oatridge asked where they were at with the merger and what it meant for management as he felt it may impact on quality.

Mrs Roberts replied that they had interviewed for their Chief Executive. She is having conversations with the two current Chief Nurses and they are aligning their work. They are working on the merger by the 1st April 2020.

Reduced CQC rating of Wolverhampton Nursing Home (Amber rated) – This is also showing an improving picture; there are now no inadequate ratings for Nursing Homes across the City. GPs have commented on the D2A and the quality of discharge information coming from RWT as it is inappropriate or not effectively communicated.

Formal Complaints – Mrs Roberts advised that she has seen a significant improvement around formal complaints at Wolverhampton CCG; there used to be some regular complainants but have managed to divert them now and added that this is showing proper numbers of complaints now.

Ms Higgins referred the Committee to the appendix to the report (Quality Matters Report) which identifies that there is an increase in quality matters for BCP; this has gone to the trust and is mainly around access and pathways.

Mr Parvez added that there had been six issues raised in the last three quarters and is mainly around waiting times.

Dr Rajcholan referred to page 44 of the papers and added that the wellbeing service needs reviewing

Ms Higgins agreed that they are looking at reviewing services and added that Quality Matters works really well thanks to GPs and the teams and advised that the information is really valuable.

Ms McKie stated that it was helpful to see the scenarios.

Mrs Roberts confirmed that there are some concerns relating to pathways at BCP currently.

Dr Rajcholan commented on the access to some services.

Mrs Corrigan joined the meeting.

Mr Oatridge referred the Committee to the graph on page 12 of the report and thought he may be misunderstanding the numbers for BCP serious incident types reported.

Mr Parvez confirmed that there was an error on this graph as BCP didn't have any SIs reported for the month of October 2019.

Mr Oatridge confirmed that the numbers for BCP was still zero.

This was confirmed.

The Committee **received** the Quality Report for **assurance** purposes.

QSC/19/119.2 Primary Care Report (Item 5.2)

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

Serious Incidents – There were no current SIs for Primary Care. However, there were a few items to go to PPIGG.

Quality Matters – There were 13 open Quality Matters but in the narrative in the report it says there were 10 open, it was confirmed that there were 13 open Quality Matters.

Infection Prevention – The average IP rating was 95%; last year was 93% so it is improving.

Flu Programme – The uptake has not been as good as expected for the under 65s and pregnant women; there had been an issue with the under 65 vaccines initially.

MMR Vaccination Programme – The uptake for this was slightly lower than average. However 2018/2019 was the latest figures available.

Sepsis/E Coli – Training is taken place and now includes catheter care.

Mr Patel joined the meeting.

Complaints – There was no new complaints data available at present.

FFT – The uptake was really good in September 2019 with three practices not submitting; this was due to annual leave.

Collaborative Contracting Visits – The new cycle started again in November; they have visited Whitmore Reans which was a good visit. Four more visits are planned before March 2020.

CQC – There were two practices that had 'Requires Improvement' rating at the time of the report being written. However, one has been lifted and has got a 'Good' rating now.

Workforce Activity – Work around GP work continues; programmes are in place for staff that are due to retire to try and retain them. There is also a programme in place for newly qualified nurses being offered mentorship.

Mrs Roberts commented on flu generally and it has also been noted that there are some CCG staff that have had their flu vaccination and added that RWT staff flu immunisation data could be improved.

Mr Leak stated that he had received an update on the flu uptake: for over 65s it was 63.6%, for the under 65s it was 32.8% and pregnant ladies was 32.6%. The 'Flu Fighters' received an award yesterday for the work undertaken.

Mr Oatridge commented on the IP audits and that some areas were non-compliant for sinks and wondered if there were any remedial actions being put in place with this.

Mrs Corrigan replied that these issues are now with Estates; the areas receive an advisory notice rather than a mandatory notice and added that if they need to replace sinks they will. The areas are audited against hospital standards.

Mr Oatridge asked if the next report could highlight if the issues are advisory or mandated.

ACTION: Mrs Corrigan

Ms Higgins thanked Mrs Corrigan for her comprehensive reports and wished her well in her new role.

The Committee **received** the Primary Care Report for **assurance** purposes.

Mrs Corrigan left the meeting and Ms Brennan and Ms Stone joined the meeting.

QSC/19/119.3 Medicine Optimisation Report (Item 5.7)

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

Mr Patel advised that there were two issues on the report that the Committee needed to be aware of:

Section 2.3 – Managing Medicines in Care Homes
Section 2.5 – Transfer of Care around Medicines (TCAM).

Section 2.3 – Managing Medicines in Care Homes: Pharmacists are going out doing appropriate reviews within the care homes; which has been commended locally and nationally.

Section 2.5 – Transfer of Care around Medicines (TCAM): Each service links the community pharmacy with local trusts. The system now delivers a discharge summary which goes to the GP and the pharmacy via e-mail through to GP from discharge. The Pharmacy then contacts the patient to identify if they have had a change of medications. This is helping with costs, time, risk, safety etc. We are the first in the region to go live

with this, Walsall are going live currently and Dudley and Sandwell following later. A reduction of Length of Stay has also been seen.

Dr Rajcholan asked how many community pharmacists there were.

Mr Patel replied that Wolverhampton have 67 community pharmacists.

Dr Rajcholan asked if this was linked to all GP practices.

Mr Patel replied that it was and it was mainly for high risk patients at the moment.

Mrs Roberts stated that she is meeting with Dr Odum (Medical Director at RWT) and Angela Davis (Head Pharmacist at RWT). It really works and it is good to properly evaluate the system.

Dr Rajcholan asked if they will benefit systems outcomes.

Mr Patel replied that yes it would.

Dr Rajcholan commented on the medication review service section on page 2 of the annual report and had noted that there were 5 fewer homes visited this year.

Mr Patel commented that there were 15 homes visited in the previous year and 10 this year. However, the homes are bigger and so they are get through a lot more.

Dr Rajcholan stated that it was very good work undertaken and led by Dr Hutchinson.

Mrs Roberts commented on RWT and their Medicines Safety and advised that they had identified issues around safety and she is not completely assured; she thought CQC may have picked that up too.

Mrs Roberts asked Mr Patel for an update on this in the next quarterly report.

ACTION: Mr Patel

Mrs Roberts stated that there is lots of really good work going on.

Mr Oatridge asked if there were any concerns around the next two to three months around medicines and have we got a system as to whom it will affect (Brexit).

Mr Patel replied that the system will identify patients and advised that legislative updates have come in now.

Mr Oatridge asked if there were any concerns about Wolverhampton patients.

Mr Patel stated that they have got everything in place that they can have.

The Committee **received** the report for assurance purposes.

Mr Patel left the meeting and Ms Henriques-Dillon, Mrs Thorpe and Mr Reid joined the meeting.

QSC/19/119.4 Safeguarding - Adults, Children and Children and Young People in Care Report (Item 5.3)

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

Safeguarding Adults

The new accountability framework has now been published and the team are working towards this.

WCCG Statutory Responsibilities: The Safeguarding Commissioning Assurance Toolkit (S-CAT) has been distributed by NHSE for completion by the WCCG Safeguarding Team by the end of November 2019.

Training: A CCG wide safeguarding training needs analysis has taken place.

Domestic Homicide Reviews (DHR) – There are currently 11 in progress.

Safeguarding Adult Reviews (SAR) – There was one SAR which was published on 9th August 2019 and the link was available in the report.

NHSE Funded Safeguarding Project (Hard to Reach Communities): £10,000 has been provided by NHS England to support extension of this project into other vulnerable communities.

Safeguarding STP Working Group: This collaborative work continues and there are nine workstreams each led by a designated professional from a CCG with members from both CCGs and providers from across the Black Country.

NHSE Funding – STP Training Event 'Our Voices, Our Shoes': The second event was held in September 2019. The conference saw 157 children, young people and professionals jointly exploring how health services can be delivered more effectively and was a great success. 127 pledges were made by the delegates of ways that the learning and messages they had been given on the day, were going to be taken in to their daily personal and working lives, in order to make changes and support this vulnerable group.

Wolverhampton Safeguarding Together (WST) – Guidelines were put out at the end of September and officially commenced on the 29th September 2019.

Section 11 Audit – A regional template was provided to self-assess services against the score descriptors assessing whether we are outstanding, good, requires improvement or inadequate which was completed by the safeguarding children designates. Positively the rating in 96% of areas within the CCG was either Outstanding or Good. An action plan is to be formulated to support the CCG becoming outstanding in all areas of this audit.

Learning Disabilities Mortality Reviews (LeDeR) – Wolverhampton continue to be at the most favourable place in the Black Country and work is ongoing across the STP.

Mrs Roberts referred to section 2.4 of the report and advised that the table top review was in regards to the West Park murder and that they are expecting significant learning. With regards to LeDeR, we are in a good position for Wolverhampton but the Black Country as a system is an issue and will continue to be scrutinised until we have zero outstanding cases.

Black Country Partnership Safeguarding Review –A meeting is planned over the next couple of weeks in regards to the concerns previously raised.

Dr Rajcholan commented that the report stated that DoLs is being replaced by Liberty Protection Safeguards in October 2020 and wondered if awareness of this had been raised with GPs and the Community.

Ms Higgins advised that she would take this query back to Ms Lawrence.

ACTION: Ms Higgins

Children and Young People in Care (CYPiC)

Local Demographics – The numbers of our CYPiC has dropped slightly over the last quarter, from 613 (June 2019) to 595 in September 2019, with Wolverhampton being one of only three authorities in the region that has reduced in numbers. Looked After Children kept in Wolverhampton has gone from 40% - 50%. Children currently placed further than 50 miles away remains low at 8%.

With regards to the STP; the commissioning arrangements for CAMHS is being bought together and should help with transferring children across areas.

Raising the profile of Safeguarding of LAC – Discussions are taking place at Safeguarding Wolverhampton Together meetings.

Mr Oatridge referred to section 5.0 of the report - Providers and commented that there appears to be a capacity issue at RWT.

Ms Brennan replied that the CCG contracts team are reviewing this.

The Committee received and **noted** the report

Ms Brennan and Ms Stone left the meeting.

QSC/19/119.5 Quality Assurance in Care Home Report (Item 5.4)

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

Serious Incidents – Wulfrun Rose have been experiencing some issues, but have now got a new team leader.

Mr Oatridge left the meeting.

Pressure Ulcers – Training has not been embedded in some homes.

Slips, Trips and Falls – There were two incidents with serious injury reported in quarter 2. Failings were due to the lack of robust assessments which also correlates with not recognising deterioration.

Performance Data – A lot of work has been done around this. A &E attendances have decreased from 8% to 5.1% and hospital admissions from 4.6% to 2.7%.

Ms Higgins added that as we are going into the Winter months, we might see a peak in this.

Ms Henriques-Dillon advised that the highest call out rates were from two homes that are dual registered as nursing and residential care homes (Wulfrun Rose and Sunrise).

Ms Higgins advised that the CCG has had their first FREED meeting and they have agreed to widen the remit to also include residential and care homes.

Ms Henriques-Dillon advised that the top reasons for call outs were respiratory, falls and suspected sepsis.

Utilisation of the RITS Team – There has been a reduction in GP call outs, but this is fluctuating month on month.

Mr McKenzie joined the meeting.

Mrs Roberts added that enhanced ward rounds will help with this and they will continue to get this data.

Ms Henriques-Dillon advised that they will review which homes this is for in the next quarter.

Mortality Data – This is showing an improved picture; people are dying in their preferred place of care/preferred place of death.

Dr Rajcholan commented on the end of life and the DNACPR forms and advised that she had tried to send a form to WMAS but they have now got another form.

Ms Higgins stated that WMAS have now said that whatever form is provided WMAS will accept and added that the system will now go with RESPECT too.

CQC Rating – There are more nursing homes in the city rated 'good' by CQC now.

Safeguarding Referrals – There are not many referrals coming through now and processes are in place.

Outbreaks in Care Homes – There have been a Norovirus outbreak in one nursing home and one residential home.

Flu – The team are promoting flu prevention; based on patients address they are targeting homes that are showing less than 60% of residents who have been vaccinated.

Quality Improvement – The team have produced a 'Best Practice Guidelines' pocket guide to support and implement best practice and NICE guidelines. As part of digital transformation there were eight nursing homes that had completed the Information Governance Toolkit and have nhs.net account to facilitate safer data transfer. Since the report was written that are now 26 homes across the City with NHS.Net.

Ms Higgins stated that the pocket sized best practice guidelines are really good.

Dr Rajcholan congratulated Mrs Henriques-Dillon and the team.

Mrs Roberts stated that the report was really good and had lots of detail in it and was commendable work.

The Committee **received** the report and **noted** the positive outcomes the QNA team are having with improving quality, safety and admission avoidance across the nursing care home sector.

Ms Henriques-Dillon left the meeting.

QSC/19/119.6 SEND Update (Item 5.5)

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

The SEND Health Local Offer review has now been reviewed. A Strategy has been co-produced and the three year delivery plan is also in place. The team are now working on what the review findings were saying. CAMHS continue to be highlighted by parents. Governance processes for SEND have now been strengthened.

Mrs Roberts advised that the system is now overdue an inspection and it was expected to be before March 2020.

The Committee **received** and **noted** the content of the report.

QSC/19/119.7 Cancer and End of Life Update (Item 5.6)

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

Projects Ongoing:

Swan Project –The Swan emblem is a visual guide and one that forms recognition that the patient is entering the last phase of their illness. It acts as a prompt for all cares and professionals to act appropriately, whatever their role is, to protect the patients' dignity and respect, whilst supporting the families and carers. This philosophy is to be rolled out into Wolverhampton care homes and community care. The ICA End of Life group has a Task and Finish group looking at the roll out of the Swan program into primary care.

Red Bag Project – A new project lead has now been appointed.

Mr King joined the meeting.

STP Community Cancer Champions – They have won £30,000 to improve screening and they have asked for members of the public who would be interested in for training programmes.

RESPECT – This is being rolled out next year; Mrs Thorpe is going to Worcester to see how they have implemented it.

Stop and Watch Early Warning Tool - This project is also being rolled out and is an early warning tool for relatives, carers and nurses to use to spot soft signs of deterioration.

Wolverhampton's Collaborative Cancer Strategy (2019 – 2024) – This is available to review if anybody wants to see it.

The Committee **received** the report and noted the work being undertaken by the Macmillan Primary Care Nurse Facilitator.

Mrs Thorpe left the meeting.

QSC/19/119.8 Equality and Diversity Report (Item 5.8)

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

Mr King advised that the CCG publications are where they should be. He recently attended the CQRM (RWT) and he advised them that there were some things missing on their website. This will be reviewed for the next quarterly update as they had informed Mr King that they were addressing it.

Mrs Roberts replied that they had received good assurance. She added that they had undertaken an internal audit of the CCG and there was nothing to flag; there was one low level assurance. Further information will be provided to the next meeting.

ACTION: Mrs Hough

The Committee **received** and noted the contents of the report.

Mr King left the meeting.

QSC/19/119.9 Infection Prevention Service Update (Item 5.9)

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

Matt Reid presented the Infection Prevention Service report and highlighted the following:

Outbreaks – Over the last quarter there was one norovirus outbreak across the homes across the region. There had also been a flu outbreak.

GP Audit data – The scores are good; there is some non-compliance and feedback is given to the areas at the time.

C *Diff* – The trust has got a trajectory of no more than 40 cases for the year and they are currently at 32 with there being one last month. The CCGs trajectory was no more than 48 cases for the year and they were at 29 by mid-December. It is not possible to compare data with where they were last year as the definitions have changed.

Gram Negative Bacteraemia – There is a meeting at the trust on 18th December 2019 regarding this and there is Quality Improvement work being undertaken around urinary catheters and documentation.

Ms Higgins suggested that it might be useful to have a Nursing Home manager present at

the meeting.

Total Gram Negative – There has been a slight decrease this year.

Ms Higgins commented that they will hopefully see an impact of the Dip or Not to Dip project soon.

Mrs Roberts stated that it was really helpful to see the data in the report with a good level of assurance.

The Committee **received** and **noted** the contents of the report.

Mr Reid and Mrs Roberts left the meeting.

QSC/19/119.10 Public Health Update (Item 5.10)

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

Mr Leak presented the Public Health report and advised that it was the first report from Public Health in its current format. Mr Leak asked what the Committee would like to see with regards to the Primary Care data. He added that there is now a principal specialist over each area within Public Health and thought it would be more useful to have quarterly reports and updates from the leads.

Ms Higgins stated that she would meet with Mr Leak to discuss this with him and she would let the Committee know what will be presented.

The Committee **received** the update of NHS facing Public Health commissioned services and other specific areas of interest for assurance and scrutiny.

QSC/19/120 Risk Review

QSC/19/120.1 Risk Register (Item 6.1)

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

There was one new risk that had been added to the Committee's risk register which was with regards to the nasal vaccine shortages (QS14). It needed to be reviewed and the Committee was asked if they wanted to reduce the current score of 12 or for it be removed.

The Committee **agreed** for the risk to be removed from off the risk register.

RWT 2 week wait breast (QS09) – The Committee were asked if they wanted to decrease the current score of 12 as the trust has sustained it for a while now.

Mr McKenzie advised that the risk was due for a review.

The Committee **agreed** to decrease the rating.

Safeguarding Transition (QS11) – Ms Higgins advised that this might need to be reviewed too.

QSC/19/121 Items for Consideration

QSC/19/121.1 CCG Complaints Policy (Item 7.1)

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

Ms Higgins advised that an extra section has been added to the complaints policy around vexatious complainants, she added that it had been to SMT and approved there.

The Committee **agreed** to the changes of the Complaints Policy.

QSC/19/121.2 Information Governance – Caldicott Guardian (Item 7.2)

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

Mr McKenzie advised that this was a formal request to change the CCG Caldicott Guardian from Helen Hibbs. He added that the guidance states that it should be a senior clinician and Sally Roberts was suggested and she was happy to take that on.

The Committee **agreed** to designate the Chief Nurse, Director of Quality (Sally Roberts) as the organisation's Caldicott Guardian.

QSC/19/122 Any Other Business (Item 8)

There were no items to be raised as any other business.

QSC/19/123 Feedback from Associated Forums

QSC/19/123.1 Commissioning Committee Minutes (Item 9.1)

The Commissioning Committee minutes from 31st October 2019 were received for information/assurance.

QSC/19/123.2 Primary Care Operational Management Group Minutes (Item 9.2)

The Primary Care Operational Management Group minutes from 23rd October 2019 were received for information/assurance.

QSC/19/123.3 CCG Governing Body minutes (Item 9.3)

The CCG Governing Body minutes from 10th September 2019 were received for information/assurance.

QSC/19/123.4 Finance and Performance Report (Item 9.4)

The Finance and Performance quarterly report was received for information/assurance.

QSC/19/123.5 Quality Surveillance Group Update (Item 9.5)

The Quality Surveillance Group update was received for information/assurance.

QSC/19/123.6 Health and Wellbeing Board Minutes (Item 9.6)

The Health and Wellbeing Board Minutes from 16th October 2019 were received for information/assurance.

QSC/19/124 Items for Escalation/Feedback to CCG Governing Body

There were no items for escalation/feedback to CCG Governing Body.

QSC/19/125 Date of Next Meeting: Tuesday 14th January 2020 at 10.30am in the Main Meeting Room, Wolverhampton Clinical Commissioning Group.

Meeting closed at 12.40pm

Signed: …… **Date**: ……
Chair

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 29th October 2019
Science Park, Wolverhampton

Present:

Mr L Trigg	Independent Committee Member (Chair)
Dr M Asghar	Deputy Clinical Lead for Finance and Performance (part meeting)
Dr D Bush	Clinical Lead for Finance and Performance
Mr T Gallagher	Director of Finance
Mr S Marshall	Director of Strategy and Transformation
Mr V Middlemiss	Head of Contracting and Procurement
Mrs L Sawrey	Deputy Chief Finance Officer

In attendance

Mrs H Pidoux	Business Operations Support Manager
Mrs E Reade	Performance Support Officer

1. Apologies

Apologies were submitted by Mr Green, Mr Hastings and Mrs Moon.

2. Declarations of Interest

FP.428 There were no declarations of interest.

3. Minutes of the last meetings held on 24th September 2019

FP.429 The minutes of the last meeting were agreed as a correct record.

Resolved: The above was noted.

4. Resolution Log

FP.430 There were no outstanding items to consider.

5. Matters Arising from the minutes of the meeting held on 24th September 2019

FP.431 There were no matters arising to discuss from the last meeting.

6. Review of the Risk Register

FP.432 The register was reviewed and there were no updates to be made.

9. Performance Report

FP.433 Mrs Reade presented the report on the behalf of Mr Hastings;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment – at the Contract Review meeting the Trust had reported that the recovery period, originally to October, will be pushed back further.
- 52 week waits – there were no patients waiting 52+ weeks to start treatment. One patient had been wrongly reported as exceeding this, however, it was identified that the patient's clock had been stopped incorrectly. This was actioned as soon as this was discovered and a root cause analysis had found that there was no harm to the patient.
- Data validation of waiting list is underway with the focus of reducing the backlog to the March 19 position.
- There had been a decrease in diagnostic performance which was below standard for the first time since January. Support from a private sector provider is being investigated to alleviate pressure on the Endoscopy Department. Full recovery is expected by October 19.
- Performance of 88.5% is being achieved against the national standard of 95% for A&E attendances admitted, transferred or discharge within 4 hours from arrival in September. Whilst performance remains challenged across the country RWT are performing well against other local providers. England performance is at 77.0% and the Black Country STP is at 83.2%
- There was one 12 hour breach which was mental health related and 3 8 hour breaches, non-mental health related, due to capacity issues.
- Cancer targets - performance against the 14 day target had improved following diversion of referrals. Daily monitoring is being undertaken across the 3 areas, Wolverhampton, Dudley and Walsall, to maintain parity. The performance for 62 waits remains static, however, the Trust was reporting that this is not expected to recover by March 2020 trajectory. A request had been made to revise the cancer trajectory and this would be discussed during the weekly cancer call held each Friday.
- C. Diff – figures had increase due to new reporting laws. The CCG's Quality team are working closely with the Trust to reduce the number of cases.

Dr Asghar joined the meeting.

- IAPT – this target is being changed and updated prevalence figures (denominator for indicator) had been made available, however, as the figures had 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.

Resolved: That the report be noted.

Finance Report

FP.434 Mrs Sawrey introduced the report relating to Month 6, September 2019 highlighting the following key points;

- All metrics in relation to financial performance were currently being met. There had not been much movement in the position.
- There is an underspend of £750k at Nuffield. An additional £1m was included in the contract last year, however, it had been identified that this was based on incorrect data. Therefore, the underspend was due to overbilling by the provider last year rather than a drop in activity.
- It was highlighted that RWT are almost at the collar of the cost and volume contract agreement. Activity is low in community and there is a need to understand why this is. Due to proposed changes vacancies had been put on hold which had impacted on activity.
- The position reported at Month 4 before the application of the agreement showed an over performance of £3.3 under National Tariff and an over performance of £1.2m after the application of the AIS.
- The impact of coding changes are being reviewed and this needs to be bottomed out in order to determine the baseline for 20/21. This will carried out internally at the CCG and brought back to the Committee for consideration when completed.
- The preferred option would be to adopt a Risk gain share agreement for the next financial year rather than the adoption of the national tariff and the impact of the coding issues needs to be resolved prior to this being implemented.

Resolved: The Committee noted the updates given

7. Contracting Report

FP.435 Mr Middlemiss presented the following key points;

Royal Wolverhampton NHS Trust (RWT)

- Dermatology – mobilisation of this service is at risk due to;
    - Workforce/TUPE - the Trust had confirmed that there are no staff that will transfer from the Trust to Circle (the new provider). It had been expected that, as previously indicated by the Trust, staff would transfer and therefore Circle could not recruit as confirmation of numbers were needed. Circle have stated that even with expedited recruitment staff

would not be in place for the service to commence on 1st December.

- IT & transition of patient data – as part of the mobilisation plan the new provider requires the Trust to agree datasets and commence downloads by 31st October, which had not occurred.

Circle have escalated these issues as they are not able to take on people on the waiting list due to the level of risk. The focus will be on the transfer from the current community provider and new referrals. RWT have stated that there are plans to clear the backlog; however, the timescale for this is unknown.

It was confirmed that there are no stranded costs for staff. The only costs are for overheads and these would be considered time limited to the end of the financial year.

Communication will need to be circulated to GPs; however, the definitive position needs to be known prior to doing this.

Consideration was given as to whether this was a specific risk for this Committee. The Committee were informed that this risk is already being considered by the Commissioning Committee. It was agreed that was the most appropriate place as the risk is organisational and not financial.

- Phoenix Walk In Centre – Acceptance of the business case to extend the service to an Urgent Treat Centre had the caveat that it was a requirement to make available to the CCG information for all attendances, based on the national dataset for Emergency Care. The response letter from the Trust had been received but did not give this assurance. A meeting is to be held to discuss as this data is essential and there are concerns around the quality of data available.

  There was no activity detail contained in the business case. It is currently a block arrangement and detailed information is required from 1st April 2020 to facilitate meaningful contract negotiations or it would remain a block arrangement.

Black Country Partnership Foundation Trust (BCPFT)

- Transfer of the Non Contract Activity funding to the Provider – the provider had requested assurance around indemnity of providers out of area placements. It is unclear why this is required as operationally the placement has not changed and all the budget is held by them. The Trust's position is that it would prefer the CCG to continue to hold the budget while improvements are made to out of area placements. This is to be

escalated to the Chief Executive at the Trust and then the regulator if necessary. It was queried if there was to be a shadow running period and where any additional costs would lie. It was agreed to share this information with Mr Marshall.

- Non-Emergency Patient Transport Services – re-procurement had concluded and the outcome had been agreed by Wolverhampton CCG's Governing Body. As this is a joint decision with Dudley CCG, the outcome of their decision is awaited.

Resolved: The Committee noted the update given and the actions undertaken.

8. Additions/updates to Risk Register

FP.436 There were no updates to the register on this occasion.

Resolved: The Committee noted the contents of the report and supported the proposal.

10. Any other Business

FP.437 There were no items raised.

Resolved: The Committee noted the contents of the report.

11. Date and time of next meeting

FP.438 Tuesday 26th November 2019 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 27th November 2019
Science Park, Wolverhampton

Present:

Mr L Trigg	Independent Committee Member (Chair)
Dr M Asghar	Deputy Clinical Lead for Finance and Performance (part meeting)
Dr D Bush	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 V Middlemiss	Head of Contracting and Procurement
Mrs L Sawrey	Deputy Chief Finance Officer

In attendance

Mrs G Moon	Business Operations Manager
Mrs H Pidoux	Business Operations Support Manager

1. Apologies

Apologies were submitted by Mr Marshall

2. Declarations of Interest

FP.439 There were no declarations of interest.

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

FP.440 The minutes of the last meeting were agreed as a correct record.

Resolved: The above was noted.

4. Resolution Log

FP.441 There were no outstanding items to consider.

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

FP.442 It was noted that a risk had been added to the Commissioning Committee Risk Register in relation to the mobilisation of the reprocured dermatology service.

6. Review of the Risk Register

FP.443 The register was reviewed and the following noted;

CR18 - Failure to Delivery Long Term Financial Strategy – Mr Green reported on the latest STP submission of meeting future targets. The final STP plan will set out how this can be addressed and the consequences. Further updates will be given to this meeting as appropriate and Mr Gallagher to update risk register to reflect this.

7. Contracting Report

Mr Middlemiss presented the following key points;

Royal Wolverhampton NHS Trust (RWT)

Contract performance – acute over-performance had been highlighted at the RWT Contract Review meeting and will continue to be closely monitored. Community performance is significantly under-performing which will impact on how this is contracted in 2020/21

The second meeting of the planning round for 2020/21 had been held and agreement was reached that the approach should be open and collaborative. The CCG flagged the additional financial challenge as a consequence of the additional contribution to support the overall regional position. A one page breakdown of the final plan submission was shared including the assumed level of QIPP and the gap, to allow discussion to be more focussed and to give direction to the sub groups.

Dermatology – The level of risk was now not as high as previously reported. A start date of 31st March 2020 had been agreed with Circle, the new provider. Interim provision had been agreed with the current provider. This approach allows Circle to commence in a planned way. Recruitment to posts had commenced as staff are not to be TUPE'd from RWT. Agreement had been reached that it will be RWT's responsibility to address the backlog and will take on new patients up to, and including, 22nd November. A breakdown of new and follow up numbers are to be confirmed by RWT for the Contract Variation Order (CVO).

The reason for there being no TUPE'd staff was raised and it was confirmed that the trust had not shared full details on this. Clarification was given that the issue of stranded costs was no longer relevant due to the change in circumstances. It was queried if the delay had caused additional costs? The detail was not known, however, plans for this were included in the procurement and provision made in the LongTerm

Financial Model. The costs for Omnes (formerly Concordia), the current provider, for the additional four months were known and it was anticipated that this would not cause a cost pressure for this year.

Phoenix Walk In Centre – in relation to the conversion to an Urgent Care Centre there are two outstanding issues; the recording of activity and the capture of the Emergency Care Dataset. Data quality is paramount for the Urgent Care Strategy. Offers of support from the CCG to resolve access to data issues had been declined. It was agreed that Mr Hastings would escalate this. Before the Contract Variation can be signed for the investment to be transferred these issues need to be resolved.

Black Country Partnership Foundation Trust (BCPFT)

Transfer of the Non Contract Activity funding to the Provider – the trust had agreed to implement this on an initial 6 month shadow period upto the end of March 2020. An implementation meeting is to be held including the appropriate people to agree a process and start date.

111 – the service integration is anticipated to increase the utilisation of the WMAS Clinical Assessment Service (CAS) leading to reduced ambulance conveyances for non-emergency situations. Initial modelling undertaken by the West Midlands Integrated Urgent Care team had shown a 2% reduction in conveyances, circa £240k savings for the CCG. However, the Business Insight team had been unable to reconcile the figures and further work is to be undertaken. This had been added as a QIPP programme and would be modelled and monitored.

Resolved The Committee noted;

- the contents of the report
- that a specific risk had been raised relating to the delayed start date for the dermatology service, with reference to the mitigations described in the report
- issues with data access for Phoenix Walk In Centre to be escalated

8. Performance Report

FP.444 Mrs Moon presented the report;

Royal Wolverhampton NHS Trust (RWT)

- Referral to Treatment – a RAP was in place for elective care and RWT had reported that performance had stabilised and the waiting list is not increasing. A waiting list validation exercise had shown an issue with patients where the clock had been stopped but not reported. This was an internal problem and RWT are working to establish the main cause and take steps to improve the system. Diagnostics – the trust was reporting

recovery by October, however this, had now changed to January 2020. It had been flagged that the RTT waiting list would not reach the same position as at March 2019. The trust had reported that NHSI had advised what would be acceptable, however, this had not been validated by the CCG.

- Urgent Care, 4 hour waits – the national position is not achieving the national target. RWT is performing better than local trusts.
- 12 hour breaches – 1 had occurred in October related to mental health bed availability
- Cancer targets - performance against the 14 day target is reported to reach standard in December. The diversion initiative had been turned off and this is being managed between Wolverhampton and Walsall. Super clinics had ceased, however, additional clinics are being held at weekends. 62 day wait RAP anticipates recovery by March 2020. Performance is steady at around 50%.
- E.A.S.2: IAPT recovery rate– performance had been flagged with the trust at the Data Quality Improvements Process (DQIP) due to the variation in reporting. Reporting on SQPR that achieving target but this was not carrying through to national data validation. Detailed work is being undertaken to determine the reason.
- E.A.3 – IAPT People who had entered treatment as a proportion of people with anxiety or depression (local prevalence) – activity currently below target. The trust is reporting that this is increasing and reporting will achieve standard by the end of the year.
- E.H.13 – Physical Health Checks for People with a Severe Mental Illness – achieved 42.07% against a planned trajectory of 50%. 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.

Resolved: That the report be noted.

9. Finance Report

FP.445 Mrs Sawrey introduced the report relating to Month 7, October 2019 highlighting the following key points;

- All metrics in relation to financial performance were currently being met. There had not been much movement in the position.
- RWT contract continued to overspend and, M7 SLAM data was indicating this was increasing
- An underspend at Nuffield is understood to be linked to the MSK pathway and how patients are referred into the system. This is being reviewed and discussed with the provider
- The RWT community contract at Month 7 was very close to breaching the collar agreement and, therefore, close monitoring would take place for Month 8

- FNC was currently forecasting an overspend of £452k due to an increase in the number of patients and higher charges. This is offset by an underspend in CHC of £696k.
- SEND reporting an over spend of £183k due to an increase in children accessing the service and the rising cost per child. This had been reviewed and the charges are legitimate and the cost has been factored into the LTFM for the next financial year.
- GP Prescribing was currently reporting an overspend of £381k for the year to date and a forecast overspend of £653 based on 5 months data. This included an assessment of the impact of new information being made available e.g. the Cat M price increase with effect from 1st August and the latest information in respect of NCSO which is anticipated to cost an additional £200k on the forecast position reported at Month 6.
- Overall Running Costs was reporting £116k underspend for year to date and a £200k underspend at year end. Running costs would have to reduce in 2020/21.
- The Cash target for Month 7 had been achieved. Recent budget holder training had included direction on invoice management.
- The risk position at Month 7 had been reviewed and the level of risk had been reduced as a consequence of assignment to individual programme areas particularly in relation to Mental Health.

Resolved: The Committee noted the updates given

10. Additions/updates to Risk Register

FP.446 There were no updates to the register on this occasion.

Resolved: The Committee noted the contents of the report and supported the proposal.

11. Any other Business

FP.447 There were no items raised.

Resolved: The Committee noted the contents of the report.

12. Date and time of next meeting

FP.448 December 2019, virtual meeting only, papers to be circulated.

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Extraordinary Meeting

Tuesday 5th November 2019 at 2pm
Christ Church,
Church Road, Tettenhall Wood, Wolverhampton WV6 8NQ

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 David Bush	Locality Chair / GP (non-voting)	Yes
Dr Manjit Kainth	Locality Chair / GP (non-voting)	Yes
Dr Salma Reehana	Clinical Chair of the Governing Body (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
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Lesley Sawrey	Deputy Chief Finance Officer (WCCG)	Yes
Andrea Clarke	Head of Consultation & Engagement (AGCSU)	Yes
Dr S F Shafi	GP Partner Tettenhall Medical Practice	Yes
Sue Sephton	Practice Manager - Tettenhall Medical Practice	Yes
Karen Irvine	Assistant Practice Manager-Tettenhall Medical Practice	Yes
Diane North	Primary Care Commissioning Committee Admin (WCCG)	Yes
Mike Hastings	Director of Operations (WCCG)	No
Liz Corrigan	Primary Care Quality Assurance Co-ordinator (WCCG)	No

Welcome and Introductions

WPCC613 Rev Phil Wooton, Vicar of Christ Church welcomed the committee and all in attendance to Christ Church. The Chair thanked Rev Wooton for hosting the meeting and welcomed the committee panel and members of the public to the meeting. Committee members introduced themselves individually. There was a show of hands to indicate which committee members had voting rights

Apologies

WPCC614 Apologies were received from Dr Ankush Mittal, Mrs Liz Corrigan, Mr Mike Hastings and Mr Tony Gallagher (with Mrs Lesley Sawrey attending in his place)

Declarations of Interest

WPCC615 Dr Kanith declared a conflict of interest due to a relative of his being a patient at the Wood Road Practice. He was permitted to stay in the meeting as he was a non-voting member.

Minutes of the Meeting held 1st October 2019

WPCC616 The minutes of the previous meeting, held on 1st October, were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from Previous Minutes

WPCC617 There were no matters arising from the previous minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC618 As this was an extraordinary meeting, the actions were deferred to the next meeting.

RESOLVED: That the above was noted.

Wood Road Surgery: Proposal for Changes

WPCC619 Ms Shelley introduced her report outlining the proposed change of services at Wood Road Surgery. She advised that Tettenhall Medical Practice provides primary medical services for around 12, 000 patients at their main site at Lower Green and the branch site at Wood Road. Patients registered with the practice were informally allocated to one site or the other but were allocated appointments at either site.

In February 2019, the practice wrote to the CCG informing of their intention to close the Wood Road site; citing the difficulty of recruiting GPs and the financial implications of the payment of service charges to NHS Property

Services (NHSPS) for the 2 sites as key factors in making the proposal. In line with NHS England guidance, the practice undertook a public consultation on the proposed closure, which was supported by the Arden & GEM Commissioning Support Unit. The consultation began on 7 May 2019, initially for 90 days and subsequently was extended to 15 September 2019.

Following consideration and reflection on the feedback from the consultation, the practice decided not to submit a formal application to close the branch surgery but instead applied to reduce the number of clinical sessions offered at Wood Road surgery from 7 to 4 sessions per week. In doing so, the Practice felt this would enable them to continue to provide quality primary medical services to their patient population without compromising services offered to patients local to Wood Road who have difficulties accessing Lower Green.

Details of both the premises at Wood Road and Lower Green were given and it was highlighted that Lower Green (where the 3 sessions currently provided at Wood Road would be run ensuring no overall reduction in the number of appointments) has the capacity to manage the additional patients. It was further highlighted that some services can only be offered at Lower Green due to the equipment required and that car parking at both sites can be very limited at times. Ms Shelley also highlighted that the practice acknowledged the difficultly of GP recruitment would still remain but confirmed they had been successful in securing funding through the General Practice Resilience Programme to support this. This would assist them to continue to pursue recruitment of GPs and review their model of service delivery to include other clinical professionals such as Advance Nurse Practitioners (ANPs), Clinical Pharmacists, Physician's Assistants and Paramedics. Ms Shelley also highlighted that the practice had undertaken an Equality Impact Assessment in relation to the proposal, which was appended to the report.

Dr Shafi, on behalf of the practice, explained that the proposal to close the branch site had occurred following the retirement of one of the partners in August 2018. The remaining partners were therefore working above the normal full time equivalent of most other practices and three other partners wished to reduce their sessions in order to maintain a better work/life balance and avoid burn out. Recruitment had been difficult and the practice was not able to sustainably cover the sessions across the two sites. The practice had however recognised the strong opposition to closure evidenced through the consultation process and therefore developed an alternative proposal. This proposal would ensure that patients would retain access to a high quality, safe and effective service that allowed patients local to Wood Road surgery, who cannot access Lower Green, to continue to access and receive Primary Medical Services near to where they live. She further advised that patients would continue to be able to access both sites on dedicated phone lines and that calls for Wood Road would be transferred to Lower Green when it was closed. Access for local patients would be enhanced with a number of both pre-bookable and on the day urgent appointments allocated specifically for patients living local to Wood Road who are unable to easily access Lower Green. Patients would also continue to be able to access the additional appointments offered via the Unity

Primary Care Hub at Pennfields Health Centre and Ashmore Park Health Centre. She confirmed that the practice had consulted on the revised proposal with the Patient Participation Group (PPG) on 22nd October 2019 for which they received their support.

Andrea Clarke from AGCSU then provided an outline of the consultation process which had included sending letters to patients, posters, an online questionnaire, drop-in events, media releases and social media activity. A meeting took place with local councillors, the local MP and the Save Wood Road (SWR) campaign group with CCG representatives. A Question & Answer session chaired by the local MP Eleanor Smith and a visit to the surgery for councillors and members of the SWR campaign group took place along with an additional drop-in event in the community following the extension of the consultation period.

She highlighted that the survey undertaken had indicated that 74.24% of respondents did not agree with the proposed closure of the branch surgery and a number of common themes relating to access and the potential impact of the closure of the branch on the population served by the practice had emerged. The full consultation report, which had been reviewed by a number of stakeholders including the Save Wood Road campaign group to confirm it accurately reflected the views expressed during the consultation, was appended to the report.

In response to questions relating to future plans should the Practice manage to recruit additional GPs Dr Shafi confirmed that the practice continued to advertise for both GPs and other healthcare professionals and that, following successful recruitment, the possibility of expanding the number of sessions would be considered but this would depend on the overall resources available. She also confirmed that, whilst the option of using ANPs to deliver the service at Wood Road had been considered, the practice felt it was a safer and better service under GP cover and that more appointments than currently would be ring-fenced for patients who lived locally to Wood Road. In response to a further question, she also confirmed that the practice had recognised the strength of feeling relating to the potential closure of the surgery and would not intend to bring further proposals to reduce sessions further.

The Chair also invited eight members of the public, who had indicated in advance that they wished to speak, to address the committee and included Stuart Anderson, Prospective Conservative Parliamentary Candidate for Wolverhampton South West who was also a patient at the surgery.

Points that were made included:-

- The high regard and reliance on the surgery by the local population, with examples given of the quality of care that had made a significant difference to patients.
- The decision not to propose to close the surgery was welcomed but some concern was expressed at the reduction in the number of sessions and the impact that this would have on access for the most vulnerable patients. The Save Wood Road Campaign group

highlighted their willingness to work with the practice to secure services for the future.

- Some concerns about the consultation process were expressed, including the incompleteness of some of the equality information but the fact the surgery had listened to the feedback was welcomed.
- Specific concerns about access to Lower Green, particularly for older and disabled people and in relation to car parking at Lower Green and the impact on local residents were expressed.
- It was noted that the Surgery was sited on land originally gifted to the local community and that this point had not been referenced in the report.
- Questions were raised about the practice being obliged to use NHS Property Services facilities management services. In response it was confirmed that the CCG was working with practices and NHS Property Services to ensure lease arrangements provided practices with flexibility around facilities management where possible.
- In response to a further question about whether the difficulties recruiting GPs was a national issue it was confirmed that there was a national problem and that steps were being taken to address it. This included increasing training places and seeking to expand the use of other healthcare professionals across General Practice.

The local MP Eleanor Smith was in attendance and she thanked the Save Wood Road campaign group and the local community for all their hard work demonstrating the value of the surgery and also thanked the CCG/CSU and Practice for listening to the views expressed during the consultation. She emphasised that the addition of professionals such as Advanced Nurse Practitioners should be strongly considered and welcomed into the surgery as they were not there to replace GPs but to enhance the service. A petition of over 2,200 signatures was presented.

The Chair thanked all present for their contributions and asked the committee to consider the proposal from the practice to reduce the number of sessions, which was unanimously agreed.

RESOLVED: That the proposal from Tettenhall Medical Practice to reduce the number of sessions provided at Wood Road Surgery from seven to four be approved.

Any other Business

WPCC620 There was no further business and the meeting was closed.

Date of Next Meeting

WPCC621 Tuesday 3rd December 2019 at 2pm – PC108, Creative Industries Centre, Wolverhampton Science Park WV10 9RU

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 3 December 2019 at 2.00pm

PC108 Conference Room, Creative Industries Centre,
Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

Name	Position	Present
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
Sue McKie	Chair (voting)	No
Dr David Bush	Locality Chair / GP (non-voting)	No
Dr Manjit Kainth	Locality Chair / GP (non-voting)	No

NHS England ~

Bal Dhami	Senior Contracts Manager – Primary Care, NHSE	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	Chief Officer of Wolverhampton LPC	Yes

In attendance ~

Tony Gallagher	Director of Finance	Yes
Liz Corrigan	Primary Care Quality Assurance Co-ordinator	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
Amy Flood	Student Nurse (Observer)	Yes

Welcome and Introductions	
WPCC622	Mr L Trigg welcomed attendees to the meeting and introductions took place. There was one member of the public present at the meeting.
Apologies	
WPCC623	Apologies were received from Ms S McKie, Dr D Bush, Dr M Kainth and Mr P McKenzie
Declarations of Interest	
WPCC624	Dr S Reehana declared that as a GP she had a standing interest in all the items relating to primary care. As this declaration did not constitute a conflict of interest, Dr S Reehana remained in the meeting whilst these items were discussed.
Minutes of the Meeting held on the 5th November 2019	
WPCC625	The minutes of the previous Primary Care Commissioning Committee (Extraordinary meeting) held on 5th November 2019 were approved as an accurate record. **RESOLVED: That the above was noted.**
Matters Arising from previous minutes	
WPCC626	There were no matters arising from the minutes. **RESOLVED: That the update was noted.**
Committee Action Points	
WPCC627	**Action 39 (Minute No: WPCC481) Tettenhall Medical Practice – Wood Road Branch closure** Following the public meeting of 5th November this issue was now resolved. The Practice had reviewed their original application and submitted an application to reduce the number of sessions from 7 to 4 per week rather than close altogether. **Action 40 (Minute No: WPCC540) Quality Assured Spirometry Business Case** There is a Spirometry report due for Feb 2020. A verbal update will be provided today as part of the Milestone Review Board report agenda item 7e. **Action 42 (Minute No: WPCC554) Social Prescribing further level of detail**

	On agenda, item 7f. Action closed **Action 43 (Minute No: WPCC554) Social Prescribing update on embedded staff** On agenda, item 7f. Action closed **Action 45 (Minute No: WPCC556) STP GP Forward View Programme Board** On agenda, item 7d. Action closed. **Action 46 (Minute No: WPCC605) FFT Activity Report & Revised FFT figures to be circulated** Revised Friends and Family Test circulated. Practices with poor FFT update had been contacted. Issues were mainly transient with no further action required. Action closed. **Action 47 (Minute No: WPCC607) An update on the implementation of the New Communications & Engagement Strategy.** A report is pending submission prior to Mar 2020 **RESOLVED: That the above is noted**
Primary Care Update Reports	
WPCC628	**Quarterly Finance Report Q2 Jul-Sept 2019** Mr T Gallagher provided a summary of the finance report for the period ending Sept 2019. As previously requested by the committee, areas of expenditure specifically relating to Primary Care had been determined and were displayed on page 3 of the report. The delegated commissioning element of primary care was forecast to breakeven this year. Wolverhampton CCG is the host for the GP Forward View allocation, so some of the £4.7m spending shown relates to the Walsall, Sandwell and Dudley CCGs. At least £1.2m will be spent by these other CCGs under the hosting arrangement and will be indicated in future reports. An overspend of £487,000 was forecast which was largely attributable to prescribing and NHS 111 services. An amount of £1m was identified for Primary Care development. Due to the proximity of the year-end it may not be possible to identify schemes to the full amount. There was discussion as to whether any underspend within the £1m could be rolled forward to the next financial year.

	The report also analysed prescribing in relation to both drug volumes and cost, which showed positive results for June and July. **RESOLVED: That the update is noted.**
WPCC629	**Primary Care Quality Report** Mrs L Corrigan presented her report summarising the following key points: There were no new serious incidents. A previous incident relating to a fridge had since been closed Mrs Corrigan recognised that content in the background of the report for Quality Matters did not reflect the narrative. This was due to due to some late additions. The report would be amended and re-circulated. Nothing had been reported to NHS England for two months but there were a couple of issues pending. Mrs Corrigan advised she would be going on secondment from next month and that Mrs D Bowden would be providing updates on Quality Matters going forward. Infection prevention audits continued and practices were doing well with average ratings up slightly on last year. The Quality team were working closely with Public Health on the Flu vaccine programme. The uptake was slightly down on last year, which had been expected because of the slight delay in vaccines being delivered. All practices now had access to the vaccines. The over 65s update at the beginning of November was 51.5 % and for under 65s 18.5%. Uptake for the over 65s was up on last year. Information on the school's programme would be available from Public Health shortly. Mr H Patel would be picking up the flu programme work. It was reported that the MMR vaccination programme uptake is slightly down on both the rest of the region and nationally but was being picked up at the collaborative contracting visits. Mr M Boyce and Ms D Bowden will cover contract visits. Work with practices to ensure the return of their Friends and Family Test information continues. This month only three Practices did not respond and each had a valid reason. Wolverhampton remains the best in England at average 2.2% returns. It was noted that both the GP and Practice Nurse workforce retention programmes were now up and running. The plan was to develop GP Nurse champions to support others who are considering, for example, a change in career or are newly qualified or considering retirement. Mrs Corrigan advised that her new role was as the Black Country GPN Professional Lead and she was excited to be co-ordinating this. The Healthcare Assistant apprenticeship programme was also in progress. Work continued around non-clinical staff, physicians associates and clinical

	pharmacists to ensure the PCNs had a spread of staff to meet the needs of patients The committee was informed that the STP had recently been successful in obtaining a bid to provide places for newly qualified nurses for within the PCNs. The nurses would attend the Fundamentals of Practice Nurse programme at Birmingham City University and there were 10 places. Work was being done with Birmingham and Wolverhampton universities to identify potential candidates. Primary Care Networks are able to submit an expression of interest for hosting one of the nurses. Dr S Reehana asked why had Birmingham City University been selected and not Wolverhampton. Ms Corrigan advised it was to do with the date of the course. Wolverhampton's course starts in January and they weren't able to put an extra course on due to short notice. It was also not possible to get the candidates through the process in time to start in January. Dr S Reehana asked if both IG breaches were new for November. Mrs L Corrigan advised it was overall but that she had noticed that the breaches were to do with blood forms again. Targeted work had been undertaken with Practices and there were plans to issues comms shortly to all. **RESOLVED: That the update was noted.**
WPCC630	**Primary Care Operational Management Group Update** Mrs S Southall advised that she had chaired the meeting and there were no major issues reported. The minutes had been circulated with a number of actions. Committee were happy to defer the item until the next meeting. **RESOLVED: That the above is noted.**
WPCC631	**STP Primary Care Programme Board Actions & Decisions** Mrs S Southall provided an overview of the discussions that took place at the STP Primary Care Programme Board. She explained there were a series of updates as referenced in the reports in relation to technology in GP practices and feedback from visits to voluntary training schemes. The Board had considered an options paper presenting opportunities to support the Locum workforce and concluded that it was not the preferred route to take and wished to take a different route and would be meeting with Clinical Directors to identify what offer can be put together for support and retention of locum GPs in the Black Country. Funding proposals were considered and approved by the Board for a GP mid-career scheme due to commence in March 2020, which affords GPs the opportunity to be part of a network and take park in a learning

	development programme. A scheme was also approved for welcoming back GPs into General Practice and a legacy scheme to help retain skills, knowledge and experience. Funding for training hubs, reception and clerical training was also approved. A separate report was considered in relation to online consultations and Digital First. Wolverhampton was quite advanced in their rollout that has since been concluded. A further piece of work to explore the feasibility of a future potential solution for the Black Country i.e. an identity for all online consultations and systems is currently being explored by the Local Digital Rollout Group. The Board received an update on the PCN development and the opportunity to share approaches taken to social prescribing and the leadership development programmes. Highlight from the NHS England and Board assurance report were given. The items presenting the greatest risk were Online Consultations primarily in relation to the GP at Hand, although the scale of the problem has been less than expected. There was also risk around 111 direct booking as there had been a delay, in relation to the work that NHS Digital were expected to undertake on our behalf which was unfortunately compromising achievement of the national target however since that meeting things were now back on track. Mr S Marshall questioned the economic viability of each of the local areas adopting a different system for online consultations. Mrs S Southall explained that the NHS Futures platform expected that each of the CCGs would re-procure separately therefore not putting all eggs in one basket. Mrs Southall advised that whatever system was chosen there would be an application (App) developed to sit in front of the system to ensure that the Black Country identity was consistent. Dr S Reehana asked in relation to workforce if the impact of pensions tax on GPs had been considered as hospital consultants and GP partners looked to cut the number of sessions they provided. Mrs S Southall advised that this was a nationally recognised issue and there were numbers of GPs cutting sessions or retiring who had not been replaced along with Clinical Directors who had been removed from the equation due to providing 2 sessions p/w in their new roles. Attempts were being made to encourage new GPs into both salaried and partnership roles however, the issue around the numbers of sessions provided would remain because whoever is earning would be subject to the same pension tax. There was some taper for hospital consultants but it did not provide much assurance and the flexibility around opening longer hours could be seriously impacted. Ms S Roberts felt the issue needed to be raised to the Sustainability and Transformation Board also to understand the impact to gain some clarity on the issue. It was felt that rather than surgeries doing longer and longer hours they

	needed to bring in more GPs to cover the sessions and there were plenty of Locums available however it was recognised that they too would be subject to the same tax. **RESOLVED: That the above is noted.**
WPCC632	**Milestone Review Board (Q2 2019/20) Report** Mrs S Southall advised that the Milestone Review Board met in October and the report provided a summary of that meeting along with a copy of the Assurance pack shared at the meeting. The Board gave recognition to the progress that had been made in relation to the work programme and a communications and engagement plan that had been requested. Approval was given to address some of the gaps in public knowledge and to ensure that practices were actively publicising the new roles to patients and giving them the opportunity of making appointments with them and the promotion of online services. There was an exception report in relation to the digital workstream that had since been rectified. The concerns were largely associated with 111 direct booking which had entered a pilot phase with an on-boarding phase for practices to be able to offer appointments from January 2020. The exception remains for branch practices unfortunately as they have no functionality for direct 111 bookings. The Primary Care Strategy and associated implementation plan was also accepted as agreed by this committee in October. The Primary Care Network Development Proposals were discussed at length and were obtained based on the self-assessments that Practices in the networks had undertaken collectively. This was included as an appendix. The meeting largely focused on the assurance pack with a number of actions in relation to the Primary Care counselling service, Sound Doctor, the GP Home Visiting service, Care navigation and Choose and Book advice and guidance were raised. **RESOLVED: That the above was noted.**
WPCC634	**Social Prescribing Update** Mrs S Southall presented the report to update the committee on the progress of the Social Prescribing service and the new roles that Primary Care Networks were able to recruit to. Social Prescribing Link workers are funded as part of the role reimbursement scheme. All six Primary Care Networks now had an allocated Link Worker based within practices to provide a social prescribing service at neighbourhood level.

	The agreed model had been signed off by each of the Clinical Directors and was based on the offer that the Wolverhampton Voluntary Sector Council (who already host the service in Wolverhampton) had put to them. Each PCN has had a Link Worker in post since October 19. There are now 11 Link Workers in place across the CCG which enables an extra 120 referrals per month to be taken across the 6 PCNs. The summary guide indicates that Social Prescribing Link workers should be receiving at least 250 referrals per year, which was expected to incrementally rise from January next year. There were 104 referrals in October with 66 from Primary Care as other professionals can refer into the service. Promotion of availability of the service within the PCNs is actively taking place and Link Workers are holding events and forming clubs based on needs identified including a Brunch club, Film Group, Walk in the Park, Craft Group and Anxiety Management course. Dr A Mittal questioned the demand and supply of the service saying that if 250 referrals per year were received across 11 PCNs it equated to just shy of 3000 capacity per year and asked how far off this it was currently. It was expressed that there was a little way still to go hence work with PCNs to ensure workers are embedded and recognised and that there is a capacity and demand model and managed centrally through the Voluntary Sector Council. There is a meeting planned with the Clinical Directors and the service providers in January to ensure this is working well as these referrals are tied in to other national targets associated with personal care planning however Wolverhampton is a little further ahead than other CCGs. Mr S Marshall felt that once referral rates stabilised they could assume that this would be the maximum demand and a review of service capacity could then be undertaken with a view to maybe re-purposing the roles if service outweighed demand. **RESOLVED: That the above is noted.**
WPCC635	**Primary Care Contracting Update** Ms Shelley presented the report. No requests for GMS contract variations between 1st August and 30th November had been received. An internal audit on effectiveness on commissioning and procurement of Primary Medical Services was attached as an appendix. The review identified one medium and one low risk recommendation. The medium risk was around the ability to get a service in place quickly if there is a problem with a practice with work being undertaken at STP level to put a process in place across all 4 CCGs. There is currently a process in the NHS England policy book, which would be followed if needed. If a caretaker was needed the CCG did not have to go out to market and could choose a provider and put them in straight away.

	The low risk was about the outdated procurement policy, which is now in the process of being reviewed and updated. The Practice merger of Parkfields Medical Centre and Grove Medical Centre which took place over 23rd-25th November had gone smoothly from a clinical systems merger perspective and planned to meet with the new providers early January to go through any troubleshooting. A contract monitoring review was undertaken at MGS Medical Practice in early November, which proved successful. When the previous contract review was undertaken in Sept 17, there had been 34 actions to complete. Following the current visit, only 3 minor actions were outstanding with a real improvement noticed in the quality of policies and the practice leaflet. The Quality team plan to ask the Practice if any of the work can be shared as an example of good practice across the city. The committee was asked to recognise the improvements the contractors had made at the Practice since the contract was terminated with RWT and an alliance formed with Our Health Partnership (OHP) in October 2018. It was reported that Dr Allen will no longer be on the contract and that a doctor from OHP will be added shortly. The practice has a Care Quality Commission (CQC) visit on 13th December 2019. Patient List Sizes were appended. **RESOLVED: That the above is noted.**
Any Other Business	
WPCC636	Agenda Item 7h Enhanced Services Post Payment Verification 2017/18 was moved from the public to the private agenda Mrs L Corrigan advised this would be her last meeting for a while due to her secondment and that Ms Mavis Foya would be delivering the reports on her behalf. Mrs Corrigan was thanked by Committee for her hard work and wished well for her secondment.
Details of Next Meeting	
WPCC637	Tuesday 4th February 2020 PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 31st October 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 ~

Peter McKenzie	Corporate Operations Manager	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Yvonne Higgins	Deputy Chief Nurse	Yes
Maxine Danks	Head of Individual Care (Adults)	Yes (part)
Andrea Smith	Head of Integrated Commissioning	Yes (part)

Apologies for absence

Apologies were received from Sally Roberts, Cyril Randles, Philip Strickland

Declarations of Interest

CCM835 There were no declarations of interest.

Minutes

CCM836 The minutes of the last committee meeting, which took place on Thursday 31 October 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM837 There were no matters arising

Committee Action Points

CCM838 The committee was update on a review of the outstanding actions from February 2019 –

CCM781 – Social Prescribing Report - An evaluation regarding the return on investment is scheduled to be carried out in October 2019 and will be reported back to the committee on completion. National funding has been received for a further additional 6 social prescribing link workers (SPLW) this will bring the total number to 11 in this service. A revised model for the services is currently under development.

Action: - The committee will be updated on this service in March 2020

CCM783 - Health Ageing Coordinator – This service has not yet commenced and the advert for the position is currently live.

Action: - The committee will be updated on this service in January 2020

RESOLVED: The committee note the update and action.

Children and Young People Continuing Care Funding Decisions

CCM839 The committee was presented with a report to implement a Resource Allocation System (RAS) for Continuing Healthcare for Children and Young People. The system had been developed in line with the National framework of 2016to ensure equity for allocation of additional NHS funding to children and young people who are eligible in need of continuing care based on alignment with their clinical needs.

Adoption of this system will ensure that there was a fair and transparent method of making funding decisions for individuals based on their individual needs.

RESOLVED: The Committee noted the contents and gave approval.

Maxine Danks left the meeting

Social Worker in ED

CCM840 The committee was presented with a report to support a 12 month pilot post for the establishment of a social worker situated within RWT Urgent and emergency department. The role of this post would be to carry out holistic assessments of patients and carers and would commence in preparation for the winter pressures to support the aim of reducing and preventing avoidable admissions.

This will be in collaboration with Wolverhampton City Council whom will provide a candidate for the post and will back fill within their Social Care department. The members raised the issue of impact that this post would have upon the current admissions to the A&E Department and requested that impact analysis should commence immediately.

RESOLVED: The Committee noted and gave approval with a requested for an evaluation analysis to commence immediately and the outcomes to be presented to the committee on a quarterly basis.

Andrea Smith left the meeting

Contracting Update

CCM841 The Committee was presented with an update for the period November 2019.

Royal Wolverhampton NHS Trust

Contract Performance

- Referral to Treatment – the performance in this service continues to deteriorate by 1% below the agreed trajectory; a Remedial Action Plan (RAP) has been agreed to aid the improvement of this indicator. 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 Staff by way of a Cancer Recovery Action Plan which is update on a monthly basis.

- Dermatology – mobilisation of the service continues, procurement phase has now completed and awarded to Circle Integrated Care whom have been attending meetings on a regular basis with both the CCG and RWT. Due to an issues raised by Circle for transfer awaiting the transfer of staff for this service, a response from the Trust has been received advising that no staff will be TUPE to the new service due to this delay of recruitment needed for the service, the commencement will now be the 1 March 2020, paediatrics will remain with RWT all other referrals will be made to the new service provider from the commencement date.

- Phoenix Walk In Centre – approval has been given for the service to become an Urgent Care Centre, a caveat of the investment is to be made available dependent on the number of CCG attendances, and will be based on the national dataset for Emergency Care.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

- Improving Access to IAPT – An update of Q1 data shows underachievement in Month 1 only of this service, recent data has shown improvement within this area. A monitoring of outstanding actions to be completed is in place and performance remains on track.

Nuffield

Contractual Issues

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

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

Urgent Care/Ambulance/ Patient Transport

Non-Emergency Patient Transport Service (NEPTS)

The moderation stage of the re-procurement has been completed and the outcome would 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, 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, meetings are already underway between the commissioner and the new provider for this service.

- Assisted Conception Service – The current contract has been extended by a year with the current provider, this will enable the re-procurement of the service to begin with Invites for tender to be issued on 17 October 2019.

RESOLVED – The Committee noted the contents of the update and the addition of a mobilisation risk to be entered on the risk register for the Dermatology service.

Review of Risk

CCM842 The Committee received an update of the risk register highlighting the current corporate and commissioning committee risks.

Corporate Risks

CR14 – Development of local accountable care Models – a deep dive has taken place and Steven Marshall has been actioned to review this risk.

CR21 – Impact of potential funding withdrawal by City of Wolverhampton Council (CWC) following consultation process – Steven Marshall requested that this risk be removed due to being fully mitigated, the CCG now provides funding for this service.

Commissioning Committee Risks

CC16 – Well-being Service BCPFT - expectations of an update to be received – Steven Marshall advised the members that a meeting has taken place and an action plan has been provided currently awaiting agreement.

RESOLVED: The Committee noted the update with an addition of the Dermatology mobilisation

Any Other Business

CCM843 None

Date, Time and Venue of Next Meeting

Thursday 28th November 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 28th November 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 R 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 ~

Philip Strickland	Governance & Risk Coordinator	Yes (part)
Vic Middlemiss	Head of Contracting & Procurement	Yes
Yvonne Higgins	Deputy Chief Nurse	Yes
Sukvinder Sandhar	Head of Individual Care (Adults)	Yes (part)
Andrea Smith	Head of Integrated Commissioning	Yes (part)

Apologies for absence
Apologies were received from Sally Roberts, Andrew Wolverson

Declarations of Interest
CCM844 There were no declarations of interest.

Minutes
CCM845 The minutes of the last committee meeting, which took place on Thursday 31 October 2019 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM846 There were no matters arising

Committee Action Points

CCM847 The committee was updated on a review of the outstanding action –

CCM840 **–** Social Worker in ED and requested the following clarifications to ensure that the pilot evaluation is thoroughly considered-

- How will this post reduce admissions
- How will admissions be audited
- When will the Outcomes be measured
- Is there a Baseline of admissions to work to/compare standards
- When patients are discharged, will extra support be give if needed

Medicines of Limited Clinical Value

CCM848 The Committee were presented with a report (in addition to the previous report of June 2019) regarding NHS guidance on items which should not be routinely prescribed in Primary Care. A three month consultation has taken place regarding the seven new items added and an engagement exercise was carried out in October to include patient input and voice through a survey monkey exercise. The results are attached in appendix one. .

Clear lines of communication are planned as follows –

- Discussions with RWT need to take place and may include the need for shared care agreements
- Patient communication will be provided by way of leaflets to be provided to GP practise for patients and consultations/review.
- Dr. R Gulati requested a refreshed guidance of low cost Needles to be provided.

The guidance will be rolled out across all areas and withdrawn from repeat prescriptions. Patients are to be identified by the GPs and discussions regarding alternative medications to take place.
The strategy will be launched on 1 December 2019 with the additional guidance.

RESOLVED: The Committee noted the contents and gave approval.

Sukvinder Sandhar left the meeting

Contracting Update

CCM849 The Committee was presented with an update on the overview and key contractual areas for November 2019.

Royal Wolverhampton NHS Trust

Activity/ Performance

Acute activity has increased in month 6 to £1.89m over-performance, though month 5 showed a reduction. This is principally due to A&E and Planned Same Day services. However the community contract is showing a significant under-performance in certain areas and is currently being challenged with RWT.

Contract Performance

- Referral to Treatment – the performance continues to deteriorate from the year starting 88.08% to 83.01% in August 2019. A recovery action plan to improve has been put in place with a particular focus on departmental actions and is overseen weekly by a newly appointed oversight group within the Trust and reviewed monthly by the CCG contracting meetings.

- Diagnostics - The service failed to achieve targets for both August and September 2019. Referrals have increased for Endoscopy and capacity issues have also been rising in the Neurophysiology department.

- Cancer – Performance has improved in Breast Cancer since the implementation referral diversion programme of across the STP . There continues however to be underlying challenges with regard to workforce recruitment in specific areas such as radiography.

RWT Planning Round for 2020/21

The first meeting took place on the 24th October 2019. the CCG has stated the wish to continue with the approach of an open and collaborative programme of discussions.

Other Contractual issues

Dermatology – the CCG has agreed with Omnes the current provider to extend the contract until 31 March 2020, this will allow 2 weeks for exit and safe transfer of patients and increased scope of minor surgery continuing for patients referred prior to 29 February 2020.

The new provider Circle has been agreed to commence from 1 March 2020 to allow time for necessary recruitment to take place.

Phoenix Walk in Centre – investment has been provided for the migration of the walk in centre to an Urgent Treatment Centre.

Black Country Partnership Foundation Trust (BCPFT)

Performance/Quality Issues

- Improving Access to IAPT – the figures for August have been received at a low of 1.49% against the monthly target of 1.83%, this is mainly due to a high number of appointment cancelations which reduced access. The Trust advised that July was an usually successful month.

Nuffield

Contractual Issues

This service is currently running under plan in Orthopaedics at month 6. The new pathway introduced for MSK referrals which requires that all patients access the service via a single point of access to Connect is the underlying factor

Contract negotiations and intentions have been issues to Nuffield with the first meeting taking place on the 15 November 2019.

Urgent Care/Ambulance/ Patient Transport

Non-Emergency Patient Transport Service (NEPTS)

This contract has been awarded to WMAS for 5 years with an option to extend for a further 2 years and will commence April 2020. All KPIs are currently being achieved with the current contract.

111 Service

This integration transferred on the 5 November 2019 to WMAS to reduce ambulance conveyances for non-emergency. Activity monitoring report is being set up which will take consider the impact A&E attendances and acute admissions.

Other contracts

- Termination of Pregnancy Service – The drafting/finalising of the contract with the new provider is now being completed. The service will commence on 1 January 2020.

- Assisted Conception Service – Invites to tender for this service have been issues for re-procurement and evaluation will commence on the 20 November 2019.

RESOLVED – The Committee noted the contents of the update.

Review of Risk

CCM850 The Committee received an update of the risk register highlighting the current corporate and commissioning committee risks.

Corporate Risks

CR14 – Development of local accountable care Models – The committee requested this risk to be closed. PM advised that this will be reviewed in the quarterly review.

CR23 – Enacting the Wolverhampton ICA Contract – The committee was requested to accept this as a new risk on the Corporate risk register.

Commissioning Committee Risks

The committee was advised of no changes or additions to risks.

Resolved: The Committee noted the update of an addition to the Dermatology mobilisation and the acceptance of CR23 to the corporate risk register.

Any Other Business

CCM851 None

Date, Time and Venue of Next Meeting

Thursday 27th February 2020 at 1pm in the CCG Meeting Room 1

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NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 30 July 2019 commencing at 11.00am
In Armstrong Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman/Governing Body Member
Mr D Cullis	Independent Lay Member
Mr J Oatridge	Deputy Chair of the Governing Body and Audit and Governance Committee
Mr L Trigg	Lay Member/Governing Body Member

In Regular Attendance:

Mr P McKenzie	Corporate Operations Manager, WCCG
Miss M Patel	PA to Chief Officer and Chair of Governing Body, WCCG (minute taker)

In Attendance:

Ms R Bajaj	Internal Audit Manager, PwC
Mr T Gallagher	Director of Finance, WCCG
Mr J Green	Chief Finance Officer, Sandwell and West Birmingham CCG and WCCG
Mr N Mohan	Senior Manager, PwC
Mr M Stocks	Partner, External Audit, Grant Thornton

Apologies for attendance:

AGC/19/65 Apologies were received from Ms Breadon, Mr McLarnan, Ms Putwa, and Ms Watson

Declarations of Interest

AGC/19/66 There were no declarations of interest.

Minutes of the last meeting held on 23 April 2019

AGC/19/67 The minutes of the last meeting were agreed as a true record.

Matters arising (not on resolution log)

AGC/19/68 There were no matters arising.

Resolution Log

AGC/19/69 The resolution log was discussed as follows;

- Item 149 – (AGC/19/15) - Counter Fraud Progress Report – Mr

Mohan advised that there was an increase in the number of fake prescriptions being circulated within Wolverhampton. Mr Mohan confirmed that it was a West Midlands issue with Wolverhampton being the prominent are and that other CGGs had been alerted with communications being circulated by the Commissioning Support Unit. The police were now involved in investigations and the Committee would continue to be updated as and when they could.

- Item 154 – (AGC/19/30) - Cyber Security - Mr McKenzie to bring back a report of the organisations performance against the 10 cyber risks once completed – This was in the internal audit workplan and would be brought to the next meeting following discussions with the Director of Operations and Internal Audit.
- Item 157 – (AGC/19/33) - Draft Internal Audit Plan for 2019/2020 - Mr McKenzie to add a line in the Board Assurance Framework to show which audit function was sending assurance around certain areas – This had been included in the Board Assurance Framework. Closed.
- Item 163 – (AGC/19/50) - Final 2019/20 Internal Audit Plan - Internal Audit to add a KPI around the proportion of audits completed through the year – There is a column added in the progress report for this meeting and will further report at the next meeting on how they are preforming and to pull this into a KPI. Mr Oatridge asked that the performance against the plan and the days worked on audit against the plan should also be in two KPI. To be added to the next progress report.
- Item 164 – (AGC/19/52) - Internal Audit Annual Report 2018/19 (which includes the Head of Internal Audit Opinion) - Internal Audit to provide a paper on learning experiences from merged organisations and risks to be shared with the Black Country Transition Board – Included in the progress report. Closed.
- Item 165 – (AGC/19/54) - Management Representation Letters to be issued in advance for Governing Body Review in the future – Bring Forward for Audit Programme.
- Item 166 – (AGC/19/60) - Receivable/Payable Greater than £10,000 and over 6 months old - Mr Kay to look into the resolution of outstanding invoices – Mr Gallagher to look into this with Mr Kay and circulate before the 11 November 2019 meeting.

Annual Audit Letter

AGC/19/70 Mr Stocks gave a general update that the annual audit letter would go onto the CCG website and said that it was a positive letter.

It reconfirmed that it gave an 'unqualified opinion' and that the External Audit Team had not had to use their statutory powers,

RESOLUTION: The Committee:

- Accepted the report

Mr Stocks left the meeting.

NHS
Wolverhampton
Clinical Commissioning Group

Internal Audit Progress Report

AGC/19/72 Ms Bajaj presented the Internal Audit Progress Report which included the Finance Report which had been circulated with the internal audit pack of papers.

Ms Bajaj also updated that the Stakeholder Engagement Report had now been finalised but had missed the deadline for this meeting so asked if it could be circulated to Committee members before the next meeting.

Highlights from the Stakeholder Engagement Report included:

- Positive comments received including work with stakeholders and the relationship with the Accountable Officer.
- Not a risk rated report so no themes or issues have come out of this.
- The stakeholders who responded (GPs, Director of Adult Social Care at Wolverhampton City Council, Director of Strategic Planning and Performance and Director of Integration from the Royal Wolverhampton Hospitals Trust and from the CCG the Director of Strategy and Transformation, Director of Nursing and Chief Nurse and the Director for Operations).
- Areas of focus included a lack of change.
- Importance of working with GPs.
- More work in Mental Health to make it more profile within the Better Care Fund and ICA arenas.

The progress report gave updates on each area and in which quarter of the plan it would be delivered. The areas identified were:

1. Corporate Governance – Equality and Diversity
2. Finance
3. Delegated Commissioning
4. Cybersecurity
5. Continuing Healthcare
6. Brexit Planning
7. Conflicts of Interest
8. Information Governance
9. HR/Restructuring
10. Audit Follow Up

Ms Watson had met with Mr Gallagher to discuss audit follow up. Internal Audit had moved away from the Connect system and emails had been sent to individuals regarding overdue risks. As a last resort, if risks were overdue by 4 weeks it would be escalated to the Chair of the Audit and Governance Committee. An update on the status of risks would be given at the next meeting.

Mr Oatridge asked why there had been a move from the Connect system. Mr Gallagher advised that this was due to the onerous nature of working and it was hoped this would be a better system to use. Mr Price asked how insufficient responses would be dealt with. Ms Bajaj advised that responses were tested and evidence was asked for and the Committee

would be kept up to date. Each area had a designated lead along with Internal Audit and the lead was responsible for closing actions.

The report also the KPIs which would be amended with Mr Oatridge's comments.

Also included was a paper that had been requested by the Audit and Governance Committee around joint working. Mr Oatridge did not feel that the paper touched on learning exercises and identified people that the CCG could speak with about mergers that had occurred previously.

Mr McKenzie updated that learning had been discussed at the Transition Board and the Transition Director had met with colleagues at Birmingham and Solihull. There were also discussions around potential committees in common, governance structures, terms of reference, audits, multiple reporting etc A lot of work was being undertaken to look at this. Coventry and Warwickshire and Herford and Worcestershire were identified as being ahead of the Black Country.

Mr Price was happy to touch on this in his summary report to the Governing Body.

Mr Green was asked to look at contracts for External Audit in the other CCGs and to bring a paper in November Meeting.

RESOLUTION: The Committee:

- Noted and accepted the report.
- Status of actions to be given at next meeting.
- Mr Green to bring findings of External Audit contracts from other CCGs to the November meeting.

Internal Audit Charter

AGC/19/73 The Internal Audit Charter was presented to the Audit and Governance Committee for approval. The Charter outlines the purpose and scope, responsibilities of internal audit and CCG management responsibility. The changes that were requested last year had been added to the Internal Audit Charter.

RESOLUTION: The Committee:

- Accepted and approved the report.

Finance Review – Final Internal Audit Report

AGC/19/74 The Finance Review focused on single tender waivers. It looked at processes, documentation and approval process. There were 2 medium and 1 low risk finding identified.

Documentation was inconsistent and there were a lack of documentation

and evidence why forms had been approved. Some forms had been approved by the Head of Contracting and Procurement at the CCG rather than at the CSU as per the detailed financial policies.

There was also a lack of understanding of how to fill in waiver forms by senior members of the CCG and that training had not been conducted since 2012.

Mr Gallagher advised that a short deadline had been set to update the form and give training to staff in order to ensure that the medium risk was not taken forward into the new financial year. Mr Mohan praised the CCG on taking a proactive approach and offered assistance if required.

RESOLUTION: The Committee:

- Noted the report.
- Review recommendations at a future date.

Risk Register Reporting/Board Assurance Framework

AGC/19/75 Mr McKenzie presented a report on the Risk Register and Board Assurance Framework to update the Committee since the last meeting.

As highlighted at the last meeting of the committee, the CCG's Operating Plan for 2019/20 set five priorities for the year ahead:-

1. Continue to commission high quality, safe healthcare services within our budget;
2. Focus on prevention and early treatment;
3. Ensure our services are cost effective and sustainable;
4. Align our clinical priorities, as appropriate, to the Black Country and West Birmingham STP/ICS;
5. Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them.

The Governing Body chose to re-assess the strategic objectives in the current GBAF in relation to the operational priorities for 2019/2020. They agreed to look at:

1. Improving the quality and safety of the services we commission
2. Reducing heath inequalities in Wolverhampton
3. System effectiveness within our financial envelope

Mr McKenzie gave updates on the risk that had been presented to this committee and asked them to note the changes that had been made.

It was hoped that a deep dive could be conducted following the refresh of the Primary Care Strategy. Processes were being looked at across the STP and there was continued engagement with colleagues across the CCGs.

The Chair asked if a programme could be presented to the committee at the next meeting around deep dives for the rest of the year.

RESOLUTION: The Committee:

- Noted the report.
- Noted the changes and actions taken against the risks in the risk register.
- Asked for a programme of Deep Dives to be presented to the Committee in November.

Review of Whistleblowing Policy

AGC/19/76 The Committee was given an update around the Whistleblowing Policy which was due for review next year. It would be picked up as a whole review of policies by HR.

There had been no instances of Whistleblowing reported and no instances of GPs approaching the CCG to use the Freedom to Speak Up Guardian.

Mr Oatridge asked if GP practices and RWT could be approached to produce a summary of whistleblowing in those organisations.

Mr McKenzie advised that nursing homes were not covered by the whistleblowing policy but would approach the Quality Team to see if they had received any soft intelligence.

RESOLUTION: The Committee:

- Noted the report.
- Mr McKenzie to produce a summary around whistleblowing in GP Practices and at RWT.
- Mr McKenzie to speak with the Quality Team around whistleblowing in nursing homes.

Requirements of an Audit Committee as referenced in HFMA Document

AGC/19/77 The Committee were presented with a briefing paper summarising the role of the Committee and External Audit.

There was a positive relationship between the CCG and External Audit.

RESOLUTION: The Committee:

- Accepted the report.

Feedback to and from the Audit and Governance Committee

AGC/19/78 Mr Price advised that the CCG had been rated as 'Outstanding' for the fourth time in a row.

The Transition Board had discussed the recruitment for a Single

Wolverhampton Clinical Commissioning Group

Accountable Officer and the advert would go out shortly.

RESOLUTION: The Committee:

- Noted and accepted the report.

Losses and Compensation Payments – Quarter 1 2019/20

AGC/19/79 The papers had been missed from the pack and would be circulated after the meeting and any comments to be sent to Mr Gallagher and Mr Kay.

RESOLUTION: The Committee:

- Noted the report.

Suspension, Waiver and Breaches of SO/PFPS

AGC/19/80 Mr Gallagher noted the below in quarter 1 of 2019/20:

- During quarter 4 of 2019/20 there were 45 invoices in breach of PFPs (6.4% of all invoices paid);
- 40 waivers were raised during quarter 1;
- 46 non-healthcare invoices were paid without a purchase order being raised during quarters 1.

The Committee discussed the number of invoices that were generated towards the end of the financial year and if this would continue to be the same. Mr Gallagher advised that this was down to the retrospective invoices being raised for the Continuing Healthcare Team and Mental Health placements.

RESOLUTION: The Committee:

- Noted the report.

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

AGC/19/81 The Committee noted that as at 30 June 2019 there were:

- There was 5 invoices greater than 10k and over 6 months old.
- 4 payables greater than £10k and over 6 months old.

RESOLUTION: The Committee:

- Noted the above.

Counter Fraud Progress Report

AGC/19/82 Mr Mohan presented the Counter Fraud Progress Report for information which gave the Committee an update on work being undertaken and to give the Committee assurance.

RESOLUTION:

- The Committee accepted the report.

NHS
Wolverhampton
Clinical Commissioning Group

Any Other Business

AGC/19/83 There were no items to discuss under Any Other Business.

Date and time of next meeting

AGC/19/84 Tuesday 19 November 2019 at 11am at Wolverhampton Science Park

Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 10 October 2019

Members:
Dr Salma Reehana, Chair, Wolverhampton CCG (Chair)
Mike Abel, Lay Member, Walsall CCG
Simon Collins, Specialised Commissioning, West Midlands
Dr Ruth Edwards, Clinical Executive for Integrated Assurance, Dudley CCG
James Green, Chief Finance Office, Sandwell and West Birmingham CCG
Matt Hartland, Chief Finance and Operating Officer, Dudley CCG
Mike Hastings, Director of Operations, Wolverhampton CCG
Julie Jasper, Lay Member, Sandwell and West Birmingham CCG
Steven Marshall, Director of Strategy and Transformation and Deputy Accountable Officer, Wolverhampton CCG
Sharon Liggins , Chief Operating Officer, Sandwell and West Birmingham CCG
Paul Maubach, Accountable Officer, Dudley CCG and Walsall CCG and preferred candidate for Accountable Officer for Black Country CCGs
Alastair McIntyre, Portfolio Director, Black Country and West Birmingham STP
Peter McKenzie, Corporate Operations Manager, Wolverhampton CCG
Helen Moseley, Lay Member Dudley CCG
Peter Price, Lay Member Wolverhampton CCG
Ian Sykes, Chair Sandwell and West Birmingham CCG
Jayne Salter-Scott, Head of Communications, Sandwell and West Birmingham CCG
Manisha Patel, Personal Assistant to Dr Helen Hibbs MBE, Dr Salma Reehana Chair of the Governing Body, Jonathan Fellows Independent Chair of the STP Wolverhampton CCG (note taker)

Apologies:
Laura Broster, Director of Communications, Dudley CCG
Jonathan Fellows, STP Independent Chair
David Hegarty, Chair, Dudley CCG
Dr Helen Hibbs, Accountable Officer Wolverhampton CCG
Dr Anand Rischie, Chair, Walsall CCG
Sally Roberts, Chief Nurse and Director of Quality, Wolverhampton CCG
Andy Williams, Accountable Officer, 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 12 September 2019 were accepted as an accurate record of the meeting. The action log was reviewed and the action log has been updated accordingly.

2. CLG Update

The Committee were presented with the draft minutes of the Clinical Leadership Group meeting from 19 September 2019. In Sally Roberts' absence, members were asked to pass on any comments directly to Sally Roberts.

3. Matters of Common Interest

3.1 Performance and Assurance Return

Alastair McIntyre presented the STP Performance Report for information. Key points noted were:

- The System Review Meeting had taken place on Tuesday 8 October 2019.
- Urgent Care system continues to be challenged in meeting the 4hour standard.
- The System Review Meeting had ask that the BCWB STP Urgent Care Board looks at unwarranted variation in UEC, shares best practice and looks to demonstrate greater system level working to resolve delivery challenges.
- There had been an improvement in 2 week breast in Wolverhampton to 22 days which was positive but had deteriorated in Walsall to 28 days due to patients from Wolverhampton being seen there. A plan was in place to address this.
- Mental Health out of area placements was also highlighted at this meeting.
- Steven Marshall gave a brief background on mental health beds throughout the Black Country.

ACTION: Steven Marshall - Mr Marshall to bring an update to the next meeting on assessments on out of hour placements which could also be shared with NHSE/I. The update should also include finances with regards to private and NHS funding.

3.1a Urgent Care Board

The agenda and terms of reference were attached for information.

ACTION: Alastair McIntyre - Mr McIntyre was asked to review the Terms of Reference to ensure Mental Health representation at the UEC Board meetings.

3.2 Place Based Commissioning Update – Dudley

Paul Maubach presented the Dudley place based commissioning update. The meeting was pleased to hear that the aim is to have the MCP in place by 1 April 2020.

3.3 Brexit Update

Mike Hastings shared a paper for assurance and information. This paper had also been sent to CCGs for sharing at CCG Governing Body Meetings. The paper gave information on:

- EU Exit Preparedness
- Operational Updates
- Medicines, Non-medicines, Freight, MHRA, Non Clinical Good & Services, Social Care, Workforce, Reciprocal Healthcare and cost recovery, Clinical Trials, Research & Networks, Vaccines, Blood and Transport, Data and Regional Update.

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.

ACTION: Mike Hastings - Mr Hastings to share SITREP information and to bring further updates to the JCC if there are major changes.

4. Formally Delegated Areas

4.1 Transforming Care Partnership

Alastair McIntyre provided an update on behalf of Dr Hibbs.

- Moorhouse Consulting were currently providing support until the end of October 2019.
- Transformational funding had been approved by the Board and
- The Board had signed off the restructured governance review.
- The numbers relating to Wolverhampton and NHSE had both improved by 1 each since the report had been produced.
- A meeting had been scheduled for Midlands region with Ray James, National Director on 16.10.19.
- Discussions with Dr Helen Hibbs and Paul Maubach on the recruitment of a TCP Programme Director will proceed outside the meeting with the aim of having support in place from early November.

4.2 Mental Health - Collaborative Commissioning Update

This item was deferred to the next meeting.

ACTION: Steven Marshall - Mr Marshall to bring update to next meeting.

5. CCG Transition Board

A verbal update was given under this item and highlighted:

- Listening Exercises to be undertaken with Stakeholders around the move towards a single CCG.
- Following the assessment and recruitment day held on 25 September 2019, Paul Maubach had been identified as the preferred candidate.
- Work has begun looking to align governance across the CCGs.

6. Risk Register

Alastair McIntyre and Peter McKenzie had met to discuss aligning governance and risk registers across the four CCGs. It was agreed that the four CCG Commissioning Committee risj registers should be combined to form a single commissioning risk register.

7. Feedback from Governing Bodies

There was no feedback to be discussed at this meeting,

8. Update from STP

Matt Hartland updated on the submission of the Long Term Plan. Submissions required by the 27 September 2019 had been completed and the review process was now in place. The draft did require more work until the final submission on 15 November 2019.

Further work is required to close the planning (financial) gap identified in the draft plan. Matt Hartland would be attending the Clinical Leadership Group meeting to ask for support in modelling various scenarios.

James Green spoke of the financial targets that had been set for the Trusts and CCGs which were more challenging than anticipated and more detail had been requested from NHSE/I. Alastair McIntyre, James Green and Matt Hartland are to meet with NHSE to discuss this.

Matt Hartland also wanted to highlight that the misalignment of activity in the SWB Trust and CCG plans needed to be resolved.

10. Any Other Business

There were no items to discuss under any other business.

Meeting closed

11. Date of Next Meeting

Thursday 14 November 2019, 09:00-10:30, Board Room, Dudley CCG, Brierley Hill Health and Social Care Centre, Venture Way, Brierley Hill, West Midlands, DY5 1 RU.

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	Nothing further to update at present.
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	Nothing further to update at present.
162	11 July 2019	A revised paper to each CCG GBs to seek investment and for approval.	Sharon Liggins	14 November 2019	Shared and taken through governance. To be kept on action log.
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.*	Paul Maubach	14 November 2019	Verbal update required for next meeting. Action to be reallocated to Paul Maubach.
175	12 September 2019	26 week choice letter to be brought to attention of Elective Care Board	Neill Bucktin	14 November 2019	A workshop and follow up meeting have taken place in relation to this. Looking to focus on general surgery in the first instance, subject to confirmation that all providers will offer and receive patients. This should be confirmed by 8 November. Specific session to agree the Standard Operating Procedure – 18 November. Weekly (Friday)

No.	Date	Action	Lead	Deadline	Status Update
					STP teleconference to take place to review capacity issues across the system commencing Friday 22 November.
176	10 October 2019	Mr Marshall to bring an update to the next meeting on assessments on out of hour placements which could also be shared with NHSE/I. The update should also include finances with regards to private and NHS funding.	Steven Marshall	14 November 2019	On agenda
177	10 October 2019	Mr McIntyre was asked to review the Terms of Reference to ensure Mental Health representation at the UEC Board meetings.	Alastair McIntyre	14 November 2019	Completed prior to the board meeting and MH trust representation was present and terms of reference amended
178	10 October 2019	Mr Hastings to share SITREP information and to bring further updates to the JCC if there are major changes.	Mike Hastings	14 November 2019	Process has since been stood down until further notice (Likely Jan 2020)

Black Country and West Birmingham
Joint Commissioning Committee (JCC)

Minutes of Meeting dated 19 November 2019

Members:
Dr Salma Reehana, Chair, Wolverhampton CCG (Chair)
Alastair McIntyre, Portfolio Director, Black Country and West Birmingham STP (part meeting)
Clare Hamilton, EA to Paul Maubach (note taker)
Dr Anand Rischie, Chair, Walsall CCG
Dr Ruth Edwards, Clinical Executive for Integrated Assurance, Dudley CCG
James Green, Chief Finance Office, Sandwell and West Birmingham CCG (part meeting)
Julie Jasper, Lay Member, Sandwell and West Birmingham CCG
Matt Hartland, Chief Finance and Operating Officer, Dudley CCG (part meeting)
Mike Abel, Lay Member, Walsall CCG
Peter Price, Lay Member Wolverhampton CCG
Ian Sykes, Chair Sandwell and West Birmingham CCG
Jayne Salter-Scott, Head of Communications, Sandwell and West Birmingham CCG
Sharon Liggins , Chief Operating Officer, Sandwell and West Birmingham CCG
Steven Marshall, Director of Strategy and Transformation and Deputy Accountable Officer, Wolverhampton CCG

Apologies:
David Hegarty, Chair, Dudley CCG
Dr Helen Hibbs, Accountable Officer Wolverhampton CCG
Helen Moseley, Lay Member Dudley CCG
Jonathan Fellows, STP Independent Chair
Laura Broster, Director of Communications, Dudley CCG
Paul Maubach, Accountable Officer for Black Country CCGs
Sally Roberts, Chief Nurse and Director of Quality, Wolverhampton CCG
Simon Collins, Specialised Commissioning, West Midlands

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 10 October 2019 were accepted as an accurate record of the meeting. The action log was reviewed and the action log has been updated accordingly.

1.5 Quoracy was queried as Paul Maubach was not in attendance as Accountable Officer. Steve Marshall advised that he is acting as AO for Wolverhampton until December therefore the meeting was quorate.

2. CLG UPDATE

2.1 This paper was accepted for information in the absence of Sally Roberts.

3. PERFORMANCE AND ASSURANCE RETURN

3.1 Alastair McIntyre provided the October performance report that went to the STP board for information. Alastair highlighted the main area for concern as Urgent & Emergency Care.

3.2 Julie Jasper queried that all four Trusts are failing the A&E targets

Action: Alastair McIntyre to circulate to JCC members the summary for the Black Country of the UEC actions in response to 'Pauline Philip and Dale Bywater letter' on UEC

3.3 Richard Beeken chairs the U&EC Care Board and also attend the regional board meeting monthly.

Action: Alastair McIntyre to provide a paper on how the U&EC Boards connect with the Place based AEDBs to provide the JCC with assurance that work is being done to share learning and meet the A&E treatment standard.

4. Place Based Commissioning Update

4.1 Ian Sykes provided an update on place based commissioning in Sandwell & West Birmingham. The CCG has agreed to second a programme manager for this work and Ian confirmed that the work is progressing.

4.2 The first board meeting of the two alliances will take place in December 2019.

FORMALLY DELEGATED AREAS

5. TRANSFORMING CARE PARTNERSHIP

5.1 Alastair McIntyre provided an update on TCP across the Black Country & West Birmingham. Alastair confirmed that they are currently eight over the agreed position for year end. Alastair asked that the document provided with the agenda is not to be shared as there is a typo error in it.

5.2 Alastair advised that TCP patient discharges have slowed down over the last quarter but external resource bought in to support this. There is also a programme director in place until the end of March.

Action: Alastair McIntyre to invite the provider to talk about TCP community service and also the new programme director to support this.

Action: Paul Maubach to confirm who is the TCP lead through to end of March 2020.

Action: Alastair McIntyre to breakdown TCP figures by CCGs

6. MENTAL HEALTH

6.1 Steve Marshall provided a paper to propose to change the contracting of mental health beds across the four areas to try and keep out of area bed costs in the Black Country & West Birmingham.

6.2 The proposal requires one contracting authority to work on behalf of the four CCGs ahead of contracting rounds.

Action: Steve Marshall to arrange for Mental Health proposal to be discussed at Governing Body development session on 4 December.

The following left the meeting to join a Long Term Plan STP finance call with NHSE/I

09.45 – Matt Hartland left the meeting

09.50 – James Green and Alastair McIntyre left the meeting

7. CCG TRANSITION BOARD

7.1 All will be in attendance at the transition board therefore an update was not required.

8. **FEEDBACK FROM GOVERNING BODIES**

8.1 All were provided assurance that the 111/999 transfer went very well and within 24 hours the service was meeting all their targets.

9. UPDATE FROM STP

9.1 No update provided in Jonathan Fellow's absence.

Action: Salma Reehana to ask Jonathan Fellows if he can attend the JCC to provide an update on the STP.

10. ITEMS FOR INFORMATION

10.1 NHSE/I slides for clinical leaders network were accepted for information only.

11. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

11.1 Meeting closed

12. Date of Next Meeting

Thursday 12 December 2019, 09:00-10:30, Board Room 2F, Kingston House, West Bromwich, B70 9LD

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. Agreed that BCWB would join the existing SWB and BSOL group and look to greater involvement of Clinicians.	Sharon Sidhu	8 August 2019	Nothing further to update at present.
162	11 July 2019	A revised paper on the respiratory proposal (from Helen Ward) to each CCG GBs to seek investment and for approval.	Sharon Liggins	14 November 2019	Shared and taken through governance. To be kept on action log.
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.*	Paul Maubach	14 November 2019	Verbal update required for next meeting. Action to be reallocated to Paul Maubach.
175	12 September 2019	26 week choice letter to be brought to attention of Elective Care Board	Neill Bucktin	14 November 2019	A workshop and follow up meeting have taken place in relation to this. Looking to focus on general surgery in the first instance, subject to confirmation that all providers will offer and receive patients. This should be confirmed by 8 November. Specific session to agree the Standard Operating Procedure – 18

No.	Date	Action	Lead	Deadline	Status Update
					November. Weekly (Friday) STP teleconference to take place to review capacity issues across the system commencing Friday 22 November.
178	10 October 2019	Mr Hastings to share SITREP information and to bring further updates to the JCC if there are major changes.	Mike Hastings	January 2020	Process has since been stood down until further notice (Likely Jan 2020)
179	14 November 2019	Alastair McIntyre to provide the summary of UEC actions in response to Pauline Philip and Dale Bywater letter on UEC	Alastair McIntyre	12 December 2019	Complete.  Winter Delivery Plan self assessment nov 2
180	14 November 2019	Alastair McIntyre to provide a paper on how the U&EC Boards connect to provide assurance that work is being done to provide A&E targets.	Alastair McIntyre	12 December 2019	
181	14 November 2019	Alastair McIntyre to invite the provider to talk about TCP community service and also the new programme director to support this.	Alastair McIntyre	12 December 2019	Confirmed Kathryn Hudson and Provider representative will attend to present on 12/12.
182	14 November 2019	Paul Maubach to confirm who is the TCP lead following Helen's departure in late November	Paul Maubach	12 December 2019	
183	14 November 2019	Alastair McIntyre to breakdown TCP figures by individual	Alastair McIntyre	12 December 2019	Will be part of presentation for action 181
184	14 November 2019	Steven Marshall to arrange for Mental Health proposal to be discussed at Governing Body development session on 4 December.	Steven Marshall	04 December 2019	Steven Marshall has liaised with Paul Maubach and is awaiting further information.
185	14 November 2019	Salma to ask Jonathan Fellows if he can attend the JCC to provide an update on the STP.	Salma Reehana	12 December 2019	

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Health and Wellbeing Together
Minutes - 16 October 2019

Attendance

Members of Health and Wellbeing Together

Councillor Jasbir Jaspal (Chair)	Cabinet Member for Public Health and Wellbeing
Dr Helen Hibbs MBE (Vice-chair)	Chief Officer, Wolverhampton CCG
Councillor Ian Brookfield	Leader of the Council
John Denley	Director of Public Health
Professor Steve Field CBE	Royal Wolverhampton NHS Trust
Dr. Ranjit Khutan	University of Wolverhampton
Councillor Linda Leach	Cabinet Member for Adults
Councillor John C Reynolds	Cabinet Member for Children and Young People
Councillor Wendy Thompson	Conservative Party Leader
Andrew Wolverson	Head of Service - Improvement
David Watts	Director of Adult Services
Kuli Kaur Wilson	Black Country Partnership NHS Foundation Trust

Employees

Alison Baggs	Co-Production Officer
Shelley Humphries	Democratic Services Officer
Michelle James	Licensing Policy Manager
Michelle Marie-Smith	Principal Public Health Specialist
Kush Patel	Commissioning Officer
Alice Vickers	Corporate Parenting Officer
Becky Wilkinson	Head of Adults Improvement

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**
Apologies were received from David Loughton, Sally Roberts, Chief Superintendent Andy Beard and Steven Marshall.

2 **Notification of substitute members**
Andrew Wolverson attended for Emma Bennett, Kuli Kaur Wilson attended for Lesley Writtle and Dr Ranjit Khutan attended for Dr. Katherine Birch.

3 **Declarations of interest**
Dr Ranjit Khutan, University of Wolverhampton declared an interest in his capacity as a member of the Healthwatch Advisory Board.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting of 10 April 2019 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

In respect of Minute 8, it was reported that Supporting Individuals and Families with No Recourse to Public Funds training sessions had taken place and had been well received. It was noted that further sessions would be planned if requested.

In respect of Minute 10, it was noted that Brendan Clifford, Black Country DAS was leading on developing and embedding the health and wellbeing dimension in all polices and taking this forward.

6 **Health and Wellbeing Together Forward Plan 2019 - 2020**

Madeleine Freewood, Development Manager presented the Health and Wellbeing Together Forward Plan 2019 – 2020.

It was noted that the Health and Wellbeing Executive Group meeting would need to be rescheduled and that Democratic Services would contact members in due course to advise of the new date and time.

It was noted that the Black Country Strategic Child Death Overview Panel Development (CDOP) Update would be deferred to a later date.

Resolved:

1. That details of the rescheduled Health and Wellbeing Together Executive Group meeting be forwarded to members.
2. That the Black Country Strategic Child Death Overview Panel Development Update would be deferred to a later date.
3. That the Health and Wellbeing Together Forward Plan 2019 – 2020 be noted.

7 **Health and Wellbeing Together Strategy Meeting – Outcomes and Next Steps**

Madeleine Freewood, Development Manager presented the Health and Wellbeing Together Strategy Meeting – Outcomes and Next Steps report and highlighted salient points. The report outlined a summary of the discussions that took place as part of the Health and Wellbeing Together strategy meeting held on 3 July 2019.

It was reported that the main focus of the discussions was the Living Well theme of the Joint Health and Wellbeing Strategy and a number of recommendations had been made under the Workforce, City Centre and Embedding Prevention Across the System priority areas.

It was noted that, also included as part of the Strategy Day, a presentation was delivered providing an overview of the opportunities for health and social care offered by 5G technology and the plans to use the City as a testbed.

The report provided a summary of the recommendations for all these priority areas and it was reported that work had commenced to drive these actions forward. The report sought endorsement from Board members in support of these actions.

Professor Steve Field CBE, Royal Wolverhampton NHS Trust agreed that the Strategy Day had been interesting and requested that future strategy meeting

invitations be extended to other colleagues from RWT wishing to engage and contribute. Dr Helen Hibbs MBE, Wolverhampton CCG added that the CCG would be happy to feed into any of the work programmes sitting underneath.

It was debated how to share the work plan with partners and a mini conference was suggested.

It was noted that there was a model that had worked well in Bradford, sharing information at a locality level. As Wolverhampton was a City, it could be taken ward by ward and work could be linked with Councillors. It was noted that Wolverhampton had previously been viewed as three localities; south east, north east and south west.

It was also reported that a meeting had been set up with partners and Council officers to further explore the possibilities of 5G technology for the future of health and social care in the City.

Resolved:

1. That the Health and Wellbeing Together Strategy Meeting Outcomes and Next Steps as outlined in section 3.0 of the report be endorsed by Health and Wellbeing Together.

8 **Public Health Annual Report 2019**

John Denley, Director of Public Health presented the Public Health Annual Report 2019 and highlighted salient points. It was outlined that the Director of Public Health's Annual report was a professional statement about the health and wellbeing of their local communities and a statutory requirement. The report aimed to inform both professionals and members of the public about key issues in the City, identify current priorities and highlight required action for the improvement and protection of the health of the local population. It was noted that the report had been produced in line with the aims and priorities that ran through the Public Health Vision 2030, Wolverhampton Council Plan 2019 – 2024 and the Health and Wellbeing Strategy 2018 - 2023.

It was highlighted that emphasis had been placed on using what had been successful in the last Annual Report and building on ways to further improve this year's report.

The Annual Report outlined the themes of Starting and Developing Well, Healthy Life Expectancy and Healthy Ageing, with the underlying theme of System Leadership. It included what challenges had been faced and what plans were in place to address these challenges. To illustrate place-based health, an infographic profile of each ward had been produced which provided a red, amber, green rating and a brief, concise narrative explaining what the statistics for each ward meant for its residents.

It was noted that the focus concentrated on conditions that resulted in poor health or making unhealthy choices and addressing them as early as possible to ensure a healthy progression through life. It was important to gain an understanding of why healthy lifestyles and life expectancy differed throughout the City and how health inequalities could be overcome.

It was highlighted that the next steps would be to focus on partnership working, build upon work already ongoing and work on all areas that could be influenced.

Poor quality housing was thought to be a contributing factor in terms of issues such as damp in properties causing respiratory and other health problems, for example. Obesity was also highlighted as an issue that may perhaps be attributed to poor education on making healthy lifestyle choices.

It was noted that a correlation existed between wards with highest outcomes in age and life expectancy and dissatisfaction with their neighbourhood area and it was queried why this should be.

In response to poor quality housing in the private sector, it was thought to be of great concern and it was queried by Councillor Wendy Thompson whether private landlords were being held to account and whether Serco had become involved. It was noted that they had in some cases however Councillor Ian Brookfield offered to investigate this and respond.

It was noted that the information represented would prove useful in future for the primary care networks as they developed. It was felt the information was well-represented and offered a clear understanding of the health of the population rather than just outlining the delivery of care.

It was noted that links had been found with certain health issues and black, Asian and minority ethnic (BAME) groups and it was queried whether future reports could include how resources could be focused on groups of people as well as areas. It was noted that the information could be represented in many different ways and this would be taken into account for future reports.

Resolved:

That the publication of the Public Health Annual Report 2019 be approved.

9 **Black Country and West Birmingham STP Five-year Plan**

Dr Helen Hibbs MBE delivered the presentation on the Black Country and West Birmingham STP Five-year Plan. It was outlined that in June 2018, the Prime Minister had made a commitment that the Government would provide the National Health Service (NHS) with funding over five years with an average increase of 3.4% per year. The NHS were asked to develop a long-term plan outlining its ambitions for improvement over the next decade and plans to meet them over the five-year period of funding.

The presentation provided details around commitments to the population, the NHS system and its workforce to support the overall vision of Working Together to Improve the Health and Wellbeing of Local People. The presentation outlined the challenges of maintaining a high quality of service to address complex health and wellbeing challenges, whilst resolving the financial challenges to sustain this. As there was a fixed amount of money, the solution lay in developing new ways of working within this budget.

It was noted that the key priorities were:

- Working to reduce health inequalities and improving health outcomes
- Ensuring Wolverhampton and the Black Country is an attractive area in which to work
- Working together to create sustainable community, workforce and health care system

The key principles were identified as:

- Creating a culture of stewardship (doing things together, shared responsibility)
- Health and social care acting as one
- All services working together as a network, delivering care and treatment around an identified need
- Providing local people with the information and support to empower them to optimise their own health and wellbeing
- Taking a collective responsibility for delivering our Long-Term Plan.

Board members were asked to think about how they could contribute and if they had any thoughts on the role of people and communities in delivering this plan.

The plan was commended for the inclusion of a mental health element.

It was thought that commissioning services locally was preferable and commissioning geographically only when appropriate. It was noted that it was important to keep Wolverhampton services and resources local.
It was also stated that ensuring there were good social care providers within communities was a priority.

Resolved:

That the presentation on the Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Five-Year Plan be received.

10 **Co-production Charter**

Resolved:

That the Co-production Charter report be deferred to the next meeting of Health and Wellbeing Together.

11 **Better Care Fund 2018-2019 Annual Report**

David Watts, Director of Adult Services presented the 2018 – 2019 Better Care Fund Annual Report and highlighted salient points. The report provided Health and Wellbeing Together with an update on the progress made towards the delivery of the Better Care Fund (BCF) programme during 2018 – 2019.

The report outlined that the programme was a Government initiative that encompassed the NHS and local government and sought to integrate health and care services. It was noted that the programme was designed to enable people to manage their own health and wellbeing and live independently in their communities for as long as possible.

It was noted that there had been plans to submit proposals to Cabinet for an increase in Extra Care beds, which would mean a significant investment but was anticipated to reap benefits.

It was reported that robust partnership arrangements had been put in place to keep the plan on target. This included four main workstreams that oversaw mental health, child and adolescent mental health services (CAMHS), adults and community and dementia.

Becky Wilkinson, Head of Service – Adult Improvement noted that, when working at NHS England, of the 14 BCF plans that were submitted, Wolverhampton's was one of the plans that had really stood out. The Wolverhampton BCF programme had been commended for strong collaboration between partners and for a robust plan.

Resolved:

That the update on the progress made towards the delivery of the Better Care Fund Programme during 2018 – 2019 be received.

12 **Substance Misuse Partnership Update and Licensing Policy Consultation**

Resolved:

That the Substance Misuse Partnership Update and Licensing Policy Consultation report be deferred to future meeting.