NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 8th March 2016 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

A G E N D A

		1	Apologies for absence		
		2	Declarations of Interest		
		3	Patient Story		
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			▪ Audit Panel Appointment	Mr J Oatridge /Mr P McKenzie	103 - 106
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		21	Any Other Business		
		22	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 12 April 2016 ~ Wolverhampton Clinical Commissioning Group Governing Body		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 9 February 2016
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

VOTING MEMBERS ~

Clinical ~		**Present**
Dr D De Rosa ~ Chair	Board Member	Yes
Dr D Bush	Board Member	No
Dr M Kainth	Board Member	Yes
Dr J Morgans	Board Member	Yes
Dr R Rajcholan	Board Member	No
Dr A Sharma	Board Member	Yes
Management ~		
Dr H Hibbs	Chief Officer	Yes
Ms M Garcha	Executive Lead for Nursing and Quality	Yes
Mr S Marshall	Director of Strategy and Transformation	Yes
Ms C Skidmore	Chief Financial Officer/Chief Operating Officer	Yes
Lay Members/Consultant ~		
Mr T Fox	Secondary Care Consultant	No
Mr J Oatridge	Lay Member	Yes
Ms P Roberts	Lay Member	Yes
Ms H Ryan	Lay Member	Yes

In Attendance ~

Ms H Cook	Communications and Engagement Manager
Ms K Garbutt	Administrative Officer
Ms V Griffin	Local Authority
Mr M Hastings	Associate Director of Operations
Ms L Hull	Administrative Officer (Observer)
Dr G Mahay	Local Medical Committee Representative
Mr P McKenzie	Corporate Operations Manager

Apologies for absence

Apologies were received from Dr D Bush, Ms R Jervis, Dr R Rajcholan, Mr T Fox and Dr A Sen.

Declarations of Interest

WCCG.1373 Dr D De Rosa reported GP Governing Body members declared an interest in the Commissioning Committee report as standard.

RESOLVED: That the above is noted

Patient Story

WCCG.1374 Ms P Roberts introduced a patient story relating to the Respiratory Innovation Promoting a Positive Life Experience (RIPPLE) project which is currently being sponsored by the Health Foundation. She stated that the project reduced loneliness and anxiety in respiratory patients. There are activities and access to a Chronic Obstructive Pulmonary Disease (COPD) specialist.

RESOLVED: That the above is noted.

Minutes

WCCG.1375 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 12 January 2016 be approved as a correct record. However the following amendments were highlighted ~

WCCG.1356 Finance and Performance Committee

Ms C Skidmore stated this should read “Quality, Innovation, Productivity and Prevention (QIPP) is not running on forecast”.

Matters arising from the minutes

WCCG.1376 There were no matters arising from the minutes.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.1377 RESOLVED: That the progress report against actions requested at previous Board meetings be noted ~

WCCG.1244 – Emergency Preparedness Resilience and Responses (EPRR)

Mr M Hastings reported that due to staff absence this report has been delayed but it is expected a report will be ready to be to be submitted back to the Governing Body in March

WCCG.1346 – Discussions with RWT – Community Services/Improving Pathways

Dr D De Rosa confirmed he is currently having discussions with Ms A Smith and Dr J Odum and the Royal Wolverhampton Trust (RWT). Dr A Sharma reported he is still waiting to hear from Dr Odum.

Chief Officer update

WCCG.1378 Dr H Hibbs presented the Chief Officer report which is submitted to provide assurance to the Governing Body of robust leadership across the Clinical Commissioning Group (CCG) that involves patients and the public and works in partnership.

Dr Hibbs highlighted item 2.1 - Commissioning Support Unit (CSU) Mobilisation. She added that agenda item 20 Commissioning Support Update gives more information regarding this item.

The Clinical Commissioning Group (CCG) Urgent Care Lead, Dr Julian Morgans, and CCG representatives visited the new Emergency Department at RWT in particular to review how the department is working and the new clinical model that has been put in place. Dr Hibbs reported there are problems with the A&E Department and the CCG are working with RWT to try to improve the situation.

RESOLVED: That the above is noted.

Update on Primary Care and other Developments

WCCG.1379 Mr S Marshall stated that co-commissioning is now up and running. Currently the CCG are working on the management structure to support primary care. At the Members Meeting on the 20 January 2016 the

Primary Care Strategy was approved and currently the CCG are going through the planning implementation.

RESOLVED: That the above is noted.

Commissioning Committee

WCCG.1380 Dr J Morgans presented the Commissioning Committee report which is to provide the Governing Body with an update from the Committee in January 2016. He pointed out item 2.2 Use of Afilbercept for patients with Wet Age Related Macular Degeneration. Dr Morgans also stated that the Committee were asked to consider and approved the commissioning proposal from the West Midlands Specialised Collaborative Commissioning Oversight Group, for a West Midlands Regional Familial Hypercholesterolemia Service.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1381 Ms M Garcha referred to the report which provides assurance on quality and safety of care and any exception reports that the Governing Body should be sighted on. She referred to the key issues of concern on page 2 and gave an overview of them. She highlighted the reduced percentage of A&E attendances where the patient was admitted, transferred to and discharged within 4 hours of their arrival at an A&E department. Ms Garcha pointed out that there are staffing issues relating to recruiting new staff and retaining existing trained newly qualified nurses which is a national.

A Quality and Safety Committee meeting took place this morning and there were no areas to escalate to the Governing Body.

Ms Roberts referred to the Cancer 62 day waits. The Trust reported in January that the Cancer 62 day standard has been achieved for the month, largely due to patients choosing not to have their procedures until January so the numbers are low; however this will impact on January's numbers and will be monitored for effect. Ms Skidmore pointed out for clarity that admitted and non-admitted patients are no longer indicators which we are measured on it is only incomplete pathways which are used as a performance measure

Dr Hibbs asked if the Mental Capacity and Deprivation of Liberty Assessments (MCA/DoLs) could be expanded. Ms Garcha confirmed that there are designated personnel working at the CCG and RWT to

ensure the responsibilities are delivered Adult safeguarding is currently being strengthened and the CCG will be recruiting a designated lead. It is also the ambition to include adults as well as children within the Wolverhampton City Multi Agency Safeguarding Hub (MASH) and Ms Griffin confirmed this should take place from August 2016.

RESOLVED: That the above is noted.

Remuneration Committee

WCCG.1382 Mr Oatridge presented the report which is to provide an update of key discussions and decisions made at the Remuneration Committee. He pointed out the remuneration for a Lay Member of the Finance and Performance Committee was discussed. It was agreed that, as the role description for the role required the individual to have a similar level of skills and experience to the Lay Members of the Audit and Governance Committee, it would be appropriate for them to be remunerated at a commensurate level.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1383 Ms Skidmore stated that month 9 is being reviewed and this is still on track. The forecast for QIPP is static at the moment.

She pointed out that at the Finance and Performance Committee in January month 8 data was considered. The percentage around the 4 hour target has deteriorated and currently the position over December and January has deteriorated further. A remedial action plan, which has been agreed with the Trust, is in place. The CCG have the ability to hold 2% of the budget line to enforce the performance notice.

Ms Skidmore referred to the 62 cancer wait. Again there is a remedial action plan in place. There are very clear stages to the performance notice if actions are not actioned. Ms Skidmore confirmed additional data will go to the Finance and Performance Committee.

She referred to the Referral to Treatment waiting times. We have achieved the core target we are measured against. The CCG are monitoring the position with discussions at specialty level. The CCG are exploring with the Trust the possibility of putting activity out to other areas to maintain the standards and continuity of service for patients.

Ms Skidmore pointed out that there is a Quality Premium achievement every year. The CCG are able, through performance targets, to achieve an awarded Quality Premium for 2014/15. Wolverhampton has achieved £564000 which is in the best in Birmingham and the Black Country. The CCG are currently working with practices to supply equipment for use within the practices. There will also be some resources for the RIPPLE scheme and funding to support Public Health around working with migrants.

RESOLVED: That the above is noted.

Primary Care Joint Commissioning Committee

WCCG.1384 Ms Roberts stated this is the first report to provide the Governing Body with an update. This is a joint report and NHS England will receive this summary. She gave a brief overview of the document. She highlighted the Primary Care Reserved Investment Plan and the schemes approved as part of the plan.

Dr Hibbs thanked Ms Roberts for picking up this work and making a lot of progress in developing the important work around primary care commissioning. Ms Garcha reported that an approved primary care workforce analysis is being carried out and will start in March 2016.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1385 Ms Roberts presented this report which updates the Governing Body on the key communications and participation activities in January 2016.

She gave an overview of the document highlighting the Members Meeting which took place on the 20 January 2016. She also referred to the Grant Policy Workshop. This was to inform and support small and Third Sector organisations to apply for funding for the financial year 2016/17. Applications for services to help to meet the CCG priorities are invited and a funding application panel will convene in February to assign the monies available. Mr S Marshall added that to enable as many organisations to apply as possible a second workshop will be held. The bids are currently being reviewed and there will be a second round of evaluation in due course

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1386 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.1387 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1388 RESOLVED: That the minutes are noted.

Minutes of the Remuneration Committee

WCCG.1389 RESOLVED: That the minutes are noted

Minutes of the Health and Wellbeing Board

WCCG.1390 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.1391 Dr De Rosa confirmed that the additional document relating to Commissioning Support Update – January 2016 was for information.

RESOLVED: That the above is noted.

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

WCCG.1392 **Question**

Why are we paying for A&E nurses from agencies?

Answer

Ms Garcha confirmed that RWT have not used agency nurses except in the Intensive Therapy Unit (ITU) as a last resort. RWT have a banking system they use for nursing staff.

Question

Should ECG equipment be available in each cubicle at RWT.

Answer

This should be directed to RWT.

Question

Why is there a long delay in the A&E department at RWT.

Answer

This is due to batches of people arriving at the same time and staffing levels previously discussed. There are a large number of patients going to A&E 12-18 months ago 300 would be a bad day. During this week this has been 400 plus people arriving in A& E each day. Dr Morgans added that the Urgent Care Centre is planned to open in April 2016 which should relieve the pressure on the A&E department.

Question

Is it necessary to have a degree to be a nurse?

Answer

Ms Garcha stated that from 2000 if you wanted to be a staff nurse you are required to have a degree. However discussions are taking place to have a further tier of nurses between a Health Care Assistant (HCA) and Staff Nurse. This would be an Associated Nurse which is not a degree programme and this has gone for National Consultation.

Question

The new A&E department is short staffed. Was this opened under staffed?

Answer

The Trust recruits their staff so it is difficult to comment. The Trust planned to recruit additional staff into the service however there are a number of vacancies and high sickness level. The answer is to train and recruit locally. In past years there was a cap on the numbers of nurses to be trained. This has now been lifted however this new training is not funded in the same way it requires self-funding. Ms Gacha added nurses recruited from Europe have to undertake local adaptation to work in A&E.

Question

Is it working using Cannock Hospital

Answer

Dr Hibbs stated that we believe this is working for patients for elective activity.

Question

Within the Primary Care Strategy are you trying to reduce face to face GP consultations.

Answer

No we are planning to use other forms of consultation as well as face to face appointment we will need to work differently in order to manage the demand in the future which will be more efficient and effective. There is the need to provide more appointments with nurses and HCA's to give a greater blend of services to be available for patients.

Question

Do patients have a choice where they have their imaging carried out for example ultrasound for elderly patients?

Answer

Dr Hibbs requested that any patient specific comments should be put through Quality Matters

Question

The old system where appointments at practices did not take place seemed to work better could we go back to this.

Answer

This was not convenient for all patients. It is important doctors have enough time to see patients.

RESOLVED: That the above are noted.

Date of Next Meeting

WCCG.1393 The Board noted that the next meeting was due to be held on **Tuesday 8 March 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.40 pm

Chair..……..

Date ……

Wolverhampton Clinical Commissioning Group Governing Body

8 March 2016

Date of meeting	Minute Number	Action	By When	By Whom	Status
14.7.15	WCCG.1244	Emergency Preparedness Resilience and Response (EPRR) Core Standards – A further update report to be brought back to meeting to include confirmation of the outcome of the process to test plans. EPRR from a GP Practice perspective should also be considered in this report.	March 2016	Mike Hastings / Andy Smith	Mr M Hastings reported that Mr A Smith has been on long term sick leave and Public Health are seeking support to submit a report to the Governing Body in March
12.1.16	WCCG.1346	Discussions with RWT – Community Services (Dr De Rosa), improving pathways (Dr Sharma)	February/March 2016	Dr De Rosa/Dr Sharma	Dr D De Rosa confirmed he is currently having discussions with Ms A Smith and Dr J Odum and the Royal Wolverhampton Trust. Dr A Sharma reported he is still waiting to hear from Dr Odum.
12.1.16	WCCG.1352	Review of Procedures of Low Clinical Value – A further report is taken to the Quality and Safety Committee regarding the points raised	February/March/April 2016	Ms M Garcha	A report will be submitted to the Quality and Safety Committee in April 2016.

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NHS
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WOLVERHAMPTON CCG

GOVERNING BODY MEETING

8 MARCH 2016

Agenda item 7

Title of Report:	**Chief Officer Report**
Report of:	Dr Helen Hibbs – Chief Officer
Contact:	Dr Helen Hibbs – Chief Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
Public or Private:	This report is intended for the public domain.
Relevance to CCG Priority:	Update on behalf of Chief Officer.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The report is primarily submitted to provide assurance to the Governing Body of robust leadership across the CCG that involves patients and the public and works in partnership. By its nature, the report also includes activity that may impact on the domains in the BAF
• **Domain2:** Performance – delivery of commitments and improved outcomes	See above.
• **Domain 3:** Financial Management	
• **Domain 4:** Planning (Long	

Term and Short Term)	
• **Domain 5:** Delegated Functions	

1. BACKGROUND AND CURRENT SITUATION

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

2. CHIEF OFFICER REPORT

2.1 Commissioning Support Unit (CSU) Mobilisation

The Joint Mobilisation Board for CCG's across Birmingham and the Black Country is now meeting as a regular programme board. At this month's meeting both Midlands and Lancashire CSU (Chris Knight) and Arden & Gem CSU (Jeannie Ablett and Ian Rosser) attended as Service Mobilisation Directors and gave assurances that the mobilisation and transition process is delivering against plan.

The Mobilisation programme plans are to be shared with the commissioning organisations for information only and progress will be updated by exception to this plan.

It was agreed that any contract variations are to be included from the outset – for example some services were 'tested' for affordability rather than the CCG committing to buying them immediately; we did this locally with Equality and Inclusion and have made the decision that the new provider does offer value for money and so this will be included within the contract at the agreed original cost. Final contracts are being drawn up and will be sent out to the CCG imminently for signing.

The biggest risks identified by the CCG are regarding data sharing between Midlands and Lancashire CSU and Arden and GEM CSU for Contracting and Strategy Intelligence and also the speed at which Arden and GEM will be able to recruit to gaps in staff provision. The Service Mobilisation Directors gave assurances that there are mitigations around both of these areas.

The CCG Associate Director of Operations has met with The Regional Service Director for Arden and GEM CSU (Jeannie Ablett) as well as the individual Service leads for all of the End to End services to discuss future service expectations. Service Leads are also meeting with the individual specialists within the CCG to ensure there are agreed lines of communication and shared expectations for delivery.

2.2 West Midlands Urgent and Emergency Care Network Meeting

A meeting of the Urgent and Emergency Care Network took place on 18 February 2016. Discussion took place around the implementation of the Bruce Keogh review. It was acknowledged that local System Resilience Groups will continue to hold operational responsibility for the delivery of urgent care. The Network is looking at more strategic items, designation of centres and potential workforce solutions.

2.3 Offender Health and Offender Mental Health Event

The Offender Health and Offender Mental Health Event took place on 24 February 2016 and was jointly organised between West Midlands Police and Crime Commissioner, West Midlands Police, NHS England North Midlands Health and Justice Team - West Midlands Centre Health and Wellbeing Team, Public Health England, National Offender Management Service and the West Midlands and Staffordshire Community Rehabilitation Company.

The event was an opportunity to discuss the offender health pathways and the need to ensure that provision is in place to improve and protect the physical and mental health of individuals who are in, or at risk of entering, the criminal justice system.

2.4 Health Scrutiny Panel

A meeting of the City of Wolverhampton Council Health Scrutiny Panel took place on 25 February 2016. Items included on the agenda for the discussion included the Wolverhampton CCG Primary Care Strategy, City of Wolverhampton Council and Wolverhampton Clinical Commissioning Group Mental Health Strategy 2014-2016 and smoking and alcohol in pregnant mothers.

2.5 Respiratory Innovation: Promoting a Positive Life Experience (RIPPLE) Project

The Health Foundation supported a project in Coventry, which enabled healthcare professionals to work with voluntary sector to provide informal clinics for patients living with COPD. The clinics are currently run in a community hall, where patients can benefit from informal advice and education from clinical staff whilst also enjoying a range of social and physical activities to help improve their general well-being and reduce social isolation. The project was deemed a success, and now the health foundation are seeking another 6 sites to be part of the study. We held a stakeholder event on 17 February 2016 where we invited a range of health care professionals, voluntary sector and patients so we could gather information as to how we would like a Wolverhampton model to look like. The event was a huge success, and we have captured a lot of information which will be submitted to the Health Foundation for consideration for Wolverhampton to be part of the study.

2.6 CCG Planning 2016/17

The CCG officers are currently working on the Operational Plan for 2016/17. Planning Guidance envisages that this Plan will form year 1 of the Sustainability Transformation Plan (STP). The Operational Plan will be based on a Wolverhampton footprint whilst the STP is being written on a Black Country footprint whilst at the same time, recognising principles of local ownership and also wider planning.

Dr Helen Hibbs
Chief Officer
Date: 25 February 2016

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (Must be completed)	**Dr Helen Hibbs**	**25/02/16**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting, Tuesday 8th March 2016

Agenda item 8a

Title of Report:	**Core Standards Assurance - Emergency Preparedness, Resilience and Response (EPRR)**
Report of:	Mike Hastings, Associate Director of Operations
Contact:	Andy Smith, EPRR Lead & Mike Hastings, Associate Director of Operations
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To give the Governing Body assurance that the CCG is compliant with EPRR requirements
Public or Private:	Public
Relevance to CCG Priority:	Planning
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	Resilient plans are in place for EPRR
• **Domain 4:** Planning (Long Term and Short Term)	The CCG and its peer organisations are aware of and assured by one another's EPRR plans.

1. BACKGROUND AND CURRENT SITUATION

1.1. Whilst designated a Category 2 responder, with limited responsibilities, by the Civil Contingencies Act 2004 (CCA), CCGs have a far wider role, and responsibilities, as identified by the NHS England EPRR Framework and NHS England EPRR Core Standards. The Core Standards assessment template requires all NHS organisations to assess EPRR compliance on a RAG (Red; Amber; Green) traffic light basis, with accompanying evidence and narrative.

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

1.3. A report was brought to the Governing Body in July 2015 which outlined the robust EPRR plans in place for the CCG. This report is to give assurance that those plans are in place and have been strengthened through more robust governance and additional EPRR training for staff.

2. MAIN BODY OF REPORT

2.1. 1 WCCG entered into a formal arrangement with the Public Health department at Wolverhampton City Council, to access 0.5 WTE resource. The EPRR Lead has been on planned sick leave since December 2015 but the robust plans in place have not been affected by this absence due to forward planning and being ahead of the curve with EPRR requirements.

2.2. The WCCG 2015 EPRR self-assessment, contained at Appendix 1, summarises the preparedness against 38 specific standards with an additional 4 specific to pandemic influenza. The WCCG 2015 EPRR Core Standards self-assessment shows the following:

RAG Rating	EPRR Core Standards	Pan Flu Core Standards
Red	N/A	N/A
Amber	6	2
Green	32	2

2.3. The strategic EPRR priorities outlined for 2015/16 are complimentary to the amber areas of compliance with a specific concentration of business continuity planning and a CCG specific EPRR training package. These form the basis of an EPRR work program presented to the Operations Board.

2.4. The CCG has delivered specific training to key identified individuals and so has increased the Green rated elements of the standards since the last report.

2.5. The recently appointed Associate Director of Operations is substantively recognised as the Accountable Emergency Officer for the CCG – this strengthens the governance arrangements for EPRR for the CCG.

2.6. A further review of the Core Standards will be carried out as a priority in early March 2016 with a view to preparing for the next submission to NHSE in June/July 2016. It is proposed that a further report is presented to the Governing Body following this review.

3. RISKS AND IMPLICATIONS

Key Risks

3.1. Whilst the EPRR Core Standards is important it doesn't capture the entire EPRR agenda. In addition to the work detailed above work is being delivered around the Prevent agenda, urgent care support and crisis communications.

3.2. The overall aim is to ensure WCCG is a resilient and capable organisation that plans to deliver over and above minimal compliance standards and embed resilience across its service delivery area.

3.3. The loss of the EPRR Lead presents a small risk to the review of the standards although prior planning of this leave mitigates this.

Quality and Safety Implications

3.4. At the present time WCCG is well placed in terms of its level of preparedness and planning and compares favourably amongst other CCGs in the NHS England locality area.

Legal and Policy Implications

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

4. RECOMMENDATIONS

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

Name: **Mike Hastings**
Job Title: **Associate Director of Operations**
Date: **24/02/2016**

ATTACHED:

EPRR Core Standards Update

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Medicines Management Implications discussed with Medicines Management team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/a**	
Signed off by Report Owner (Must be completed)	**M Hastings**	**24/02/2016**

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The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Pandemic Influenza :- with deep dive questions to support the pandemic influenza 'deep dive' for EPRR Assurance 2015-16 (blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V3.0. The following changes have been made :

• Inclusion of Pandemic Influenza questions to support the pandemic influenza 'deep dive' for EPRR Assurance 2015-16
• Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
• Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
• Updated the requirements for primary care to more accurately reflect where they sit in the health economy
• update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**AEO role tasked to Mike Hastings, Associate Director of Operations**	**N/A**		
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		**Annual work program has been signed off by Governing Body July 2015. Priorities based on existing risk**			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		**WCCG EPRR policy in place and reviewed annually**			
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		**EPRR reports to board no less than annually. EPRR priorities agreed by Board.**			
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	Combined EPRR risk register undertaken in partnership with Walsall CCG.			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y		WCCG engaged with Local Health Resilienece Partnership, Local Resilience Forum, Wolverhampton resilience Group and local NHS Providers to ensure commanlity and appropriateness of local risk assessment and associated planning			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y		Local identified risks shared as above.			
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.				
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y		BC policy and MoU for mutual aid with Walsall CCG agreed. BC is a planned priority for delivery over next 12 months.			
		HAZMAT/ CBRN - see separate checklist on tab overleaf						
		Severe Weather (heatwave, flooding, snow and cold weather)	Y		Severe weather plans in place however will also be a component part of BC planning			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		WCCG draft plan in place. Will be developed and validated through an exercise with provider early 2016.			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)						
		Mass Casualties						
		Fuel Disruption	Y		Included in BC planning as above			
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y		Surge and escalations plans in place with urgent care and SRG			
		Infectious Disease Outbreak	Y		Conops and service spec agreed with provider and public health.			
		Evacuation	Y		Fall within overall building evacuation policy and process.			
		Lockdown						
		Utilities, IT and Telecommunications Failure	Y		IT provider has robust BC plans for IT and comms. In addition ket staff have mobile comms capability			
		Excess Deaths/ Mass Fatalities						
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab						
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab						
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	MIRP, and sub plans, all developed in line with existing good practice.			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	WCCG MIRP has idenified activation trigger. MIRP supports 24/7 access to Director on Call.			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y		Mutual aid MoU agreed with Walsall CCG to enable priority relocation in the event of a BC incident. Detailed BC planning part of delivery program for 2015/16			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management						
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	Governing body have signed off EPRR strategy and MIRP. In addition regular reports to CCG Operations Board to ensure organisational engagement and ownership.			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y		WCCG has a debriefing ploicy in place in line with NPIA Structured Debrief model.			
Command and Control (C2)								
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	24/7 on call rota in place with black country CCGS			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	On call Execs have attended SLIC and EOT. Further localised training being developed and delivered in line with NOS			

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	WCCG has idenified its Boardroom as its ICC. New meeting room being designed as ICC upgrade. MIRP contains action cards for specific roles. Mutual aid with Walsall CCG in event of loss of building.			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y		WCCG has trained loggist staff.			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		Sitrep reporting embedded as required. Compliance demonstrated with recent IA reporting and breach reporting.			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials						
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident						
Duty to communicate with the public								
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	WCCG comms plan in place and agreed with CSU. Allows for 24/7 response capability and is complimentary to MIRP.			

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Mobile comms (voice and data) capability throughout CCG at senior level. Resilient comms (voice & data) provided as part of contract with Acute provider.			
Information Sharing – mandatory requirements								
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	Information sharing enabled through existing LRF and LHRF arrangments			
Co-operation								
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	Represented at LRF and GWG through lead DPH and NHS England			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		Regular engagement through LHRF, WRG . Support joint training/exercising wherever possible.			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y		Mutual aid MoU for EPRR/BC agreed with Walsall CCG			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.							
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.							
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		MIRP consistent with NHS E expectations and incident management levels.			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared							
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		Regular representation by AEO/ADO at LHRP meetings.			
Training And Exercising								
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Revised TNA to be completed as part of 2015/16 EPRR priorities. EPRR training completed against scheduled exercise for November 2015 developed in line with CCA NOS.			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y		EPRR exercisecarried out in Nov 2015 in conjunction with Walsall CCG. Media awareness and validation of MIRP and Comms Plan. Comms tested regularly as part of "live" breach escalation process, both in and out of hours.			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y		Organisational engagement with MA exercising where opportunities arise.			
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		TNA under development will ensure ongoing EPRR CPD development.			

	Core standard	Clarifying information	CCGs	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive								
DD1	Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing	• changes since April 2013 are reflected in local plans including formation of NHS England, CCGs and PHE; as well as the move of the previous PCT public health function into local authorities • key changes to the national pandemic influenza strategy (such as de-coupling from WHO, development of DATER phases, and removal of UK alert levels) as well as relevant local learning is reflected	Y	• updated planning arrangements reflect changes and learning • version control indicates changes made and timeliness	Revised CCG Pan Flu plan drafted and in line with new structures.			
DD2	Organisations have developed and reviewed their plans with LHRP and LRF partners	• relevant local partners (particularly other NHS providers/ commissioners, PHE and local authority public health and social care teams where appropriate) have been engaged in the development of local plans - at a minimum through an opportunity to comment on draft versions	Y	• indication of the process used to develop updated arrangements, including identification of organisations involved in contributing or commenting on drafts • agendas/ miniutes illustarting where the updated arrangements have been discussed	Planning for pan flu exercise with partners early 2016. Plans will be shared prior to exercise to ensure common planning assumptions.			
DD3	Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	• local organisations have held an internal exercise or participated in a multi-organisation exercise since updating their local arrangements to reflect changes and learning described in DD1 • if this has not taken place, there is a clear plan to deliver an exercise in the next six months	Y	• documentation related to exercise since the 2013 publication, including lessons identified OR • invitation letters/ documentation related to exercise scheduled to take place in next six months, including an indication of how lessons identified will be addressed	MA pan flu health exercise to be delivered in partnership with provider by March 2016			
DD4	Organisations have taken their plans to Boards / Governing bodies for sign off	• updated arrangements that reflect changes and learning described in DD1 have been taken to Boards or Governing Bodies, and even if they have not yet have been signed off by such bodies, the process towards this has been started	Y	• Board/ Governing Body agenda or meeting papers indicating updated pandemic influenza arrangements have been discussed and/ or signed off	Pan flu plan to governing body July 2015			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control				
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump				
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements				
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness				
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y							
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y							
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y							
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y							
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y							
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme				
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y							
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y					

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body March 8th March 2016

Agenda item 9

Title of Report:	**Better Care Fund Programme - Progress report Jan – Mar 2016**
Report of:	Andrea Smith, Head of Integrated Commissioning
Contact:	Andrea Smith, Head of Integrated Commissioning
Governing Body Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To update Governing Body on planning for Better Care Fund Programme 2016/17 To advise Governing Body on the progress of development of a Section 75 agreement between the City of Wolverhampton Council (CWC) and the Wolverhampton Clinical Commissioning Group (WCCG) for the purposed of delivering the Wolverhampton BCF and the associated timelines of development and sign off. To request guidance on sign off of plans.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Delivery of Better Care Fund, Care Closer to Home
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	N/A

• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The report gives an update on progress against both local and national outcomes and targets.
• **Domain 2b:** Quality (Improved Outcomes)	The report demonstrates the progress of integrated health and social care working to deliver improved services and outcomes to patients and service users.
• **Domain 3:** Financial Management	Section 75 agreement and Pooled budget is managed by the Senior Responsible Officers of the work stream and this is overseen at an operational level by the Finance and Information Core Group and ultimately by the Integrated Commissioning and Partnership Board
• **Domain 4:** Planning (Long Term and Short Term)	Better Care fund forms part of the CCG annual operational plan from 2016.
• **Domain 5:** Delegated Functions	N/A

N.B. Please use Paragraph Numbering in all documents for easier referencing.

1. BACKGROUND AND CURRENT SITUATION

1.1. In the last spending review Government confirmed the intention to move Health and Social Care into a more integrated state by the financial business year 2019/20. The Government also reconfirmed the Better Care Fund (BCF) as a key national policy directive for the rest of the current parliament and that the BCFwould be the vehicle used to support that integration. The principle aims of the BCF continue to be the reduction of accident and emergency admissions, improvement to the level of delayed transfers and reduction in the number of care home admissions by investing in joined up health and social care services focused on prevention

1.2. Planning for the BCF is now incorporated into CCG planning and now forms part of the CCG Operational Plan. Whilst the first submission for the CCG plan was 8th February, the publication of the planning guidance for the BCF was delayed, therefore submission deadlines were unknown.

1.3. To support the Pooled Budget a Section 75 agreement needs to be produced and signed by both Wolverhampton CCG (WCCG) and City of Wolverhampton Council (CWC).

1.4. On 11th January 2016 the Department of Health /Department for communities and Local Government released the BCF Policy Framework for 2016/17. From this guidance the key points relating to the operation of the BCF in 2016/17 are:-

- The £1.5bn payment for performance element of BCF has been removed and replaced by two new national conditions

  - Local areas to fund NHS commissioned out of hospital services (to ensure continued investment in NHS commissioned out of hospital services, which may include a wife range of services including social care).
  - To develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. Councils, CCGs and NHS Providers will have to agree a local target for cutting delayed transfers of care.

2. MAIN BODY OF REPORT

2.1. The national planning guidance was released on 23rd February 2016. The submission dates for plans are as follows:-

2nd March: Local areas to submit the completed BCF Planning Return template detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.

21st March: First submission of full narrative plans for Better Care alongside a second submission of the BCF Planning Return template.

25th April: Final submission, once formally signed off by the Health and Wellbeing Board.

2.2 **Programme of Work for 2016/17**

Planning is being undertaken to determine the detail of the Programme of work for 2016/17. There will be 5 workstreams going forward:-

Adult Community Care - This is an amalgamation of last year's Primary and Community and Intermediate and Reablement workstreams. It has become apparent that there was significant cross over between the two workstreams previously therefore to ensure that projects complement each other and to reduce duplication the work streams have been brought together. This workstream will continue the development of the Community Neighbourhood teams including the proactive case management of patients with long Term conditions and the reactive Rapid Response models.

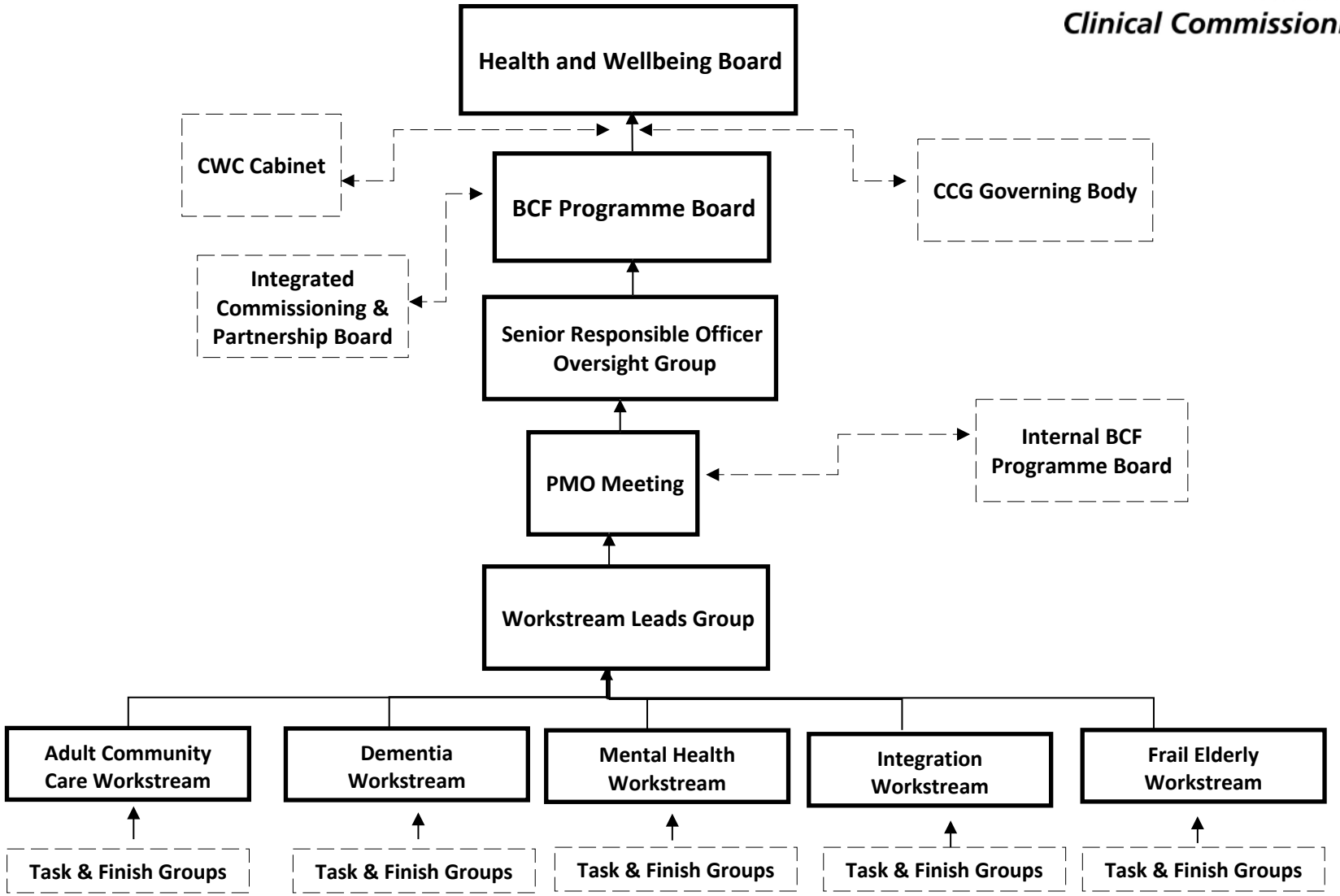
Frail Elderly Pathway – This workstream will assess the current provision of services for frail elderly patients and develop a local, integrated Frail Elderly Pathway.

Mental Health – This workstream will build on the excellent work undertaken this year in the development of a Psychiatric liaison team and the Crisis car and will develop further the planned care element of reducing out of area and complex care placements.

Dementia - During 2015/16 a draft specification for a City Dementia hub was produced. 2016/17 will see the scoping of requirements for the dementia hub and bids for capital funding to enable the progression of this scheme.

Integration – The integration work stream has two purposes. Primarily, the operational requirements to enable health and social care teams to work in an integrated way i.e. Estates, IT, HR and Information governance. In addition this workstream will begin to develop a plan for the wider integration of health and social care as determined at a national level.

The existing Governance structure for the Programme has been amended to reflect the changes in work stream but remains mainly the same with the delivery of the Programme being managed by the BCF Programme Board and the Section 75 being managed by the Integrated Commissioning and Partnership Board. Overall delivery of the programme is managed by the Health and Well Being Board.



.Figure 1 Governance Structure

2.3 Section 75 Agreement

2.3.1 A Section 75 (S.75) Agreement is an agreement made under the section 75 of the National Health Services Act 2006 between a Local Authority and an NHS body in England (in this case Wolverhampton CCG and City of Wolverhampton Council). S.75 Agreements can include arrangements for pooling of resources and delegating certain NHS and local authority health related functions to the other partners if it would lead to an improvement in the way those functions are exercised.

2.3.2 The BCF arrangements require a pooled fund, and the Care Act 2014, Section 121 provides for this.

2.3.3 A S.75 agreement is already in place for 2015/16. Amendments are required for 2016/17. Wolverhampton City Council and Wolverhampton Clinical Commissioning Group have been working collaboratively to explore the details of a proposed S. 75 agreement in order that there will be a proposal which is effective, sustainable, and mitigates risk where identified and possible. This has been done taking into account lessons learned from the current S.75 agreement

2.3.4 The draft proposal aims to address the following areas taking the following recommended approach;

- *Commissioning* – There is not a formal requirement to make commissioning arrangements as part of the S.75 agreement, though in practice, having shared strategic vision and commissioning plans which maximise opportunities for effective commissioning approaches will be advantageous.

  The current agreement sets out the approach to integrated commissioning. This provides the Council and the CCG the flexibility and focus to make decisions for which they are responsible in a way that supports effective co-ordination and shared planning and development. The continuation and development of these arrangements will ensure that both the Council and CCG board are sighted on the overarching commissioning intentions and the integrated plans to deliver them.

  This supports the Governments Autumn Statement that states "*by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020*".

- *Governance* – The governance arrangements for the Pooled fund currently set out in the agreement have been designed to be as streamlined as possible. Day to day operational management and oversight of the pooled fund will be the responsibility of the Integrated Commissioning and Partnership Board whose members will have delegated responsibility from both partner organisations to hold the Executive work stream leads to account and to make necessary decisions from a planning and performance management perspective.

The scope of these powers will continue to be within existing limits set by both organisations schemes of delegation. Beyond these limits decision making will remain with the responsible bodies (Governing Body and Cabinet) in line with organisational Prime Financial Policies. Beyond this the Health and Well Being Board will continue to oversee both organisations for the performance of the fund against the objectives set out in the BCF plan.

- *Contracting Arrangements* – Existing contractual arrangements between the CCG and its providers and the Council and its providers continue. Arrangements for funding these arrangements through the pooled fund hosted by the Local Authority are described in the agreement.

2.3.5 In line with planning guidance the signed Section 75 agreement has to be submitted to NHS England by 25th April 2016

3. CLINICAL VIEW

3.1. Clinicians are involved at an individual work stream level.

4. PATIENT AND PUBLIC VIEW

4.1. A number of engagement events were held in February 2015. Planning is underway to develop a schedule of patient and public engagement events in March / April 2016 in order to inform people of progress but also it obtain engagement on the future implementation of the Programme.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. A key risk is the content of the Pooled budget (section 75 agreements) in particular the amount of resource that the each party will put into the pool. and also the level of risk that the each party will under write as a result of over / under performance.

5.2. A further risk is the Risk Share agreement itself which outlines the level of risk that each party will under write as a result of over /under performance.

5.3. Risks for the Better Care Fund Programme and for individual work streams are recorded on the CCG risk register (Datix).

Financial and Resource Implications

5.4. As mentioned above, work is currently being undertaken to determine the services to be included in the pool and the budgets associated with them. The current Section

75 only stands for 12 months therefore the risk sharing agreement will be reviewed for 2016/17.

Quality and Safety Implications

5.5. Quality and Safety implications are identified on a project by project basis. Quality Impact Assessments are completed for each project.

Equality Implications

5.6. Equality implications are identified on a project by project basis. Equality Impact Assessments are completed for each project.

Medicines Management Implications

5.7. Medicines Management implications are identified on a project by project basis

Legal and Policy Implications

5.8. Legal advice will be sought in the development of the Section 75 agreement and Information Governance leads are involved in the programme to ensure that relevant policies are adhered to.

6. RECOMMENDATIONS

6.1. The Governing Body is requested:-

- To receive and discuss this report
- To note and be aware of the development of the Section 75 agreement
- To advise on sign off process for Better Care Fund 2016/17 plans in line with submission dates

Name: Andrea Smith
Job Title: Head of Integrated Commissioning
Date: 25th February

ATTACHED:

(Attached items:)

RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	**N/A for progress report**	
Public/ Patient View	**N/A for progress report**	
Finance Implications discussed with Finance Team	**Lesley Sawrey**	**25.02.16**
Quality Implications discussed with Quality and Risk Team	**Sarah Southall**	**25.02.16**
Medicines Management Implications discussed with Medicines Management team	**David Birch**	**25.02.16**
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliette Herbert**	**25.02.16**
Information Governance implications discussed with IG Support Officer	**Peter McKenzie**	**25.02.16**
Legal/ Policy implications discussed with Corporate Operations Manager	**Mike Hastings**	**25.02.16**
Signed off by Report Owner (Must be completed)	**Andrea Smith**	**25.02.16**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 8th March2016

Agenda item 10

Title of Report:	**Commissioning Committee – Reporting Period February 2016**
Report of:	Dr Julian Morgans
Contact:	Steven Marshall
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in February 2016.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	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.
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	N/A
• **Domain 2b:** Quality (Improved Outcomes)	N/A

• **Domain 3:** Financial Management	N/A
• **Domain 4:** Planning (Long Term and Short Term)	N/A
• **Domain 5:** Delegated Functions	N/A

1. PURPOSE OF REPORT

1.1. The purpose of the report is to provide an update from the Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) for the period of February 2016.

2. MAIN BODY OF REPORT

2.1 Contracting & Procurement Update

Contracting 2015-16

All 2015/16 contracts have now been signed.

Royal Wolverhampton NHS Trust

Percentage of A&E Attendances where the patient was admitted transferred or discharged with 4 hours.

The Trust's monthly performance has been below 95% since September and deteriorated further in December to 88.53%.

The Trust has been reminded that 2% of the A&E budget would be withheld for failing to achieve against this trajectory, in line with General Conditions (GC) 9 of the contract.

Cancer Targets

The percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer was 85.71% in December against an 85% target.

The Trust anticipated that it would be likely to breach again in January 2016 as a number of patients had opted to have surgeries following Christmas, rather than before. A remedial action plan is in place to support the recovery of the Trust's position and, like the A&E 95% target, the CCG will enact GC9 if the Trust failures to achieve.

For the 62 day target associated with referral from an NHS screening service to first definitive treatment for all cancers, the Trust achieved 100% in December.

Referral to Treatment within 18 weeks (September and October data)

The percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral was on target for December. The trust is failing to achieve the following areas:

- General Surgery – 86.87%
- Oral surgery – 84.74%
- Trauma and Orthopaedics – 90.29%
- Urology – 86.47%

The Trust has given assurances in relation to actions being taken to improve performance through an updated action plan and a recovery plan for General Surgery.

E- Discharge - RWT

The Trust achieved 95.39% against a target of 95% for completion and dispatch of an electronic discharge summary to inpatients within 24 hours of discharge for all wards. However, the Trust failed to achieve its target for assessment areas.

An updated remedial action plan has been agreed with a revised trajectory where performance is not meeting the standard. This will continue to be closely monitored through the quality and contract meetings.

Performance/Sanctions

- The 2015-16 total sanctions levied to RWT to date equates to £1,096,150.
- Contract escalation meetings have been put in place to address this area.

Activity & Finance

Speciality performance - Plan versus Actual:

- The Top 10 Specialties equate to £8.5m of over performance
- General Surgery is currently £2.8m (27%) above plan
- General Medicine is currently £1.0m (3%) above plan

Community Services by commissioner:

- The Community element of RWT contract is £136k under plan
- Dudley CCG is currently £14k (3%) above plan
- Wolverhampton CCG remains “break even”

Community – Top 10 over performing specialties:

- Community Matrons continues to be the top over performing specialty, and is now £188k above plan YTD
- District Nursing is now £172k over plan
- CICT Rehab has over performed by £72k
- 14 specialties are under plan, equating to £694k of under-performance

Black Country Partnership Foundation Trust

General

Action plans are in place for the following areas which are being monitored through the Contract Quality Review Meeting. The action plans are joint plans for both Wolverhampton and Sandwell & West Birmingham CCG with the exception of the early intervention services action plan which is for Wolverhampton CCG only:

- Early Intervention Services
- CPA
- Safeguarding training. A remedial plan is now in place.
- BCPFT Mandatory Training for Infection Prevention and Control. A revised trajectory has been agreed plus fines if not settled.

Performance issues

Two contract performance notices remain open which are being managed through remedial action plans.

Action – The Committee request that Governing Body note the contents of the report.

2.3 Introduction of NICE TA293 – Eltrombopag for Treating Chronic Immune (Idiopathic) Thrombocytopenic Purpura

Eltrombopag is recommended by NICE as an option for treating adults with chronic immune (idiopathic) thrombocytopenic purpura, within its marketing authorisation (that is, in adults who have had a splenectomy and whose condition is refractory to other treatments, or as a second-line treatment in adults who have not had a splenectomy because surgery is contraindicated), only if:

- their condition is refractory to standard active treatments and rescue therapies, or
- they have severe disease and a high risk of bleeding that needs frequent courses of rescue therapies and
- the manufacturer provides eltrombopag with the discount agreed in the patient access scheme

Currently Romiplostim is used for patients that meet the above criteria (TA 221). However, as per the recommendation of NICE, future practice will be that patients and clinicians have the choice of Romiplostim or Eltrombopag in line with the respective TAGs.

Commissioning Committee were assured by the contents of the report and acknowledged the mandatory requirement to introduce the use of Eltrombopag.

Action – The Committee request that Governing Body note the content of the report.

2.4 Public Health Commissioning Intentions

The commissioning intentions were received by the Health and Wellbeing Board and the Integrated Commissioning Board in February 2016.

A number of commissioning and procurement exercises have taken place as planned to redesign and implement an integrated model of sexual health services, a befriending service to support vulnerable women at risk of child safeguarding proceedings, the re tender of adult weight management services and revision of the portfolio of local enhanced primary care services into a healthy lifestyles community framework. Healthy lifestyles services cover smoking cessation, NHS health checks, needle exchange, supervised consumption, GP shared care (substitute prescribing of controlled medication to replace the use of opioids for drug users on a treatment programme) and nicotine replacement therapy.

Mobilisation of these services including new performance and quality standards will be embedded in 2016/17. To support the healthy lifestyles community contracts a new technical data solution has also been purchased for pharmacy services monitoring and a GP and community system will be separately specified and procured in 2016.

National health profiles show that Wolverhampton has higher than national averages for deaths attributable to stroke, lung cancer, respiratory disease, alcohol, coronary heart disease and infant mortality. To respond to these issues tackling the key contributory lifestyle factors; smoking, physical activity and alcohol are Corporate Plan priorities under Promoting and Enabling Healthy Lifestyles.

Action – The Committee request that Governing Body note the above.

3. RECOMMENDATIONS

- **Receive** and **discuss** this report.
- **Note** the action being taken.
- **Note** the recommendations made by Commissioning Committee

Name	**Dr Julian Morgans**
Job Title	**Governing Body Lead – Commissioning & Contracting**
Date:	**25th February 2016**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 8th March 2016

Agenda item 11

Title of Report:	**Executive Summary from the Quality & Safety Committee**
Report of:	Dr Rajshree Rajcholan – GP Lead Quality
Contact:	Manjeet Garcha
(add board/ committee) Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	Provides assurance on quality and safety of care, and any exception reports that the Governing Body should be sighted on.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	CCG is committed to ensuring the highest of Quality for all services commissioned.
Relevance to Board Assurance Framework (BAF): **Domain 2b: Quality**	Delivery of commitments and improved outcomes; a key focus of assurance of how well the CCG delivers improved services, maintains and improves clinical quality and ensures better outcomes for patients.

Key issues of concern for noting

Key Issue	Level	Comments	Detail on page
Board Assurance Framework and Risk Register	Business as usual	No Concerns, all risks are managed as per requirement Staff training currently being planned to use Datix and update risks	
Escalated issues	Escalated	Action: SBAR to Chief Nurse and MD in December concerning • Delayed diagnoses • Delayed treatment • NEs • Sub-optimal care (transfer of patient) On-going scrutiny for confidential leaks, improvement in December not sustained Pressure Ulcers – increase in grade 3 & 4s including community- close observation Further Assurance: CQRM agenda March 2016 (Feb meeting was internal commissioners only)	6 7 8
Health Acquired Infections- CDiff	Escalated	Increasing incidence of Cdiff, trust has failed its 2015/16 target- close observation January improvement needs to be sustained.	9
Never Events	downgraded	NE RCAs received and reviewed, assurance on actions taken received.	7
Falls	downgraded	Improvements seen in number of falls causing serious harm. CCG will maintain focus	8

Performance Improvement notices impacting on Quality	Escalated	Meetings with RWT held regularly and action plans agreed. More detail will be covered by the Finance and Performance paper.	
Workforce- RWT Risk Register	Escalated	RWT Nursing and consultant recruitment issues are impacting on Quality and Patient Safety	14
NHS Safety Thermometer	Red/Amber	Close monitoring and correlation with wider intelligence in progress- awaiting assurance	10
BCP Provider Performance:- Safeguarding training Early Intervention Service CPA Mandatory training	 Red/Amber Red/Amber	Remedial action plans in place, monitoring via Quality & Contract Review Meetings. Is in line with trajectory, but close scrutiny at quarterly reviews. Progress is being made and remains under scrutiny.	11-12
CQC Inspection Report	Amber	Rating 'requires improvement' for RWT. Action Plan completed March 2016, however the Trust is still awaiting the final report.	12
HONOS 7 day services	Downgraded Downgraded	All actions completed and closed. All actions on track and closed.	12
CQC General Practice	Downgraded	Practice has had a re inspection, have achieved good overall.	12
Mortality	Green	Within expected limits, some data cleansing and audits being conducted.	12
Nice Assurance	Downgraded	Formal correspondence received	

		from MD at RWT that internal processes have been aligned. Improvements seen in NICE TAG implementation. Further assurance will be monitored by NICE Assurance Group.	

1. BACKGROUND AND CURRENT SITUATION

The CCG's Quality and Safety Committee meet on a monthly basis.
This report is a material summation of the Committee's meeting on 9th February, 2016 and any other issues of concern requiring reporting to the Governing Body since that time. In addition, the presenter of this report will provide a verbal update on any key issues that have come to light since this report was written and about which the Committee decided needed be escalated to the Governing Body.

2. PURPOSE OF THE REPORT

2.1 To provide assurance to the Governing Body that the CCG Quality and Safety Committee continues to maintain forensic oversight of the Clinical Quality and Patient Safety in accordance with the CCGs statutory duties.

2.2 The Governing Body will be briefed on any contemporaneous matters of consequence arising after submission of this report at its meeting.

3 CURRENT SITUATION

3.1 Weekly Exception Reports

Weekly Exception Reports were introduced in 2014 to highlight key areas of concern which may attract media attention, may be an organisational reputation threat or a heads up alert is required before the next formal meeting. In the last few weeks the key concerns raised were:

- RWT Final CQC Report is still awaited (is now much later than expected, CQC acknowledge that there is a delay in their process).
- Walsall Health Care NHS Trust- CQC report rated 'inadequate' media attention.
- Junior doctor's strike was managed by RWT with minimum disruption to services.
- 2 Confidential leaks were reported, both are being investigated
- One treatment delay was reported, initial 48 hour report has been shared with the CCG and the full investigation report is being awaited.

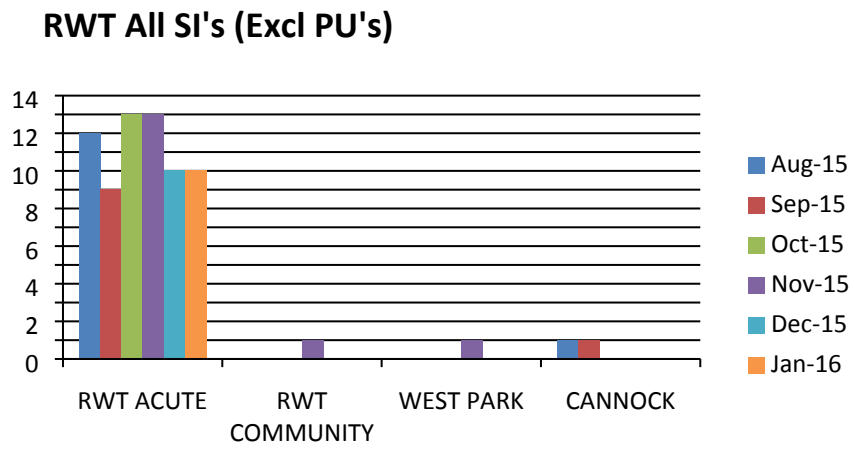
3.2 Board Assurance Framework (BAF) and Red Risk Register Update

It was agreed at a previous Governing Body meeting that quarterly updates on the BAF and Red Risk Register will be incorporated into the Quality and Safety Executive Summary. The next update is scheduled to be presented in May 2016.

4. THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

10 new Serious Incidents were reported by RWT in January 2016, and they were all from RWT site.



Key trends seen over a six month period which were escalated to the trust in December 2015:

- Sub optimal care of patient transferred to another hospital
- Delay in diagnosis/delay in commencing treatment
- Patient identifiable data loss

Assurance sought – These items were discussed in detail at the January CQRM, the Trust have undertaken a review and found the following:

- Most incidents occur in A&E/radiology.
- Human factors are an issue in these departments.
- No one member/team/professional group are causing this effect.
- Excess use of locum staff in A&E is compounding on the issue.

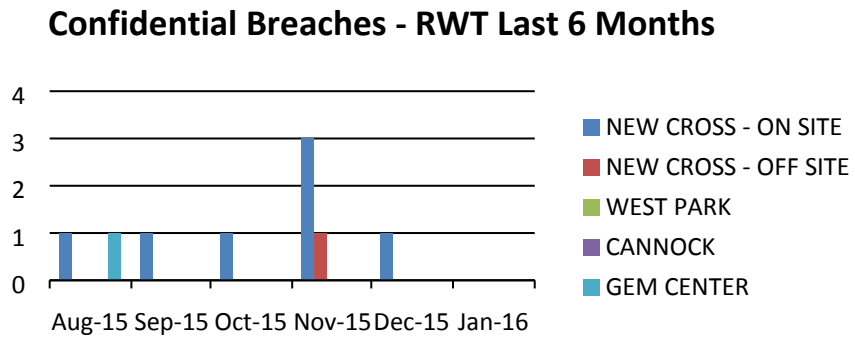
Actions agreed:

- Focussed work on human factors with an external provider.

- Concerted effort to recruit to the consultant vacancies, the Trust has already contacted a 'head hunter' company.
- Nurse recruitment/retention/attrition and sickness, full report was requested for the next CQRM. This is covered in more detail in the workforce section of this section 4.13.
- Further assurance on the impact of the previous initiatives i.e. Assurance is also required about how arrangements for shared learning have been implemented from the: Radiology Discrepancy Meetings, General Surgery Governance Meetings, Grand Rounds and Sharing synopsis of RCA's with all clinical directorates.
- February CQRM was cancelled due to RWT not having enough executives available; a full report is scheduled for the March meeting.

4.2.1 Confidential Breaches

Following a disappointing surge in November, there were zero incidents reported in January. The Trust has held an IG week in January for all new and existing staff, including specific groups as junior doctors, overseas nurses and staff from other sites. An increased awareness may show an increase in reported incidents, this will be monitored closely.



4.3 Never Events

One Never Event was reported by RWT in January 2016. A wrong tooth was extracted in 2014 and not discovered till January 2016. Full duty of candour has been applied and an investigation is in progress. In the current year there have been four NEs reported by RWT.

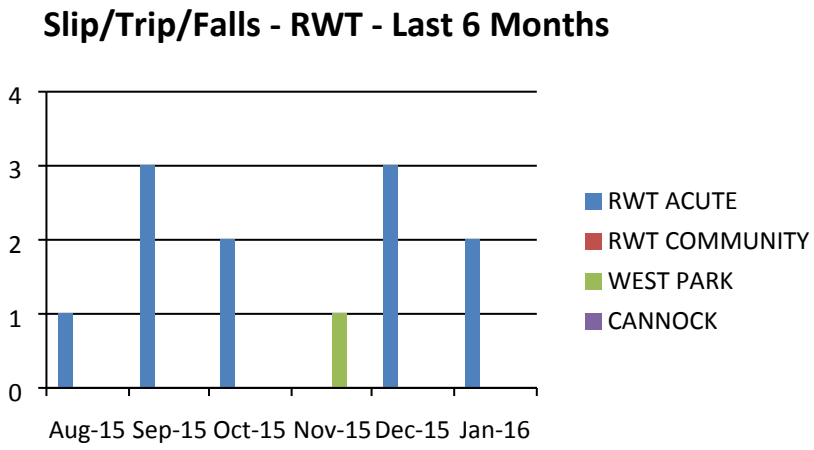
Assurance will be given at the March CQRM re changes made to the running of ophthalmic clinics in response to findings of the RCAs for the previous NEs.

4.4 Slips Trips and Falls

The Trusts Fall's Group was re-launched in October. Full reports are received at the monthly Patient Safety Improvement Group and there has been a reinvigorated effort to drive an increased falls awareness which is supported by the Chief Nurse. Falls is also a priority for the Trust in the Sign Up to Safety Campaign.

Assurance – the Deputy Chief Nurse advised CQRM in January that the Falls Prevention Group are reviewing Safer Staffing on wards Vs. patient 1:1 observations. There has been a reduction of falls month on month and the Trust is reporting below the National average. There are also local workshops and national events taking place in which Trust champions will be attending and reporting back.

2 slip/trip/falls incidents meeting the SI criteria were reported by RWT in January 2016. This is a sustained improvement over the last six months and is being monitored closely. In January, the Chief Nurse reported that an improvement had been seen in the new AMU, this is a more spacious environment and the nurses are based in the bays to undertake their paper work; thus allowing for improved supervision.



4.5 Pressure Ulcers Grade 3

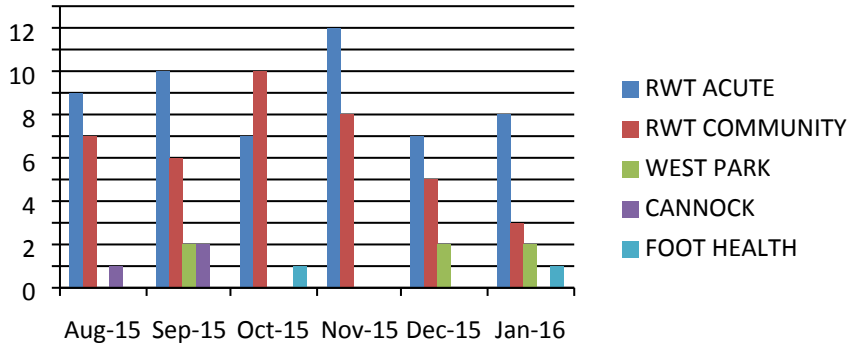
As discussed and agreed with NHS England Area Team, a new approach is needed. A new local health economy wide project is being launched, TOR has been agreed and first meeting was on 25th February 2016, chaired by Dr Dan De Rosa. Led by the CCG this will include and require all key health and social care stakeholders to make

sustainable improvements. CCG Q&SC will receive regular updates and Governing Body will be appraised of any exceptions.

14 Grade 3 pressure ulcer incidents were reported by RWT in January 2016.

6 Grade 3 pressure ulcer incidents were reported by the Community and 8 reported by the Acute Trust. A trend has been observed in foot health services and this is currently being investigated.

G3 Pressure Ulcers - RWT Last 6 Months



Zero grade 4 pressure ulcers were reported for the same time period.

4.6 Health Care Acquired Infections
Clostridium Difficile- escalated to Level II

The Trust has breached the number of CDiff cases for 14/15 and on-going assurances have been sought.

Key themes - January assurance meetings include:

- There have been no MRSA Bacteraemia cases reported within the quarter.
- C Difficile objectives are challenging for Wolverhampton and the Trust has breached its yearend target; 65 actual V target of 35. However, the concerted efforts have resulted in a reduction in the number of cases of CDiff in January which was 7. All 7 were externally unavoidable i.e. met the national minimum standards of care for hand, environment hygiene and no breaches in prescribing. As seen on page 10 chart, Janaury 2016 has been the best performance against Cdiff since October 2014.
- Fidaxomicin is now in use for first recurrences and Human Probiotic Infusion (Faecal Transplant) is also available. Three cases successfully undertaken since pilot in 2014.
- 21 cases have been deemed **avoidable** up until the time of writing this report

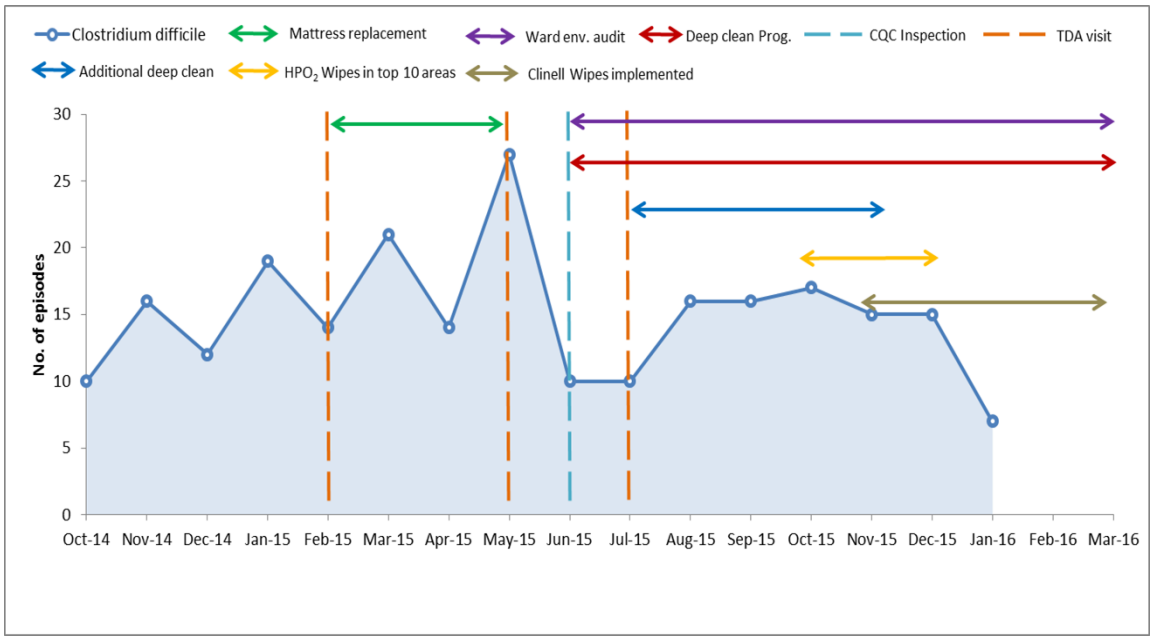
- There have been isolated cases of norovirus since the last quarterly report; all have been managed as per incident protocol.
- It had been reported that influenza 'flu' is circulating in Wolverhampton and there is a programme of see and treat with isolation, Tamiflu injection and monitor.
- The Trust wide HCAI action plan was shared, a review of antimicrobial prescribing guidelines will be undertaken by Dr David Jenkins, Consultant Medical Microbiologist at Leicester Royal Infirmary in April 2016.

Assurance

- Time to isolate has improved
- Treatment delay had decreased.
- HPV use 100% on discharge
- Time between cases improving
- Areas of most concern are currently being targeted
- The CDI rate remains high and exceeds control limit on SPCC funnel plot against region. Though early, there is some improvement seen in January.

CCG attend the monthly Infection Prevention & Control Group meeting and action plans are monitored closely to challenge impact, in addition all quality visits have a specific section on HCAI to ensure that ward audits, hand hygiene and patient comments are taken into account.

Action progress plan against positive cases can be seen below with plan to keep actions live post March 2016. See chart below for cumulative progress.



4.7 West Midlands Quality Haemoglobin Disorders Review

This was a follow up review visit in December 2015 following an initial visit in 2014. There were no immediate concerns identified and some general recommendations have been made to strengthen relationships across the network localities. The report is available on the WMQRS website.

4.8 Quality - Performance Indicators are discussed in full detail in the CCG Finance and Performance Paper.

4.9 NHS Safety Thermometer

Harm free care for December was 94.87%. This is an improvement over the last few months, it is important to consider this in conjunction with other data which may also be of concern i.e. increase in pressure ulcers, increase in HCAIs and other alerts which could be of significance.

Action: The CCG Quality and Safety Team undertake a robust triangulation of all the data and intelligence from the wider system to then make a decision as to the level scrutiny which needs to be given. Currently, the scrutiny is high due to the number of escalations to level 2.

Assurance: data from several sources were triangulated and action taken to escalate these concerns to level 2. All issues were discussed at the January CQRM and further reports are expected at March CQRM for improvements to be demonstrated. All actions are reported back to Q&SC and Governing Body will be kept appraised of the exceptions.

4.10 Birmingham and Black Country Provider on going and escalated issues

a) Safeguarding Training
Remedial action plan performance in line with trajectory, now subject to monitoring at quarterly intervals until closure of the plan that is anticipated post December 2016.

b) HONOS
All actions achieved, Remedial Action Plan closed. Escalation downgraded February 2016.

c) Early Intervention Service

Patients continue to receive appointments within 5 working days, however don't always choose to accept or attend. Monitoring continues via CQRM to ensure all reasonable actions are being taken including liaison with a mental health provider who is performing well in this area.

d) CPA

There is a rate of 93.9% compliance and continual improvement. The dashboard shows as green, but there is a target of 95% on the trajectory. To be reviewed in January with a view to close but the RAP was not received in time. Difficulties in maintaining contact with some patients i.e. homeless. This was discussed and further narrative to be provided. To be reviewed February CQRM.

e) Seven Day Services

All outstanding actions complete and good progress is being made with on-going work. This RAP has been closed and deescalated.

f) Mandatory Training Compliance

This continues to perform well since the infection prevention improvement plan was closed down late 2015. Monitoring at divisional and trust level takes place at each quality review meeting, exceptions are provided and assurance provided.

4.11 Regulator concerns

The Governing Body has previously been appraised about the CQC inspection at RWT. The Trust has appealed its position of 'requires improvement' and a response from CQC is anticipated early in the New Year. In the meantime, a full and very comprehensive action plan is in place, has been discussed at CQRM and has been shared with the group. Good progress has been made and all actions are due to be completed by March 2016.

A General practice previously rated as 'inadequate' has recently been rated as overall 'good'. Two other are being supported to improve from 'requires improvement'.

BCPFT CQC report is currently awaited.

4.11.1 Primary Care Joint Commissioning Committee

The Primary Care Liaison Group has now morphed into The Primary Care Operational Management Group, this group met for the first time on February 16th 2016. One of its key roles will be to continue to monitor CQC concerns in Primary Care. The one medical practice, which was rated as 'inadequate' has made significant progress and improvements were noted by the very recent CQC visit. It is now rated overall 'good' whilst some improvements in safety domain are being monitored. Two other surgeries rated as 'require improvement' are currently working to their action plans. As part of the improving quality in primary care initiatives, the CCG will be considering what other support we can give and how this will be delivered and monitored.

Assurance – it has been agreed that there will be a monthly report from the PCOMG to the Primary Care Joint Commissioning Committee (PCJCC) to monitor areas of escalated concern.

4.12 Mortality

The Trust and CCG Mortality Review Groups met in October 2015 and January and February 2016. There is on-going work with audits and further discussions are planned for next meeting in New Year to agree a way forward to capture and analyse avoidable primary care deaths. The first of these meetings chaired by NHSE was held on 2nd February 2016. Work has commenced to improve mortality governance and WCCG is represented on the group and wider Tri partite Clinical Forum, first meeting is scheduled for March 22nd 2016.

There is currently one Dr Foster Mortality Outlier Alert; Chronic Kidney Disease (CKD) open and the Trust have submitted their data for review and have had a response that whilst the data is valid there will be a period of observation. The CCG will be kept appraised of progress and outcome and will take appropriate action.

The Trust Mortality Review Assurance Group met on 27th January and the February meeting was cancelled. Key areas discussed in January included:

- HSCIC data processing issues- delayed response from HSCIC
- Senility Audit feedback of the 31 cases reviewed using the NCEPOD grading tool; 26 were graded as good practice, 2 as room for improvement,1 as less than satisfactory but deemed that death was not preventable and 2 not enough information. An action plan has been agreed by the Trust Mortality Review Group which is presented to the assurance group which is also attended by CCG and Public Health.

- MBRRRACE- UK Report (Jan- Dec 2013) published December 2015. A first National (UK) Report into perinatal deaths for 7 years. It provides valuable comparative data which has been lacking. It also makes adjustments to mother's age, socio economic deprivation based on mother's residence and ethnicity. It also adjusts for multiple pregnancy and gestation. A very detailed presentation was presented by RWT obstetricians and action plans currently being worked to by the risk management midwives.

  Assurance – whilst assurance was given re the system and processes in place and the sign off by other regulators i.e. CQC, the Regional Network. The discussions concluded that assurance should be sought from an 'expert' for objectivity. This will be actioned immediately.

- Report of Neonatal Mortality Data was presented by a neonatologist. This includes all babies born at The Royal Wolverhampton NHS Trust BUT died anywhere in England in their early (0-7 days) or late (8-28 days) of life. Results of a clinical case review of 21 cases from 2013 were shared along with 9 cases from 2014. There is a marked reduction in the 2013 to 2014 figures.

  Assurance - In 2013 an Infant Mortality Scrutiny Panel Review was setup in Wolverhampton with membership from the local health economy; this was presented to WCC Cabinet in July 2015 and favourably received by Councillor Darke. WCCG profiles for 2015 are now available and a further piece of work is planned. In the meantime to strengthen the work already undertaken at RWT, an external audit was supported to be undertaken.

  HED/HSMR (Oct 14- Sept 15)

  HED/HSMR index is at 111, an increase in last Quarters rolling 12 month position of 107. This is being explored with the Trust via clinical notes reviews.

  The HED/HSMR has increased for other circulatory conditions, other perinatal conditions and chronic renal failure. These areas have not changed and it is being explored with the Trust as to how their mortality plan is prioritising these areas of improvement.

  HED/SHMI (Oct 14- Sept 15)

  HED/SHMI index is at 101 and not an outlier. Over the last 12 month period no obvious upward or downward trends have been observed.

RWTs overall SMHI for Q2 15/16 is 95. At a local health economy level this compares well with other West Midlands providers.

4.13 Workforce

Following recent concerns regarding failing safer staffing numbers for various wards at RWT, an extra ordinary meeting was held on 28th January 2016 chaired by the TDA. The CCG Chief Nurse attended. The Trust gave an outline of current developments and challenges for recruitment including:

- Retention
- Impact on quality on areas of low fill rates and how this is managed
- Early capture of new graduate
- Local recruitment timelines
- Overseas recruitment timelines
- Workforce strategy direction
- Risks and mitigations
- Impact on recruitment following acquisitions of new site
- Planning assumptions reflection and going forward to next planning round.

Assurance- the Trust has addressed this challenge from various angles and gave detailed descriptions of the various initiatives in place. TDA and CCG have requested further assurance on how quality and safety of patients/staff is being maintained especially in the areas of low fill. This assurance will be sought at the next CQRM and the TDA will follow up at the March QSG meeting.

In addition, this issue has been escalated. Issues were raised at NHSE Directors of Nurses (provider and commissioner) meeting and an extraordinary meeting has been convened with Ms Jane Cummings, Chief Nurse of England in March 2016. This meeting will address recruitment of local students, changes with HEE rules for bursaries, overseas recruitment and the high failure rate of overseas nurses passing the IELTS test requirement which is impacting on immigration.

The CCG is undertaking a Primary Care Workforce Analysis from March till July/August 2016. This will enable the workforce work stream of the Primary Care Strategy to be progressed.

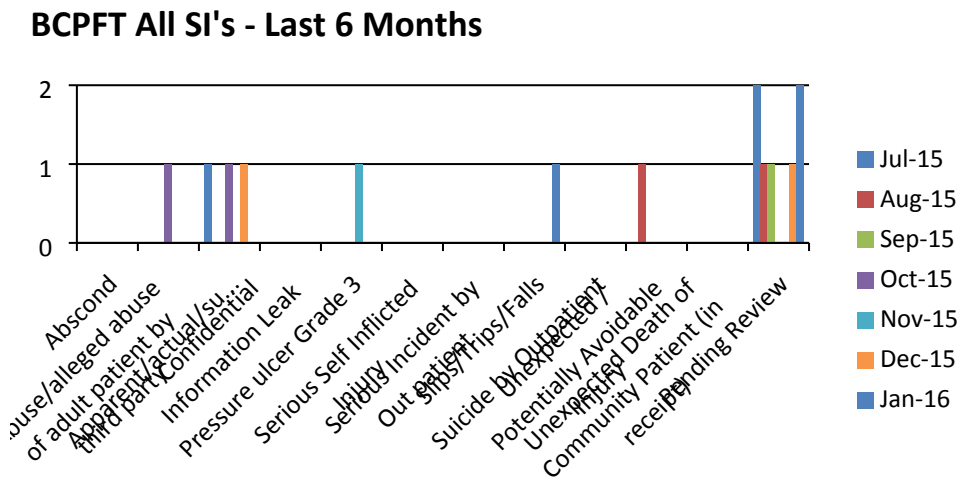
5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

5.1 Serious Incidents

- **Level of Concern as of 31st January 2016**
-

Black Country Partnership	
Month	**Concern Level and Actions**
January 2016	**Level 1** – Business as Usual

Two new SI's were reported by BCPFT in January 2016:



5.1.2 Never Events – zero reported

5.1.3 Falls – one incident reported

5.1.4 Numbers of Overdue SI's – zero

5.1.5 Overdue National Patient Safety Alerts (NPSA) – nil that we are aware of.

5.2 NHS Safety Thermometer

BCPFT's harm free care rate for December 2015 was 99.39%.

5.3 Items to Note from Clinical Quality Review Meeting

The theme of the quality review meeting which took place in January 2016 was Mental Health Services and the agenda covered:

- Serious incidents – all are scrutinised individually
- Medication incidents have increased; include prescribing errors identified by Modern Matron spot checks, immediate actions taken and action plan implemented.
- Long-term sickness is an issue and the Trust are reviewing policies and staff surveys
- Retention of staff, vacancy rate is 118.5 fte

It was agreed that the following items were to be escalated and be monitored at CQRM:

I. CQC visit in November 2015, initial reports suggest that there were no serious safety concerns, minor issues were addressed immediately the full report will be available late January/early February.

5.4 Safeguarding - Children

The Wolverhampton City Multi Agency Safeguarding Hub (MASH) had a 'soft' opening on Tuesday 5th January 2016. The CCG and other health stakeholders as RWT, BCP and Public Health met to agree the representation from health into this very important development. WCCG are funding 2 band 7 nurses who will be employed by RWT and BCP to be members of the core team at the MASH. In addition the CCG are recruiting 2 band 3 administrators to support the work of the health professionals. The CCG remains committed to this important development and are key members of the strategic and operational groups. The Governance arrangements for the MASH Service Level Agreements have been covered in the Chief Operating Officers Report.

The CCGs contribution to the Children's and Adults Safeguarding Boards for 15/16 was and in line with the expansion of the work to include; CSE, FGM, PREVENT this funding has been increased to £78.000 for 16/17 and recurrently.

5.5 Safeguarding - Adults

The usual work for safeguarding adults continues and is monitored at Q&SC monthly. One key area of concern which has been escalated with the Local Authority Safeguarding Team is the delay in getting MCA/DoLs (Mental capacity and deprivation of Liberty Assessments) undertaken in a timely manner. The CCG has asked for a remedial action plan to identify trajectory of when the delayed assessments will be completed and on-going plan for more referrals received.

The Quality Nurse Advisors Roles have now been made substantive; this affords more security to the roles and enables a robust plan for improving quality of care in care homes across Wolverhampton.

Assurance- Following staff changes in the safeguarding teams at RWT and BCPFT recently, the interim Safeguarding Lead at RWT has made some changes to strengthen processes. He is reviewing the capacity and capability of the team and administrators that support the work, undertaking an activity analysis and wider review is planned for June. This will be undertaken by the CCG and the services of an external independent reviewer will be considered to offer the review some independent objectivity. Chief Nurses at both Trusts are engaged with the CCG Chief Nurse to ensure that quality standards for all safeguarding are being met appropriately.

6.0 Clinical View

The statutory duty of the CCG is to ensure the quality of services commissioned on behalf of the population of Wolverhampton is fit for purpose. The CCG strives to ensure the services it commissions are achieving minimum standards of clinical quality as defined by regulatory requirements, contractual requirements and best practice. The Quality Team engages with Secondary Care Consultant, Nursing professionals and GP colleagues.

7.0 Quality and Safety Committee

At the Quality & Safety Committee Meeting held in December, information from Quality Review Meetings held during the month of October and November were considered. Minutes of this meeting are available for information on the agenda.

Minutes from associated groups were also considered and discussed, all in accordance with the committee's terms of reference.

Items for escalation have been reported at the front of this report.

8.0 Patient and Public View

Patient Experience is a key domain within the Clinical Quality Framework and therefore forms part of the triangulation of various sources of hard and soft intelligence considered by the Quality & Safety Committee.

9.0 Risks and Implications

9.1 Key Risks

- Quality & Risk Team and nominated Board Members
- Risk of litigation has resource implications as well as organisation reputation risk

10.0 Quality and Safety Implications

- Provides assurance on quality and safety of care, and any exceptions reports that the Governing Body should be sighted on.

11.0 Equality Implications

EIA not undertaken for the purposes of this report, however, all commissioned services are planned and evaluated with an emphasis on impact on all users.

12.0 Medicines Optimisation Implications

- Medicines Optimisation ensures that the right patients get the right choice of medicine at the right time.
- The goal is to improve compliance therefore improving outcomes. Monitoring of this is undertaken by the medicines safety officer.

13.0 Legal and Policy Implications

- Risk of litigation has resource implications as well as organisation reputation risk. Risk of failure to meet organisational statutory responsibilities.
- Impacts on Quality Strategy, Patient and Public Engagement Strategy, CCG Board Membership, Quality and Safety Committee.
- Clinical Quality and Patient Safety Strategy has been refreshed & currently being consulted upon.

14.0 Recommendations

For **Assurance**

- **Note** the action being taken.
- **Discuss** any aspects of concern and **Approve** actions taken
- **Continue** to receive monthly assurance reports

Name: **Manjeet Garcha**
Job Title: **Director of Nursing & Quality**
Date: **22nd February 2016**

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	**M Garcha Dr Rajcholan**	
Public/ Patient View	**Pat Roberts**	
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**Report of Q&RT**	
Medicines Management Implications discussed with Medicines Management team	**David Birch**	
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliet Herbert**	
Information Governance implications discussed with IG Support Officer	**Michelle Wiles**	
Legal/Policy implications discussed with Corporate Operations Manager	**NA**	
Signed off by Report Owner (Must be completed)	**Manjeet Garcha**	**22/02/2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
8th March 2016

Agenda item 12a

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC)- 23rd February 2016**
Report of:	Jim Oatridge – Chair, Audit and Governance Committee
Contact:	Claire Skidmore – Chief Finance and Operating Officer
Governing Body Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG. • Ratify Conflict of Interest Policy • Auditor Panel establishment.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The AGC delivers its remit in the context of the CCG's priorities in order to provide assurance to the Governing Body of the robustness of system and process.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The AGC is accountable to the group's governing body and its remit is to provide the governing body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them.

	The AGC shall critically review the group's financial reporting and internal control principles and ensure that an appropriate relationship with both internal and external auditors is maintained.

1. BACKGROUND AND CURRENT SITUATION

1.1 Chief Internal Auditor Progress Report

The Committee was updated on the progress of 2015/16 Internal Audit work including summaries of the key outcomes (including agreed actions) of assignments finalised and reported since the previous meeting.

1.2 Management Action Plan Update

The Committee was informed of the current position and progress in respect of the implementation of Internal Audit recommendations. It was noted that the outstanding recommendations had recently been considered by the Senior Management Team

1.3 Draft Head of Internal Audit Opinion

The Committee received the Head of Internal Audit's annual opinion, based upon and limited to, the relevant Internal Audit work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The draft overall opinion was **'Significant Assurance'.**

It was noted that in accordance with guidance the Opinion was submitted to NHS England on 22nd February, the day prior to the AGC meeting. Members had been given the opportunity to raise any concerns or queries prior to the submission.

1.4 Draft Internal Audit Plan 2016/17

An introductory report form PricewaterhouseCooper was received and an updated report will be brought to the next meeting.

1.5 Local Counter Fraud Specialist Progress Report

The Committee received and noted the activity undertaken as part of the Counter Fraud annual work plan since the last meeting.

1.6 Counter Fraud Policies for Sign Off

The Committee considered and signed off the new policy relating to the applications of Sanctions and Redress against anyone that commits fraudulent acts against the CCG.

1.7 Fraud, Bribery and Corruption Standards for Commissioners, Self Review Tool (SRT)and CCG Work plan

The Committee received an update on progress against the work plan and noted that it is on track with actions due to be completed by the end of March.

1.8 Draft Counter Fraud Plan

An introductory report from PricewaterhouseCooper was received and an updated report will be brought to the next meeting.

1.9 External Audit Progress Report

The Committee received a refreshed version of the Audit Planning Report for 2015/16 following further guidance from the National Audit Office on the new approach to the value for money conclusion. It was noted that the report summarised the assessment of key issues which drive the development of an effective audit for the CCG and outlined the planned audit strategy in response to those risks.

1.10 Risk Register Reporting/Board Assurance Framework

The Committee noted the report which provided an update on Quarter 3 activity. The Committee agreed to hold deep dives from the Risk Register on a quarterly basis going forward following a successful pilot.

1.11 Annual Governance Statement

The Committee received an overview of the work being undertaken to prepare the Statement for 2015/16. An updated draft will be brought to the April meeting.

1.12 AGC Committee Annual Report

The Committee considered the first draft of it's annual report, which highlights the work of the Committee during the year against its terms of reference and provides an opportunity to discuss how effectively the Committee discharges its remit.

1.13 Review of Conflict of Interest Policy

The Committee considered the proposed changes to this policy and recommended the revised version to the Governing Body.

1.14 Auditor Panel

The Committee noted the progress made to date regarding the creation of an Auditor Panel. The draft terms of reference were discussed and it was noted that final approval of these must be made by the Governing Body. The first meeting is due to be held in April.

1.15 Final Accounts and Preparation Plan

The Committee was informed of the outcome of the Month 9, Interim Accounts submission process and was advised of the process for producing the CCG's 2015/16 Year-End Accounts.

1.16 Losses and Compensation Payments – Quarter 3 2015/16

The Committee noted the contents of the report. The CCG had not recorded any losses during the third quarter of 2015/16 and had not made any special payments during the same time period.

1.17 Suspension, Waiver and Breaches of SO/PFPs

The Committee noted the contents of the report. There have been no suspensions of SO/PFPs, 4 waivers have been utilised appropriately.

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

The Committee noted that as at 31st December 2015, there was 1 sales ledger invoices greater than £10k and over 6 months old and 8 purchase ledger invoices greater than £10k and over 6 months old.

1.19 Financial Control Environment Assessment (FCEA)

The Committee noted the progress in delivering the FCEA Metrics.

2. KEY RISKS AND IMPLICATIONS

2.1 The Audit and Governance Committee will regularly scrutinise the risk register and the 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 will suffer a loss of control with potentially significant results.

3. RECOMMENDATIONS

- **Receive** this report and **note** the actions taken by the Audit and Governance Committee
- **Ratify** Conflict of Interest Policy
- **Support** establishment of Auditor Panel using Terms of Reference Shared at meeting

Name: **Claire Skidmore**
Job Title: **Chief Finance and Operating Officer**
Date: **24th February 2016**

ATTACHED:

Appendix 1 – Conflict of Interest Policy

Appendix 2 – Auditor Panel Terms of Reference

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
8 MARCH 2016

Agenda item 12b

Title of Report:	**Review of Declaring and Managing Interests Policy**
Report of:	Corporate Operations Manager
Contact:	Peter McKenzie, Corporate Operations Manager
Governing Body Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To outline a revised version of the CCG's Policy for Declaring and Managing Interests which has been considered by and recommended by the Audit and Governance Committee.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Developing and Strengthening Leadership Capacity and Capability.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The policy for managing potential conflicts of interest and the registers of interest and gifts and hospitality are key parts of the CCG's governance arrangements.
• **Domain 3:** Financial Management	The effectiveness of the operational arrangements for managing potential conflicts of interests is a key element of robust financial management procedures, particularly in relation to procurement.
• **Domain 5:** Delegated Functions	Having robust arrangements for managing potential conflicts of interest is a key issue for the successful

	exercise of the delegated functions under joint Co-Commissioning as there is the potential for greater exposure to risk in these areas.

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG's policy for declaring and managing interests was subject to a wholesale review in January 2015. This review took into account best practice from other areas of the public sector and refreshed guidance from NHS England, which was issued to support CCGs in preparation for the advent of Co-Commissioning of Primary Care.

1.2. As a result of the level of change made to the policy, it was agreed that it would be reviewed in 12 months' time to ensure it remained fit for purpose and was being effectively implemented. The Audit and Governance Committee have conducted the review and are recommending a revised version of the policy to the Governing Body.

2. REVIEW OF POLICY

2.1. In conducting the review, the Audit and Governance Committee have not identified any evidence that the policy is not operating effectively, so no major changes are being proposed. Those changes that are suggested are intended to provide clarity in areas of ambiguity and to strengthen arrangements for confirmation of the accuracy of interests.

2.2. A copy of the revised policy is attached that includes the following changes:-

- The definition of relevant interests in paragraph 3.2 has been refined to clarify that interests that should be registered by individuals are those which may impact on the CCG;
- The requirement for individuals to confirm their interests on an annual basis has been strengthened
- The Register of Interests form has been updated to reflect the changes in paragraph 3.2
- A number of typographical errors have been corrected.

3. FURTHER REVISED

3.1. NHS England have indicated that they are likely to issue revised guidance on managing conflicts of interest during 2016. Amongst other things, this is likely to address concerns raised nationally around gifts and hospitality provided by pharmaceutical companies during 2015. Similar issues have recently been raised around hospitality provided to Civil Servants in Government Departments with further media coverage.

3.2. The guidance is currently being developed and it is understood that it will aim to clarify both expectations for CCG policies and a number of operational standards (such as how declarations of interest are recorded at meetings). Any further changes to the policy that are required to comply with the new guidance will be considered when it is issued and reported to the Governing Body.

4. CLINICAL VIEW

4.1. Clinical members of the Governing Body are invited to comment on the policy prior to its final adoption.

5. PATIENT AND PUBLIC VIEW

5.1. Not applicable.

6. RISKS AND IMPLICATIONS

Key Risks

6.1. There is a risk that an ineffective approach to managing potential conflicts of interest would leave the CCG's decisions open to challenge. Maintaining a robust policy through a review as outlined in the paper, mitigates this risk.

Financial and Resource Implications

6.2. There are no resource implications relating to the review or the implementation of the policy.

Quality and Safety Implications

6.3. There are no quality and safety implications relating to this report.

Equality Implications

6.4. There are no equality implications arising from this report.

Medicines Management Implications

6.5. There are no medicines management implications relating to this report.

Legal and Policy Implications

6.6. The Policy for Declaring and Managing Interests must reflect the provisions of the constitution that refer specifically to Standards of Business Conduct, the relevant sections of Standing Orders and statutory guidance from NHS England.

7. RECOMMENDATIONS

That the Governing Body

- **Approves** the revised Policy.

Name	Peter McKenzie
Job Title	Corporate Operations Manager
Date:	February

ATTACHED:

Revised version of the Policy for Declaring and Managing Interests

RELEVANT BACKGROUND PAPERS

CCG Constitution
Managing Conflicts of Interest, Statutory Guidance for CCGs, NHS England December 2014 http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	N/a	
Medicines Management Implications discussed with Medicines Management team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	Report author	25/02/2016
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**25/02/2016**

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NHS
Wolverhampton
Clinical Commissioning Group

Declaring and Managing Interests

Including Managing Conflicts of Interest

DOCUMENT STATUS:	**To be Approved**
DATE ISSUED:	**January 2015**
DATE TO BE REVIEWED:	**January 2016**

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1.1	November 2014	First Revision
1.2	December 2014	Revised following comments by Jim Oatridge
1.3	December 2014	Reviewed to incorporate revised guidance from NHS England
2.0	**January 2015**	**Reviewed following comments from the Audit and Governance Committee**
2.1	October 2015	Revision by Peter McKenzie

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Peter McKenzie	Corporate Operations Manager	November 2014	1.1
Jim Oatridge	Lay Member for Audit and Governance	December 2014	1.1
Peter McKenzie	Corporate Operations Manager	October 2015	2.1

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Governing Body	13 January 2015	1.3
Audit and Governance Committee	20 January 2015	2.0
	23 February 2016	2.1

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Contents

1. Introduction and Purpose

1.1. This policy is a key element of the Group's Business Conduct Policies[1] and is available on the group's website at www.wolvescityccg.nhs.uk. It sets out how NHS Wolverhampton Clinical Commissioning Group (CCG) will manage conflicts of interest arising from the business of the organisation and should be read alongside the constitution (including the standing orders in Appendix E) and the Codes of conduct for staff and Governing Body Members and clinical leads.

1.2. The policy has been drafted in accordance with relevant legislation and guidance including:-

- NHS England Code of Conduct: "Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services" (October 2012)
- NHS England: "Managing conflicts of interest: Statutory Guidance for CCGs"
- The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013, SI 2013/257
- Royal College of General Practitioners' ethical commissioning guidance (October 2011)
- The four principles set out in the NHS England Towards Establishment: Creating responsive and accountable CCGs, Technical appendix 1:-
  - Doing business properly
  - Being proactive not reactive
  - Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest
  - Being balanced and proportionate

1.3. The CCG is responsible for the stewardship of vast public resources and the commissioning of healthcare services for the community. It is therefore determined to inspire confidence and trust by demonstrating integrity by ensuring all of the group's decisions are taken and demonstrably seen to be taken for the right reasons and in line with the following principles:-

- The interests of patients remain paramount at all times;
- The Group's business is conducted in an impartial and honest manner;
- Public funds are used to the best advantage of the service, always ensuring value for money;
- No employees or appointees abuse their position for personal gain or to the benefit of their family or friends;
- No employees or appointees seek to advantage or further private or other interests in the course of their duties.

1.4. This ethos underpins this policy, by setting out steps to avoid any potential or real situations where there could be suggestions of undue bias or influence in the decision making of the CCG. This is of particular significance in relation to decisions with financial implications, as the group is mindful of its responsibilities under The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013[2], which stipulate that the Group:

[1] Paragraph 8.1.2 of the group's constitution
[2] SI 2013/257

- when procuring health care services, must treat providers equally and not treat a provider or type of provider more favourably, in particular on the basis of ownership - Regulation 3(2)(b);
- must not award a contract for the provision of health care services where conflicts or potential conflicts between commissioning and providing the services affect or appear to affect the integrity of that contract award – Regulation 6(1);
- must maintain a record of how it managed any such conflicts of interest in relation to each such contract that it has entered into – Regulation 6(2);
- must provide Monitor with any specified information in its possession for the purposes of an investigation into any complaint received by Monitor regarding the Group's failure to comply with the above – Regulation 13(4).

2. Scope of Policy

2.1. This policy applies to:-

- Member practices in their capacity as members of the group, not as providers of primary medical care;
- Governing Body Members and members of the Group's committees;
- Employees of the group; and
- Any individuals contracted to work on the group's behalf or otherwise provide services or facilities to it.

2.2. In addition, anyone engaging with the Group in relation to the actual or potential provision of services or facilities to it will be required to comply with this policy as regards the declaration of any relevant actual or potential conflict of interest.

2.3. A conflict of interest is defined as a situation in which:-

- There is a real possibility that any interest will lead an individual to act in a way that is not impartial and independent in carrying out their duties on behalf of the group;
- There is a real possibility that any interest held by a close personal relation, business associate or other person known to an individual will lead an individual to act in a way that is not impartial and independent in carrying out their duties on behalf of the group;
- A fair minded and informed observer would conclude that one of the above interests exists and that there was a real possibility that the interest could lead the individual to act in a way that is not impartial or independent in carrying out their duties on behalf of the group.

2.4. As highlighted above, when considering conflicts of interest, there may be circumstances when it is not necessary for an actual conflict to exist. It may be sufficient that there is a perceived conflict, where there is a reasonable perception that the individual is influenced or could be open to influence.

2.5. The definition of close personal relations includes spouses, civil partners, partners, parents, children (adult and minor) and siblings. It also includes other people living in the same household as the individual. For the avoidance of doubt, GPs on the Governing Body, other GPs in their practice will be considered to be business associates for the purpose of this policy.

2.6. Further details on the interests that must be registered is given in Section 3 of this policy, but in general potential conflicts of interest may arise from:-

- **direct pecuniary interests:** where an individual or their close personal relations may financially benefit from the consequences of group decision (for example, a decision to commission a provider of services);
- **indirect pecuniary interests:** for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;
- **non-pecuniary interests:** where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);
- **a non-pecuniary personal benefit:** where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

2.7. Failure to comply with this policy is taken very seriously by the group and may have significant consequences including investigations into potential gross misconduct for employees or as a breach of the code of conduct for governing body members. Failure to comply with this policy by member practices will be treated as a dispute in line with paragraph 7.10 of the Constitution.

3. Registration of Interests

3.1. It is the responsibility of all individuals to whom this policy applies to ensure that they are not placed in a position which creates a potential conflict between their private interests and their CCG duties. The CCG needs to be aware of all situations where individuals' interests may have the potential to cause a conflict so all persons covered by the policy are required to declare any relevant interest held by themselves or any person defined by paragraph 2.5 above using the Declaration of Interest Form (Appendix A).

3.2. With regard to declaring and registering them, relevant interests that may impact on the work of CCG may include:

- Roles and responsibilities held within member practices
- Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies) which may seek to do business with the CCG (or, where relevant, its providers)
- Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the CCG (or, where relevant, its providers)
- Significant share holdings (more than £25,000 or 1% of the nominal share capital) in organisations which may seek to do business with the CCG (or, where relevant, its providers)
- Employment with an organisation which currently does or may seek to do business with the CCG (or, where relevant, its providers)

- Membership of or a position of trust in a charity or voluntary organisation in the field of health and social care
- Receipt of research funding/ grants from the CCG
- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared)
- Formal interest with a position of influence in a political party or organisation
- Current contracts with the CCG in which the individual has a beneficial interest
- The receipt of individual Gifts and Hospitality worth over £25 or several gifts worth over £100 in a 12 month period from a single source (see Section 6 for more details)
- Any other employment, business involvement or relationship that conflicts, or may potentially conflict with the interests of the CCG.

3.3. As outlined in the constitution, the arrangements for appointing members to the Governing Body will include a requirement to declare any potential conflicts of interest. The Accountable Officer (in consultation with the statutory Lay Members of the Governing Body) will then assess whether any identified conflicts would prevent the individual concerned making a full and proper contribution to the governing body. If such significant conflicts do exist, the individual concerned will be excluded from the appointment process.

3.4. Induction arrangements for staff, Governing Body Members and committee members will include training on the arrangements for managing conflicts of interest. In addition, advice on the registration of interests is available to all individuals covered by this policy from the Corporate Operations Manager. This will include any clarification of the categories listed above and advice on whether situations not covered by the above categories should be registered.

3.5. The Group will use these declarations to maintain and publish on its internet site Registers of Interests for:
- the members of the Group;
- the members of its Governing Body;
- other members of any committees or sub-committees;
- other employees and anyone else required to declare interest under a contract for their services.

3.6. If an individual feels that information relating to an interest that must be registered is sensitive they can request that the information not be included the public register. Such requests must be made in writing to the Chief Finance and Operating Officer, who will determine whether the request is valid and maintain a separate register of any information not included on the public version.

3.7. For the purposes of paragraph 3.6, information is considered to be sensitive if making it open to public inspection could lead to the individual or a close personal relation suffering violence or intimidation.

3.8. On at least an annual basis, all those persons covered by this policy will be formally reminded of the need to declare interests and to confirm the accuracy of the interests

already registered against their name. The Registers will also be reviewed quarterly by the Corporate Operations Manager to ensure that they accurately reflect all of the declarations of interest submitted or withdrawn since the previous such review.

3.9. Any person covered by this policy who becomes aware that they have a relevant interest because:

- their personal circumstances change;
- they become aware, either in the course of any transaction (including conversations between two or more individuals, e-mails, correspondence and other communications) on behalf of the Group or when they find out about a decision to be made by the Group that they have a relevant interest that they had not previously recognised and declared;

must inform the Corporate Operations Manager of the change in their interests, as soon as practicable after they become aware of it to ensure that this interest is registered within 28 days.

4. General Principles for Managing Potential and Actual Conflicts of Interest

4.1. The Group's constitution sets out the responsibility of the Lay Member for Audit and Governance to ensure arrangements are in place to manage conflicts of interests[3]. All individuals covered by this policy must comply with the arrangements outlined below and any instructions given to them under those arrangements. As highlighted in Paragraph 2.7 above, failure to comply will be considered as a serious issue with potential disciplinary consequences.

4.2. When an actual or potential conflict of interest is identified, the individual with the conflict of interest will normally be instructed to withdraw from any activity, transactions or meetings relating to the conflict on a permanent basis. Where the conflict only becomes apparent in the course of activity, transactions or meetings, the individual must withdraw at the point the conflict is identified and their interest communicated to all relevant parties.

4.3. As a consequence of paragraph 4.2, individuals with a conflict of interest should also not be party to any information relating to the matter in which they have a conflict other than information that is publicly available. This means that, if they are a member of a committee or governing body, they should not receive copies of any private papers relating to the matter in which they have a conflict of interest.

4.4. For decisions that affect all of the practices in the Group, any individual with a resulting conflict of interest can be involved in developing relevant proposals and their discussion at Committees and Governing Body level. They will not be able to vote on the decision and another non-conflicted party must be involved in formally putting recommendations to any Committee or the Governing Body.

4.5. In addition, in regard to conflicts as regards any decision required of the Group with regard to services actually or potentially provided by the members of the group the

[3] Paragraphs 8.4.2 to 8.4.4, Sections 4 and 5 are approved by the Lay Member as the Group's arrangements under these paragraphs

Group will follow the NHS England Code of Conduct and use the template in Appendix B for all relevant commissioning decisions. In particular the Group will:

- arrange for access to robust, independent advice and support with regard to procurement and contract management;
- publish the details of all contracts, including their value, on the Group's website as soon as they are agreed;
- publish on the Group's website the types of services being commissioned though Any Qualified Provider and the agreed price for each service;
- liaise with NHS England when commissioning any service from a primary care provider that is related to the services that some or all GP practices provide under the GP contract

4.6. A register of all procurement decisions made by the Group will be maintained and published on the Group's website and made available for inspection at the Group's offices. This register will include the details of the decision, who was involved in making the decision (including whether this involved the Governing Body or a Committee) and a summary of any conflict of interests that were declared and how they were managed.

4.7. Where, due to the specific nature of the interests involved, a different approach is required, the Lay Member for Audit and Governance (or their nominee) will communicate the arrangements for managing the actual or potential conflict of interest to all relevant parties within 7 days of a conflict being identified[4].

4.8. As outlined in the constitution, alternative arrangements may include the following actions:

- referring the matter to the group's governing body to progress;
- inviting one or more of the following, who do not have the conflict of interest, to attend the relevant meeting to provide additional scrutiny to the matter and advice to those who can participate:
    - A practice representative;
    - A member of a relevant Health and Wellbeing Board;
    - A member of a governing body of another clinical commissioning group.

This list is not exhaustive, and any arrangements will be recorded and communicated in line with the requirements of paragraph 4.7 above and paragraph 8.4.10 of the Constitution.

5. Declarations of Interests at Meeting

5.1. The agenda for meetings of the Group, the Governing Body and their Committees and Locality Boards will contain a standing item at the commencement of each meeting, requiring members and other invited attendees to declare any interests relating specifically to the agenda items being considered.

[4] This may include circumstances covered by paragraphs 8.4.9 and 8.4.10 of the constitution when a quorum of the Governing Body or a Committee cannot be reached due to the existence of conflicts of interest.

5.2. Participants must be specific when declaring interests. They should state which agenda item their interest relates to, the nature of the interest and whether or not their interest creates a potential conflict of interest.

5.3. If a member or other invited attendee becomes aware of an interest during the course of the discussion on a particular item they must declare it as soon as they become aware of it and, if it has not previously been included in the register of interests, take the steps outlined in paragraph 3.9 to ensure the interest is registered.

5.4. Where the interest declared constitutes an actual or potential conflict of interest, the participant in question will leave the room prior to the item being discussed and not take part in the discussion or any vote that takes place[5].

5.5. If there is any doubt as to whether an interest that has been declared constitutes a conflict of interest advice should be sought from the Corporate Operations Manager. In general terms, it is often safest to assume that a conflict does exist and act accordingly, particularly where the interest relates to a decision to be made at the meeting. If the Chair has to make a ruling on any potential or actual conflicts, their ruling will be final.

5.6. If the application of paragraph 5.4 above means that a meeting cannot be quorate for any decision, that matter will be deferred until the meeting is quorate or dealt with under paragraphs 8.4.9 to 8.4.10 of the constitution as necessary.

5.7. Paragraphs 8.4.9 and 8.4.10 of the constitution cover situations where a quorum could never be reached due to actual or perceived conflicts of interest. It sets out the responsibility of the chair of the meeting to consult with the Lay Member for Audit and Governance on alternative actions that could be taken.

5.8. If a part of a meeting of the Governing Body cannot be quorate due to conflicts of interest, standing order 3.6.2 will apply and the relevant parts of such meetings will be chaired by the Deputy Chair or, in their absence, another non-conflicted member selected from among and by the non-conflicted members present. Those members allowed to vote will do so having ensured that they have received independent advice[6], either before or at the relevant meeting.

5.9. All declarations of interest, any subsequent action taken and any other relevant information – including any advice given will be recorded in the minutes of the meeting.

6. Gifts and Hospitality

6.1. In general terms, in order to support the broad aims of this policy, offers of gifts and hospitality beyond those defined in paragraph 6.4 should be politely but firmly declined as accepting such offers could lead to similar claims of undue influence as

[5] Unless alternative arrangements have been put in place by the Lay Member for Audit and Governance under paragraphs 8.4.3 or the Chair under Paragraphs 8.4.9 and 8.4.10 of the Constitution

[6] In line with paragraph 8.4.10(b) of the constitution

with other conflicts of interest. It is an offence under the Bribery Act 2010 for anyone to request, agree to receive or receive any financial or other advantage as an inducement to or reward for improper behaviour by them or anyone else.

6.2. For the purposes of this policy, the offer of a discount that would not normally be available to the individual is to be considered the offer of a gift.

6.3. All relevant offers of gifts or hospitality should be declared to the Corporate Operations Manager, who will maintain a register of gifts and hospitality both received and declined and who will advise individuals when the receipt of gifts or hospitality becomes a relevant interest as defined in paragraph 3.2 above.

6.4. Gifts of low intrinsic value (less than £25 per item) such as pens, diaries, calendars and mouse mats need not be refused and do not need to be declared in most cases. However if several such gifts are received from the same or related source over any 12-month period and their cumulative value exceeds £100, they should be declared.

6.5. Hospitality provided to individuals in connection with events, meetings or working visits at another organisation is acceptable without being declared, provided it is similar to the scale of hospitality which the Group would be likely to offer to a representative of another organisation attending one of its events or visiting the Group for similar reasons.

6.6. Where the Group receives or solicits offers of sponsorship for meetings, training events or publications this Policy requires that:-

- the sponsor's involvement must be made public without giving their advertising or promotional material undue significance;
- nothing said or issued during a meeting or training event or written in the publication must give any explicit or implicit suggestion that the Group is endorsing the products or services of the sponsor;
- receipt of the sponsorship must be declared and recorded in the gifts and hospitality register;
- sponsorship should not be sought from and should be declined if offered by any organisation if it is known or considered likely that they will be submitting a competitive bid to the Group within three months either side of the sponsored event or publication.

6.7. Employees of the group should only accept sponsorship to fund their attendance at relevant conferences, courses or work-related visits with the prior approval of their line manager, who needs to ensure there can be no perception of a conflict of interest in relation to the motives of the organisation making the offer. All such offers, whether accepted or not, should be declared and recorded in the gifts and hospitality register.

6.8. The Group might wish to sponsor (i.e. contribute part of the funding for) local events or publications in which they have no other involvement but which contribute to the aim of the Group. This must be done such that the Group is not seen to be endorsing everything said at the event or in the publication and with due regard to the timing of the event/publication and any actual or potential commercial relationship between the Group and the organisation being sponsored.

6.9. If an employee or representative of the Group is asked to contribute on behalf of the Group to a conference or other event arranged by another organisation, the invitation is accepted as part of the individual's job or role with the Group and the contribution delivered during time for which they are already being paid, it is not appropriate for them to be paid for doing so. The Group may wish to reimburse any related expenses, particularly any overnight accommodation and related meals, if they are not funded by the organisers of the event. Anyone accepting such an invitation needs to ensure that doing so does not create any potential conflict with any other relationship between the Group and the event organisers. Expenses and hospitality directly associated with contributing to an event in this way need not be declared, provided that the event takes place in the UK.

6.10. Such an offer can also be accepted by an individual in their own right, to be carried out in their own time and with any views expressed to be explicitly those of the individual, not necessarily the Group. It is then acceptable for them to be paid for their contribution provided that this does not create any conflict of interest with their role within the Group or any potential relationship with the other organisation. All related expenses must be met by the individual or the event organisers; if the latter, any such expenses, except reimbursement of travel expenses within the UK, should be declared and recorded in the gifts and hospitality register.

6.11. The Group and its members must follow the toolkit issued by the Department of Health and Association of the British Pharmaceutical Industry (ABPI)[7] whenever any joint working is undertaken with pharmaceutical companies. This defines the difference between sponsorship (where pharmaceutical companies simply provide funds for a specific event or work programme) and joint working, where goals are agreed jointly by the NHS organisation and company, in the interest of patients, and shared throughout the project. Whenever the group engages in any joint work with a pharmaceutical company a working agreement must be drawn up and management arrangements conducted with participation from both parties in an open and transparent manner.

7. Review of Policy

7.1. The Audit and Governance Committee will keep the effectiveness of this policy under review and the lay Member for Audit and Governance will ensure that the arrangements outlined remain fit for purpose in line with the requirements in paragraph 8.4.2 of the Group's Constitution.

7.2. The review process will include consideration of any lessons to be learned from any non-compliance with the policy during the year. This may include the committee

[7] Moving Beyond Sponsorship, 2010, underpinned by important pieces of Guidance. "Best Practice Guidance for Joint Working between the NHS and the Pharmaceutical Industry" was issued by the Department of Health in February 2008. "The ABPI Code of Practice for the Pharmaceutical Industry" and "Guidance Notes on Joint Working between Pharmaceutical Companies, the NHS and Others for the Benefit of Patients"

undertaking an incident review in addition to any disciplinary or conduct procedures undertaken with the individual(s) concerned.

8. Further Advice and Guidance

8.1. Further advice on this policy can be obtained from the Corporate Operations Manager in the first instance. Other sources of advice and guidance will include the local Counter Fraud Specialist service and the lay member for audit and governance.

NHS
Wolverhampton
Clinical Commissioning Group

DECLARATION OF INTERESTS FORM

Name:	
Position within CCG:	

As Highlighted in paragraph 3 of the Declaring and Managing Interests policy, the CCG needs to be aware of relevant interests that may impact on the work of the CCG. If you have any queries about whether an interest needs to be included on this form, please contact Peter McKenzie, Corporate Operations Manager for more information.

Type of Interest	Details	Who holds the interest? (Self or other[8])
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies) which may seek to do business with the CCG (or where relevant, its providers)		
Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the CCG (or where relevant, its providers)		
Significant share holdings (more than £25,000 or 1% of the nominal share capital) in organisations which may seek to do business with the CCG (or where relevant, its providers)		
Employment with an organisation which currently does or may seek to do business with the CCG (or where relevant, its providers)		

[8] See Paragraph 2.5

Type of Interest	Details	Who holds the interest? (Self or other[8])
Membership of or a position of trust in a charity or voluntary organisation in the field of health and social care		
Receipt of research funding/ grants from the CCG		
Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared)		
Formal interest with a position of influence in a political party or organisation		
Current contracts with the CCG in which the individual has a beneficial interest		
Any Gifts or Hospitality registered in accordance with Section 6 of the Conflicts of Interest Policy		
Any other employment, business involvement or relationship that conflicts, or may potentially conflict with the interests of the CCG.		
Any other information you wish to declare		

In accordance with the requirements of the requirements of Paragraph 8.4 of the Constitution and Section 3 of the Managing Conflicts of Interest Policy I declare that I hold the above interest and confirm that:-

- **To the best of my knowledge and belief, the above information is complete and correct and that a failure to comply with the requirements of the Conflict of Interest Policy will be treated seriously.**
- **I will review and update this information as necessary in accordance with the requirements of Section 3 of the Managing Conflicts of Interest Policy at least annually and within 28 days of my becoming aware of a change of circumstances.**
- **I understand that the information contained in this form will be published in the Register of Interests published on the Group's Website.**

Signed_____ **Date:**_____

Appendix B

NHS Wolverhampton Clinical Commissioning Group
NHS England Challenge Template

To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest

Service:	
Question	**Comment/Evidence**
Questions for all three procurement routes	
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	
Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?	
Why have you chosen this procurement route?[9]	

What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?	

Additional question for AQP or single tender (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions for AQP only (where GP practices are likely to be qualified providers)	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for single tenders from GP providers	
What steps have been taken to demonstrate that there are no other providers that could deliver this service?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	
What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

[9] Taking into account S75 regulations and NHS Commissioning Board guidance that will be published in due course, Monitor guidance, and existing procurement rules.

NHS Wolverhampton Clinical Commissioning Group Constitution Annex to Appendix H1

Governing Body's Audit and Governance Committee – Auditor Panel

Terms of Reference

1. Introduction

The Governing Body has appointed the Audit and Governance Committee to act as its Auditor Panel in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the AGC when it is acting as the Auditor Panel and shall have effect as if incorporated into the constitution and standing orders.

The Auditor Panel is a non-Executive Committee of the Governing Body and has no executive powers, other than those specifically delegated in these terms of reference. The terms of reference will be published on the group's website (www.wolverhamptonccg.nhs.uk) and available by post or email, if requested.

2. Membership

The Auditor Panel shall comprise the entire membership of the Audit and Governance Committee. This means that all members of the Auditor Panel are independent, non-executives in line with legislative requirements.

In line with the requirements of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (regulation 6) each member's independence has been reviewed against the criteria laid down in the regulations.

3. Chair

The Chair of the Audit and Governance Committee will be appointed as Chair of the Auditor Panel. If the Chair is unable to be present, the Panel will nominate a Member to act in their place during a meeting.

4. In Attendance

The auditor panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not members of the auditor panel.

5. Secretary

A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Panel's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

6. Quorum

A meeting of the Auditor Panel will be quorate provided that two members are present of whom at least one is a member of the governing body.

6. Voting

Should a vote need to be taken, only the members of the Auditor Panel shall be allowed to vote. In the event of a tied vote, the Chair shall have a second and casting vote.

7. Frequency and notice of meetings

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit and Governance Committee.

A separate agenda for Auditor Panel business shall be circulated and Audit Committee members shall deal with these matters as Auditor Panel members NOT as audit committee members.

The Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the Audit and Governance Committee.

8. Conflicts of Interest

In line with the CCG's Policy for Declaring and Managing Interests and conflicts of interests must be declared and recorded at the start of each meeting of the Auditor Panel. If a conflict of interest arises, the chair may require the affected auditor panel member to withdraw at the relevant discussion or voting point.

As members of the Audit and Governance Committee, Auditor Panel members' interests will be recorded in the CCG's Register of Interests.

9. Remit, duties and responsibilities

The auditor panel is authorised by the Governing Body to carry out the following functions:-

- Advise the organisation's board/ governing body on the selection and appointment of the external auditor. This includes:
    - agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules;
    - making a recommendation to the Governing Body as to who should be appointed;
    - ensuring that any conflicts of interest are dealt with effectively
- Advise the Governing Body on the maintenance of an independent relationship with the appointed external auditor
- Advise the Governing Body (if required) on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor
- Advise the Governing Body on any decision about the removal or resignation of the external auditor.

10. Relationship with the governing body

The Chair of the Auditor Panel must report to the Governing Body on how the auditor panel discharges its responsibilities following each meeting. The Chair must draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action.

The minutes of the panel's meetings must be formally recorded and submitted to the Governing Body by the Chair following approval at a panel meeting.

11. Policy and best practice

In seeking to apply best practice in the decision-making process, the Auditor Panel has full authority can seek any information it requires from any employees/ relevant third parties. All employees are directed to cooperate with any request made by the Auditor Panel.

The auditor panel is authorised by the Governing Body to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the organisation's existing rules.

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WOLVERHAMPTON CCG

GOVERNING BODY
8th March 2016

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Finance and Performance Committee- 23rd February 2016**
Report of:	Claire Skidmore – Chief Finance and Operating Officer
Contact:	Claire Skidmore – Chief Finance and Operating 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.
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):	

• **Domain2: Performance**	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.
• **Domain 4: Planning**	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;

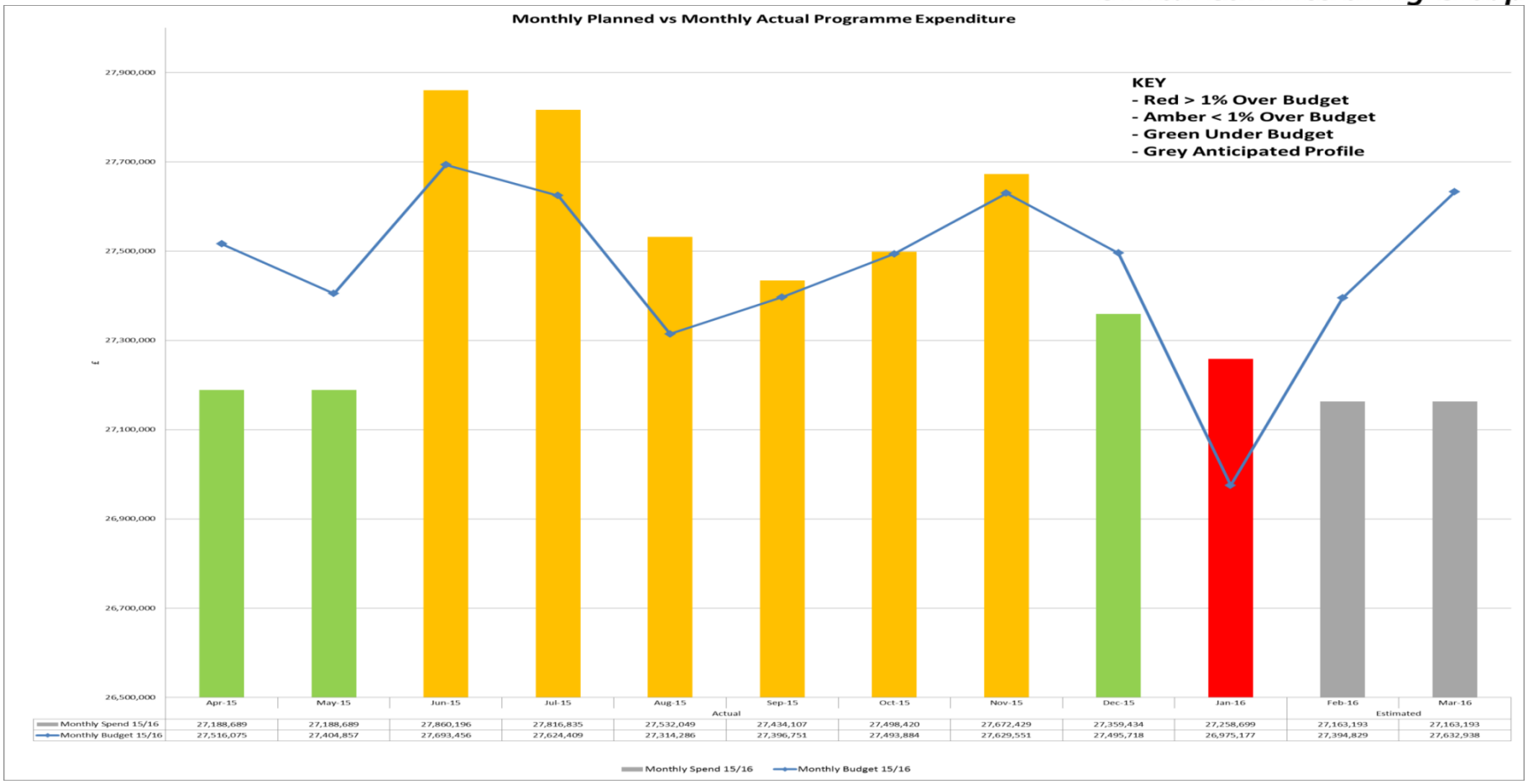
Financial Target	Target M10	Achieved M10	Variance	RAG
Programme Cost £'000*	271,762	273,119	1,357	G
Reserves £'000*	2,782	1,024	-1,758	G
Running Cost £'000*	4,906	4,537	-369	G
Maximum closing cash balance £'000	289	211	-78	G
Maximum closing cash balance %	1.25%	0.91%	-0.71%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G

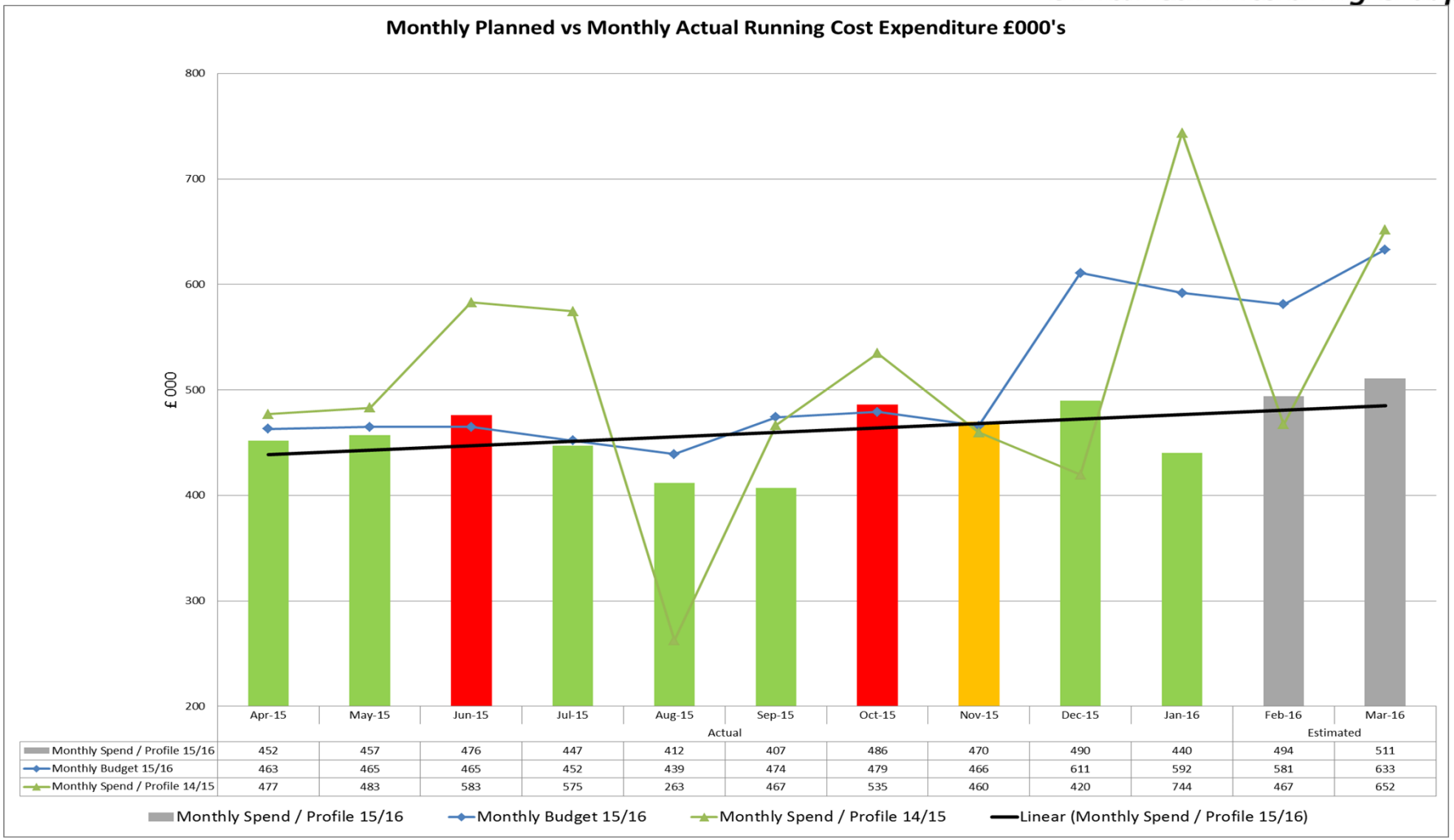
The table below highlights year to date performance as reported to and discussed by the Committee;

		YTD Performance M10			
	Annual Plan £'000	Plan £'000	Actual £'000	Variance £'000	Var %
Acute Services	175,062	145,566	147,292	1,726	1.19%
Mental Health Services	33,997	28,331	28,175	-156	-0.55%
Community Services	33,108	27,590	27,591	1	0.00%
Continuing Care/FNC	13,198	11,136	10,261	-875	-7.86%
Prescribing & Quality	49,936	41,614	40,615	-999	-2.40%
Other Programme	21,028	17,526	19,185	1,659	9.47%
Total Programme	**326,328**	**271,762**	**273,119**	**1,357**	**0.50%**
Running Costs	6,120	4,906	4,537	-369	-7.52%
Reserves	3,244	2,782	1,024	-1,758	-63.20%
Total Mandate	**335,692**	**279,450**	**278,680**	**-770**	-0.28%
Target Surplus(deficit)	5,905	7,005	-	-7,005	-100.00%
Total	**341,597**	**286,455**	**278,680**	**-7,775**	-2.71%

The table below details the forecast out turn by service line

		Forecast Outurn at M10		
	Annual Plan £'000	Actual £'000	Variance £'000	Var %
Acute Services	175,062	177,141	2,079	1.19%
Mental Health Services	33,997	33,834	-163	-0.48%
Community Services	33,108	33,111	3	0.01%
Continuing Care/FNC	13,198	12,050	-1,148	-8.70%
Prescribing & Quality	49,936	48,726	-884	-1.77%
Other programme	21,028	23,324	1,971	9.37%
Total Programme	**326,328**	328,187	**1,859**	**0.57%**
Running Costs	6,120	5,556	-564	-9.22%
Reserves	3,244	949	-2,295	-70.75%
Target Surplus	5,905	5,905	0	0.00%
Total Mandate Spend	**341,597**	**340,597**	**-1,000**	-0.29%


Monthly Planned vs Monthly Actual Programme Expenditure
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£
27,900,000
27,700,000
27,500,000
27,300,000
27,100,000
26,900,000
26,700,000
26,500,000
Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16
Actual
Estimated
Monthly Spend 15/16 27,188,689 27,188,689 27,860,196 27,816,835 27,532,049 27,434,107 27,498,420 27,672,429 27,359,434 27,258,699 27,163,193 27,163,193
Monthly Budget 15/16 27,516,075 27,404,857 27,693,456 27,624,409 27,314,286 27,396,751 27,493,884 27,629,551 27,495,718 26,975,177 27,394,829 27,632,938
Monthly Spend 15/16
Monthly Budget 15/16



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
	Actual										Estimated	
Monthly Spend / Profile 15/16	452	457	476	447	412	407	486	470	490	440	494	511
Monthly Budget 15/16	463	465	465	452	439	474	479	466	611	592	581	633
Monthly Spend / Profile 14/15	477	483	583	575	263	467	535	460	420	744	467	652

2. CONTRACT AND PROCUREMENT REPORT

The Committee received the latest overview of the contract and procurement situation. There were no significant changes to the procurement plan.

3. QIPP

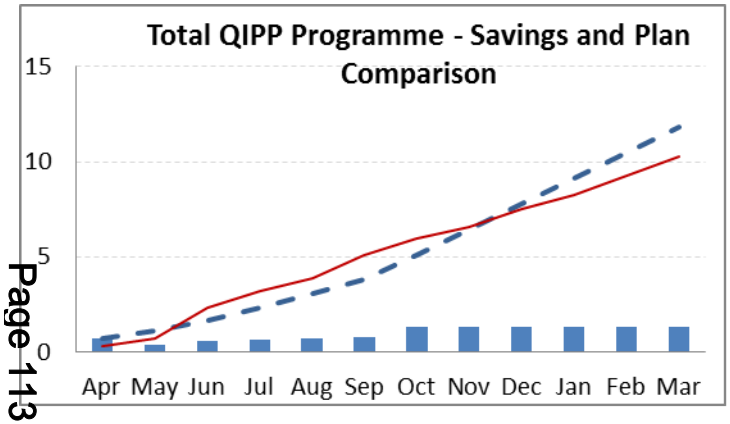
The Committee noted the current position of QIPP Programme performance as at Month 10.

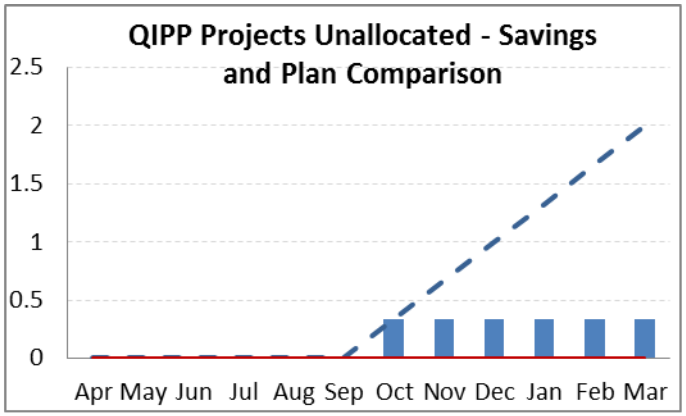
2015- 16 M10

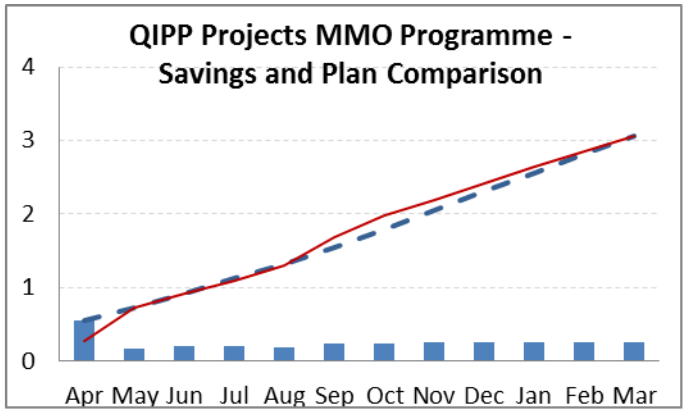
Delivery Board	Current Mth Plan	Current Mth Savings	Variance from Plan	Annual Plan	FOT	FOT Variance from Plan
Modernisation and Medicines Optimisation	2.553	2.643	0.090	3.063	3.060	-0.003
Integrated Care	1.612	2.582	0.970	2.050	3.325	1.275
Primary Care	2.193	1.986	-0.207	2.771	2.455	-0.316
Better Care Fund	1.450	1.045	-0.405	1.914	1.429	-0.485
Unallocated	0.000	0.000	0.000	0.000	0.000	0.000
Other	1.332	0.000	-1.332	2.000	0.000	-2.000
Total	9.140	8.257	-0.883	11.798	10.270	-1.528

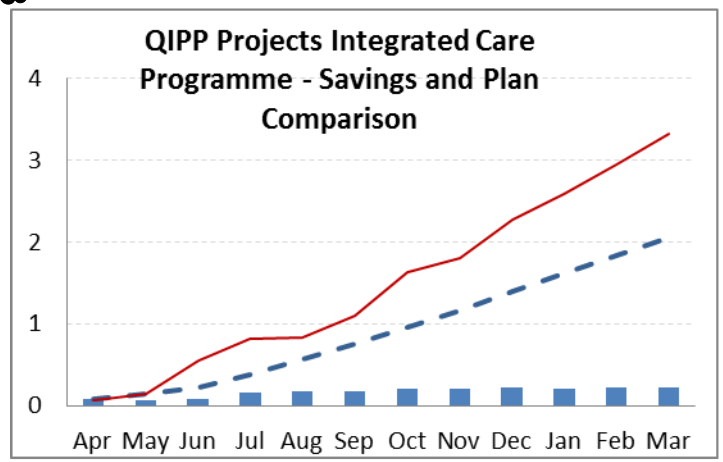
Details of the Savings Plans

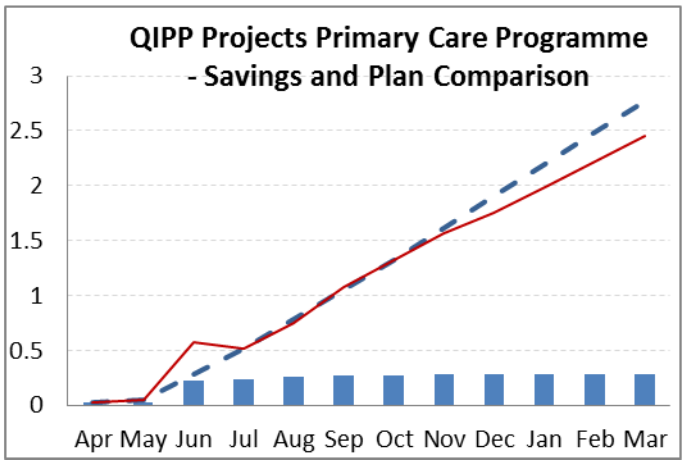
Key: QIPP 15/16 Plan; QIPP 15/16 Plan CUM; Delivered Savings CUM and FOT

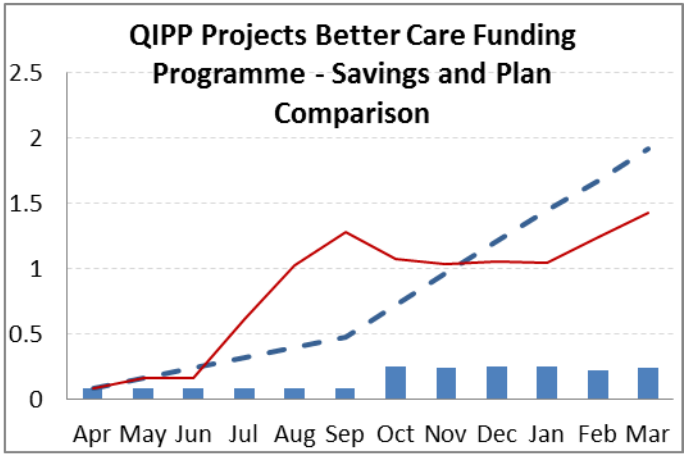












4. PERFORMANCE

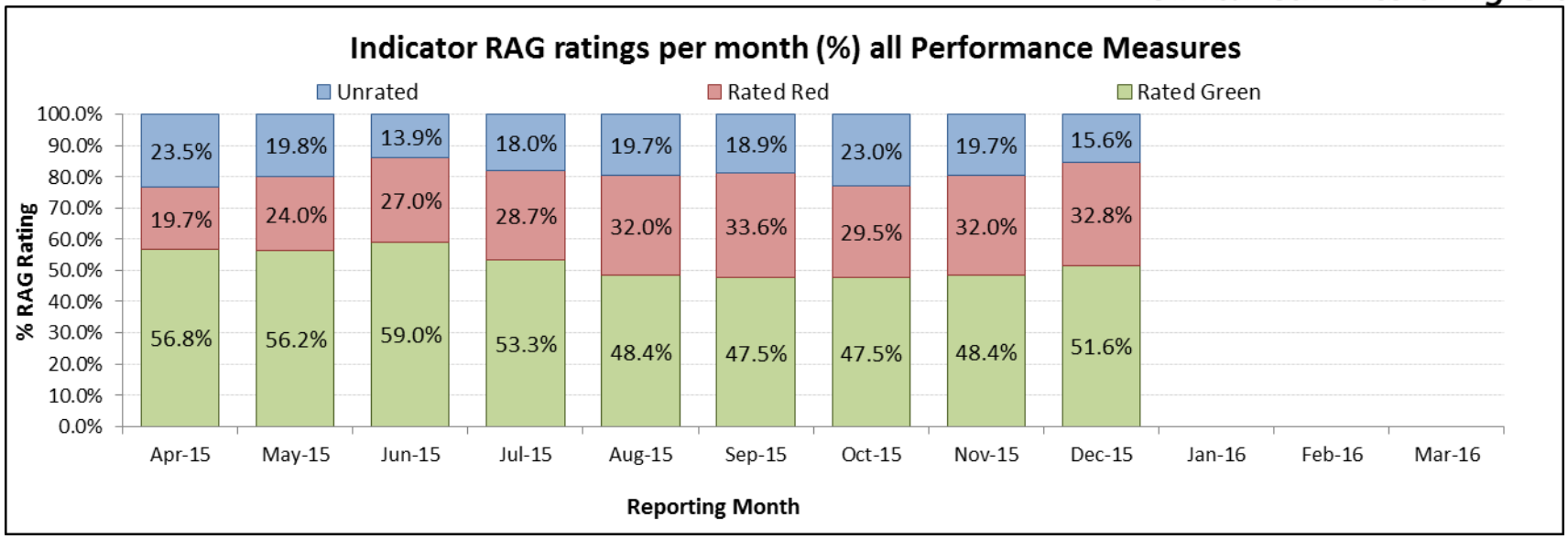
The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Dec-15

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	18	17	10	11	0	0	28
Outcomes Framework	13	17	13	13	11	7	37
Mental Health	28	29	16	16	13	12	57
Totals	59	63	39	40	24	19	122

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	64%	61%	36%	39%	0%	0%
Outcomes Framework	35%	46%	35%	35%	30%	19%
Mental Health	49%	51%	28%	28%	23%	21%
Totals	48%	52%	32%	33%	20%	16%


Indicator RAG ratings per month (%) all Performance Measures
Unrated
Rated Red
Rated Green
% RAG Rating
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
23.5%
19.8%
13.9%
18.0%
19.7%
18.9%
23.0%
19.7%
15.6%
19.7%
24.0%
27.0%
28.7%
32.0%
33.6%
29.5%
32.0%
32.8%
56.8%
56.2%
59.0%
53.3%
48.4%
47.5%
47.5%
48.4%
51.6%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Reporting Month

Exceptions were highlighted as follows;

Executive Summary - Commentary	
Dec-15	
NHS Constitution	
17 of the 28 Indicated areas are rated green. There were 0 unrated indicator(s) -eg. data not received. The 11 red rated areas are :	

Description	Commentary
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 6th consecutive month (81.86% - SQPR report and unconfirmed) against the 90% target. This is a 2.48% increase from the previous month, however, it should be noted that the following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in December at (92.00%). The CCG will continue to monitor Admitted and Non Admitted levels locally.
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 5th consecutive month (92.22% - SQPR report and unconfirmed) against the 95% target. This is a 0.88% decrease from the previous month, however, it should be noted that the following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in December at (92.00%). The CCG will continue to monitor Admitted and Non Admitted levels locally.

Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	This indicator dropped below 90% for the first time since December 2014, breached both in month (88.53%) and YTD (93.07%). Attendances have continued to increase with an additional 1,103 (10.01%) attendances compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. The Trust have issued a Remedial Action Plan (RAP) focussing on the primary drivers for failures in achieving the 95% target e.g. Bed availability, patient flow, delays in patients having first assessment, patients and ambulances arriving in batches and other Emergency Department delays. Several action have been identified to resolve the issues including: improving the suitability of the ED department to manage the current levels of activity, improving flow pf patients in acute medicine, additional support for Ambulatory Care Sensitive Condition patients to support patient flow from AMU beds, improving access to Diagnostics to support patient flow, additional support to facilitate bed management and patient flow, management of patients at first assessment and securing additional staffing capacity. Radiology will provide 24/7 service for A&E radiography and CT scanning (A&E CT head scans will be performed within 1 hour, Inpatient CT scans will be performance within 48hrs unless clinically urgent). To improve bed flow across the Trust a minimum of 20 people are to be within discharge lounge by noon daily by the end of January 2016. Provisional data for January indicates a continued increase in A&E attendances and has only met the daily 95% target three times during the month. The performance calculating at 84.7%. It was noted that the GP in Car pilot ceased 31st December which will increase pressure on emergency services. The RWT public facing website was updated 5th January to provide guidance and urge people to help ease the pressure on the emergency services and promote the NHS 111 service.
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	This indicator has breached the 96% (95.86%) for the 1st time this year. The Trust have identified the failure is due to very few numbers of breaches impacting against a small cohort of patients. The validated figures for December confirm that there were 6 breaches (181/187=96.8%) and is therefore GREEN.
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator failed to meet the 94% target for the second consecutive month (Nov15 = 86.96%, Dec = 86.36%) and YTD (93.39% based on static SQPR submissions, 93.74% on revised submissions). There were 6 patient breaches in December which were all due to capacity issues. The validated figures for December confirm that there were 6 breaches (42/48=87.5%) and is therefore remains RED.

Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	The performance for this indicator achieved the 85% target for the first time this year (85.71%), however the YTD is below target at 75.63%. There were 15 patient breaches during December (6 x Tertiary referrals received between days 28 and 81 of the patients pathway, 2 x Capacity Issues, 2 x Patient Initiated and 5 x Complex Pathways. The Trust have provided a breakdown of performance by speciality for information with the high breach areas as follows: Upper GI (66.67%), Head & Neck (71.43%), Urology (73.81%), Gynaecology (75.00%), Breast (85.19%), Lung (94.74%) and with both Haematology and Skin achieving 100%. A Remedial Action Plan (RAP) has been agreed. Following initial actions from the remedial action plan, December has seen a 7.63% increase in performance from the previous month (78.08%) and has been rated GREEN for the first time this year. The CCG will continue to monitor performance. There is a recognised problem in Urology as there is a national shortage of Urologists - it is noted as a risk to delivery of the RAP as failure to secure sufficient capacity could limit the ability to achieve the trajectory.
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	This indicator has achieved the 90% target for December with 100% performance, however the YTD is still in breach (89.20%). The performance for this indicator is affected by small numbers and performance will be monitored closely for any fluctuations. The validated figures for December confirm that there were 1.5 breaches (29/30.5=95.1%) and therefore remains GREEN.

Rates of Clostridium difficile	The C-Diff performance in Month 9 brings the Year to Date number of breaches to 63 and has already breached the full year threshold set for RWT by NHSE of 35. There were 14 positive cases by toxin test, 6 of these were attributable to RWT using the external definition of attribution. All CDI's are monitored locally at the monthly Clinical Quality and Safety Review Meetings and via the Incident Scrutiny Group. The Trust also provides a regular verbal updates to the CCG Risk and Patient Safety Manager in meetings and during telephone discussions. Outbreak meetings attended by CCG action plan in place (Trust Wide). The Quality and Risk team are awaiting the 48 hours reports regarding these cases. Contractual sanctions will be imposed at year end based on the number of avoidable attributable cases for RWT. C-Diff Action Plan in place (Trust wide) and the CCG are to contribute to the Infection Prevention Control Group meetings. The HCAI Provider data for December indicates that 1 patient was a non Wolverhampton resident (Walsall). The Commissioner view confirms that there were only 5 cases for Wolverhampton CCG in December.
All handovers between ambulance and A & E must take place within 30 minutes	Month 9 breached the zero target with 128 breaches (128 within 30-60minutes, 4 >60 minutes) which follows the same trend increase in numbers over Winter as in previous reporting years, however Dec15 has shown a higher number of breaches (Dec 13/14 = 66, Dec 14/15 = 84, Dec 15/16 = 128). The cumulative position for 15/16 is still ahead of last years position (91 few breaches overall this year). There were no patients who breached the 12 hour target during December. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department It is recognised that ambulances require free cubicles in A&E to able to hand over quickly. Free cubicles are only possible if there is flow within the system. The SRG are focussing on how patients can be discharged more quickly and in a safe manner. The focus is now on reducing delayed transfers of care (Trust to ensure TTO's and discharge summaries are completed as part of ward rounds as soon as possible and the proactive use of discharge lounge), developing a discharge to assess model and improving flow within the hospital system. These should all contribute to freeing up capacity in A&E thus aiding the ambulance handovers. RWT have informed the CCG that batches of ambulances are arriving at A&E which is causing delays in patients being processed. The total fine for ambulance handover during December is predicted at £29,600. This fine is calculated on 128 patients between 30-60 minutes @£200 per patient and 4 patients >60 minutes @£1,000 per patient.

All handovers between ambulance and A & E must take place within 60 minutes	Month 9 breached the zero target with 4 breaches (128 within 30-60minutes, 4 >60 minutes) which follows the same trend increase in numbers over Winter as in previous reporting years, however December breaches are lower than when compared to last year (Dec 13/14 = 0, Dec 14/15 = 21, Dec 15/16 = 4). The cumulative position for 15/16 is still ahead of last years position (15 few breaches overall this year). There were no patients who breached the 12 hour target during December. The following actions were put in place during December : WMAS have received funding for a "Frequent Fliers" project (the GP Practice visit programme targeting A&E "Frequent Fliers" is continuing to end of March) and additional HALO cover funded to assist with handovers at time of pressure. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department It is recognised that ambulances require free cubicles in A&E to able to hand over quickly. Free cubicles are only possible if there is flow within the system. The SRG are focussing on how patients can be discharged more quickly and in a safe manner. The focus is now on reducing delayed transfers of care (Trust to ensure TTO's and discharge summaries are completed as part of ward rounds as soon as possible and the proactive use of discharge lounge), developing a discharge to assess model and improving flow within the hospital system. These should all contribute to freeing up capacity in A&E thus aiding the ambulance handovers. The total fine for ambulance handover during December is predicted at £29,600. This fine is calculated on 128 patients between 30-60 minutes @£200 per patient and 4 patients >60 minutes @£1,000 per patient.
Trolley waits in A&E	There were no 12 hour trolley breaches for December, however this indicator has breached the annual target (zero) with 1 patient breach in June 2015. Multi agency review has taken place, and cross agency action plan developed. Actions are being reviewed and monitored. The Trust were in discussions regarding the 12 hour breach and the fines associated to the breach. They believed that they did everything they could for the patient, and the issues occurred as Mental Health were unable to accept the patient in time. It was discussed as part of the CQRM meeting and confirmed that RWT would not be fined.

Outcomes Framework

17 of the 37 Indicated areas are rated green. There were 7 unrated indicator(s) - eg. data not received. The 13 red rated areas are :

Description	Commentary
Falls per 1,000 occupied bed days	The performance for this indicator has achieved target for the 6th consecutive month. The number of falls (by occupied bed days) remain under the 5.6 threshold. The year to date average has fallen by 1.09 since last month and is now reporting at 3.70. Rapid improvement model undertaken on one of the wards is being reviewed with the intention to roll out. The RWT Falls Steering group in the process of reviewing it's Terms of Reference and membership. Data available has been discussed with governance to identify if there are further trends the Trust can explore from data currently captured. Staff have been identified to attend a regional Citywide falls prevention event and a National best practice event in the forthcoming months. RWT are also looking to implement a "fall safe" event to assist in the re-energising of falls prevention across the Trust.
Electronic Discharge summary to be fully completed and dispatched within 24 hrs. of discharge for all wards excluding assessment units	This indicator has been split for 15/16 into LQR2a (excluding Assessment Units) and LQR2b (all Assessment Units). December data indicates a 0.35% increase in performance to 95.39% for all wards (excluding assessment units). This is the 3rd month standard has been achieved for this indicator. It should be noted that the assessment units (see LQR2b) saw a 2.09% increase from the previous month (85.55%) and is still below target in month. The performance for both indicators remains below target on the YTD performance. A Remedial Action Plan (RAP) has been developed (Dec15 V2) as performance has failed to achieve the desired standard with base ward areas close to compliant every month but with individual factors contributing to non-compliance. Actions include : Review of pathway for regular attenders into clinics to understand requirements around discharge, possible inclusion of patient return (for further investigation/overnight leave etc.), Trust training package and delivery plan, making e-discharge more accessible by moving link to front page of intranet, continue to target areas of poor compliance and weekly performance reports distributed to Divisional Medical Directors. Improvement and maintenance of performance is largely due as a result of a meeting held between Clinical leads from across the Trust to better understand the reasons for non-compliance with e-discharge and with a number of suggestions proposed with a view to improving performance.

Electronic Discharge summary to be fully completed and dispatched within 24 hrs. of discharge for all assessment units (e.g. PAU, SAU, AMU, AAA, GAU etc.)	This indicator has been split for 15/16 into LQR2a (excluding Assessment Units) and LQR2b (all Assessment Units). December data indicates a 2.09% increase in performance (85.55%) for all assessment units but is still below the 95% target. It should be noted that the assessment units (see LQR2a) saw a 0.35% increase in the same month and has achieved standard for the 3rd time in the year. The performance for both indicators remains below target on the YTD performance.
Serious incidence reporting - Report incidences within 48 hours	There were no breaches in December 15, however this indicator has already failed the Year End with 3 breaches. 2015/20802 - June15, Slip/Trip/Fall 2015/22544 - Jul15, Sub-optimal Care 2015/30119 - Sept15, Pressure Ulcer Grade 3 (overturned) 2015/34262 - Oct15, Slip/Trip/Fall
Serious incidence reporting - Update on immediate actions of incident within 72 hours	This indicator did not breach in month however, the Year End total has breached the zero target (currently reporting at 8 breaches for 15/16). Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings.
Serious incidence reporting - Share investigation report grade 2 within 60 days	This indicator has breached both in month (2) and Year End (9) against the zero target for 15/16. The December breaches consist of : 2015/29238 - Category pending (Unexpected Death with on-going investigation) 2015/25934 - Sub-optimal care of the deteriorating patient meeting SI criteria. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. The fine for these breaches is estimated to be £500.

Number of cancelled operations - % of electives	The M9 performance has breached the 0.80% threshold (0.84%) however the Year End is still within tolerance (0.72%). 63 operations were cancelled during December with the highest number attributed to Orthopaedics (21 cancellations, 33.3% of the total). 7 cancellations relate to Cannock Chase Hospital. Breakdown of cancellation reasons for December: 31.7% = Other 28.6% = More Urgent Cases 20.6% = Ran out of Theatre Time 15.9% = No Beds 3.2% = Staffing Issues For Wolverhampton, Electives activity has seen a significant decrease in 15/16, however this has been tempered by the significant increase in Non Elective activity outside of Wolverhampton (Cannock/Staffs) this will have impacted on the outcome of this indicators performance.
% emergency admissions seen and have a thorough clinical assessment by a suitable consultant within 14 hours of arrival at hospital	As per the CRM minutes for June, it has been noted that this indicator has become a Quarterly submission. The December performance has seen an increase (of 1.64 to 96.88%) but is still below the 98% target. Feedback from the Trust indicates that the average is 8hrs, however exceptions affect total percentage e.g. late arrival on a Friday night will not be seen until the next ward round over 14hrs later.
% of specialist roles - named professionals to have up to date level 4 Safeguarding Children training.	This indicator has achieved 100% for every month with the exception of July (66.67%), this means that this indicator has failed Year End. We are awaiting confirmation that the methodology for this indicator is correct (as it has noted that Level 3 training methodology has been incorrect and based on 12 months rolling rather than a 3 year period).

% type 1 A&E attendances where the patient was admitted, transferred or discharged within four hours of arrival.	This indicator is for Surveillance Only. This indicator has breached the 95% target since April and has been reported at 83.91% for December (a 4.94% decrease from previous month). Attendances have continued to increase with an additional 1,103 (10.01%) attendances compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. The Trust have issued a Remedial Action Plan (RAP) focussing on the primary drivers for failures in achieving the 95 % target e.g. Bed availability, patient flow, delays in patients having first assessment, patients and ambulances arriving in batches and other Emergency Department delays. Several actions have been identified to resolve the issues including: improving the suitability of the ED department to manage the current levels of activity, improving flow of patients in acute medicine, additional support for Ambulatory Care Sensitive Condition patients to support patient flow from AMU beds, improving access to Diagnostics to support patient flow, additional support to facilitate bed management and patient flow, management of patients at first assessment and securing additional staffing capacity. Radiology will provide 24/7 service for A&E radiography and CT scanning (A&E CT head scans will be performed within 1 hour, Inpatient CT scans will be performance within 48hrs unless clinically urgent). To improve bed flow across the Trust a minimum of 20 people are to be within discharge lounge by noon daily by the end of January 2016. The SRG have agreed to increase funding to extend the GP in ED until 31st March 2016, WMAS have agreed to extend the HALO's - with the decision makers able to assist the flow within the department and discussions with Staffordshire regarding delayed discharges for Staffs patients are continuing. Provisional data for January indicates a continued increase in A&E attendances and has only met the daily 95% target three times during the month. The Trust are working on actions as detailed within the remedial action plan.
Radiology Reporting (CQ1314_6) - % images reported upon for patients who have had radiological images taken - Results of all direct access imaging diagnostics will be provided to the GP 95% within 10 days	This indicator met the 95% target for December (98.55%). The Year End continues to breach due to below target performance during April, May, September and October. Previous actions of an additional member of staff and implementation of a waiting list initiative appear to have improved performance and reductions in the backlog of patients.

Radiology Reporting (CQ1314_6) - % images reported upon for patients who have had radiological images taken - Results of all direct access imaging diagnostics will be provided to the GP 99% within 20 days after the date of the imaging appointment	This indicator met the 95% target for December (99.83%). The Year End continues to breach due to below target performance during April, May, September and October. Previous actions of an additional member of staff and implementation of a waiting list initiative appear to have improved performance and reductions in the backlog of patients.
The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time	This indicator has already breached the annual target of zero this year due to the 3 previously reported Never Events (retained swab incident in July 2015, wrong side drain and incorrect eye Lucentis injection in September15). Each breach is reviewed at the Contract Review and Clinical Quality Review Meetings. A full RCA will be conducted for each breach with actions and recommendations.

Mental Health

29 of the 57 Indicated areas are rated green. There were 12 unrated indicator(s) - eg. data not received. The 16 red rated areas are :

Description	Commentary
Sleeping Accommodation Breach	The Provider SQPR indicated that there was 1 mixed sex accommodation (MSA) at Edward Street Hospital in May which breaches the full year target of zero. The National Unify return has confirmed that this is attributable to NHS Sandwell and West Birmingham CCG and not Wolverhampton CCG.
Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	This indicator has met the December 2015 performance and reported 97.14% of CPA follow ups within 7 days. However, the indicator is breaching the 95% Year End target (93.18%). The use of daily reports that are produced for all community teams highlighting those patients that have been discharged from hospital appears to have had a positive impact on the performance.

CPA Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	This indicator has breached the 90% target for December (80.00%) and Year End (87.57%). The performance percentage is affected by small number variations and the December drop in performance is due to four patients (4 out of 20 patients). The Trust are to clarify the figures as there have been some queries regarding submissions.
EIS More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral	This indicator has failed the 50% target for each month since April with the December performance at 20% (numerator = 1, denominator = 5). 15 assessment slots unavailable during December due to annual leave and Bank Holidays. Staff training also impacted on availability and one member of staff was on jury duty for 6 days. The EI service continue to experience high DNA's and the service continue to send texts and telephone all new clients as an appointment reminder. Reports have been compiled with findings identified in regards to client reasons for DNAs, if the team are able to address the DNA reason then alternatives can be offered to the need of the client (e.g. travel costs identified, appointments closer to home).
EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed both in month (33.3%) and Year End (35.97%) against a target of 95%. The team continue to offer 100% of referrals an appointment for assessment to meet the 5 day target, however continues to experience high DNA's. The team are continually reviewing the high number of DNAs and exploring ways to reduce them, including contacting clients who DNA to establish the reasons why. A report has been compiled to identify DNA rates and reasons. 15 assessment slots unavailable in December due to staff annual leave and Christmas bank holidays. Staff availability outside assessment clinic slots was also affected by staff attending training and one member of the team out of the office on jury duty for 6 days. The deputy team leader post remains vacant and results in a loss of capacity as the post holder would have a 50/50 split of caseload and management responsibilities. It is worth noting that several attempts have been made to recruit to the post and that the candidate pulled out of the interview scheduled for December.

Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for December (13.6%). This indicator relates to the total number of delay days for the month over the total number of occupied bed days (excluding leave for the month) and is based on the Provider total (All Commissioners) and cannot currently be split by individual commissioner. It has been noted that amendments to previous submission have been received from the Trust and they have confirmed that these are due to data quality improvements. A high number of delays has been reported across the female and Older Adult wards of Penn Hospital. As at the end of December the Trust were reporting 6 delays (4 adults and 2 older adults). 2 of the delays were due to insufficient beds in external providers. The weekly bed management meeting continues to take place with representation from Adult Local Authority and now with regular attendance from P3. The Local Authority Older Adults have confirmed that an attendance rota has been put in place. Winter pressure monies have become available to assist with placing temporary placements quicker. Each individual delay is discussed in detail and agreed actions signed up to on a weekly basis.
Proportion of patients with a Care Plan when discharged from Older Adults Ward	Performance for this indicator achieved 100% against the 95% target for December (based on 2 patients with a Care Plan on discharge). However due to the under performance in April and May, the Year End is below target (87.30%). As there is only 1 Older Adult ward, and due to the small number of patients the performance percentage is greatly affected by any breach.
IAPT Percentage of people who are moving to recovery of those who have completed treatment in the reporting period	This indicator has achieved the 50% target for the 3rd consecutive month this year (56.22%) and is reflective of the changes made to the model of care. Due to the previous months performance the Year End is still below target (45.99%). Discussions have taken place at the CQRM meetings with the Trust regarding the different IAPT model (WCCG commission an IAPT plus service clusters 1 - 7) which impacts on performance levels. Target has been met for the last 3 months and performance will continue to be monitored closely. Any decline in performance will be discussed via the Contract Review meeting.
SUIs Provide commissioners with Grade 1 RCA reports within 45 working days where possible, exception report provided where not met	This indicator failed to meet the 100% target for the first time during August and although have met target every month since, the indicator has breached the Year End target (96.30%).

SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for December 2015, however the YTD has breached the 100% target (96.30%) due to 3 breaches in May. Numbers of serious incidents and RCA's are monitored by the Quality & Risk Team. All breaches are reviewed at the Contract Review and the Quality Review Meetings.
HCAIs IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	This indicator has breached the 95% target for the ninth consecutive month. A Remedial Action Plan (RAP) is in place and further discussions regarding failure to hit trajectory took place on 4th December with the Trust and Sandwell Commissioners. Discussions indicated that this indicator should hit target by 18th December and the Trust have confirmed that by 18th December they had achieved 95.02%, however the SQPR submission does not reflect this achievement and figures have been queried to confirm.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and December has achieved the 85% target for the third consecutive month (91.68%). The Year End performance is below target at 78.64% and the Remedial Action Plan is still in place as covers other Safeguarding indicators.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 3.	Performance for this indicator has seen a steady improvement since June and achieved a significant increase in December (from 68.42% to 83.95%). The Year End performance is below target at 63.25% and the Remedial Action Plan is still in place as this covers other Safeguarding indicators. The Trust previously informed the CCG that they had met target, however the SQPR submission has reported performance as RED. This has been queried via the CQRM meeting.
SAFEGUARDING CHILDREN (WCCG Only) % compliance with staff safeguarding training strategy at Level 4 - Named Professionals.	This indicator has achieved the 100% target for the third consecutive month, however the Year End is still below target (82.34%) due to previous months below target performance and missing data for April, May and July submissions.

SAFEGUARDING ADULTS % compliance with safeguarding adults higher level training	This indicator has seen a steady improvement since June and has achieved 69.68% for December, and although the best performance so far this year, is still below the 85% target. The Year End performance is also below target at 46.80% and the performance is now in line with the Remedial Action Plan trajectory.
SAFEGUARDING ADULTS % compliance with MCA/DoLS training	This indicator has seen a steady improvement since June and has achieved 69.68% for December. Although this is the best performance so far this year, it is still below the 85% target. The Year End performance is also below target at 46.80% and there are on-going discussions with the Trust regarding a Remedial Action Plan to improve performance and the Trust has advised that this indicator is linked to the Adult Safeguarding level 2 training.

5. 16/17 FINANCIAL PLAN AND BUDGET

The Committee was presented with the draft financial plan for 2016/17, noting adherence to the 16/17 planning rules and flagging risks to the financial position.

NHS England confirmed in December 15 that it has set firm three year allocations for CCGs, followed by two indicative years. NHSE have also confirmed that CCG admin allowances (Running Costs) will remain flat until 20/21. The CCG has now received recurrent allocations as detailed below.

£'000	sign	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Programme Baseline Allocation	+ve	325,750	337,458	344,217	351,056	358,352	371,468
Post Mth07 Recurrent Transfers in 15/16	+ve/(-ve)	-	-	-	-	-	-
Primary Care Co-Commissioning	+ve/(-ve)	-	-	-	-	-	-
Running Cost Allocation	+ve	5,556	5,555	5,535	5,515	5,497	5,481
Total Notified Allocation		**331,306**	**343,013**	**349,752**	**356,571**	**363,849**	**376,949**

Draft financial information submitted to the Area is included at Appendix 1 for information.

At the time of developing the Long Term Financial Model (LTFM) a draft National Tariff had been published which includes the efficiency and inflation assumptions stated above. The CCG has applied the draft percentages to tariff based/healthcare contracts. For other budgets the CCG has modelled inflation and efficiency based on trends and local knowledge.

The planning guidance sets out specific business rules which also need to be met as follows;

- Commissioners must plan for a cumulative reserve (surplus) of 1%
- Commissioners must plan to draw down all cumulative surpluses above the 1% in the next three years
- Commissioners must set aside 1% of their allocation for non-recurrent expenditure and this should be uncommitted at the start of the year
- Commissioners must set aside an additional 0.5% as contingency
- Better Care Fund plans for 2016/17 must explicitly support reductions in unplanned admissions and delayed transfers of care
- Maintain the parity of Esteem for Mental Health Services by ensuring growth in spend is at least the same as overall allocation increase (3.65% for CCG)

Within the plan for 2016/17 the CCG is planning to draw down £800k of its cumulative surplus, as the first tranche for reducing its non-recurrent surplus to 1%. The CCG is planning to draw down the cumulative surplus to a residual level of 1% as per the planning guidance.

In order to submit a balanced plan in February the CCG included a QIPP programme of £11.9m, 3.4% of its allocation. This is a stretching target when considering the achievement of QIPP in 15/16 included the more readily available savings.

Risk and Mitigations

In its February return, the CCG identified risks included within the 2016/17 budgets which total £5.5m. After risk adjusting for likelihood of occurrence the risk reduces to £3.75m as detailed in the following table. The key risks are as follows:

- £1.5m related to two issues being (i) the non-publication of the final National Tariff (due March16) which could increase costs over and above planned figures and (ii) the risk of over performance against contracts during the financial year.
- £500k associated with further slippage in the QIPP delivery as contract negotiations have not yet concluded.
- £1.5m associated with BCF where many schemes are transformational in nature and it is prudent to reflect a possible slower than anticipated change in practice.
- £250k associated with service transfers from Specialised Services in terms of tariff changes and volumes of patients. This relates to the Morbid Obesity transfer due in 2016/17.

Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
CCGs				
Acute SLAs	2,000	75.0%	1,500	40.0%
Community SLAs			-	0.0%
Mental Health SLAs			-	0.0%
Continuing Care SLAs			-	0.0%
QIPP Under-Delivery	1,000	50.0%	500	13.3%
Performance Issues			-	0.0%
Primary Care			-	0.0%
Prescribing			-	0.0%
Running Costs			-	0.0%
BCF	2,000	75.0%	1,500	40.0%
Other Risks	500	50.0%	250	6.7%
TOTAL RISKS	5,500	68%	3,750	100.0%

The CCG has identified mitigations to cover 100% of the risk identified as outlined in the table below.

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Uncommitted Funds (Excl 1% Headroom)				
Contingency Held	1,779	100.0%	1,779	47.4%
Reserves			-	0.0%
Investments Uncommitted			-	0.0%
Uncommitted Funds Sub-Total	**1,779**	**100%**	**1,779**	**47.4%**
Actions to Implement				
Further QIPP Extensions	500	35.0%	175	4.7%
Non-Recurrent Measures	800	100.0%	800	21.3%
Delay/ Reduce Investment Plans	500	100.0%	500	13.3%
Mitigations relying on potential funding	500		500	13.3%
Actions to Implement Sub-Total	**2,300**	**85.9%**	**1,975**	**52.6%**
TOTAL MITIGATION	**4,079**	**92.0%**	**3,754**	**100.0%**

- £1.8m - as in 2015/16 the CCG will utilise all of the Contingency reserve to offset overspends if they arise.
- £500k – relates to the Primary Care Reserves held by NHSE. It is important to note that the CCG is currently underwriting the non-sign off of plans for spending 16/17 reserves although this is not deemed to be a significant hurdle.
- £800k – requires the diversion of the planned drawdown to support the bottom line and mitigate risk if overspends arise.
- £500k – further QIPP extension to an already stretched QIPP programme
- £500k – small delay to the Primary Care Strategy implementation.

Conclusions

Whilst the CCG financial plan for 2016/17 meets all the planning requirements and can withstand the mitigation of a certain level of risk there are still a number of variables that, without their resolution, place undue additional risk on the position that may make it undeliverable. In summary these are:

- National Tariff has yet to be finalised (Potential additional cost pressure beyond current estimates is unknown)
- Contract negotiation with main acute and Mental Health providers (RWT and BCPFT) are not yet complete (final contract figures cannot be tested against the LTFM)
- Scale of the QIPP target given that an element is yet to be attributed to specific schemes
- Planning assumption that £800k drawdown will be made available to the CCG in 2016/17. (If not awarded the CCG is limited in its ability to pump prime the Primary Care Strategy).

Given the number of variables requiring resolution the Finance and Performance Committee determined that it would receive a further report at its March meeting once tariff is finalised and contract negotiation is more advanced. The Governing Body will be asked to sign off the 2016/17 budget at its meeting in April.

6. 16/17 QIPP Plan

The Committee received an update on QIPP plans and delivery for 2016/17, including a summary of the proposed QIPP schemes and a risk assessment of their deliverability.

7. 16/17 NATIONAL TARIFF PAYMENT SYSTEM

The Committee received a summary of the 16/17 National Tariff Payment System for information.

8. KEY RISKS AND IMPLICATIONS

Financial Risk
2015/16 Risk
The table below details the current assessment of financial risk for the CCG.

Risks	Potential Risk Value £m
CCGs	
Acute SLAs	0.50
Community SLAs	0.00
Mental Health SLAs	0.00
Continuing Care SLAs	0.00
QIPP Under-Delivery	0.00
Performance Issues	0.00
Primary Care	0.00
Prescribing	0.00
Running Costs	0.00
Other Risks	0.00
TOTAL RISKS	**0.50**

Mitigations	Expected Mitigation Value £m
Uncommitted Funds (Excl 2% Headroom)	
Contingency Held	0.00
Contract Reserves	0.00
Investments Uncommitted	0.00
Uncommitted Funds Sub-Total	**0.00**
Actions to Implement	
Further QIPP Extensions	0.00
Non-Recurrent Measures	0.00
Delay/ Reduce Investment Plans	0.00
Other Mitigations	0.50
Mitigations relying on potential funding	0.00
Actions to Implement Sub-Total	**0.50**
TOTAL MITIGATION	**0.50**

- M10 shows a steady level of risk reported by the CCG following the inclusion of BCF risk at the re assessed level within the overall reported financial position.

- current assessment of risk for the CCG; a gross risk of £0.75 but risk assessed to £0.5m. This has not changed from last month.
- The CCG has identified potential mitigations to the risks identified. The current assessment of mitigations, £0.5m. The key mitigation listed below relates to other non-recurrent flexibilities which have been identified.
- Although this position has not changed from M9 and the CCG is now able to identify sufficient mitigations to cover its risks the position remains very finely balanced.
- In delivering the financial surplus in M10 the CCG has already committed its Contingency reserve of £1.714m therefore this cannot be considered as mitigation.

Future Finance Risk

With reference to the conclusions relating to 16/17 (page 27 of this report) the risk to underlying position, a number of variables are still to be determined (eg tariff and contract negotiation). Position will be clearer at March Finance and Performance meeting.

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.
- **Agree** to receive the 2016/17 budget for sign off at the April meeting

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **24th February 2016**

ATTACHED

Appendix 1 – February 2016 draft finance plan

Revenue Resource Limit

£ 000	2015/16	2016/17
Recurrent	331,306	343,013
Non-Recurrent	10,627	5,905
Total	341,933	348,918

Income and Expenditure

Acute	177,272	176,388
Mental Health	34,744	36,560
Community	33,348	35,080
Continuing Care	11,957	12,447
Primary Care	50,522	55,203
Other Programme	22,628	20,799
Primary Care Co-Commissioning	-	-
Total Programme Costs	**330,472**	**336,478**
Running Costs	5,556	5,555
Contingency	-	1,779
Total Costs	**336,028**	**343,812**

£ 000	2015/16	2016/17
Surplus/(Deficit) In-Year Movement	(3,301)	(799)
Surplus/(Deficit) Cumulative	5,905	5,106
Surplus/(Deficit) %	1.7%	1.5%
Surplus (RAG)	GREEN	GREEN

Net Risk/Headroom		4
Risk Adjusted Surplus/(Deficit) Cumulative		5,111
Risk Adjusted Surplus/(Deficit) %		1.5%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN

Underlying position - Surplus/ (Deficit) Cumulative	(0)	6,700
Underlying position - Surplus/ (Deficit) %	0.0%	2.0%
Contingency	-	1,779
Contingency %	0.0%	0.5%
Contingency (RAG)		GREEN
Notified Running Cost Allocation + Quality Premium	6,120	5,555
Running Cost	5,556	5,555
Under / (Overspend)	564	-
Running Costs (RAG)	GREEN	GREEN
Population Size (000)		252
Spend per head (£)	#DIV/0!	22.07

Key Planning Assumptions

	2016/17
Notified Allocation Change (£'000)	11,707
Notified Allocation Change (%)	3.5%
Tariff Change - Acute (%)	1.1%
Tariff Change - Non Acute (%)	1.6%
Demographic Growth (%)	0.3%
Non Demographic Growth - Acute (%)	2.4%
Non Demographic Growth - Cont.Care(%)	5.7%
Non Demographic Growth - Prescribing (%)	3.0%
Non Demographic Growth - Other Non Acute (%)	1.9%
Mental Health Parity of Esteem	3.8%

Net QIPP Savings

£ 000	2015/16	2016/17
Recurrent (inclusive of full year effect)		11,946
Non-Recurrent		-
Total	-	11,946
% of Notified Resource	0.0%	3.4%
% Unidentified		0.0%

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
9 MARCH 2016

Agenda item 14

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 2 February 2016**
Report of:	Pat Roberts, JCC Chair
Contact:	Pat Roberts, JCC Chair Peter McKenzie, Corporate Operations Manager
(add board/ committee) Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide the Governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee meeting on 2 February 2016
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	To ensure the operations of the CCG align with, support and augment transformational change in the way services are delivered, via the Better Care Fund and co-commissioning of primary care services, to further the preventative and public health agenda and opportunities for early intervention and proactive care through greater integration.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 5:** Delegated Functions	This report provides an update on the work of the Joint Commissioning Committee, through which the CCG exercises delegated functions for commissioning Primary Medical Services

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Joint Commissioning Committee met on 2 February 2016. This report provides a summary of the issues discussed and the decisions made.

2. TERMS OF REFERENCE

2.1. The Committee received and noted the final terms of reference for the Committee and Primary Care Operations Management Group. It was also noted that the amended committee terms of reference will be incorporated into the CCG constitution at the next available opportunity.

3. PRIMARY CARE STRATEGY AND IMPLEMENTATION PLAN

3.1. The Committee were updated on the CCG's Primary Care Strategy that was approved at a Members meeting on 20 January. This included details of work to ensure the CCG has an appropriate management structure to support the implementation of the strategy.

3.2. Details were also given on progress with the development of new models of primary care across Wolverhampton. This includes a pilot project to develop a 'Primary Care Home' model and work between Royal Wolverhampton Hospital and some GP practices to discuss vertical integration.

4. FINANCIAL PLANNING UPDATE

4.1. The Committee received a verbal update from Charmaine Hawker (NHS England) on financial planning for 2016. This included details of allocations for GP services for 2016/17 and the Committee noted that 4.14% growth has been allocated for Wolverhampton, recognising that the CCG area is 6% below target for GP services.

4.2. Financial plans are being developed for 2016/17 in line with the national operational planning process. This will ensure that Primary Care services will be delivered within the overall envelope of NHS England's business rules. It was noted that, due to the deadlines associated with the planning process, assumptions had been made around the level of inflation to be applied through GP contract negotiations. Other in-year costs, including the impact of infrastructure fund costs will also need to be considered.

5. OTHER ITEMS DISCUSSED

5.1. Brief updates were provided by NHS England and the CCG on on-going and upcoming work. The Committee noted that discussions continued to support the development of the CCG's Memorandum of Understanding with NHS England for the operation of the Primary Care Hub. The hub would provide transactional support for delivery of the committee's responsibilities across a range of services.

5.2. Following discussions at the previous meeting, details were circulated around 'Pharmacy First'. The Committee also noted that Karen Helliwell was due to leave her post with NHS England and wished her well in her new role.

5.3. The Committee also met in private session to discuss issues around the procurement of a new GP practice for Showell Park and agreed 'caretaking' arrangements to cover the period should there be a gap between the end of the existing contract and the mobilisation of a new one. Agreement was also given to the addition of a scheme relating to Primary Care Workforce analysis to the CCG's Primary Care Investment Plan.

6. CLINICAL VIEW

6.1. Not applicable.

7. PATIENT AND PUBLIC VIEW

7.1. Not applicable.

8. RISKS AND IMPLICATIONS

8.1. The Committee noted that the Primary Care Workforce analysis would have financial implications for the CCG beyond the period covered by the Investment plan.

9. RECOMMENDATIONS

That the Governing Body Note the Report

Name	Pat Roberts
Job Title	Lay Member for Public and Patient Involvement, Committee Chair
Date:	February 2016

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	Date
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	N/a	
Medicines Management Implications discussed with Medicines Management team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a	
Signed off by Report Owner (Must be completed)	**Pat Roberts**	**23/02/2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – 8 March 2016

Agenda item 15

Title of Report:	**Communication and Participation update**
Report of:	Pat Roberts – Lay member for PPI
Contact:	Pat Roberts and Helen Cook, Communications & Engagement Manager
Communication and Participation Team Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	This report updates the Governing Body on the key communications and participation activities in February 2016. The key points to note from the report are: 2.1.2 **Junior Doctors strike** 2.4.1 **Grant Policy applications**
Public or Private:	This report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	1,2,2a,4
• **Domain 1:** A Well Led Organisation	• Involves and actively engages patients and the public • Works in partnership with others
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	• Delivering key mandate requirements and NHS Constitution standards
• **Domain 2b:** Quality	• Improve quality and ensure better outcomes for patients
• **Domain 4:** Planning (Long Term and Short Term)	• Assurance that CCG plans will be a continuous process, covering not only annual operational plans but the 5 Year Forward View and longer term strategic plans including the Better Care Fund.

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body on the key activities which have taken place in February, to provide assurance that the Communication and Participation Strategy of the CCG is working satisfactorily.

2. MAIN BODY OF REPORT

2.1. Communication – key updates

2.1.1 **Stay Well This Winter** (SWTW) is the single winter campaign from NHS England. It aims to **reduce admissions** via behaviour change among the following cohorts:

- **older people**
- **carers**
- **parents of under-fives**
- **people with long-term conditions**

The campaign will run until the end of March 2016.

2.1.2 **Junior Doctors strike**
Work was prepared to inform all stakeholders and general public of measures taken by the CCG and its providers to ensure delivery of healthcare across the borough during the Junior Doctors Strike Wednesday 10 February. Communications plan completed and signed off to compliment CCG action plan.

2.1.3 **Urgent Care Centre Communications**
A joint communications and engagement plan has been developed to communicate the changes in the urgent care services that will take place on 1 April 2016.

2.2. Communication and Participation framework

2.2.1 **GP Locality meetings** - The following items were discussed:

- Peer Review development
- Clinical networks development
- Residential care home initiative
- Better Care Fund update
- Basket services and minor injuries review

2.2.2 **PPG Chairs and Citizen Forum Groups**
These groups met on 18 February at a combined meeting. Discussion from PPG's focused on recruitment to PPG groups and Access to GP appointments. Presentations were made on: Primary care strategy update, the new Urgent Care Centre, Joint Commissioning with NHSE and Grant policy update. The evaluation of the joint meeting is still being collated.

2.2.3 **JEAG**
The meeting took place in February - The patient themes/issues from: Quality Matters, Healthwatch report, GP Localities, Practice Managers and patient representatives and providers present all provide assurance that the Engagement Framework is fully operational and working well.

2.2.4 **GP Bulletin**
The GP bulletin is now a fortnightly bulletin and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

2.2.5 **Practice Nurse Bulletin**
The first edition of the Practice Nurse bulletin went out in early February and was well received. This will be a monthly e-bulletin which we hope that the Practice Nurses will help to develop.

2.3. **Practice Managers Forum has concentrated on the following:**

- GP new registration process, training and rolled out across practices with the help of the migrant centre
- Interpreter services, introduced and contact details rolled out to all practices to also be used to help in the registration process by phone for the non English speaking patients
- Healthwatch presented the 'Enter and View' programme. What the process was for this, what would instigate this and how they manage complaints from patients and communicate with practices regarding these
- Discussed the primary care strategy
- Discussion around the peer review specification. How this will work, our expectations on the organisation and help and support needed to make it not only worthwhile but to work it alongside our daily jobs
- Training on the foot health portal, also gave a good opportunity to feedback patient and practice comments to the foot health team
- Training and presentation from Public Health on the sexual health tender, introduction and training on how to tender for Public Health Community Services, we have been seen through this process and have had training on the Due North portal
- Updates on Better Care fund, projects and workstreams and the positive impact these will have on primary care services for both patients and staff
- Introduction to Aristotle, risk stratification tool that we will all be using in Primary care to monitor our referral data
- Discussion around safer sharps, how we get hold of the stock of these for primary care. Very few practices are receiving this stock
- Display energy certificates – DEC – we are working together to get these in place
- Regional Manager of NHSE for Capita Primary Care discussed records management changes, online portal for ordering stores and support/registrations advice and guidance

2.4. **Patient, Public and stakeholders views**

Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

2.4.1 **Grant Policy applications**

A workshop was held on Monday 25 January to inform and support small and Third Sector organisations to apply for funding for the financial year 16/17. Applications for services to help to meet the CCG priorities closed on the 9 February and a panel met on the 15 February to assess the applications.

2.4.2 **Engagement Commissioning Cycle**

This meeting took place in February and is forward planning four events on mental and physical health to engage on specific issues for the current commissioning intentions. A 'You said we did' is in preparation to be distributed on last year's engagement in the commissioning cycle. Project leads are requesting patients for particular focus groups on an on-going basis.

2.5. **Lay member's report of key meetings**

The Lay Member has been informed by the Chair of Healthwatch and discussed the changes to local Healthwatch now that the contract will be transferred to Healthwatch Staffordshire in the future. All the staff will/may transfer to the new company and it is very much business as usual.

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.

4. RISKS AND IMPLICATIONS

None to note

5. RECOMMENDATIONS

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

Name – Pat Roberts
Job Title - Lay member for PPI
Date: 23 February 2015

ATTACHED: None

RELEVANT BACKGROUND PAPERS
(NHS Act 2006 (Section 242) – consultation and engagement
NHS Constitution – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)

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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 and Practice View	**N/A**	
Public/ Patient View	**Grant Policy applications**	**09 February 2016**
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (must be completed)	Pat Roberts	23 February 2016

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
QUALITY & SAFETY COMMITTEE

Minutes of the Quality and Safety Committee Meeting held on 12th January 2016
Commencing at 10.30am in the Main CCG Meeting Room, Wolverhampton Science Park

Present:

Dr Rajcholan	(RR)	Board Member, WCCG (Chair)
Manjeet Garcha	(MG)	Executive Lead Nurse, WCCG
Annette Lawrence	(AW)	Quality and Safety Manager
Pat Roberts	(PR)	Lay Member Patient & Public Involvement
Kerry Walters	(KW)	Governance Lead Nurse, Public Health
Marlene Lambeth	(ML)	Patient Representative
Mr Tony Fox	(TF)	Surgeon/Secondary Care Consultant, WCCG
Sarah Southall	(SS)	Head of Quality and Risk, WCCG
Jim Oatridge	(JO)	Lay Member, WCCG
Laura Russell	(LR)	Administrative Officer, WCCG

Part Attendance:

Peter McKenzie	(PMK)	Corporate Operations Manager
Michelle Wiles	(MW)	Information Governance Project Manager
David Birch	(DB)	Head of Medicines Optimisation

Apologies:

Geoff Ward	(GW)	Patient Representative
Gary Mincher	(GM)	Internal Auditor , WCCG
Dr Helen Hibbs	(HH)	Chief Officer, WCCG

Declarations of Interest

QSC451 There were no declarations of interest raised.

RESOLVED: That the above is noted.

Minutes, Actions from Previous Meetings

QSC452 The following amendments were highlighted from the minutes of the Quality and Safety Committee held on 8th December 2015;

Page 4 - Bullet Point 7 regarding Mortality Assurance Review, RR asked if there would be anymore GP awareness taking place.

Page 9 – In relation to the BIA roles it was asked if the roles would be on-going.

Subject to these changes the minutes were accepted as a true and accurate record.

The Action Log from the Quality and Safety Committee held on 8th December 2015 were discussed, agreed and an updated version will be circulated with the minutes.

RESOLVED: That the above is noted.

Matters Arising

QSC453 **Meeting Papers**

Discussions took place in relation to the timeliness of the meeting papers, it was highlighted the difficultness of waiting for data and information from other Colleagues and Providers in order to prepare the reports in time for the meetings. It was also explained that hard copies of papers could be posted once received, however they needed to be mindful papers will be sent gradually and not in one full pack. It was agreed people would prefer full packs. The Committee discussed the issues in relation to how the papers were posted and receiving the papers in readiness to prepare for the meeting.

Therefore, whatever papers have been received by the Wednesday before will be sent and any others submitted late will be e-mailed and a paper copy available at the meeting.

RESOLVED: That the above is resolved.

Feedback from Associated Forums

QSC **a) Draft Governing Body Minutes**

There was no Governing Body Meeting held in December 2015.

b) Health and Wellbeing Board Minutes

The minutes from the Health and Wellbeing Board were shared with the Committee for information.

c) Quality Surveillance Group Minutes

It was reported that discussions had taken place in relation to making the agenda for the group themed to review issues across the region.

d) Primary Care Operational Management Group

The group met for the first time in January 2016, the Area Team were unable to attend. The Group will be in shadow form until the end of February and will go live from March 2016.

e) Draft Clinical Commissioning Committee Minutes

There was no Commissioning Committee Meeting held in December 2015.

f) Clinical Mortality Oversight Group

The meeting had taken place on the 24th November 2015, the meeting was short and discussions took place around making links with the coroner and the work being undertaken locally. It was agreed to send the action notes out with the minutes for the Committees Information.

MG asked TF what Shrewsbury and Telford (SaTH) do they review all deaths, expected as well as unexpected. TF confirmed surgery cases they review as all deaths and it is a standing agenda item for their Governance Meetings.

RESOLUTION: CMOG action log to be shared with Committee, enclosed.

Assurance Reports

QSC455a **Monthly Quality Report**

SS presented the Monthly Quality Report and highlighted the following key points to the Committee;

Royal Wolverhampton NHS Trust

As of the 1st December the Trust were at concern level 2, the areas of concern include;

- Infection Control (Cdiff)
- Pressure Ulcer Prevalence
- Recurring Serious Incidents (Treatment delays)
- Never Events(s)
- Quality Indicators (A&E/Cancer)

SS shared the mitigating actions with the Committee and informed the group an SBAR had been prepared and issued. The CCG are expecting a response at the next Clinical Quality Review Meeting.

- There were 4 new serious incidents reported in December 2015.
- There have been 13 grade 3 pressure ulcers reported in December 2015.
- There has been 1 slip/trip/fall causing serious harm reported by RWT in December 2015.
- The number of confidential breaches has reduced in December with the Trust reporting zero.
- There have been no New Event Events reported.
- The NHS Safety Thermometer remains reporting at 94.32% in November.

- The Friends and Family Test response rates were challenged at the Trusts Clinical Quality Review Meeting. SS will be meeting with the New Patient Experience Lead to discuss the results and what the CCGs expectations are as well as seeking assurances around the Trusts actions of those patients who would not recommend the services.
- Staff turnover has been slowly increasing throughout 2015, this is very challenging for the Trust, with workload and stress levels being the main reasons for staff leaving the Trust.

Black Country Partnership Foundation Trust

- The Trust are reporting at concern level 1.
- There have been 2 serious incidents reported in December 2015.
- There have been no Never Events reported in December 2015.
- The NHS Safety Thermometer harm free care rate for November 2015 was 98.75%.
- The theme of the Clinical Quality Review Meeting in December was Learning Disabilities, there were discussions around incidents types with medication errors on a downward trend. In relation to the workforce, there was total sickness reported at 5.3% in Learning Disabilities Group for September 2015. Discussions took place in relation to Trust merging with Dudley, Walsall and Birmingham and what the implications are for the CCG in relation to Van Guard. A meeting will be taking place to discuss the assurance and planning and SS agreed to update the Committee following this meeting.

RESOLUTION: SS to update the Committee in relation to BCPFT planning and assurance around the BCPFT merging with Dudley, Walsall and Birmingham Community Trust.

Private Sector/Other Providers – Clinical Quality Review Meeting

- The current concern levels as of 1st January 2016 is level 1.
  - Nuffield - The CCG are now working towards a separate contract with Wolverhampton Nuffield Hospital and will invite other CCGs to join the contract.
  - Heantun – there are some concerns around lack of documentation. Notice has been served for the RWT End of Life Service, the CCG will be re-tendering this service.
  - Birmingham's Women Hospital – they will be merging with Birmingham's Children's Hospital, the Committee need to be mindful of the assurance and governance around the merge.

Care Quality Commission (CQC)

- Black Country Partnership – They have not received the formal report from their inspection in November it is anticipated this will be early February, the Trust will review for factual accuracy and comment.

- Royal Wolverhampton Hospital Trust – A response is awaited form CQC in relation to their appeal.
- Poplars Practice –their report has been published, the rating assigned is requires improvement. Actions continue to be taken to improve safety.

User and Carer Experience

- There were no new complaints during December 2015, and two complaints remain on-going.
- Ombudsman Complaint (BCBFT) investigation has now been concluded and the award has been paid.
- From April 2014 to December 2015 there have been 15 formal complaints, of which x3 related to CCG, X4related to commissioning, x3 CHC/IFR, 1x Continuing Care and x4 related to Providers.

Quality Matters

- There were 22 new Quality Matters raised during December 2015 and 7 Quality Matters rejected due to missing information.

Nurse Revalidation

- Action plans for nurse revalidation are currently being worked on by respective providers and are being monitored via CQR meetings.
- Providers continue to review policies and procedures to ensure they are robust enough to support staff.
- National and local training is on-going and training dates have been circulated to all CCG nurses, nurses working within Care Homes and practice nurses within GP surgeries.

WCCG Quality Visits to GP Practices

- The schedule of visits was shared with the group, there were no visits undertaken in December 2015. The visits will provide learning which will be used for the next stage of scheduled visits.
- Latest NHS Friends and Family data (October 2015) puts the % of patients would recommend services in Wolverhampton (88%) on par with regional (91%) and national (89%) results.
- The GP Patient Survey have been published and results are shared within the visit packs and included within future reports.

QSC455b **Information Governance**

MW attended the Committee to present the quarterly Information and Governance Report. MW highlighted there were two documents in which they need the Committees approval, these were as follows;

- IG Staff Handbook ~ to approve the adoption of the handbook for use by all CCG Staff.

- Fair Processing Notice ~ to approve the adoption of this Notice which CCG legal requirement is informing the public on how the CCG manage their data on their behalf.

PR asked how the Fair Processing Notice would be communicated to the public, PMK stated it would be uploaded on to the CCG website. The Committee acknowledged and approved the IG Staff Handbook and Fair Processing Notice.

The bi-monthly report was presented to the Committee, which covers one month's information and a more up to date bi-monthly report will be circulated at the end of January as a lot had progressed throughout the month. The following key points from the report were raised;

- The current IG Toolkit score reports at 52%, by the end of the year they expect to be 92%.
- The information Policy has been discussed at the October 2015 Committee, in which the Committee ratified the IG Policy for further 12 months.
- There has been a huge drive with the Mandatory IG Training as this needs to be completed by the end of March 2016. The current training compliance is reporting at 74% and a further 'mop up' session has been booked for the 21st January 2016. The Governing Body Members have received their training on the 24th November 2015.
- In relation to the Information Risk Management Pan there are concerns there needs to be more asset entries on the system and plans need to be reviewed, if this not improved this will be a major downfall on the IG Toolkit requirements. SS stated that she has had a number of problems with passwords, MW agreed to liaise directly with SS.
- There have been no IG incidents have been reported.
- Information spot checks will take place in January 2016.
- There have been two Privacy Impact Assessments carried out since April 2015, it has been agreed that further awareness are needed.
- There have been no Subject Access Requests since April 2015.

RESOLUTION: MW to liaise with SS to discuss issues regarding access difficulties for the risk management plan.

QSC455c **FOI Report**

PMK presented the FOI report to the Committee which provides the activity for the period of 1st August 2015 to November 2015. The CCG have received 97 requests for information with the majority of the requests being received from Commercial Organisations. There are still issues with the FOIs not being responded to within a timely manner, as there have

been problems with the system and Teams are not responding to the CSU within timescales. PMK highlighted as there are changes within the CSU the way FOIs will be managed in future could potentially change and this is be monitored.

QSC455d **Equality and Diversity Quarter 3 Update**

This item has been deferred to the February Meeting.

RESOLUTION: Agenda Item for February 2016 Committee Meeting.

QSC455e **Medicines Optimisation Update Report**

DB informed the Committee of the progress that has been made against the Medicines Optimisation work programme the key points to note were;

- Healthcare professionals have received communication about safety measures and alerts via the monthly newsletter and/or ScriptSwitch which is an interim measure until Practices have their own systems in place to capture this information.
- A lot of strategic work has been undertaken around the use of inhalers in line with the Wolverhampton formulary.
- Pharmacists have undertaken IMPACT Antibiotic Training and will now be discussing antibiotic prescribing with GPs to help put action plans in place to reduce antibiotic prescribing.
- NHS England have updated the data on the Medicines Otimisation dashboard, in relation to Electronic Prescribing Service Wolverhampton CCG are ahead of other local areas and be above the England average. In relation to Antibiotic prescribing the number of prescription items for antibacterial drugs, Wolverhampton CCG are only slightly above the England's average. RR asked if delayed prescriptions included, DB confirmed all were collected.
- The January Area Prescribing Committee was cancelled.
- In September 2015 the team conducted an audit on electronic discharge letter the report was shared with the Committee. DB outlined the audit criteria and the areas in which GP would struggle to correlate the data especially if patients were in hospital. The area which reported low at 57% was around the 'formulation could easily be identified' as this information was not routinely recorded on the electronic discharge information. Work is being undertaken to address which would be helpful for GPs in order to continue the clinical management of the patient.

A discussion took place around ScriptSwitch the completion of the free text option as this is seen as good medical practice to state the reason for prescribing.

QSC455f **Business Continuity Update Report**

This item has been deferred to the February Meeting.

RESOLUTION: Agenda Item for February 2016 Committee Meeting.

QSC455g **Safeguarding Adults Quarter 3 Update Report**

AL shared the quarterly update with the group and highlighted the following progress;

- Wolverhampton Safeguarding Adults Board (WSAB) met on the 10th December 2016 the minutes were attached to the report for information. The following points were highlighted;
  - A new group has been formed called the Safeguarding Adults Review Committee. Its purpose is to review any outstanding recommendations from Serious Case Reviews (Adults) in order to complete and update the action plans. The (WSAB) also discussed the need to make stronger links between the coroner, MARAC and DHR Standing Panel.
  - The Board received assurance from Wendy Ewins who provided a report on the National Transforming Care Policy. RR asked in relation to her report if the following ages in the following statement were correct, AL agreed to confirm.

    The increasing number of adults with learning disabilities in the City following transition from Children's' Services, often with very complex needs. An example of this is that the current average age in our local Assessment and Treatment hospital for adults is just 21. On a similar date 5 years ago, the average age of the inpatients was 59. [confirmed by LD Commissioner]

  - The WASB development day is due to take place on the 11th March 2016.
  - A regional launch of the West Midlands Multi Agency Safeguarding Policy and Procedures is planned for February 2016.

- MCA/DOLs Project Steering Group met on the 18th November 2015. The presentation on the projects process was shared with the Committee for information.
- Domestic Homicide Reviews (DHR) AL is currently representing on the CCG on the reviews, DHR3 has been published on the 17th December 2015. A number of actions assigned to BCPFT are still open in relation to DHR01 and Kathy Cole Evans will be attending the next BCPFT Clinical Quality Review Meeting to progress outstanding actions.

RESOLUTION: AL to confirm with Wendy Ewins regarding average ages in our local Assessment and Treatment hospital.

QSC455h **Quality Care Homes Quarter 3 Update Report**

MHD informed the Committee of the progress that has been made against the Care Home Improvement Plan during the quarter and stated the following key points;

- The Quality Nurse Advisors have supported the Care Home Mangers with conducting 11 RCA investigations for grade 3 and 4 pressure ulcers during the quarter; this is a reduction from the previous quarter which was 14.
- Participation in the Quality Indicator Survey Monkey questionnaire has increased with 31 homes participating in September, 28 in October and 24 in November. The Quality Nurse Leader is working with the Local Authority to analyse the data received.
- The Clinical Guidelines have been launched to the Care Home Sector at an event in November 2015.
- No progress has been made on the End of Life Care guidelines, this is being considered at the End of Life Care Strategy Group. The Primary Care Macmillan role has now been appointed to.

QSC455i **Board Assurance Framework Report**

SS presented the Board Assurance Framework Report to the committee the following points were raised;

- There were 7 red risks live on the risk register at the end of Quarter 3.
- There are 7 red risks which remain live on the risk register as of 6th January 2016.
- 1 red risk has been added to the risk register since quarter 2, in relation to the 62 day Cancer Waits from NHS Screening Service to first definitive treatment.
- The following risks have been downgraded to amber since the previous quarter –
    - 380 – Eversleigh Care Centre
    - 371 – Financial position 15/16
    - 310 – Better Care Fund, provider commissioner separation
    - 292 – Better Care Fund, principle risk entry
- Risk Management Strategy is currently under review by the Quality and Risk Team and needs to be re-launched and will be shared with the Committee in March.
- The Domain scores were shared and the Committee were asked to note and approve the scores, discussions took place around the level of assurance of the BAF being a live document and the accountability and ownership of staff to update the risks. The Committee had concerns regarding the following three red risks;
    - 295 - Better Care Fund – Financial Risk to CCG of Funding BCF.

- 267 – Tier 4 CAMHS.
- 345 – Children who display sexually harmful behaviour.

It was agreed to raise at the Governing Body as the Committee felt it was not good practice for risks to remain red for long periods of time. As THE Committee had concerns this could be interpreted that the CCG are not taking any action to mitigate the risks, which is not the case.

RESOLUTION: RR to raise at the Governing Body the Committee concerns regarding 3 red risks and the length of time they have remained on the BAF.

QSC455j **Quality and Risk Action Plan**

SS provided the Quality and Risk Action Plan to the Committee for assurance and highlighted progress against items in quarter 3 has been achieved. The following items will continue into quarter 4;

- Risk Management Strategy – a review is underway and will be shared at the March Committee.
- Quality Strategy – implementation is underway.
- Advisory role to LPN chair for commissioning of community pharmacy services that support CCG priorities.
- Compliance of standards against Section 11 of Children Act 2004.

The Committee noted the progress made within the quarter and agreed the 4 exceptions.

RESOLVED: That the above is noted.

QSC455k **Health and Safety Performance Report Quarter 2 and 3**

SS advised the Committee of the CCGs position for quarter 2 and 3, the following routine activities have been undertaken;

- Health & Safety Checklist(s) completed as per plan
- Health & Safety Dashboard maintained no red indicators
- Health & Safety Management Plan/Policy available to managers and teams

SS noted the following key items;

- There has been a review of office seating which has identified a number of chairs need replacing and these have been ordered.
- Options for office space have been explored due to increase of staffing levels.
- A number of issues have been raised with the landlord in relation to the building and maintenance.
- Mandatory Training is due to be completed by all staff by the end of March 2016.

- Staff sickness has increased and HR are supporting Managers.

RESOLVED: That the above is noted.

QSC455l **National Reports and Inquiries**

SS confirmed that the following updates have taken place since September 2015;

- Robert Francis & Culture Change in the NHS - updated
- Rotherham Inquiry – updated & proposed for closure
- Lampard (Saville) – updated & proposed for closure

Forthcoming updates are as follows:-

- Cavendish Review – Review into Healthcare Assistants & Support Workers in the NHS & Social Care Settings
- Winterbourne View
- Freedom to Speak Up (Francis)

A further update will be made to the Committee in April 2016

RESOLVED: That the above is noted.

Items for Consideration

QSC456a **Terms of Reference Review**

The Terms of Reference was shared for the Committee to review; PR suggested the quoracy needs to be amended to reflect Governing Body concerns to ensure there is a clinician in attendance. It was agreed by the Committee any further comments need be sent to SS for inclusion.

RESOLUTION: Any comments for the Terms of Reference to be sent to SS.

Polices for Consideration

QSC457a **WCCG Serious Incident Policy**

AL presented the WCCG serious incident policy which has been through Senior Management Team and endorsed by NHS England. The Committee was asked to approve the Serious Incident Policy, it was formally approved.

RESOLVED: That the above is noted.

Items for Escalation/Feedback to CCG Governing Body

QSC458a The Committee asked for the BAF and its accountability to be raised.

RESOLVED: That the above is noted.

Any Other Business

QSC459a **Antibiotic Awareness Day**

ML raised her concerns around the communication for this event, it was a highlighted the event was a joint event in conjunction with RWT and was help publicised.

RESOLVED: **That the above is noted**

Date and Time of Next Meeting

QSC460a Tuesday 9th February 2016 at 10.30am – 12.30pm, CCG Main Meeting Room

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 28 January 2016
Commencing at 1 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~		**Present**
Dr J Morgans (JM)	Chair	Yes
Dr K Ahmed (KA)	Wider Health Community/Practice Representative	No

Patient Representatives ~

Malcolm Reynolds (MR)	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall (SM)	Director of Strategy & Transformation	Yes
Claire Skidmore (CS)	Chief Financial Officer	Yes
Manjeet Garcha (MG)	Executive Lead Nurse	No
Viv Griffin (VG)	Assistant Director, Health Wellbeing & Disability	No
Juliet Grainger (JG)	Public Health Commissioning Manager	Yes (Part)

In Attendance ~

John Ferguson (JF)	Interim Head of Contracting & Procurement	Yes
Vic Middlemiss (VM)	Head of Contracting & Procurement	Yes
Sarah Fellows (SF)	Mental Health Commissioning Manager	Yes
Sarah Southall (SS)	Head of Quality & Risk	No
Sharon Sidhu (SSi)	Head of Strategy & Transformation	Yes
Hemant Patel (HP)	Deputy Head of Medicines Optimisation	Yes (Part)
David Birch (DB)	Head of Medicines Optimisation	Yes (Part)
Laura Russell (LR)	Observer	Yes

Apologies for absence

Apologies were submitted on behalf of Dr Ahmed, Manjeet Garcha, Sarah Southall and Viv Griffin.

Declarations of Interest

CCM446 DB declared an interest in Item CCM454 – Medication Reviews in Nursing/Residential Homes and advised that his wife works for the service provider.

RESOLVED: That the above is noted.

Minutes

CCM447 Minutes of Commissioning Committee held on Thursday 26 November 2015 were accepted as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM448 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

CCM449 (CCM431) End of Life Business Case – It was confirmed that a regular reporting mechanism has been identified and the Business Case strengthened. Action closed.

(CCM443) Commissioning Committee Annual Report 2015/16 – This has been shared with patient representatives. Action closed.

(CCM444) Commissioning Emergency Care Pathways – It was confirmed that dialogue will take place between GPs and consultants, to clarify the pathways. Action closed.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM450 The Committee was presented with an overview of contract performance for Month 7 and 8 (October and November).

Outstanding contracts for signature:

- BSMH contract now signed. Therefore all outstanding contracts signed.

Royal Wolverhampton NHS Trust

Percentage of A&E Attendances where the patient was admitted transferred or discharged with 4 hours.

The Trust managed to achieve 90.35% (Oct) and 92.04% (Nov) against a 95% target. Continuity of performance remains being monitored through the System Resilience Group (SRG) on a monthly basis.

A contract performance notice has now been issued to RWT to reach and maintain 95% moving forward. CCG will enact GC9 for failure to achieve these from January 2016 resulting in a 2% withholding of A&E budgets.

Cancer Targets

The Trust achieved 74.30% (Oct) and 78.08% (Nov) against an 85% target. The evidence suggests the areas of concern continue to be around urology and tertiary referrals on the 62 day target.

A contract performance notice has now been issued to support the recovery of the target.

Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers, the Trust achieved 96.00% (Oct) against a 90% target but fell to 89.47% in November.

Referral to Treatment within 18 weeks (September and October data)

Overall the Trust are achieving 92.23% (Oct) and 92.04% (Nov) against a target of 92%. However at a speciality level the trust are failing to achieve the following areas:

- 84.72% (Sep) and 86.09% (Oct) in General Surgery.
- Oral surgery 86.27% (Sep) and 82.08% (Oct)
- 90.69% (Sep) and 90.92% (Oct) in Trauma and Orthopaedics
- 87.29% (Sep) and 85.26% (Oct) in Urology

This represents a worsening position for the Trust on these specialities although the headline is being met. The Trust has given assurances in relation to actions being taken to improve performance through an updated action plan.

Other contract Performance Notices

E- Discharge – RWT

The Trust achieved 95.03% (Oct) and 95.04% (Nov) against a target of 95%.

For all assessment units the Trust achieved 84.88% (Oct) and 83.46% (Nov) against a target of 95%.

An updated remedial action plan has been agreed with a revised trajectory.

Contract Variations

RWT contract variations

1. Chemotherapy – signed by WCCG, RWT and several collaborative commissioners. Still outstanding from other CCGs.
2. WHIP – CVO retracted, will be invoiced separately and modelled for 16/17.
3. CVO for neuro rehab relating to SESSP to be distributed and seeking agreement at next contract meeting.

Performance/Sanctions

The 2015-16 total sanctions levied to date £837,770.00

Activity & Finance - Acute

Month 7 Acute – October

Month 7 and highlights variance against the plan which with a current position of an over performance currently at £6.5m with Cannock equating to £6.5m Wolverhampton equating to a positive position of £0.44m

- 10 Specialties of over performance with the highest being General Surgery and General Medicine

- Under performance is being seen in 28 specialities – equating to £5m of underspend. T&O currently continues to be the top underperforming speciality - £2.2m (11%). Rheumatology £918k under plan (19%) and Clinical Oncology £330k under plan (25%)

Month 8 Acute – November

- Top 10 Specialties equate to £8.0m of over performance with the highest being General Surgery and General Medicine.

- Under Performance is being seen in 27 specialties – equating to £5.5m of underspend. T&O currently continues to be the top underperforming specialty £2.6m (11%) under plan despite continuing to be over plan in PBR Emergency. Rheumatology £1.0m under plan (19%) and Clinical Oncology £379k under plan (26%).

Activity & Finance – Community

Month 7 Community – October

- Community Matrons is now £175k above plan YTD
- District Nursing is now £128k over plan, down from £176k above plan YTD at month 6.
- CICT Rehab also continues to over perform at £62k in month 7
- The tolerance marginal rate has been implemented and this is included within the overall contract performance figures.

Month 8 Community – November

- Community Matrons continues to be the top over performing specialty, and is now £183k above plan YTD
- District Nursing is now £177k over plan.
- CICT Rehab also continues to over perform although over performance has dropped from £62k over in month 7 to £56k in month 8.
- Information requests and RWT front line discussions on-going with CCG commissioners to greater understand the variance to activity.

Black Country Partnership Foundation Trust (October and November updates)

Action plans are in place for the following areas and are being monitored through the Contract Quality Review Meeting.

- Early Intervention Services
- CPA
- Safeguarding training. A remedial plan is now in place.
- BCPFT Mandatory Training for Infection Prevention and Control. A revised trajectory has been agreed plus fines if not settled.

Activity and Finance

A refresh of the Price Activity Matrix is being debated between the CCG and the provider to ensure that pricing and activity is appropriate going forward.

RESOLVED: The Committee noted the contents of the update report and it was acknowledged that an update report will be submitted to the next meeting in relation to WCC Public Health procurement for Sexual Health Services.

Use of Aflibercept for Patients with Wet AMD

CCM451 The Committee was presented with a report, for assurance, in relation to the mandatory introduction of NICE TA294 – Aflibercept (Eylea) for the treatment of Wet Age Related Macular Degeneration (Wet AMD).

All patients with wet AMD are treated with Ranibizumab (Lucentis®) according to NICE guidance TA155. Aflibercept is licensed for wet AMD and has been approved by NICE, July 2013; NICE technology appraisal (TA) guidance 294. Currently patients and clinicians have accessed the treatment via the prior approval mechanism within the IFR process.

A small cohort of patients that are currently being treated with Ranibizumab for wet AMD are failing to respond to treatment and would benefit from switching to Aflibercept. Over the course of the treatment use of this medicine would reduce the number of injections and monitoring visits required by each patient. Aflibercept is therefore used in lieu of Ranibizumab in these patients only and not in all patients. No switching of treatment is expected for those patients currently prescribed Ranibizumab where the treatment is providing visual improvements.

In accordance with NICE guidance new patients should be offered the choice of treatment following a discussion with their clinician. RWT predict 15% are likely to be prescribed Aflibercept.

Total savings for Wolverhampton CCG over two years equal £58,692.

RESOLVED: Commissioning Committee noted the contents of the report and were assured by the mandatory requirement to introduce the use of Eylea (Aflibercept) for the treatment of Wet AMD in line with NICE TA 294.

West Midlands Specialised Collaborative Commissioning Oversight Group – West Midlands Regional Familial Hyper Cholesterolaemia

CCM452 The Committee was asked to consider the commissioning proposal from the West Midlands Specialised Collaborative Commissioning Oversight Group, for a West Midlands Regional Familial Hypercholesterolaemia Service.

In June 2015, the West Midlands Strategic Clinical Network (SCN) put forward a bid to the British Heart Foundation (BHF) as part of their opening for a second round of funding applications. The SCN, in collaboration with local clinical colleagues, were successful in securing £375,000 from the BHF to support the introduction of a West Midlands regional FH service. The funding will cover the cost of 5 specialist FH nurses for a period of 18

months only. The bid made clear at time of submission that CCGs needed to pick up all other costs including exit costs for nurses after the 18 months, full genetic testing costs and clinic infrastructure costs. The bid needed to be submitted in a short time period, so the bid was made without this being agreed with CCGs.

The regional approach will maximise quality across the region and minimise costs. The service will be hosted by UHBFT with linkage to the Rare Disease Centre at the QEH. The host organisation will provide governance, administration, nursing, management and IT support. The cohort of specialise BHF FH specialise nurses will run peripatetic clinics in the West Midlands region, each nurse covering the populations served by a number of lipid clinics, to optimise equity is geographical access and service efficiency. They will primarily undertake provision of the regional cascade screening service in primary care settings rather than acute hospital settings to deliver care closer to patient needs and ensure maintenance of close links to the patient's primary care provider.

Implementation Costs - £90,000 over a 4 year period and business case indications are that eventually this service would become cost neutral in the short term.

The Committee considered the following recommendations:

- The proposed West Midlands model of care for the identification and management of FH.
- The host arrangements for the service should be via UHB as the regional centre.
- The funding of FH specialist Nurses post BHF funding.
- The funding for genetic and cascade testing.
- The share of funding for phase 1 in year 1 - £15,625 and in year 2 - £20,997.

RESOLVED: Commissioning Committee agreed in principal to the recommendations but requested assurance on cascade arrangements once the service is in place.

MASH Service Specification

CCM453 A report was presented to the Committee which recommended that WCCG commission a service to ensure health representation within the Wolverhampton MASH and it was recommended that the Committee approve the Service Specification.

RESOLVED: The Committee approved the recommendations in principal, subject to finance and the activity element of the Service Specification being completed.

Medication Reviews in Nursing and Residential Homes

CCM454 The Committee received a report that recommended a long term plan for medicine reviews in Nursing and Residential Homes.

The Integrated Care Programme Board has taken into account the potential for integrating medication reviews within the LIS for the Residential Care Home Business Case in 2016/17 to avoid duplication and included input from both Medicines Management and Finance.

Feedback received indicated that there will be no duplication with other medication reviews taking place as this service focuses on polypharmacy and provides the opportunity to optimise as well as 'de-prescribe', which clinicians can be reluctant to do. Two new studies have been published in JAMA Internal Medicine recently to support this.

Funding was not secured until July 2015 for this financial year and ends March 2016. Savings made in October were £12,184. Year to date gross savings are £35,633.

Currently, three primary care pharmacists conduct medication reviews using MARS charts and care plans and a brief GP summary calculating risk versus benefit of current medications. Clinical leadership is provided by a Consultant Geriatrician and he writes to each GP with any recommendations/suggestions for change. The decision to accept those recommendations ultimately rests with the GP; however, approximately 90% of recommendations are implemented by the patient's GP. (See attachments 1/2).

The team have been visiting both nursing and residential homes.

Previous funding approved and savings to date:

Year	Funding received	Net Savings made
2013/14	£40,896	£80,823
2014/15	£40,896	£84,882
2015/16	£30,672 (9 months due to delay in securing the funding)	Gross Savings made July to October £35,633

Savings to date are based on a five month period, and during that time the Consultant worked alone for 2 months so the activity is lower. However, the expectation is that this service will continue to make savings or be cost neutral.

Finance has reviewed the way in which savings are currently calculated. In the current method, savings are based on a 12 month period. Their concern is that savings are being counted which may run into the next financial year. Medicines Optimisation base their calculations on a 9 month period which Finance felt was a better approach.

It was recommended that this project becomes a mainstream contract and sits within the Medicines Optimisation budget, with the caveat that the role of the Consultant Geriatrician is written into the Service Specification.

RESOLVED: The report was well received by the Committee and recommendations were approved in principal subject to further information about the procurement process and criteria for assessment being included in the Service Specification.

Any Other Business

Repatriation of Patients Receiving Immunosuppressive Drugs Post-Transplant to Specialist Centres

CCM455 The Committee was presented with a paper on behalf of the West Midlands Specialised Collaborative Commissioning Oversight Group to request support for repatriation of patients, receiving immunosuppressive drugs post-transplant, to specialist centres.

RESOLVED: The Committee supported the request and agreed that responsibility for buying immunosuppressive drugs will transfer to the Trust.

Date, Time & Venue of Next Committee Meeting

CCM456 Thursday 25th February 2016 at 1pm in the CCG Main Meeting Room.

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 26th January 2016
Science Park, Wolverhampton

Present:

Mr J Oatridge	Independent Committee Member (Chair)
Mrs C Skidmore	Chief Finance and Operating Officer
Mr S Marshall	Director of Strategy and Transformation
Mr M Hastings	Associate Director of Operations
Dr D Bush	Governing Body Finance and Performance Lead

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer (part meeting)
Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mr J Ferguson	Interim Head of Contracting and Procurement
Mr P McKenzie	Corporate Operations Manager
Mrs H Pidoux	Administrative Officer

1. Apologies

Apologies were received from Mr Mincher.

Mr Oatridge introduced Dr Bush and explained that as from the February meeting he would be taking over as Chair of this Committee. The Governing Body has agreed that, following Dr Handa's resignation, Dr Bush would take over the role as Governing Body Finance and Performance Lead.

2. Declarations of Interest

FP.16.01 There were no declarations of interest.

3. Minutes of the last meeting held on 24th November 2016

FP.16.02 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.16.02 Item 81 (FP.15.116) – External Placements Panel (Children) – on agenda – item closed.

4. Matters Arising from the minutes of the meeting held on 24th November 2016

FP.16.03 There were no matters arising from the minutes of this meeting.

5. Finance Report

FP.16.04 Mrs Skidmore introduced the Month 9 report, the close of Quarter 3. She explained that based on these figures a first draft set of full accounts has been produced as a test run for year end. It was noted that this will be reported to the CCG's Audit and Governance Committee in February.

Mrs Skidmore highlighted that there is nothing fundamentally different being reported in Month 9 and the CCG is expecting to meet all financial requirements at end of year. However there are 3 areas of concern as follows;

1. RWT Overperformance – a prudent view has been taken in setting the Forecast Outturn assumptions for 2015/16, however, the activity levels are not as high as expected and the assumption is being scaled back.
2. Better Care Fund (BCF) – this is an improved position in month 9, however, figures recently received from the Local Authority (LA) suggest that the position may have worsened significantly. The LA has been asked to review the figures and the forecasting methodology in preparation for month 10 reporting. Broader strategic discussions are also taking place regarding the BCF Pooled Budget.

Mrs Sawrey joined the meeting.

3. Slippage in QIPP Programme – discussed in more detail in agenda item 7, QIPP Report.

Mrs Skidmore clarified that whilst it expected that all targets will be met further work is required to ensure all non-recurring spend occurs as planned before year end. The Committee was made aware that Mrs Skidmore is involved with discussions with NHS England Area Team (NHSE AT) regarding options to manage surplus monies.

Mrs Sawrey raised with the Committee that the contents and requirement of this report were reviewed 12 months ago and asked whether the Committee would like any amendments. It was agreed that the report should be reviewed following the sign off of the final accounts. It was noted that Practice Level reporting will need to be considered as part of the review.

Resolved: The Committee;

- Noted the contents of the report.

6. QIPP Report

FP. 16.05 Mrs Sawrey presented the QIPP report. The annual QIPP plan is £11.8m. The QIPP Forecast Outturn has decreased slightly from last month, as a result of the validation of activity levels, to £10.2m (a gap of £1.6m). It was noted that the changes involved are not material.

Mrs Sawrey explained that Transactional QIPP is doing well; mainly achieved by savings related to CHC, however, the opportunities for these savings to be made is reducing. Therefore, Transformational QIPP, (e.g. service transformation), savings need to increase and this will be a focus in 2016/17.

Resolved: The Committee;

- Noted the contents of the report and the concerns raised.

7. Monthly Contract/Performance Report

FP.16.06 **Contract and Procurement**

Mr Ferguson reported the contractual process is being followed with providers where performance is declining.

It was highlighted that the RWT year to date sanctions has led to fines of £837,770.00

Resolved: The Committee noted the contents of the report.

FP.16.07 **Performance**

Mr Bahia reported that at Month 9, of the indicators, 59 are green and 39 are red. There are in total 122 indicators, 24 of which are for information only. The following key points from the report were highlighted;

- RTT (Referral to Treatment 18 Weeks) – Performance continues to meet headline targets. Three specialities are underachieving; Urology, General Surgery and T&O. Recovery trajectories have been implemented for General Surgery and T&O to be achieved by March 2016. The recovery plans for Urology are dependent on recruitment which is a national problem. A Remedial Action Plan (RAP) is in place for the recruitment issues to be resolved by July and this has been supported by NHSE. It was noted that the Trust has tried to recruit to 2 posts but was unsuccessful. Clarification was given that patients cannot be referred elsewhere as waiting times are similar across the health economy.

It was noted that Mrs Skidmore and Mr Marshall have recently met with RWT directors and offered £400k to be used this year to reduce waiting lists, however, a response from RWT has not yet been received.

A discussion took place regarding the promotion and use of Choose and Book at a locality level to encourage awareness of capacity available elsewhere.

Mrs Sawrey left the meeting.

- A&E 4 hour waits – failed to meet target in November and provisional data for December performance indicates a significant decline in performance with the lowest single day performance to date reported in December. Attendances have continued to increase compared with the same period last year. A new model of care was introduced following the opening of the Urgent and Emergency Care Centre (UECC) on 25th November and there have been significant issues affecting performance including increases in volume, batches of ambulances arriving at the same time and issues with logistics and patient flow. It was noted that bed capacity and discharges have improved. A RAP has been issued and recovery trajectory is on target.

Mrs Sawrey re-joined the meeting

- Cancer waits (62 Day Wait indicators) – there are several issues including Urology and Tertiary referrals. A Contract Performance Notice has been issued and a RAP approved with a trajectory date of June 2016. It was noted that the target was met in December, however, this may be because of patients choosing to delay procedures until the new year). Wider services/parties have been included in the RAP which is a good start to an approach to include whole health economy management.

- DTOC (Delayed Transfer of Care) – An improvement has been seen with the indicator meeting target in November (excluding Social Care delays). It was noted that there is an increase in Step Down which has a cost for the CCG and this is being challenged.

A query was raised regarding the high rates of Clostridium difficile cases. Clarification was given that there are 2 types of cases; unavoidable (where a patient has CDiff on admittance) and avoidable (where it is contracted in hospital). Reporting is 3 months behind due to

investigation into each individual case with which the Quality and Safety Team are involved and these are traced through the Clinical Quality Review Group.

Resolved: The Committee;

- Noted the contents of the report.

8. External Placements Panel (Children) update

FP.16.08 Mr Marshall reminded the Committee that a report was presented and discussed at the November meeting. There were previous concerns regarding the level of assurance given and the aim of this report was to give an update on the planned financial outturn and provide assurance of the matters in hand to provide appropriate financial and clinical governance.

Mr Marshal reported that the CCG has a legacy situation with regard to the funding arrangements for externally placed young people whereby there is a recharge of 40% of the total cost of the package. The spend is variable due to movement of or new patients.

A new process has been agreed in principle and is being finalised with the Local Authority. This will provide a greater transparency of the governance of financial commitments and clinical oversight to the CCG. Prior to each placement a full health (physical and psychological) needs assessment of each Child or Young Person (CYP) will be undertaken, an appropriate provider will then be identified and the placement monitored regularly. This process is due to be finalised in January, with a view to a full implementation by 1st April 2015. This process will be reviewed six months from implementation.

It was highlighted that there are discussions taking place regarding some of the charged elements which the CCG is challenging.

Mr Oatridge commented that whilst the previous report to the Committee gave clinical and quality assurance this report was relating to finance and did not go as far as providing financial assurance'.

Resolved: The Committee;

- Noted the contents of the report
- Took assurance that the process to be implemented shortly will give assurance regarding the governance around procurement transparency of the packages and will give a clearer financial understanding.

9. Finance and Activity Plans for 2016/17

FP.16.09 This report was brought to the Committee to provide an overview of the key requirements of the 2016/17 planning round and an outline of the timetable.

Mrs Skidmore stated that this was discussed in high level detail with the Governing Body prior to this meeting.

Mrs Sawrey highlighted that there are 3 submissions of the 2016/17 Operation Plan as follows;

- First full draft submission 8th February
- Second full draft submission 2nd March
- Final submission aligned with contracts 11th April

In addition to the national timetable further submissions are required by NHSE.

The CCG is also required to produce a Sustainability and Transformation Plan, STP, which is a 5 year plan covering from October 2016 to March 2021. This is an economy wide plan and is due to be submitted in June.

A concern was raised by Mrs Skidmore that the National Tariff is only out as draft and will not be finalised and available until very close to the end of the current financial year. It was clarified that activity levels can be agreed with the Trust without knowing costs; however, this poses a risk to the CCG with regard to managing the overall budget.

Mrs Skidmore gave the Committee a briefing on the key highlights of the allocation and business planning rules confirmed by NHSE and noted that a number of items have now been included within the baseline. It was noted that commissioners must plan for a cumulative reserve (surplus) of 1% and must plan to draw down all cumulative surpluses above the 1% over the next 3 years.

There are concerns regarding the level of the QIPP target required in 16/17 and work is on-going to review growth and cost pressure assumptions in the current Long Term Financial Model (LTFM).

It was noted that although the QIPP target for savings has not been met this year, it is the highest level of savings achieved so far by the CCG. There are also a significant amount of QIPP schemes already being worked up for 2016/17 and contract negotiations are well underway; and assurance can be taken from this.

Draft budgets and an updated plan will be shared at the February Committee meeting in readiness for the Governing Body sign off of budgets in March. It was highlighted that due to the uncertainty of the timing of/receipt of finalised tariff figures and the Governing Body meeting schedule, this will either be at the meeting due to be held on 8th March or at an additional meeting which may be required alongside the Development Session planned for 22nd March.

Resolved – The Committee;

- Noted the key requirements and outline timetable of the 2016/17 planning round.

- Agreed to highlight to the Governing Body the challenges posed by the reporting deadlines and uncertainty regarding tariff.

10. Quality Premium

FP.16.10 The Committee was given an update on the Quality Premium achievements for 2014/15 based on the provisional results received. A payment of £564,000 has been received by the CCG. It was noted that the spend must occur in the 2015/16 financial year and the following plans were discussed;

- Immigration Population Project – work with Public Health. 2 components to ensure registration and initial screening.
- Respiratory Innovation Promoting a Positive Live experience (RIPPLE) – this is a roll out programme with the Health Foundation to increase support for patients with COPD with third sector providers.
- Equipment for Primary care – practices have been asked to bid for clinical equipment and these will be reviewed.

It was highlighted to the Committee that the CCG performance was the highest in the Birmingham and Black Country area.

Resolved: The Committee noted:

- The amount received and the plans to spend this by 31st March 2016.
- The level of achievement on the Quality Premium for 2014/15 against other local CCGs.

11. Recruitment of Lay Member of the Finance and Performance Committee

FP.16.11 This report was brought by Mr McKenzie to ask the Committee to consider appointing an additional (non-Governing Body) Lay Member to support the development of the Committee by adding an additional impartial strategy viewpoint to aid challenge and discussion.

Mr Oatridge explained that due to the timing of the meetings, this role had already been considered by the Remuneration that morning and an appropriate level of remuneration for the role agreed. The cost of which will be met from the CCG's running costs. Mr Oatridge, Dr Bush and Mrs Skidmore were in attendance at that meeting.

Resolved: The Committee:

- Agreed to appoint a lay member of the Committee in line with the role description attached to the report.
- Agreed to proceed with the recruitment process outlined in the report.
- Noted the Remuneration Committee's agreement on the appropriate level of remuneration for the role.

12. Any other business
FP.16.12 there were no items raised under any other business.

13. Date and time of next meeting
FP. 16.13 Tuesday 23rd February 2016 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 20th October 2015 commencing at 11.30 am
In Main Meeting Room, Science Park, Wolverhampton

Attendees:

Members:

Mr J Oatridge	Chairman
Mr P Price	Independent Lay Member (part meeting)
Mr L Trigg	Independent Lay Member

In Regular Attendance:

Mr J Kelly	Local Counter Fraud Specialist, WMAS
Mr AC Larby	Deputy Head of Audit and Assurance, WMAS
Mr P McKenzie	Corporate Operations Manager, WCCG
Mr G Mincher	Internal Audit, WMAS
Mr H Rohimun	Executive Director, E&Y LLP
Mrs C Skidmore	Chief Finance and Operating Officer, WCCG
Mr M Surridge	Senior Manager, E&Y LLP
Mrs H Pidoux	Administrative Officer, CCG

In Attendance

Mrs S Southall	Head of Quality and Risk, WCCG (part meeting)

Apologies for attendance:
AGC/15/81 No apologies for absence were submitted.

Declarations of Interest
AGC/15/82 There were no declarations of interest.

Minutes of the last meeting held on 21st July 2015
AGC/15/83 The minutes of the last meeting were agreed as a correct record.

Matters arising (not on resolution log)
AGC/15/84 There were no matters arising.

Resolution Log
AGC/15/85 The resolution log was discussed as follows;

- Item 48 (AGC/15/7) – Conflict of Interest Policy to be reviewed in 12 months' time – it was agreed to bring a draft review to the October meeting – on agenda – action closed.
- Item 56 (AGC/15/15) – A Counter Fraud Strategic Governance Readiness Assessment – self review to be submitted by the 31.7.15 deadline. Forward looking plan with actions to be brought to October meeting – on agenda – action closed.

RESOLUTION: Resolution log to be updated accordingly.

Chief Internal Auditor Progress Report

AGC/15/86 Mr Larby reported that, in compliance with the Public Sector Internal Audit Standards (PSIAS), Walsall Council Internal Audit Services undertook an independent validation of WMAS self-assessment of compliance against PSIAS.

In the subsequent report some notable areas of good practice were identified, including;

- the use of an own electronic working paper system ("Aardvark") to record compliance with PSIAS; and
- comprehensive in-house procedure manuals available to all internal audit staff providing guidance on the processes to be followed.

A number of suggestions for improvement were made in order to enhance compliance; these broadly related to three areas:

- including reference to the public sector interpretations and requirements (where applicable) for each standard in our self-assessment;
- additional references to our procedure manuals being added to the evidence section of the self-assessment, and
- minor updates to the Internal Audit Charter and procedure manuals so that they fully reflect the requirements of the standards.

Mr Larby stated that based upon the suggestions for improvement an action plan has been compiled to address all of the points raised in the report.

Mr Mincher gave an update on the audit work currently being undertaken. Draft reports are being discussed with management relating to financial systems, budgetary control and financial reporting. Mr Mincher reported that the assurance rating for Human Resource processes, at the time of the report was written, was 'requires improvement', however, further evidence has been received which has change the opinion to 'substantial'. Examples were given of the evidence received to support this change of opinion. This report is now being reviewed by management,

It was highlighted that a review of prime financial policies has taken place and suggested changes have been accepted by the Finance and Performance Committee.

A final review and assessment of the CCG Constitution prior to its submission to NHS England (NHSE) is due to commence.

Discussion took place relating to the review of the CCG's arrangements for managing the financial risk on Continuing Health Care (CHC) budgets, in particular that 92% of credit notes (£68,427) from care homes were in respect of overcharges for patients who had died or were no longer eligible for NHS funded care. Information regarding patients, for example deaths or changes of address, is no longer received from the Registrations Team at NHSE due to information governance issues. It has been suggested by Internal Audit that CHC could use the Exeter system. Mrs Skidmore clarified that this is not a material or high risk to the CCG. Mr Kelly reported that he is carrying out an audit into registration updates.

It was agreed that the information in the report relating to CHC should be shared with the Finance and Performance Committee. The Head of Individual Care to be invited to attend to discuss the issues at that Committee.

A point was raised suggesting that it would be useful going forward for the report to include how the overall plan for the year is progressing against target. It was agreed that this would be included in future reports.

RESOLUTION: The Committee noted the updates given.

Management Action Plan Update

AGC/15/87 Mr Mincher shared with the Committee the current position. Since the July meeting 3 of the amber recommendations have been closed. However, there are currently 5 amber recommendations as 3 have been added since that report.

Mrs Skidmore stated that the report has been considered at the Senior Management Meeting that morning and gave the following updates;

- Quality Framework – assurance given that this in on the agenda for the November Quality and Safety Committee and no extended slippage is expected.
- Formulary sub-group - review of Medicines Optimisation within CCG governance structure has taken place. Intentions will be finalised shortly.

- Gap analysis to establish action plan to ensure compliance with March 2015 NICE guidance – formal contract routes are being followed. Have written to RWT and escalated through contract.
- Contract monitoring procedure in respect of IGT level 2 – decision awaited from NHSE, beyond CCG control.
- Role of Corporate Chief Finance Officer (CCIO) should be clearly defined – discussion has taken place around restructuring management team. The specification for this role has been embedded in a job description which was taken to Senior Management Team.

RESOLUTION: The Committee:

- Noted the contents of the report and current position.

Audit Charter

AGC/15/88 Mr Larby informed the Committee that following discussions at the July AGC meeting, paragraph 7.2 of the Charter has been updated.

RESOLUTION: The Committee:

- Noted the amendments made to the charter as indicated.

Local Counter Fraud Specialist Progress Report

AGC/15/89 Mr Kelly updated the Committee on the activity undertaken since the last AGC meeting.

- Counter Fraud newsletter was issued in August
- Mr Kelly had attending the CCG staff meeting in September and given a fraud awareness presentation
- A proactive exercise has commenced looking at the possibility of care homes continuing to submit invoices for patients that are deceased.
- An issue has been raised relating to a pharmacy in Wolverhampton, which has made a charge for a special prescription which was not special. The details and next steps were discussed. There has been a previous investigation into this pharmacy and it expected that this allegation will be taken further. Clarification was given regarding the terminology in the report.
- Meetings have taken place between Mr Kelly and Mrs Skidmore to discuss the NHS Protect Standards for Commissioners including how the CCG can raise the overall score. An action plan has been prepared and was shared with the Committee.
- Self Review Tool (SRT) submission was made on 31st July 2015 to NHS Protect. The overall SRT score was AMBER.

RESOLUTION: The Committee;

- Noted the contents of the report and the work currently being undertaken and the exercises due to commence.
- Noted the overview of the NHS Protect Intelligence Update- Statistical Fraud Taxonomy Report for 1/4/14-31/3/15 circulated for information.

Fraud, Bribery and Corruption Standards for Commissioners, Self Review Tool (SRT) and CCG Workplan

AGC/15/90 Mr Kelly reminded the Committee that as part of an annual return the CCG must complete and submit to NHS Protect a self-review tool (SRT) detailing counter fraud activity undertaken in order to comply with the standards for commissioners. As previously reported this was submitted on 31st July 2015 with an overall rating of AMBER.

Mr Kelly reported that he had met with Mrs Skidmore to create an action plan in order to improve the compliance within each standard and ultimately improve the overall rating. This will be used to inform the counter fraud work plan for the rest of the year.

The aim is to maintain performance in areas well rated and, where it is possible, make improvements. It was felt that some improvements can be made reasonably easily and quickly, however, some areas are out of the control of the local counter fraud services as they are based on the work done by the CSU.

Clarification was given in relation to the Red ratings in section 4 'Hold to Account'. These will always remain red unless the CCG has a case to report and investigate.

Mrs Skidmore commented that where the measure is 'embeddedness' there needs to be appropriate time elapsed to allow a process to embed.

The Committee noted that an AMBER rating would be expected for most organisations and External Audit would take assurance at this whilst maintaining an oversight of the key messages.

Mr Kelly with support from Mrs Skidmore will continue to review the actions and work towards proactively addressing the issues. Drafts will be brought back to this Committee in appropriate timeframes. The review will be referenced in the Annual Governance Statement

RESOLUTION: The Committee;

- Noted the outcome of the SRT and the actions being undertaken to proactively address the issues where appropriate.

Mrs Southall joined the meeting.

External Audit Plan

AGC/15/91 Mr Rohimun introduced the report which provides the Committee with a basis to review the proposed audit approach and scope for the 2015/16 audit in accordance with auditing stands and in line with the Committee's service expectations.

Mr Rohimun gave an overview of the proposed approach to be taken and highlighted the areas of audit focus based on initial assessment of the CCG's key business and financial statement risks. The Committee was asked to consider and feedback back if there was anything else that should be included.

He reported that a meeting has been held with Mrs Skidmore to discuss the plan and the key risks identified.

Assurance was given that all key data protection requirements are met in relation to data analytics tools. It was clarified that no personal data is used and parameters can be set to exclude this information from data searches. Assurance was also given that information used for past audits is not retained.

Mr Surridge explained that there are two significant risks which will be considered as part of the audit;

- Fraud and management override risk.
- Risk of fraud in revenue recognition.

Two other financial statement risks that will be considered as part of the audit are:

- Operating within the Revenue Resource Limit
- Better Care Fund (BCF) – Pooled Budget

It was raised that as the BCF is a significant new arrangement there is a risk that the CCG's share of the pooled budget will not have been accounted for correctly and that anticipated benefits will not be realised in accordance with original plans. Mr Surrige stated that if any concerns arose during the process these would be raised with the AGC and any risks identified but not highlighted in the plan would be taken forward.

A question was raised regarding Governance Arrangements and working with Wolverhampton City Council External Auditors. Clarification was given that EY's focus is to ensure that the CCG accounts are correct. A value for money conclusion will be made as to how bodies are working with other organisations. If there are any concerns other external auditors can raise these with EY. Mr McKenzie stated that governance of the BCF is covered in a section 75 agreement and includes audit details.

Cybercrime was discussed and whilst external audit consider high level control, more assurance in this area is taken through the internal audit

route. If weaknesses were identified during the external audit work this would be raised.

RESOLUTION: The Committee noted the scope of the external audit plan.

Risk Register Reporting/Board Assurance Framework

AGC/15/92 Mrs Southall presented the Committee with a summary of red risks and risk scores as at the end of Quarter 2. She noted that this report has been to the Quality and Safety Committee where it was discussed in detail and no significant concerns were identified. The report is also regularly discussed with Senior Management Team.

Mrs Southall gave an overview of the current red risks and the one new risk added since the end of Quarter 1.

Mr Price questioned the process relating to downgrading a red risk. It was clarified that this must have director approval and these are reviewed monthly at SMT.

Mrs Southall stated that proactive work is being undertaken to reduce the amount of overdue risks and a process is in place for the Quality and Safety Team and Directors to regularly review risks.

Mr Trigg commented that it would be useful, in the table showing the number of risk entries and their status, to show a comparison between Quarter 1 and Quarter 2.

RESOLUTION: The Committee noted

- The contents of the report and actions being undertaken.
- The table showing the number of risk entries and their status, to be revised to show a comparison between Quarter 1 and Quarter 2.

Mrs Southall left the meeting.

Annual Governance Statement

AGC/15/93 Mr McKenzie shared with the Committee an overview of the initial considerations and work being undertaken to prepare the Statement for 2015/16. He reported that there were no major concerns and that more detailed work would take place when national guidance is issued. An updated draft will be shared with the Committee at the February meeting.

RESOLUTION: The Committee noted the current draft and will expect to receive a further draft in February.

Review of Conflict of Interest Policy

AGC/15/94 Mr McKenzie reminded the Committee that it reviewed this policy last year and signed it off in January 2015. That review took into account best practice from other areas of the public sector and refreshed guidance from NHS England, which was issued to support CCGs in preparation for the advent of Co-Commissioning of Primary Care.
The process for managing conflicts of interest forms part of the assurance process being followed by NHS England and no concerns have been raised regarding the CCG's arrangements.

The register of interest has been refreshed and staff members and Governing Body have been provided with training on the content of the refreshed policy, their responsibilities and sources of advice and guidance. Reminders were given regarding the recording of the receipt of gifts and hospitality.

A review of the policy has commenced and whilst it is not anticipated that major changes are required, it is important to ensure the policy remains fit for purpose and takes into account any additional best practice.

Mr McKenzie asked the Committee to review the Policy and to forward any comments to him prior to an updated Policy being brought to the February meeting.

RESOLUTION: The Committee;

- Noted the Assurance given to NHS England on the operation of the CCG's arrangements for managing potential conflicts of interest.
- Noted the proposed arrangements for reviewing the policy.
- Agreed to forward any comments regarding potential revisions on the policy to Mr McKenzie.
- Will receive updated draft at the February meeting.

Prime Financial Policies

AGC/15/95 Mr McKenzie reported that due to the timetable of meetings and the deadline for submitting changes to the Constitution to the NHS England Area Team, these have already been taken to the Governing Body.

He confirmed that all the comments he had received had been considered and were included in the revision.

The Governing Body signed off the revised policies and approved the variation to the Constitution. These will be submitted to NHS England as part of the revisions to the Constitution.

RESOLUTION: The Committee noted and agreed that the revised version of the CCG's Prime Financial Policies is included in the application to vary the constitution to be submitted in November 2015.

Financial Control Environment Assessment (FCEA) Submission and update on actions

AGC/15/96 Mrs Skidmore reminded the Committee that at the July meeting she brought information regarding this assessment and the change to the Assurance Regime by NHSE.

Mrs Skidmore reported that she and the Deputy Chief Finance Officer (DCFO) met with NHSE to present the CCG's assessment of the FCEA. Robust and legitimate challenges were made by NHSE on the self-assessment ratings. There were 5 out of the 18 sections where NHSE required further evidence to support the CCG rating or the CCG agreed to a different rating. A further meeting was held between the DCFO and NHSE to review the evidence provided by the CCG and the final ratings were agreed. It was noted that there was minimal change in the ratings.

Going forward the CCG will be required to reassess ratings at regular intervals and will need to maintain good standards and records to maintain and improve ratings where possible. This will form part of the revised assurance process.

Mrs Skidmore stated that this had been a useful process particularly the action plan included in the FCEA.

Updates will be brought back to the AGC as appropriate and work will continue to maintain the current position and improve in areas as required.

RESOLUTION: The Committee

- Received assurance from the update and outcome of the assessment.
- Noted the action plan.

Mr Price left the meeting.

Continuation of Financial Risk Share Agreement

AGC/15/97 Mrs Skidmore informed the Committee that as part of the FCEA process the NHSE Area Team had requested that the agreement, which had been implemented at the inception of CCGs, should be updated and resigned.

The agreement is with Dudley and Walsall CCGs and is the governance solution to an agreed risk share if required.

The agreement is being taken to the AGC of each of the CCGs and reaffirmed and resigned by each of the three Chief Finance Officers.

RESOLUTION: The Committee noted and supported the continuation of the agreement.

Losses and Compensation Payments – Quarter 1 2015/16

AGC/15/98 The CCG has not recorded any losses during quarter 2 of 2015/16 and has not made any special payments during the same time period.

RESOLUTION: The Committee noted the contents of the report.

Suspension, Waiver and Breaches of SO/PFPs

AGC/15/99 There have been no suspensions of SO/PFPs.

1 waiver has been raised during quarter 2 which relates to the extension of the contract with the Interim Children's Commissioner until the role is filled on a permanent basis in December. Clarification was given that the extension was required due to issues with recruitment which have now been resolved. A concern was raised regarding the amount paid for the interim arrangements. Assurance was given that it was felt that this has given value for money due to the level of work provided by the interim.

PFP breaches continue to relate mainly to Continuing Health Care packages which are generally unavoidable.

RESOLUTION: The Committee noted the contents of the report.

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

AGC/15/100 The Committee noted that as at 30th September there were:

- 2 sales ledger invoices greater than £10k and over 6 months old.

The Committee noted that overall, aged debt has reduced significantly since quarter 1 due to the settlement of a number of outstanding debts with Wolverhampton City Council and Black Country Partnership Foundation Trust.

- 15 purchase ledger invoices greater than £10k and over 6 months old.

It was highlighted that the two outstanding invoices with NHS Property Services relate to 2014/15 charges and the CCG has been in regular contact to try resolve these. A response to the CCG's latest communication is awaited.

Ten of the remaining invoices were issued by RWT. The CCG is actively chasing resolution to the queries that are preventing payment being made.

RESOLUTION: The Committee noted the contents of the report and updates given.

Guidance for setting up an Audit Panel

AGC/15/101 Mrs Skidmore explained that the guidance has been circulated for information only. An update including timelines for setting up the panel and the structure will be brought to the next meeting. Endorsement will be sought from the Governing Body.

RESOLUTION: The Committee;

- noted the guidance and process being undertaken.
- Agenda item for next meeting.

Any other business

Proposed dates for 2016 Committee meetings*

AGC/15/102 The dates for 2016 Committee meetings were confirmed as follows;

- 23rd February
- 19th April
- 24th May (Annual Report, Accounts and Governance Statement sign off)
- 19th July
- 15th November

*All meetings will be held on Tuesdays at 11.00am in the main meeting room, CCG Offices, Science Park.

Date and time of next meeting

Tuesday 23rd February 2016 at 11.00am in the CCG Main Meeting Room, Science Park

Signed:

Dated:

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 10 February 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Sandra Samuels OBE	Chair, Cabinet Member for Health and Wellbeing
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Paul Singh	Shadow Cabinet Member for Health and Wellbeing
Alan Coe	Chair Wolverhampton Safeguarding Board
Ian Darch	Third Sector Representative
Simon Hyde	Chief Superintendent West Midlands Police
Linda Sanders	Strategic Director, People
Steven Marshall	Director of Strategy & Transformation
Dr Arko Sen	Wolverhampton Healthwatch
Jeremy Vanes	Chairman The Royal Wolverhampton NHS Trust

Employees

Carl Craney	Democratic Support Officer
Richard Welch	Head of Community Recreation
Manjeet Garcha	Executive Lead Nurse
Juliet Grainger	Substance Misuse Commissioning Manager
David Loughton	Chief Executive of Royal Wolverhampton Hospital NHS Trust

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Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence had been received from Karen Dowman (Black Country Partnership NHS Foundation Trust), Dr Helen Hibbs (Wolverhampton City Clinical Commissioning Group), Cllr Val Gibson (City of Wolverhampton Council), Tim Johnson (City of Wolverhampton Council), Professor Linda Lang (University of Wolverhampton), Cllr Roger Lawrence (City of Wolverhampton Council) and Cllr Elias Mattu (City of Wolverhampton Council) together with Viv Griffin (City of Wolverhampton Council).

2 **Notification of substitute members (if any)**
Steven Marshall attended as a substitute member for Dr Helen Hibbs (Wolverhampton City Clinical Commissioning Group).

3 **Declarations of interest (if any)**
No declarations of interest were made relative to matters under consideration at the meeting.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 2 December 2015 be confirmed as a correct record subject to the addition in Minute No. 1 of "Alan Coe – Independent Chair, Wolverhampton Children's and Adults Safeguarding Boards" as having submitted an apology for absence.

5 **Matters arising**

With reference to Minute No. 8, ("Beat the Streets" initiative), Ian Darch advised that he had expressed his concerns at the previous meeting on the perception of the voluntary sector in relation to the process for commissioning the "Beat the Streets" initiative especially in the light of the funding cuts experienced by that sector. Ros Jervis, Director of Public Health, explained that "Beat the Streets" was a national initiative and could only be delivered by that company. She advised that the voluntary sector would play an integral role in delivery of the Obesity Action Plan and many other such initiatives. Ian Darch commented that he understood that the Public Health Funding Settlement had yet to be announced but that in the event that this would lead to further reductions in funding of the voluntary sector that any information be made known at the earliest opportunity. Linda Sanders, Strategic Director – People confirmed that the Public Health Funding Settlement had yet to be announced and commented that the "Beat the Streets" initiative was a national brand which could be delivered quickly.

Resolved:

That a meeting be held between Ian Darch, the Director of Public Health and Richard Welch, Head of Service for the Healthier Place Service to discuss this matter further.

With reference to Minute No. 10 (Better Care Technology), Dr Arko Sen suggested that optimum use need to be made of technology across the health and social care economy. The Strategic Director – People advised that technology was used across a range of services and its use was not confined to older people.

6 **Chair's Update**

The Chair, Cllr Sandra Samuels OBE reported that the official launch of the "Beat the Streets" initiative had been launched formally at Woodthorne School that morning. She reminded the Board that currently within the city 34.5% of adults and 65% of young people were classed as inactive. The initiative would run for seven weeks from Wednesday 24 February to Wednesday 13 April 2016 and that on-line registration for the scheme would be available from 15 February 2016.

190 Beat Boxes would be fitted across the city and 60,000 cards would be distributed. Up to 30,000 would be distributed to schools that registered for the scheme and the remainder would be available from distribution points which were at a variety of facilities including community centres, leisure centres, Phoenix Health Centre, the Civic Centre and the Wolverhampton Art Gallery. As at Friday 5 February 2016 45 schools had signed up to the initiative.

She advised that maps indicating the location of Beat Boxes were available for inspection together with examples of the fliers which were to be used to publicise the

initiative. The objective of the initiative was to encourage children and young people to become active and also to encourage parents out of their cars with children walking to school. The Director of Public Health reported that registration was open to teams and groups as well as individuals. Ian Darch asked whether there was any material available which could be distributed by the voluntary sector.

Resolved:

That a copy of the hyperlink together with a supply of fliers be forwarded to Ian Darch for onward transmission to voluntary sector organisations.

The Chair reported that she had attended, as an observer, a meeting held in January 2016 of the Wolverhampton City Clinical Commissioning Group (WCCCG) where discussions had been held in relation to funding and capital projects. She had raised the lack of General Practitioner (GP) facilities in the Whitmore Reans area. Subsequently, a bid had been made by the WCCCG to upgrade the facilities at the Whitmore Reans Health Centre.

The Chair reported on an outbreak of Novovirus at New Cross Hospital which had affected two Wards. David Loughton CBE Chief Executive of the Royal Wolverhampton NHS Trust advised that the outbreak had been spasmodic and was now relatively under control. He reported that the opening of the new Accident and Emergency Centre had created sufficient additional bed space to enable Wards to be closed and a deep clean exercise to be undertaken. The Director of Public Health commented that similar outbreaks had been experienced by many Acute Trusts across the country and on the excellent working relationship between the Council and the Trust's Infection Prevention and Control Team.

The Chair reported that she had attended a meeting of the National Tuberculosis (TB) Board when it had been considered whether the issue of TB should be included within Joint Strategic Needs Assessments (JSNA's). She advised that treatment was currently available for TB at the Refugee and Migrant Centre. Funding was available for patients to be screened at the Refugee and Migrant Centre with a target of 125 patients being screened from Wolverhampton and Walsall by the end of March 2016. Consideration was also being given to screening for Hepatitis at the Refugee and Migrant Centre.

Resolved:

That the Director of Public Health draw to the attention of the JSNA Working Group the possible inclusion of the issue of TB within the emerging JSNA.

The Chair reported on the problems with the Zika virus and that 3,893 cases which had been experienced in Brazil. A Briefing Note had been prepared by the Director of Public Health to appraise Councillors of the issue and the information was also available to employees. Dr Arko Sen commented that it had yet to be confirmed that mosquitos were the source of the problem. The Director of Public Health confirmed that the cause of the problem had yet to be confirmed and on the need to provide clinicians with the latest information. She reported that the Public Health Team was working closely with the Acute Trust and the Clinical Commissioning Group on the dissemination of relevant information.

The Chair reported on the future governance partnership arrangements for the Black Country NHS Partnership Foundation Trust, following a period of consultation, a combined partnership between the Black Country Partnership NHS Foundation Trust, Birmingham Community Healthcare NHS Trust and Dudley and Walsall Mental Health Partnership Trust had been agreed. This was a constructive move that would ensure the sustainability of Mental Health Services across the Black Country and beyond and bring with it both clinical expertise and economies of scale.

At the invitation of the Chair, the Director of Public Health reported on a broad healthy lifestyle survey was being undertaken on a face to face basis with 9,000 residents. The purpose of the survey was to enable a greater understanding of lifestyle choices.

Resolved:

That a further report on the initial results of the survey be submitted to the next meeting.

7 **Summary of outstanding matters**

Resolved:

That the summary of outstanding matters be noted.

8 **Health and Wellbeing Board Forward Plan 2015/16**

Resolved:

That the report be received and noted.

9 **Better Care Fund 2015/16 progress report and 2016/17 outline plans**

Steven Marshall, Director of Strategy and Transformation, Wolverhampton City Clinical Commissioning Group presented a report on the development and progress of the Better Care Fund including progress with the Dementia and Mental Health Workstreams and the outline plans for 2016/17. He reminded the Board that the Better Care Fund programme was delivering system wide changes with the aim of delivering the following six outcomes:

- Reduced Delayed Transfer of Care (“DTOC”);
- Reduction in avoidable emergency admissions;
- Reduced admissions to residential and nursing homes;
- Ensured effectiveness of reablement;
- Improvement patient/service user experience;
- Improved dementia diagnosis rates.

He advised that “DTOC” remained a key issue to be delivered but that difficulties were still being encountered in achieving the target. A tri-partite agreement had been established between the Council, Clinical Commissioning Group and the Acute Trust to address this matter. With regard to the reduction in emergency admissions he advised that there had been an increase but this was due to the method of calculation with episodes of care and emergency admissions having conflicting numbers. There was , however, a requirement to report against the MAR (hospital data). He explained that the number of emergency admissions had actually reduced. In relation to the reduced admission to residential and nursing homes target, he reported that the figures had reduced and that Wolverhampton was one of the best performing areas in the country.

He reported that with the exception of the “DTOC” progress in achieving the targets was positive. He drew to the attention of the Board the establishment of the Community Neighbourhood Team (CNT) model. This model would see the establishment of three CNT’s wrapped around small numbers of GP practices. He outlined the composition of the core teams which would include District Nurses and Social Workers.

He drew to the attention of the Board the current financial position together with the current projected overspend. With regard to the 2016/17 financial year, he explained that the final guidance was still awaited and the timetable for sign off of the Delivery Plan which necessitated a requirement for delegated authority to be granted in order to meet the time frame.

The Chief Executive of the Royal Wolverhampton NHS Trust commented on the emergency admissions target and advised that attendance at the A&E Centre had broken records three times in as many weeks and that this presented an issue with 19 patients waiting in corridors on the previous evening. For the first time in his NHS experience however, bed availability had not been a problem. With regard to “DTOC” he reported that the position had improved enormously in Wolverhampton in recent times. The Strategic Director – People commented that the Council, the Acute Trust and the WCCCG continued to work together to address this problem but that maintaining people at home did have financial implications.

Jeremy Vanes, Chair of the Royal Wolverhampton NHS Trust enquired whether the Better Care Fund programme would be continued beyond 2018/19. The Director of Strategy and Transformation responded that there was an assumption, at national level, that Health and Social Care would be integrated more by 2020 and that the Better Care Fund would continue but would require more than joint commissioning.

Resolved:

1. That the progress report on the current year’s activity be noted.

2. That the intention to advise the Health and Wellbeing Board of the intention to establish a Section 75 agreement between City of Wolverhampton Council (CWC) and the Wolverhampton CCG for the purposes of delivering the Better Care Fund in the business year 2016/17, and process for developing this agreement, along with the progress to date be endorsed.

3. That the draft Section 75 agreement be taken to the CCG governing body meeting on the 8 March and to the CWC Cabinet meeting scheduled for 23 March 2016 for final approval by both partner organisations.

4. That the process for developing the 16/17 delivery plan, the progress to date be noted, and that the final approval of the 16/17 BCF delivery plan be delegated to the Chair of the Health and Wellbeing Board, Cllr Samuels and Cllr Mattu with advice from the Transformation Director CCG (Steven Marshall), and BCF Lead for the CWC (Viv Griffin) during March 2016.

10 **Joint Strategy for Urgent Care - Equality Analysis - Implementations of recommendations**

The Director of Strategy and Transformation presented a report which detailed action taken following the previous update in June 2015 on the equality analysis report relating to the Joint Strategy for the Provision of Emergency and Urgent Care in Wolverhampton.

The Independent Chair of the Children's and Adults Safeguarding Boards referred to paragraph 3.3 of the report inasmuch as it only indicated the training undertaken by the WCCCG staff. The Director of Strategy and Transformation explained that the report was a response to the Strategy Document which was the responsibility of the WCCCG. The Chair of the Royal Wolverhampton NHS Trust advised that a new approach had been adopted by the Trust in relation to the collation and collection of training data and that it would be possible for figures in relation to training undertaken by Trust employees to be provided. The Strategic Director – People commented that specific training was not provided by the Council in relation to equality and diversity as it was an integral part of the Council's operating procedures. The Independent Chair of the Children's and Adults Safeguarding Boards reminded the Board that the original recommendations had required training data to be provided by all relevant agencies. The Strategic Director – People reiterated her earlier comments that this did not relate to the Council inasmuch as it had no responsibility for the urgent care of patients. Manjeet Garcha, Director of Nursing and Quality, WCCCG commented that generic information from the WCCCG was submitted regularly to the respective Safeguarding Boards on this issue and reminded the Board that the WCCCG as a Commissioner, was required to ensure that its Service Providers satisfied its requirements in respect of such training.

Dr Arko Sen enquired as to the possibility of equality and diversity training being provided to volunteers alongside NHS staff.

Resolved:

1. That the progress in relation to implementation of recommendations 8, 10, 11, 19, 20 and 21 in the Equality Analysis document which supported the Joint Strategy for Urgent and Emergency Care be noted;
2. That the relevant data in relation to training on equality and diversity undertaken by employees of the WCCCG and RWT be provided to the Independent Chair of the Children's and Adults Safeguarding Boards;
3. That the training needs of volunteers in relation to equality and diversity matters be considered alongside the needs of NHS staff, if appropriate.

11 **Obesity Call to Action - Progress Update**

The Director of Public Health presented a report which provided an update in relation to progress made for the Obesity Call to Action and subsequent production of an Action Plan on 29 July 2015. The report outlined the development of a whole systems approach which had been adopted and progress made against the five year Action Plan.

Cllr Paul Singh welcomed the report and initiatives but enquired as to whether there was any data available against which progress could be measured. The Director of Public Health advised that the aim of the plan was to reduce the percentage of residents who were overweight or obese. She explained that there was a 12 month

delay involved with the collection and publication of the relevant data. Data collected by School Nurses had recorded, however, a slight reduction in the number of overweight children but there had been no movement in the number of obese children. Cllr Paul Singh expressed concern in relation to the ability of the Council to measure progress in the absence of relevant data. The Chair advised that the data would be available but was not to hand immediately. The subject of progress with Child Obesity was also being considered by a joint meeting of the Health and Children and Young People and Families Scrutiny Panels.

She reminded the Board that it was estimated that 40% of eleven year olds in the city were obese. She referred to paragraph 4.1 of the report inasmuch as it referred to the Public Health Funding Settlement and the cut imposed in the Autumn Statement. The Director of Public Health advised that the Wolverhampton budget had been reduced by 6.2% which amounted to a £1.33 million in year reduction. A further reduction to the budget of 3.5% was anticipated. The funding formula was being revised and could lead to further significant reductions in the money available to the City of Wolverhampton Council.

Resolved:

That progress made against the Obesity Call to Action be noted.

12 **Public Health Commissioning Intentions 2016/17**

The Director of Public Health presented a report in connection with the Public Health commissioning intentions for 2016 – 17 and the aspirations for commissioning to improve the health of the population to 2019. She reminded the Board that a five year contracting strategy had been approved in 2014 and since that time a huge amount of work had been undertaken which would continue into future years. She reported that the Healthy Child programmes; 0-5 (Family Nurse Partnership and Health Visiting) and 5-19 (School Nursing) would remain as currently specified with the Royal Wolverhampton NHS Trust until August 2017. Redesign of these services and planning for a comprehensive consultation had commenced and would be fully developed during 2016 – 17 with a new contract commencing on 1 August 2017.

She referred to section 3 of the report inasmuch as it referred to “aspirations: tackling the big six health issues in Wolverhampton” and explained that in the absence of the Public Health Funding Settlement it was only possible to confirm the continuation of mandated services at the present time. In order to achieve longer term impact to improve the health of the population of Wolverhampton certain interventions were required but this would be dependent on the availability of resources. She emphasised that discretionary services were at risk depending on the funding made available in the Settlement.

She advised the Board that the spending review and Autumn Statement covering 2016 – 17 onwards represented an average real term saving of 3.9% each year to 2020 – 21. The savings would be phased in at 2.2% in 16 – 17, 2.5% in 17 – 18, 2.6% in each of the following two years and flat cash in 20 – 21. To prepare for this anticipated reduction scenario planning had been undertaken to prioritise Public Health programmes. Minimum provision would cover only prescribed service delivery. After the prescribed provision prioritisation would be undertaken to retain critical services tackling the key health issues for Wolverhampton. Discretionary

activity would then only be provided if it was affordable within a revised total programme.

The Chair of the Royal Wolverhampton NHS Trust welcomed the report. He referred to Public Health voluntary sector contracts for the delivery of peer support, young people's counselling and welfare and advice services expiring in 2016 and noted that a review commissioning and procurement exercise would be commenced later this year. He commented that there was a sense of trepidation felt by the providers of services to young people especially having regard to the reduced level of the voluntary sector. He requested that the voluntary sector be informed of the financial position at the earliest opportunity. The Director of Public Health acknowledged the position and the need to be open, honest and transparent with the voluntary sector on the financial position.

Resolved:

1. That the commissioning intentions be endorsed;
2. That the implications of the spending review and Autumn Statement on the public health grant allocation might require the reprioritisation of future commissioning intentions and the current contracting portfolio be noted;
3. That it be noted that any reductions would be applied to ensure delivery of prescribed services: Children 0 – 5 (health Visiting), sexual health, NHS health checks, National Child Measurement programme and surveillance and monitoring of health protection incidents, outbreaks and emergencies as primary functions.

13 **Francis Inquiry - progress on implementing recommendations**

The Director of Nursing and Quality, Wolverhampton City Clinical Commissioning Group presented a report which updated the Board on the progress made by the CCG in implementing the recommendations from the Francis Inquiry and a number of other reports. She suggested that an over- arching report on quality be submitted to future meetings.

The Chair of the Royal Wolverhampton NHS Trust commented that organisational memory was an issue in the short term for a variety of reasons especially having regard to staff turnover. He questioned how the health and social care economy would make the necessary steps to retain the knowledge and avoid moving backwards. The Chair suggested that quality checks needed to be conducted on at least a quarterly basis.

The Independent Chair of the Wolverhampton Children's and Adults Safeguarding Boards supported the comments made previously and commented on the duplication of reporting between this Board and the Safeguarding Boards. He opined that when lessons had been learnt from previous experiences that there was a need to ensure that this had actually occurred.

The Director of Public Health commented that improvements in the quality and safety of care provided had improved. She suggested that a quality and safety framework was required which ensured that continued improvement occurred.

The Chief Executive of Royal Wolverhampton NHS Trust reported on the difficulties the Trust encountered after recruiting nurses from abroad in obtaining the necessary

immigration documentation. Furthermore, he commented on the problems with retaining qualified nurses once they had commenced their duties, with many choosing to seek alternative employment in locations such as Southampton. He advised that following the Care Quality Commission (CQC) inspection of the Manor Hospital at Walsall there was now an expectation that the RWT Maternity Unit would take responsibility for a further 500 deliveries. This was likely to re-ignite previous complaints regarding the closure of the Maternity Unit at Stafford Hospital.. The Chair queried whether the RWT had sufficient capacity to cope with the additional demands. The Chief Executive of Royal Wolverhampton NHS Trust reminded the Board of the decision taken by the Trust to undertake capital expenditure on a major project prior to the formal approval of the Business Case by the Department of Health while other Trusts had awaited formal approval or had taken no steps whatsoever.

Ian Darch commented that the human factors needed to be taken into account and that while the quality and safety issues were important the culture of each organisation was equally important.

Resolved:

1. That the report be received and noted;
2. That further consideration be given to the development of a quality and safety framework with the outcome being reported to a future meeting with a view to quarterly reports being submitted to the Board;
3. That the framework include an indication as to the most appropriate body to receive progress reports on specific developments from the various Inquiries / reports.

14 **Wolverhampton City Clinical Commissioning Group Primary Care Strategy**

The Director of Strategy and Transformation presented a report which informed the Board of developments with regard to the Wolverhampton City Clinical Commissioning Group (WCCCG) Primary Health Care Strategy. The Strategy had been approved in principle by the WCCCG Governing Body on 12 January 2016 and which had been ratified at a Members Meeting on 20 January 2016. He reported that the Strategy detailed what was to be delivered in relation to Primary and Community Care.

The Independent Chair of the Wolverhampton Children's and Adults Safeguarding Boards suggested that the document needed to make more reference to Safeguarding and in terms of GP engagement with Safeguarding issues to ensure that GP's were equipped to deliver what was expected of them. The Director of Nursing and Quality undertook to ensure that this issue was addressed through workforce development. Dr Arko Sen suggested that reference needed to be made in the document to tackling inequality issues.

Ian Darch commented that the WCCCG with support from the Voluntary Sector Council had been successful in obtaining a grant from the Big Lottery Commissioning Better Outcomes Fund to develop a Business Case that would appraise the option of using a Social Impact Bond to finance Voluntary and Community Sector (VCS) preventative well-being interventions for older people. WCCCG's overall aim was to make savings by reducing ambulance call outs, emergency hospital admissions and delayed discharges of older people. Initial cost profiling had indicated that investment

in VCS prevention could lead to cashable savings of approximately £1 million over 5 years to the WCCCG. The City of Wolverhampton Council would also benefit in terms of savings and improved outcomes for older people. He suggested that reference to the Social Impact Bond proposition could be included in the Strategy.

The Director of Strategy and Transformation advised that an allocation of funding was also available for voluntary sector organisations to apply for funding to assist community care providers.

Resolved:

1. That it be noted that the Strategy had been adopted by the WCCCG Governing Body and ratified by the WCCCG members;
2. That the comments made during the consideration of the Strategy be noted.

15 **NHS Planning and Strategic Transformation Plan 2016/17**

The Director of Strategy and Transformation reported on planning guidance received from the Department of Health which required an Operations Plan to be produced for 2016 -17 and a Sustainability and Transformation Plan for 2020. Three years fixed funding had been indicated together with indicative funding for a further two year period. The Sustainability and Transformation Plan required a larger footprint than just Wolverhampton to be considered and the recognition that it had a wider footprint than the Black Country given the treatment of patients from South Staffordshire and Shropshire. He advised that various configurations of Trusts and organisations would be looked at.

He commented that this would be a thorny issue to address and would pose a challenge to social care providers. A systems submission was required by the end of June 2016 and a number of cross organisation Working Groups were being established to work on these requirements. The Strategic Director – People commented that there was a need to add value without duplicating effort and that there was a desire for the Black Country Authorities to work together at a Combined Authority level and/or across the Black Country.

The Chair queried whether these issues were to be considered by the Combined Authority, once established. The Director of Strategy and Transformation advised that the responses would be health driven nationally.

The Chair of the Royal Wolverhampton NHS Trust questioned what the changes would mean for that Trust. He suggested that local solutions were required rather than a footprint being imposed by the Department of Health. He commented that the identification of “the Wolverhampton ask” was required as the first step in responding to this issue.

Resolved:

That the report be received and noted.

16 **Children and Young People's Plan - progress report**

Resolved:

That this matter be considered at the next meeting of the Board.

17 **Minutes from Sub Groups**

Resolved:

That the minutes of the following meetings be received and noted:

i) Children's Trust Board – 1 December 2015;

ii) Integrated Commissioning and Partnership Board – 3 December 2015.

[Carl Craney, Democratic Support Officer, reported that it would not be necessary to pass a resolution to exclude the press and public as the report on NHS Capital Programme due to be considered at Agenda Item No. 19 was not available]

18 **Exclusion of the Press and Public**

See Minute No. 17 above.

19 **NHS Capital Programme**

See Minute No. 17 above.

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