NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 12th April 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		
		4	Minutes		1 - 8
		5	Matters arising from the minutes		
		6	Committee Action Points		9 - 10
		7	Chief Officer Report	Dr H Hibbs	11 - 16
		8	Auditor Panel	Ms C Skidmore	17 - 28
		9	Budgets 2016/17	Ms C Skidmore	29 - 36
		10	Better Care Fund Update	Ms A Smith/ Mr S Marshall	37 - 58
		11	New Models of Primary Care	Ms P Roberts/ Mr M Hastings	59 - 64
		12	Commissioning Committee	D J Morgans	65 - 88
		13	Quality and Safety Committee ▪ Sustaining Maternity Services at Walsall update	Dr R Rajcholan	89 - 116
		14	Finance and Performance Committee	Ms C Skidmore	117 - 140
		15	Primary Care Joint Commissioning Committee	Ms P Roberts	141 - 144
		16	Communication and Engagement update	Ms P Roberts	145 - 148
			Items for Information		
		17	Minutes of the Quality and Safety Committee		149 - 158

		18	Minutes of the Commissioning Committee		159 - 164
		19	Minutes of the Finance and Performance Committee		165 - 172
		20	Any Other Business		
		21	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 10 May 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 8 March 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	Yes
Dr M Kainth	Board Member	Yes
Dr J Morgans	Board Member	Yes
Dr R Rajcholan	Board Member	Yes
Dr A Sharma	Board Member	No
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	Yes
Mr J Oatridge	Lay Member	Yes
Ms P Roberts	Lay Member	Yes
Ms H Ryan	Lay Member	Yes

In Attendance ~

Ms K Garbutt	Administrative Officer
Ms V Griffin	Local Authority
Mr M Hastings	Associate Director of Operations
Mr P McKenzie	Corporate Operations Manager

Apologies for absence

Apologies were received from Dr A Sharma, Ms R Jervis and Dr A Sen.

Declarations of Interest

WCCG.1402 Dr D De Rosa reported no declarations of interest.

RESOLVED: That the above is noted

Patient Story

WCCG.1403 No patient story took place.

RESOLVED: That the above is noted.

Minutes

WCCG.1404 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 9 February 2016 be approved as a correct record. However the following amendments were highlighted ~

WCCG.1381 – Quality and Safety Committee

Dr H Hibbs stated for clarity the last paragraph should read “information regarding the Mental Capacity and Deprivation of Liberty Assessments (MCA/DoLs) could be expanded on further for the Governing Body”

Matters arising from the minutes

WCCG.1405 There were no matters arising from the minutes.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.1406 RESOLVED: That the progress report against actions requested at previous Board meetings be noted ~

WCCG.1352 – Review of Procedures of Low Clinical Value

Ms M Garcha confirmed a report will be submitted to the Quality and Safety Committee in April 2016.

Chief Officer update

WCCG.1407 Dr Hibbs presented the Chief Officer report which is primarily 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 pointed out the Commissioning Support Unit (CSU) Joint Mobilisation Board for Clinical Commissioning Groups (CCG's) across Birmingham and the Black Country is now meeting as a regular programme board. She also highlighted that a letter had been received from the Area Team regarding Quarter 2 Assurance Review. The review had been indicatively judged as assured as good across all areas which is good news for Wolverhampton CCG and she thanked all the staff for their hard work and contributions. Dr Hibbs confirmed the letter will be circulated to Governing Body members.

RESOLVED: That the letter from the Area Team is circulated to Governing Body members.

Emergency Preparedness Resilience and Response (EPRR)

WCCG.1408 Mr M Hastings presented the report to give the Governing Body assurance that the CCG is compliant with EPRR requirements. He outlined the main body of the report on page 2. He pointed out that 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 NHS England in June/July 2016. It is proposed that a further report is presented to the Governing Body following this review in May 2016.

RESOLVED: That a further report is presented to the Governing Body following the review in May 2016.

Better Care Fund update

WCCG.1409 Mr S Marshall gave an overview of the progress report reflecting the major changes to the better care fund for next year. He also advised the Governing Body on the progress of development of a Section 75 agreement between the City of Wolverhampton Council and the CCG for the purpose of delivering the Wolverhampton Better Care Fund and the associated time lines for development and sign off. He also highlighted the submission dates for plans and the programme of work for 2016/17. There will be 5 work streams going forward ~

- Adult Community Care
- Frail Elderly Pathway
- Mental Health
- Dementia
- Integration

Mr Marshall confirmed that the sign off process for Better Care Fund 2016/17 plans are in line with submission dates. The Governing Body supported that the delegated authority for sign off is given to Dr H Hibbs and Ms C Skidmore.

Mr J Oatridge referred to the risks and implications relating to reporting and frequency. Ms Skidmore confirmed a structure is in place through the Programme Board and there is also a combined performance report.

RESOLVED: That the Governing Body supported delegated authority for sign off process for the Better Care Fund 2016/17 to Dr H Hibbs and Ms C Skidmore.

Commissioning Committee

WCCG.1410 Dr J Morgans referred to agenda item 10 which 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.

Dr Morgans pointed out that the Royal Wolverhampton Trust (RWT) performance against its 4 hour wait has deteriorated significantly. The providers of the new Urgent Care Centre have agreed to early implementation to attempt to aid the delivery of improved performance. A number of commissioning and procurement exercises run by public health have taken place to redesign and implement an integrated model of sexual health services. Dr D Bush asked where these services will be delivered in the future.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1411 Dr S Rajcholan summarised the Quality and Safety Committee Executive Summary.

Ms Garcha explained that the February Clinical Quality Review Meeting (CQRM) with RWT was cancelled due to lack of availability of executive directors to attend however an internal commissioner only meeting was held at the Science Park. Dr Bush raised a question around the importance given to the CQRM meetings and Dr Hibbs suggested that the importance of regular joint CQRM meetings be raised with the trust at the next meeting.

Ms Garcha pointed out that the Trust have been trying to tackle the issue regarding high numbers of new pressure ulcers. As discussed and

agreed with NHS England Area Team, a new approach is needed. A new local health economy wide project is being launched, Terms of Reference have been agreed and the first meeting was on the 25 February 2016 chaired by Dr De Rosa. This forum will enable a whole system approach to quality improvement.

Ms Garcha confirmed that the Care Quality Commissioning (CQC) report for Black Country Partnership (BCP) is still awaited.

Ms P Roberts stated that at the Quality and Safety Committee meeting which took place today a discussion had taken place around Care Homes. A great amount of work is currently being undertaken and she requested that this is included in the Quality and Safety report. Ms Garcha supported this.

RESOLVED: That the above is noted.

Audit and Governance Committee

WCCG.1412 Mr Oatridge presented the report. He pointed out 1.3 Draft Head of Internal Audit Opinion which was 'Significant Assurance'. He pointed out that an introductory report from Price Waterhouse Cooper was received relating to the draft internal Audit Plan 2016/17 and an updated report will be brought to the next meeting. This is a change of provider for 2016/17.

Mr P McKenzie referred to the report relating to Review of Declaring and Managing Interests Policy. We are expecting at some point in April 2016 further guidance form NHS England regarding conflicts of interest and the policy will need to be further reviewed. He confirmed that there is a requirement annually to review declarations. Dr De Rosa pointed out if the sponsorship for Together Everyone Achieves More in Wolverhampton (TEAM W) should be declared under Gifts and Hospitality within the policy. Mr McKenzie confirmed this could be included.

Mr Oatridge highlighted that under National Guidance there will be a Panel addressing selecting external auditors for 2017/18. The draft terms of reference have been discussed and the final approval of these must be made by the Governing Body. The first meeting is due to take place in April 2016.

RESOLVED: That the Governing Body approves the revised Declaring and Managing Interests Policy. The Governing also support the establishment of the Auditor Panel using the Terms of Reference shared at the meeting.

Finance and Performance Committee

WCCG.1413 Ms Skidmore summarised the Finance and Performance Committee report. She welcomed Dr Bush who is now chairing the meetings. There has been little change in the finance position this period. The current position of Quality, Innovation, Productivity and Prevention (QIPP) programme performance as at Month 10 is outlined on page 6 of the report.

Ms Skidmore gave an overview of the 2016/17 financial plan and budget. NHS England confirmed in December 2015 that it has set firm three year allocations for CCGs, followed by two indicative years, NHS England have also confirmed that CCG administration allowances will remain flat until 2020/21. 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 requested to sign off the 2016/17 budget at its meeting in April.

RESOLVED: That the above is noted.

Primary Care Joint Commissioning Committee

WCCG.1414 Ms Roberts gave an overview of the report which is to ensure the operations of the CCG align, with, support and augment transformational changes in the way services are delivered. This will be done through the Better Care Fund and Co-commissioning of primary care services and will also further the preventative and public health agendas and provide opportunities for early intervention and proactive care through greater integration.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1415 Ms Roberts presented this report which updates the Governing Body on the key communications and participation activities in February 2016.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1416 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.1417 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1418 RESOLVED: That the minutes are noted.

Minutes of the Audit and Governance Committee

WCCG.1419 RESOLVED: That the minutes are noted

Minutes of the Health and Wellbeing Board

WCCG.1420 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.1421 There were no items.

RESOLVED: That the above is noted.

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

WCCG.1422 **Question**

Why was there no patient story presented today at the Governing Body?

Answer

Ms Roberts stated that unfortunately we did not have a relevant story we could present. She added our stakeholders are requested to supply these which need to be relevant and local.

Question

Can patients access their GP practices records on line?

Answer

Dr De Rosa confirmed this is a national mandate with effect from 1 April 2016. Mr Hastings added that 60% of patients have access to a summary of their records on line.

Question

Are delayed transfers of care being monitored?

Answer

This is currently being picked up through various Committee meetings for this to be addressed and improved.

Question

Can you let me know when the patient engagement dates are?

Answer

Ms Roberts stated these have not been finalised as yet but would be made available as soon as they are.

Question

Has Musculoskeletal been finalised?

Answer

At present we are waiting for providers to return their bids. Moderation will take place in April/May and this will then go for approval at the Private Governing Body in June 2016.

RESOLVED: That the above are noted.

Date of Next Meeting

WCCG.1423 The Board noted that the next meeting was due to be held on **Tuesday 12 April 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 3.00 pm

Chair...

Date ....

Wolverhampton Clinical Commissioning Group Governing Body

12 April 2016

Date of meeting	Minute Number	Action	By When	By Whom	Status
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. Dr De Rosa reported on the 8 March 2016 that Dr Shama is still waiting to hear from Dr Odum.
8.3.16	WCCG.1407	Chief Officer Report – Quarter 2 Assurance Review letter from Area Team to be circulated to Governing Body members	March 2016	Dr Helen Hibbs	Circulated on the 9 March 2016.
8.3.16	WCCG.1408	Emergency Preparedness, Resilience and Response (EPRR) – a further report is presented following the review.	May 2016	Mike Hastings/ Andy Smith	

This page is intentionally left blank

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING

12 APRIL 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 mobilisation of the new commissioning support organisations continues with local variations being the theme of the last few weeks. NHS Arden and Greater East Midlands (GEM) CSU have been confirming expectations with CCG's to ensure that their plans for delivery will match these. Arden and GEM are keen that any issues, however minor they are perceived to be are raised with them at the earliest opportunity following go-live (01/04/2016). This message has been passed on to all CCG staff via managers.

The transfer of services will be signed off by a representative of all CCG's on a conference call on 29 March 2016. It has been agreed that there will be no contractual sanctions imposed on the providers during the first three months of delivery in order to give them an appropriate amount of time to iron out any delivery issues identified however, performance will still be monitored against KPI's (Key Performance Indicators).

The risk log was discussed at the last Mobilisation Board and CCG's were given further assurances regarding data sharing arrangements and recruitment of staff to posts which have been the highest rated risk for the CCG.

As a reminder of the service changes:

- Lot 1 End to End Services (Human Resources, Communications and Engagement, Information Governance, Contract Management, Finance, Procurement, SSSI (Strategy Unit)) – Moves to Arden and GEM CSU
- Lot 1 Business Intelligence – Stays with Midlands and Lancashire CSU
- Lot 1 IT – Supplied by the Royal Wolverhampton NHS Trust, not a CSU
- Lot 2A (Medicines Management Optimisation) – Stays with Midlands and Lancashire CSU
- Lot 2B (Individual Funding Requests / Continuing Healthcare) – Moves to Arden and GEM CSU
- Regional Capacity Management is sub-contracted from Arden and GEM back to Midlands and Lancashire CSU due to the interdependency requirements of the service across wider providers

A key point to note is that ALL of the specifications for services have been reviewed and improved as a part of the procurement process, so even if the supplier has not changed the CCG will be monitoring delivery against a new specification and will expect an enhanced service delivery as a consequence.

2.2 West Midlands Accountable Officers Meeting

A meeting of the West Midlands Accountable Officers took place on 16 March 2016. Items discussed included 2016-17 planning, Financial Strategy - use of the 1% non-recurrent funds and a proposal for a single process across the West Midlands for the management of Excess Treatment Costs. Discussion also took place around the Sustainability and Transformation Plans (STP) for each area and also the new assurance process for 2016/17 for Clinical Commissioning Groups.

2.3 Quality Surveillance Group (QSG)

A meeting of the Quality Surveillance Group took place on 17 March 2016. Items discussed included Walsall Healthcare Trust Enhanced Risk Surveillance Rating Report, the Heart of England Foundation Trust (HEFT) Enhanced Surveillance Report, a Maternity Review and Intelligence Sharing. It was agreed that an escalation and de-escalation model should be agreed for QSG

2.4 Sustainability and Transformation to 2020

A meeting was held to discuss the emerging Sustainability and Transformation Plans. We are in the Black Country footprint and the Accountable Officer for Sandwell and West Birmingham CCG is chairing the meetings. Work streams have been identified and discussions are ongoing as to how to transform services across the region to provide sustainability for the future

2.5 Black Country Accountable Officers

The Black Country Accountable Officers are meeting on a monthly basis to look at ways of aligning our plans and working together particularly with regard to STP planning.

2.6 CCG Planning 2016/17

We have submitted our first draft of the Operating Plan which forms year one of our STP plan. We are also working with Black Country colleagues on our first submission of the STP.

Dr Helen Hibbs
Chief Officer
Date: 31 March 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**	**31/03/16**

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
12 April 2016

Agenda item 8a

Title of Report:	**Auditor Panel**
Report of:	Claire Skidmore – Chief Finance Officer
Contact:	Maria Tongue – Head of Financial Resources
Governing Body Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To seek approval for the setting up of a CCG Auditor Panel to comprise members of the existing CCG Audit & Governance Committee
Public or Private:	This report is intended for the public domain
Relevance to CCG Priority:	Mandatory requirement under the Local Audit and Accountability Act 2014
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG has a statutory duty to put in place an Auditor Panel by 2016/17 for the appointment of external auditors and to oversee their work.
• **Domain 3:** Financial Management	Audit fees have previously been set by the Audit Commission. This process gives CCGs the opportunity to appoint auditors from an open and competitive market and to secure value for money.

1 BACKGROUND

1.1 The Local Audit and Accountability Act 2014 abolished the Audit Commission who were previously responsible for the appointment of external auditors. The Act sets out the need for CCGs to have an auditor panel to advise on the appointment of external auditors and to oversee and advise on the maintenance of an independent relationship between the CCG and their auditor.

1.2 The Auditor Panel must be in place ahead of the deadline for the appointment of external auditors for the 2017/18 financial year. The deadline for this is the 31st December 2016 and so the panel must be in place early in 2016.

2 THE AUDITOR PANEL

2.1 Department of Health guidance recommends that CCGs nominate their existing Audit Committee to act as its Auditor Panel. The CCG recommends that the existing Chair of the AGC also be appointed as the Chair of the Auditor Panel. AGC members' responsibilities will therefore be expanded to include membership of the Auditor Panel.

2.2 The Panel will usually meet quarterly and for efficiency it is recommended that these meetings be held immediately prior to the AGC meetings each quarter. The agenda for these meetings is not expected to be onerous once the auditor appointments have been made and so the meetings will be scheduled to start one hour before each AGC meeting. 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.

2.3 Appendix 1 provides the draft terms of reference which have been drawn up for the auditor panel. These are largely based on the national template provided by the Department of Health with minor local amendments.

2.4 It is important to note that the Auditor Panel is an advisory body. Responsibility for the actual procurement and appointment of the auditors remains with the Governing Body.

3 THE AUDITOR APPOINTMENT PROCESS

3.1 The CCG must appoint a local auditor to audit the annual accounts by 31/12 of the preceding year. This means that the auditor needs to be appointed by 31st December 2016 for the 2017/18 financial year. The appointment can be for longer than a year but there must be a new appointment process at least once every 5 years, (an auditor can be reappointed for further terms).

3.2 The Financial Reporting Council (an independent government body) will hold the register of firms that are eligible for appointment. Standard procurement guidance as set out in the Prime Financial Policies and EU requirements must be followed. An informal agreement has been made between local CFOs to share the administration arrangements for the procurement process. For instance, interviews could be held in one central location with several CCGs attending.

3.2 The auditor panel's key role is to check that:

- Contract arrangements (i.e. procurement and the selection of external auditors) are appropriate;
- The relationship and communications with the external auditors are professional;
- Conflicts of interest are effectively dealt with.

4 NEXT STEPS

4.1 The first meeting of the Auditor Panel is planned to take place immediately prior to the April AGC meeting. A draft agenda is attached at appendix 2 and the intention of the meeting will be to ensure all AGC members understand the role of the Auditor Panel and to agree actions required to secure the appointment of external auditors by the 31st December 2016 deadline.

5 PATIENT AND PUBLIC VIEW

5.1 Not applicable

6 RISKS AND IMPLICATIONS

6.1 Key Risks

6.1.1 The Auditor Panel will need to be in place early in 2016 to secure the appointment of external auditors by 1st April 2017.

6.2 Financial and Resource Implications

6.2.1 The Auditor Panel will need to ensure local and EU procurement guidelines are followed during the appointment process.

6.3 Quality and Safety Implications

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

6.4 Equality Implications

6.4.1 There are no equality implications arising from this report.

6.5 Medicines Management Implications

6.5.1 There are no medicines management implications arising from this report

6.6 Legal and Policy Implications

6.6.1 Members will need to ensure the CCG complies with the new regulations under the Local Audit & Accountability Act 2014.

7 RECOMMENDATIONS

7.1 Members are asked to approve the recommendation that the CCG's existing Audit and Governance Committee is nominated to act as the CCG's Auditor Panel.

Name: **Maria Tongue**
Job Title: **Head of Financial Resources**
Date: **29.02.16**

ATTACHED:

Appendix 1 – Auditor Panel draft Terms of Reference
Appendix 2 – Auditor Panel draft agenda April 2016

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	n/a	
Public/ Patient View	n/a	
Finance Implications discussed with Finance Team	Maria Tongue	Feb 16
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)	Maria Tongue	29/02/16

This page is intentionally left blank

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.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Auditor Panel will take place on

Tuesday 19th April 2016 commencing at 10.00am

CCG Main Meeting Room, Science Park, Wolverhampton

AGENDA

1. Apologies for absence
2. Declarations of interest
3. Terms of reference
4. External auditor appointment process
5. Any other business
6. Date and time of next meeting

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
12th April 2016

Title of Report:	**Budgets 2016/17**
Report of:	Claire Skidmore, Chief Finance Officer
Contact:	Lesley Sawrey, Deputy Chief Finance Officer
Finance and Performance Committee Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	• To provide the Governing Body with the financial plan for 2016/17, noting adherence to the 16/17 planning rules and flagging risks to the financial position. • To request formal sign off of the 2016/17 Budgets.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Strong Financial Management and sound planning and performance
Relevance to Board Assurance Framework (BAF):	Supporting and delivery of the strategic direction of the CCG
• **Domain 1:** A Well Led Organisation	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The financial plan is set with consideration for the delivery of NHS targets (both constitutional and otherwise) and with a view to supporting the CCG's work to improve outcomes for its population
• **Domain 2b:** Quality (Improved Outcomes)	The CCG must use its resource to commission services that are safe and of a high quality. When agreeing expenditure regard must be given to the

	quality impact that spending decisions have.
• **Domain 3:** Financial Management	A robust financial model is essential to the CCG's success. This paper sets out the resources available to the CCG for 2016/17; detailing the financial risks and challenges that the organisation faces.
• **Domain 4:** Planning (Long Term and Short Term)	The CCG's financial plans reflect its strategy for healthcare in Wolverhampton. This is set with reference to the National mandate, 5YFV and modelling the allocations attributed to the organisation.
• **Domain 5:** Delegated Functions	

1. Purpose of the paper

The purpose of the paper is:

- To provide the Governing Body with the financial plan for 2016/17, noting adherence to the 16/17 planning rules and flagging risks to the financial position.
- To request formal sign off 2016/17 Budgets.

2. Context and Overview

2.1 The Finance and Performance Committee received a paper last month which outlined the planning assumptions, QIPP, risks and mitigations and Budget Holder involvement in setting a balanced financial plan for 2016/17. 2.2 The report confirmed that the CCG was compliant with all of the NHSE planning assumptions and Business rules for finance.

2.3 At the time a **draft** National Tariff had been published which indicated an overall net 1.1% inflation, efficiency -2% and inflation 3.1%. The CCG applied such percentages to tariff based/healthcare contracts.

2.3 In order to submit a balanced plan the CCG included a QIPP programme of £11.9m, 3.4% of its allocation of which £830k was unallocated (7% of total QIPP).

2.4. Risks included within the 2016/17 budgets totalled £5.5m. After adjusting for likelihood of occurrence the risk reduced to £3.75m which was fully mitigated.

2.5 Whilst the plan noted by the Governing body last month met planning requirements it was agreed that a further iteration would be brought to the April meeting. Once more was known about a number of outstanding risks to the position. These are discussed in the next section of this paper.

3. Developments in Financial Planning 2016/17 since last submission

Contract Negotiation

3.1 At the time of the Finance and Performance Committee contracts had not been agreed with RWT and BCPFT as in both cases unresolved issues have been escalated to Executives. It is pleasing to report that since then, both contracts have now been agreed. Figures negotiated have not placed additional pressure on CCG budgets.

Impact of Tariff

3.2 The CSU has provided an in depth analysis of the impact of the draft National Tariff, consultation which closed 10th March 2016. The analysis was undertaken at HRG and POD level. Although the national and regional steer was a net 1.1% inflation, on running the actual draft tariff on the CCG's data the overall inflationary impact identifies a worst case impact of 1.86%, an increase of c £700k on current plans. The

CCG is not unique in this issue as across the geographical area the range of increase is 0.93%-1.90%, the majority being around 1.8%. The CCG believes this additional pressure can be contained within the overall envelope for Healthcare contracts.

Access to Drawdown

3.3 The CCG has planned to access £800k of its available drawdown during 2016/17. To date the CCG has not received confirmation from the NHSE that this is agreed.

Scale of QIPP

3.4 The CCG has been able to reduce the overall QIPP target to £11.59m or 3.3% of allocation. This is near to the NHSE upper tolerance of 3.5%- 4%, and schemes have been RAG rated as detailed below:

Risk Category	£m	
Plans well developed and/or delivered through contracts by 1.4.16	3.15	Green
Schemes still to be finalised	6.272	Amber
High risk and/or no plans (includes unallocated)	2.168	Red

Unallocated QIPP schemes, (£1.59m) currently account for 13.72% of the total QIPP target; a figure well within the NHSE tolerance of 30%.

Additional Risk arising since last Report

3.5 Further guidance has been received from NHSE relating to the 1% reserve .The guidance confirms that the 1% reserve must be uncommitted at the start of the financial year. Guidance is clear that the reserve should provide headroom to mitigate financial risk and cannot be paid over to providers to directly support provider financial positions. The default position is that the 1% non-recurrent will only be used to offset pressures within the transformational footprint and the process for the release of these funds is being developed. This further guidance presents a considerable risk for the CCG as expenditure, which had been largely pre-committed against the 1% reserve has now to be included within the general expenditure thus leaving the 1% reserve uncommitted. Section 4, Risk expands further on the potential impact on the CCG's financial position.

4. Risks and Mitigations

4.1 The issues highlighted in the previous section raise risks which need to be incorporated into the risk profile for the CCG. Previously the CCG reported risks of £3.75m balanced by mitigations of £3.785m. Following the update of risk identified within this paper, (most notable being establishing an uncommitted 1% reserve) the risk and mitigations are as follows:

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	23.7%
Community SLAs			-	0.0%
Mental Health SLAs			-	0.0%
Continuing Care SLAs			-	0.0%
QIPP Under-Delivery	2,168	50.0%	1,084	17.1%
Performance Issues			-	0.0%
Primary Care			-	0.0%
Prescribing			-	0.0%
Running Costs			-	0.0%
BCF	1,500	70.0%	1,050	16.6%
Other Risks	3,375	80.0%	2,700	42.6%
TOTAL RISKS	**9,043**	**70%**	**6,334**	**100.0%**

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	1,785	100.0%	1,785	41.7%
Reserves			-	0.0%
Investments Uncommitted			-	0.0%
Uncommitted Funds Sub-Total	**1,785**	**100%**	**1,785**	**41.7%**
Actions to Implement				
Further QIPP Extensions			-	0.0%
Non-Recurrent Measures	1,500	100.0%	1,500	35.0%
Delay/ Reduce Investment Plans	500	100.0%	500	11.7%
Mitigations relying on potential funding	500		500	11.7%
Actions to Implement Sub-Total	**2,500**	**100.0%**	**2,500**	**58.3%**
TOTAL MITIGATION	**4,285**	**100.0%**	**4,285**	**100.0%**

4.2 The CCG has carefully considered potential mitigations however, is left with a residual, unmitigated risk of £2.049m.

4.3 As a consequence of the risks and mitigations the CCG starts 2016/17 with the following:

	Surplus £m	
Most Likely Case	6.106	No risks or mitigations, achieves control total
Best Case	10.391	Risks do not materialise and mitigations achieved, exceeds control total
Worst Case	(0.228)	No mitigations achieved but risks materialise

5. 2016/17 Budgets

5.1 Following the last plan submission further refinements have taken place in relation to 2016/17 and Appendix 1 details the budgets by service and Budget Holder.

6. RECOMMENDATIONS

The Governing Body is requested:

- To receive and discuss the report
- To note the level of financial risk associated with the proposed 2016/17 budgets.
- To approve and sign off the 2016/17 budget.

Name **Lesley Sawrey**
Job Title **Deputy Chief Finance Officer**
Date: **31st March 2016**

APPENDIX 1 –Summary of 2016/17 Budgets

Budget	Budget Holder	Budget Manager	16-17 Budget £ DRAFT
Programme			
Acute contracts	Steven Marshall	Vic Middlemiss	164,215,506
Community contracts	Steven Marshall	Vic Middlemiss	33,956,636
Community Physios	Steven Marshall	Vic Middlemiss	1,068,384
Ambulance	Steven Marshall	Vic Middlemiss	10,487,987
Mental Health contracts	Steven Marshall	Vic Middlemiss	29,199,846
MH NCA	Steven Marshall	Sarah Fellows	614,400
Other MH	Steven Marshall	Sarah Fellows	3,067,240
CAMHs	Steven Marshall	Sarah Fellows	587,000
LD	Steven Marshall	Sarah Fellows	849,920
WCC Income	Steven Marshall	Sarah Fellows	-1,300,000
Grants	Steven Marshall	Vic Middlemiss	3,444,482
Enhanced Services	Steven Marshall	Vic Middlemiss	2,438,314
Urgent Care	Steven Marshall	Vic Middlemiss	2,502,081
CHC	Steven Marshall	Maxine Danks	8,619,007
OOA Children	Manjeet Garcha	Manjeet Garcha	1,813,139
FNC	Steven Marshall	Maxine Danks	3,227,986
NCA	Steven Marshall	Vic Middlemiss	2,453,727
IFR	Steven Marshall	Vic Middlemiss	365,904
Patient Transport	Steven Marshall	Vic Middlemiss	1,529,690
Continuing Care Children	Steven Marshall	Maxine Danks	535,000
Reablement	Steven Marshall	Steven Marshall	590,517
Prescribing	Manjeet Garcha	David Birch	49,312,149
Oxygen	Manjeet Garcha	David Birch	321,575
Safeguarding	Manjeet Garcha	Manjeet Garcha	632,903
WHIP	Claire Skidmore	Mike Hastings	756,228
CHC Staff	Steven Marshall	Maxine Danks	634,139
Aiming High	Steven Marshall	Steven Marshall	176,000
Interpretting	Claire Skidmore	Mike Hastings	269,600
BCF	Steven Marshall	Vic Middlemiss	6,418,000
Reserves	Claire Skidmore	Claire Skidmore	5,722,270
TOPs	Steven Marshall	Vic Middlemiss	306,219
PEARS	Steven Marshall	Vic Middlemiss	180,726
GP IT	Claire Skidmore	Mike Hastings	679,000
Winter Pressures	Steven Marshall	Dee Harris	1,702,000
Unidentified QIPP	Claire Skidmore	Claire Skidmore	-1,590,522
Other	Claire Skidmore	Claire Skidmore	2,470,948
Running Costs			
Medicines Management	Manjeet Garcha	David Birch	133,632
CEO	Claire Skidmore		1,280,297
Admin	Claire Skidmore	Mike Hastings	246,333
Finance	Claire Skidmore	Lesley Sawrey	502,832
Business & Performance	Claire Skidmore	Mike Hastings	368,866
Continuing Care team(running costs only)	Steven Marshall	Maxine Danks	20,202
Quality & Risk	Manjeet Garcha	Sarah Southall	242,097
Strategy & Solutions	Steven Marshall		843,563
Communications	Claire Skidmore	Mike Hastings	103,900
Clinical Board	Claire Skidmore		312,600
DDGS	Steven Marshall	Andrea Smith	147,000
Charges from CSU	Claire Skidmore	Mike Hastings	1,353,678
			343,813,000
Planned Surplus			6,106,000
Notified RRL			**349,919,000**

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		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Medicines Management Implications discussed with Medicines Management team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Signed off by Report Owner (Must be completed)		

NHS
Wolverhampton
Clinical Commissioning Group

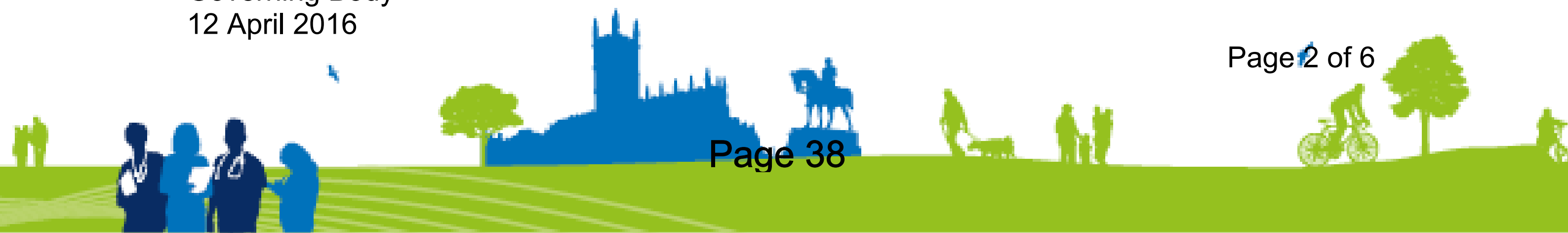
WOLVERHAMPTON CCG

Governing Body 12 April 2016

Agenda item 10a

Title of Report:	**Better Care Fund Update**
Report of:	Andrea Smith
Contact:	Andrea Smith
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide a progress report to Governing Body members on the development of the Pooled Budget for the Better Care Fund and the supporting Section 75 agreement.
Public or Private:	Public
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	N/A
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	N/A
• **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	Section 75 agreement and Pooled budget is

Management	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



1. BACKGROUND AND CURRENT SITUATION

1.1. The continuation of the Better Care Fund Programme into 2016/17requires a Pooled Fund and supporting Section 75 (S75) agreement between the Wolverhampton CCG and the City of Wolverhampton Council (CWC). There is a S75 already in place for 2015/16 therefore this will be updated to reflect the changes for 2016/17.

1.2. Previously, delegated responsibility was given to Claire Skidmore and Dr Helen Hibbs by Governing Body for sign off of the Pooled Fund arrangement and the S75, therefore this report is to update Governing Body on the progress of development.

2. MAIN BODY OF REPORT

2.1. The content of the Pooled Fund has now been agreed by Senior Responsible Officers (SROs) and Finance leads for the Programme, Those involved in discussion and decision making are:-

- Steven Marshall (Director of Strategy and Transformation - CCG)
- Claire Skidmore (Chief Finance Officer – CCG)
- Anthony Ivko (Service Director, Older People - CWC)
- Viv Griffin (Service Director, Disabilities and Mental Health - CWC)
- Alison Shannon (Finance Business Partner -CWC)
- Lesley Sawrey (Deputy Director of Finance - CCG)
- Tony Marvell (Programme Manager – CWC)
- Andrea Smith (Head of Integrated Commissioning – CCG).

2.2. The Financial value of the Pooled Fund for 2016/17 is £54.3m. The CCG contribution is £32.6m and the CWC contribution is £21.7m.

Workstream	Council Contribution	CCG Contribution	Total
Adult Community	18,637,402	24,015,104	42,652,506
Dementia	319,909	2,585,586	2,905,495
Mental Health	2,718,230	5,996,636	8,714,866
Total	21,675,541	32,597,326	54,272,867

2.3. As last year, the Risk share agreement is based upon the percentage contribution to the Pooled Fund, resulting in a Risk Share of 60% CCG to 40% CWC.

2.4. A report was presented to the Local Authority Cabinet meeting on 23rd March (attached) and a report will also be presented at Health and Wellbeing Board in April 2016, which outlines the content of the agreement.

2.5. Now that the content of the Pooled Fund has been agreed the legal teams from both organisations are being asked to review and update the S75 agreement.

2.6. The agreed Pooled Fund and S75 agreement is due for submission to NHSE on 25th April 2016.

3. CLINICAL VIEW

3.1. There is no specific clinical input into the content of the Pooled Fund or the S75 agreement; however clinical input is constantly sought from the work stream when redesigning pathways and services.

4. PATIENT AND PUBLIC VIEW

4.1. Not Applicable

5. RISKS AND IMPLICATIONS

Key Risks

5.1. The percentage risk share of the Pooled Fund arrangement continues to be a risk with the CCG bearing the majority share.

Financial and Resource Implications

5.2. The content of the Pooled Fund has been agreed by Claire Skidmore, Chief Finance Offer for the CCG.

Quality and Safety Implications

5.3. There are no specific quality implications from the Pooled Fund and S75.

5.4. Quality Impact Assessments are completed for individual projects within the Better Care Fund Programme.

Equality Implications

5.5. There are no specific equality implications from the Pooled Fund and S75.

5.6. Equality Impact Assessments are completed for individual projects within the Better Care Fund Programme.

Medicines Management Implications

5.7. Not applicable

Legal and Policy Implications

5.8. The S75 Agreement is currently being reviewed and updated by the CCG and Local Authority Legal teams.

6. RECOMMENDATIONS

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

Name: **Andrea Smith**
Job Title: **Head of Integrated Commissioning**
Date: **29th March 2016**

ATTACHED:

Local Authority Cabinet report

RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**Claire Skidmore**	**29.03.16**
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	**Mike Hastings**	**29.03.16**
Signed off by Report Owner (Must be completed)	**Andrea Smith**	**29.03.16**

Agenda Item No: **7**

CITY OF WOLVERHAMPTON COUNCIL

Cabinet Meeting

23 March 2016

Report title	Better Care Fund Section 75 Agreement (Pooled Budget 2016/17)
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Sandra Samuels, Public Health and Wellbeing Councillor Elias Mattu, Adults
Key decision	Yes
In forward plan	No
Wards affected	All
Accountable director	Linda Sanders, People
Originating service	Disabilities and Mental Health
Accountable employee(s)	Viv Griffin — Service Director, Disabilities and Mental Health Tel — 01902 555370 Email — Vivienne.griffin@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team — 22 February 2016 Strategic Executive Board — 1 March 2016 Integrated Commissioning and Partnership Board — 10 March 2016 Better Care Fund Programme Board — 10 March 2016

Recommendation(s) for action or decision:

The Cabinet is recommended to:

1. Agree to continue the Section 75 Agreement (Pooled Fund) with NHS Wolverhampton Clinical Commissioning Group (“WCCG”) for 2016/17, on the terms and conditions outlined in this report along with any other ancillary legal agreements necessary for the joint administration of the Better Care Fund, including setting up a pooled fund to be managed by the Council.

2. Delegate authority to approve the final terms of the proposed section 75 agreement to Cabinet Members for Adults, Public Health and Well Being and Resources, (Cllrs Elias Mattu, Sandra Samuels, and Andrew Johnson) in consultation with the Strategic Director for People and Director of Finance.

1.0 Executive Summary

1.1 In the last spending review Government confirmed the intention to move Health and Social Care into a more integrated state by the business year 2019/20, in recognition of the fact that health services cannot operate effectively without good social care. To support Local Authorities to meet growing social care needs government also confirmed an option for local authorities who are responsible for social care to levy a new social care precept of up to 2% on council tax. The additional money raised will have to be spent exclusively on adult social care.

1.2 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 Better Care Fund would 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.

1.3 In December 2015 NHS also published the guidance "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21"

Which in summary mandates:

- A five year Sustainability and Transformation Plan ("STP"), place-based and driving the Five Year Forward View; and a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP

- Place based planning - Planning by individual institutions will increasingly be supplemented with planning by place for local populations, and the agreement of transformation footprints' and the programming of clear deliverables across the STP

1.4 Work across both the Black Country and West Midlands regional areas is underway to jointly agree regional footprints and the Wolverhampton STP.

1.5 On 11 January 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 National £1 billion payment for the performance element of the Better Care Fund and mandated local targets for the reduction of delayed transfers of care have been removed from BCF arrangements 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 wide range of services including social care).

- To develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system. Councils, CCGs and NHS providers will have to agree a local target for cutting delayed transfers of care.

- The policy framework provides for more flexibility for Councils and CCGs to put more money into the pool funding arrangement with more flexibility to agree local risk sharing agreements.

- The framework also suggests that a more "streamlined" assurance process for better care fund plans will be in place for the 2016/17 period. Assurance plans will not be subject to a national assurance process. Instead, local plans will be assessed by regional teams including NHS England and local government officials. Plans will only be approved centrally where areas are designated "high risk".

1.6 The detailed technical guidance was due to be published by DCLG/DH in mid-December; however this was not received until March which has led to challenges around the production of the detailed BCF submission.

1.7 The proposed revenue value of the pooled fund to be managed via the S. 75 agreement is £53.9 million (absolute values to be confirmed) and consists of £32.3 million (60%) of CCG funded services alongside, £21.6 million council funded services (40%). The council contribution includes £6.4 million representing the NHS transfer to social care ('Section 256 funding). The pooled budget also include a capital grant (Disabled Facility Grant) amounting to £2.4 million which are managed by the council.

1.8 This paper explains the basis for the S. 75 agreement, and the requirement to set up a pooled fund using the hosting arrangements already in place. It also outlines the risk share arrangements that will operate once the pool is in place. The requirement for a S.75 agreement considered in this paper is for the financial year 2016/17.

2.0 Purpose

2.1 The purpose of the report is:

- To brief Cabinet members on the function of the Section 75 agreement proposal for the management of the Better Care Fund and to obtain Cabinet approval to the continuation of the Section 75 pooled fund for 2016/17;
- To appraise Cabinet members regarding the approach to risk share and performance management within the agreement;
- To appraise Cabinet members of the proposed governance arrangements for the Section 75 Agreement

3.0 Background

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

3.2 The Better Care Fund arrangements require a pooled fund, and the Care Act 2014, Section 121 provides for this.

3.3 A S.75 agreement is already in place for 2015/16, this paper outlines the amendments to this existing agreement for 2016/17. The S.75 agreement governing the creation and management of the pooled fund must be in place before the beginning of the 2016/17 financial year (the year to which it applies).

4.0 Progress, options, discussion, etc.

4.1 City of Wolverhampton Council and Wolverhampton Clinical Commissioning Group have been working collaboratively to explore the details of a proposed S. 75 agreement in order that Cabinet may be presented with 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 Section 75 agreement. The draft proposal considers the following and in summary below is the recommended approach;

4.2 Commissioning

4.2.1 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 plan which maximises opportunities for effective commissioning approaches will be advantageous.

4.2.2 The proposal for supporting the management of the S. 75 pooled fund and its planning therefore is the adoption of an integrated commissioning approach which provides the Council and the CCG with the flexibility and focus to continue to take their own decisions with the arrangements supporting effective co-ordination and shared planning and development. This arrangement will ensure that both the Council and CCG board are sighted on the overarching commissioning intentions and the integrated plans to deliver them.

4.2.3 The 2016/17 Better Care Fund Policy Framework emphasises the need for integration, as did the Government's Autumn Statement 2015 in saying "the Spending Review sets out an ambitious plan so that 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."

4.3 Governance

4.3.1 The governance arrangements for the fund have been designed to be as streamlined as possible, bearing in mind the scale of the financial commitment involved and the scope of the overall project. Day to day operational management and oversight of the 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.

4.3.2 The scope of these powers will be within the existing limits set by both organisations schemes of delegation, particularly from a financial and procurement perspective. Beyond these limits, decision making will remain within the responsible bodies in the individual organisations (Cabinet and the CCG's Governing Body), to whom the members of the Integrated Commissioning and Partnership Board will be accountable for the operation of the fund. Beyond this, the Health and Wellbeing Board will continue to oversee both organisations for the performance of the fund against the objectives set out in the BCF plan and the Health and Wellbeing strategy.

4.3.3 The governance arrangements ensure that there is sufficient authority to take appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. The Governance arrangements have been developed over the last 12 months, and clearly articulate the reporting requirements. They will be set out in full in Schedule 2 of the S.75 agreement. Existing contracts between the CCG and providers and the Council and their respective providers will not be affected by the continuation of a single host for the pooled fund.

4.3.4 To reflect the high number of partners and stakeholders and to ensure effective programme delivery a governance structure has been agreed by the programme's Senior Responsible Owners (attached at appendix 10.2)

4.4 Pooled fund management

4.4.1 Each individual work stream where there is a pooled fund has designated pooled fund management from both a health and social care perspective (commissioner). This role is undertaken by existing commissioners within each of the statutory partners, with the following duties and responsibilities:

- The day to day operation and management of the pooled fund;
- Ensuring that all expenditure from the pooled fund is in accordance with the provisions of the S.75 agreement and the relevant scheme specification;
- Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the pooled fund;
- Ensuring that full and proper records for accounting purposes are kept in respect of the pooled fund;
- Reporting to the Integrated Commissioning and Partnership Board (ICPB) as required (this would be through Executive work stream lead);

- Ensuring action is taken to manage any projected under or overspends relating to the pooled fund in accordance with the S.75 agreement;

- In conjunction with the overall pooled fund manager preparing and submitting to the Health and Wellbeing board/Integrated Commissioning and Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the pooled fund together with such other information as may be required by the HWB to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns;

- In conjunction with the overall pooled fund manager, preparing and submitting performance reports to the Health and Wellbeing Board on a quarterly basis.

4.5 Risks, Risk Share Arrangements and Management of Risk

4.5.1 The proposed risk share arrangements are detailed in this section. This is based on the risk assessment attached at appendix 10.1

4.6 Risk Share – Underperformance

4.6.1 The proposed revenue value of the pooled fund to be managed via the S. 75 agreement is £53.9 million (absolute values to be confirmed) and consists of £32.3 million (60%) of CCG funded services alongside, £21.6 million council funded services (40%). The council contribution includes £6.4 million representing the NHS transfer to social care (‘Section 256 funding). The pooled budget also includes a capital grant amounting to £2.4 million which are managed by the council.

4.6.2 The council’s contribution to the pool includes £3 million (which is relates to demographic pressures applied in the year 2015/16 of £2 million , and £964,000 of funding relating to the Care Act) that must be abated in order to retain funds for the burden of demographic growth and the new costs associated with the implementation of the Care Bill. This also creates a cost pressure within the pool and this risk is being shared across each work stream according to its size. Each work stream will be responsible for delivering efficiencies to meet this cost pressure and failure to do so will be dealt with in line for the arrangements for overspends below.

4.6.3 The risk sharing arrangement will be based on the proportion of each partner contribution (currently CCG 60% and CWC 40%). Please refer to table in section 4.5

4.7 Risk Share – Overspend

4.7.1 The host organisation shall produce monthly financial reports and share these with the other party. The first reconciliation to recoup any overspend shall take place at quarter two (month six), and quarter three (month nine). Month 11 reporting will incorporate year end estimates on the pool fund.

4.7.2 The Integrated Commissioning and Partnership Board shall consider what action to take in respect of any actual or potential overspends. The Board will take into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints and agree appropriate action in relation to overspends which may include the following:

- Whether there is any action that can be taken in order to contain expenditure;
- Whether there are any underspends that can be vired from any other fund maintained under this Agreement;
- How any overspend shall be apportioned between the Partners, such apportionment to be determined on the basis of the individual partner's contribution to the individual work stream as detailed in the section 4 of this report.

4.8 Approach to Risk Management

4.8.1 The two main bodies at the heart of the risk management process, and oversight of the S.75 agreement are;

- The Integrated Commissioning and Partnership Board (ICPB):
- The Integrated Commissioning and Partnership Board will be the governing body for integrated commissioning and also the pooled fund arrangements for the S.75 agreement. The ICPB operates at a strategic planning and approval level for all commissioning plans and associated delivery plans which form the body of the partnership.

4.8.2 The ICPB membership includes executive level, senior managerial decision makers from the Council (Strategic Director-People, Service Director Older People and Service Director Disabilities and Mental Health) and CCG Executive Commissioning and Finance Leads. It aims to develop stronger and deeper integration of health and social care and enhance joint working, including the pooling of budgets where appropriate. The ICPB will hold the system to account and performance manage against key performance indicators on a monthly basis. They will include mandated reporting against a dashboard for:

- Metrics
  - Admissions to residential and care homes
  - Effectiveness of reablement
  - Delayed transfers of care
  - Patient / service user experience
  - A locally – proposed metric
  - NHS Commissioned out of hospital services
  - Development of a clear, focused action plan for managing delayed transfers of care

- Finance
  - Budget Allocation
  - Actual Spend
  - Mitigation against overspend

4.8.3 This forum is not a statutory body and therefore needs to work in accordance with its delegated responsibility and also the accountability arrangements of the Council and CCG when it comes to, for example, considering the allocation of resources, undertaking mitigating actions or making policy commitments. It is the ICPB that will monitor the implementation of the integrated commissioning plans, the BCF work programme, and undertake a performance management role. It will report its findings to:

4.8.4 The Health and Wellbeing Board will operate as the governing body for natural oversight and facilitated discussions between NHS England, Wolverhampton CCG and Wolverhampton City Councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resource. The HWB provides the following in support of the S. 75 agreement :

- Leadership – providing strategic support to the developing relationship between the CCG and council, developing a shared vision of future services, holding a helicopter view of resources across the whole system, oversight of the impact of transformational change and risk management;

- Public, patient/user and community engagement;

- Professional and administrative support – engagement of public health in assessing need, deriving evidence, and harnessing opportunities for fuller approaches to integrated commissioning, support to the integrated commissioning process and its fit with existing programmes of integrated care, agreement and use of performance metrics for BCF, oversight of organisational capacity;

- Plan delivery – oversight and exception reporting via the Integrated Commissioning and Partnership Board

4.8.5 In addition individual organisational systems of governance will remain intact, and the approach to delivering the ongoing programme of work for the Better Care Fund will continue to deliver in accordance with the governance requirements of both Governing Body (CCG), and City Council Cabinet requirements, as per the current Better Care Fund approach.

4.8.6 The Better Care Fund Programme Board consists of Commissioners and Provider representatives and oversees the delivery of the programme and its associated work streams.

4.9 Risk Analysis - management of the proposed section 75 agreement

4.9.1 A detailed risk assessment has been undertaken to understand document, and mitigate the risks that could occur in relation to the operation of the pooled fund in 2016/17. This is attached at appendix 10.1

5.0 Financial implications

5.1 The value of the pooled fund for 2015/16 was £70.7 million revenue; of which £22.8 million related to council funded services and £47.9 million related to CCG funded services. The fund also includes £2.1 million capital grant which is managed by the council.

5.2 The draft BCF revenue pooled fund for 2016/17 is £53.9 million, of which, £21.6 million is made up of services that are managed by the council and £32.3 million for the CCG. This includes £6.4 million representing the NHS transfer to social care ('Section 256 funding). In addition to the revenue services the bid includes capital grants amounting to £2.4 million (Dedicated Facilities Grant).

5.3 The pooled fund requires efficiencies to be realized to fund the council's demographic growth of £2 million and care act implementation funding of £964,000. (Plus inflation to be confirmed). The risk sharing agreement sets out how these costs will be shared between the partners if the efficiencies are not found (see section 5.5 below).

5.4 The pooled budget is broken down into the following work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000)	Total Services (£000)
Adult Community Services	24,015	18,639	42,654
Dementia	2,586	321	2,907
Mental Health	5,705	2,645	8,350
Total Contribution to Pooled Fund	**32,306**	**21,605**	**53,911**
(Ring Fenced Capital Grants)		2,440	2,440

5.5 The risk sharing arrangements for any over/underspends with the pooled fund and the non-delivery of efficiencies as detailed in section 5.3 will be shared as follows:

	CCG Risk %	Council Risk %
Adults Community Services	56	44
Dementia	89	11
Mental Health	68	32
Ring Fenced Capital Grant	0	100
Demographic Growth	60	40
Care Act Monies	60	40

[AS/14032016/I]

5.0 Legal implications

5.1 The section 75 agreement must be in place for the start of the 2016/17 financial year.

5.2 Section 75 of the NHS Act 2006 (the “Act”) allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority. The Act precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

For local authorities, the services that can be included within section 75 arrangements are broad in scope and a detailed exclusions list is contained within Regulations of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000.

5.3 The agreement has been drawn up using a template produced for the programme based on pilot projects and has been developed following advice from the Clinical Commissioning Group and Council’s Legal Services and external solicitors. It will contain detailed provisions concerning a number of key issues, including performance, governance, fund management and risk sharing as outlined above.

5.4 The agreement describes the detailed arrangements that will be covered by the individual BCF projects and work streams, outlines the financial commitment of both organisations and outlines the governance structures and hosting arrangements for the pooled fund.

5.5 The governance arrangements will ensure that there is sufficient authority to take appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. This is outlined in Section 3 above, and will be included in detail within Schedule 2 of the agreement.

5.6 A Section 75 agreement with the CCG in relation to the BCF is required to be in place before the beginning of the financial year 2016/17

5.7 Work is underway to ensure that the S.75 schedules, which form a critical part of the agreement, are completed and agreed. The Council’s legal department has been leading on the provision of legal advice to the process alongside the CCGs legal representation in support of the partners through the development stage.

5.8 Prior to signing both partners will secure independent legal review of the final agreement.

5.9 The S.75 agreement is a vehicle for the delivery of the BCF plan. This plan was developed jointly across the CCG, City Council and involving other lay partners and providers and aims to support the delivery of the Councils and CCGs strategic vision, supporting the achievement of effective, efficient and integrated community and neighbourhood facing services.

5.10 The notice period for ending the Section 75 agreement, by negotiation, is 3 months. (RB/09032016/X)

6.0 Equalities implications

6.1 Individual schemes and initiatives funded by the Better Care Fund will be subject to robust Equality Impact Assessments. This is to ensure compliance with the Equality Act 2010 and to pay due regard to the Public Sector Equality Duty.

6.2 All identified opportunities for integrated delivery of care and effective integrated commissioning in Wolverhampton will be informed by the local population needs identified in the Joint Strategic Needs Assessment, in detailed analysis of local neighbourhoods, and set out in the City Council's Corporate Plan and CCG's Strategic Vision.

7.0 Environmental implications

7.1 No apparent environmental impact.

8.0 Human resources implications

8.1 No apparent HR impact.

9.0 Corporate landlord implications

9.1 None identified

10.0 Schedule of background papers

Appendices

10.1 Risk Assessment
10.2 Programme governance

Appendices
10.1 Risk Assessment

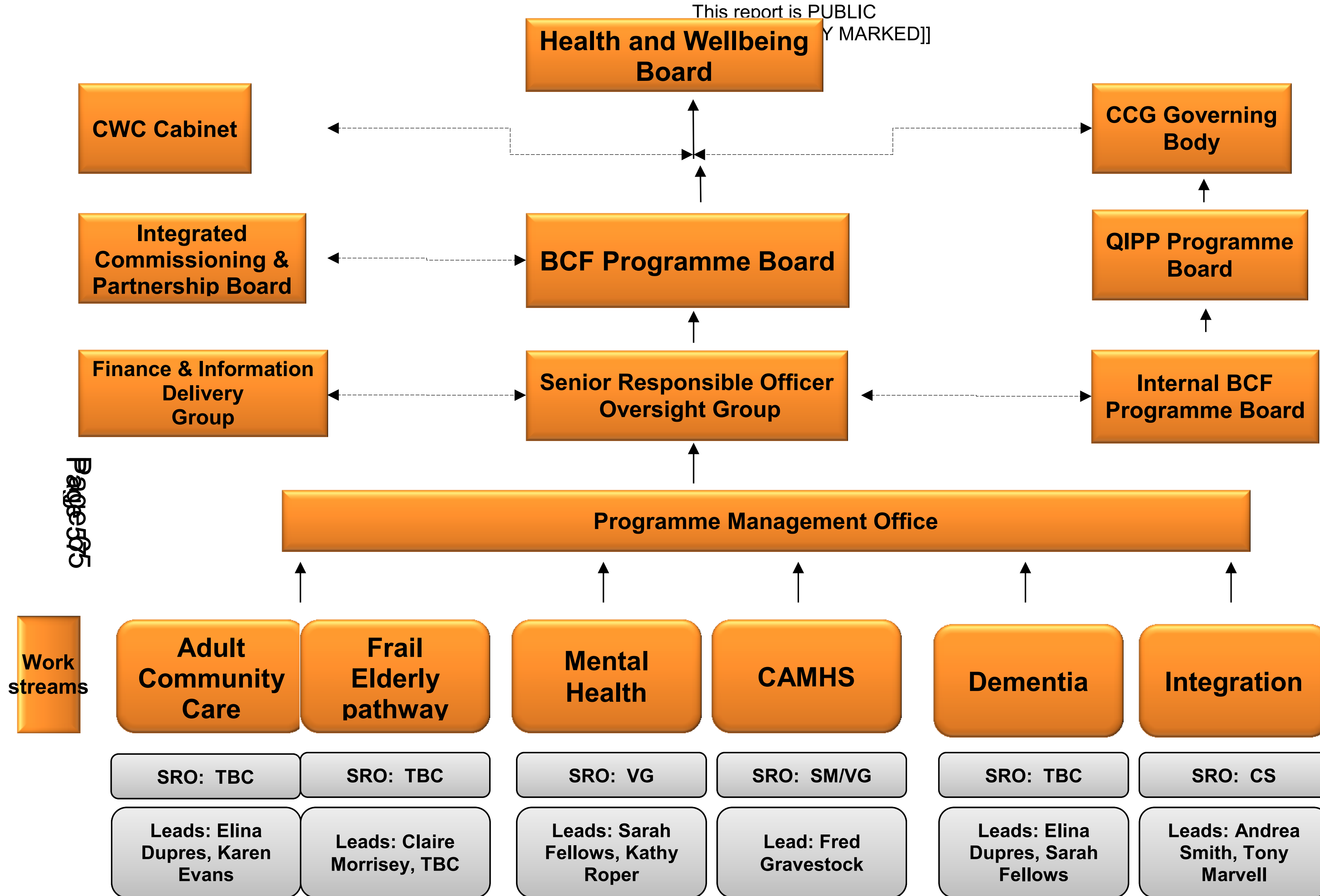
Financial Risk	Mitigation	Maximum Negative Pooled Financial
Overspends across work streams within the pool fund. Budgets are net of efficiencies required by both organisations (savings programmes (CWC Medium Term Financial Savings ("MTFS") and CCG QIPP)).	• CCG set budgets based on previous years out-turn, mitigating against the carry forward of any overspend. • Monthly financial monitoring reports Development of a Transformation • Programme Board and PMO approach • within the City Council • Existing performance management	Unable to quantify
The proposed 2016/17 BCF allocation includes funding of £2.0 million for the forecast financial impact of demographic growth on social care, and £964,000 for Care Act implementation costs. Efficiencies will need to be realised within the pooled budget to fund these costs. The ongoing demographic growth pressure for 2016/17 and beyond is forecast to increase by £2.0 million per year: it is essential that the pooled fund is of sufficient scale to enable these efficiencies to be realised. The council's medium-term financial strategy (MTFS) currently assumes that these pressures will be funded in full from the BCF.	• Ongoing financial and redesign modeling in progress • Care Act costs are incremental • Redesign and development enables further efficiencies to be achieved • NHS England has not yet identified how non recurrent contingency funds will fit in with the broader requirements for contingency and transformational funding.	£3.0 million (Withheld from the pool by the Local Authority at pooled budget commencement to cover local authority risk. Pooled budget risk apportioned based on the total revenue contribution of both parties to the pool.

Operational Risk	Mitigation
Better Care Fund schemes will not succeed in reducing A&E attendances and as a result the 4-hour target will be missed.	• Provider engagement with planning and development has been significant and plans were agreed across the commissioning and provider landscape. • A dedicated resource (senior nurse) is now in place within the acute provider specifically working on implementation plan development and support, in order to build capacity into the system
	• Monitoring monthly against identified HRG codes Performance reporting via TCB and HWB • Ongoing leadership from the local acute and community providers • Further urgent development of primary care models (completion 13.03.2015) to harness this resource in delivering alternatives to A&E attendance through design •
Better Care Fund schemes will increase demand for community services, resulting in higher waiting times for community care assessment.	• Plans for redesign to minimise this impact are in place. Fully integrated health and social care teams are planned to reduce duplication (identified through mapping), and increase capacity • Further urgent development of primary care models (completion 13.03.2015) in place to harness this resource in delivering alternatives to A&E • Capacity demand modeling in progress
Better Care Fund schemes shift staff to community services, resulting in deteriorating performance against the 18-week referral-to-treatment target.	• No immediate plans to shift staff into community but through redesign, capacity is being developed, and through capacity modeling, capacity in current structure has been identified

Quality Risks.	
The disruption associated with Better Care Fund schemes reduces social care related quality of life for service users.	All plans are designed to improve social care related quality of life for service users Quality and Risk group established
The disruption associated with Better Care Fund schemes impacts on patient experience of NHS services as measured through the Friends and Family Test.	Implementation plans in development will take the potential for disruption into account and mitigation plans Communication and engagement with the public regarding the plans, rationale, and impact – plan in development Establishment of a communication group has commenced linked to the national communication network

Appendix 10.2 – Programme Governance

This report is PUBLIC
[[NOT PROTECTIVELY MARKED]]



This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
Tuesday 12 April 2016

Agenda item 11

Title of Report:	**New Models of Primary Care**
Report of:	Mike Hastings
Contact:	Mike Hastings
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update on the emerging new models of care within the CCG membership
Public or Private:	The report is appropriate for the public meeting
Relevance to CCG Priority:	
• **Domain 4:** Planning (Long Term and Short Term)	Implementing new models of care within primary care in line with the Five Year Forward View
• **Domain 5:** Delegated Functions	Supporting GP practices as a part of joint commissioning of primary care

1. BACKGROUND

1.1 The Five Year Forward View (5YFV), published by NHS England in October 2014, identified several potential new models of care for the future delivery of National Health Services in England.

1.2 The CCG's Primary Care Strategy recognises the need to explore and develop new models of care, highlighting the need for practices to work together to create a critical mass in terms of patient population. In addition to the support from the CCG to develop these models of care, there are two emerging pilot projects for delivery for Primary Care within Wolverhampton CCG member practices – the Primary Care Home (PCH) grouping and the RWT Vertical Integration arrangement.

1.3 Work with these projects is on-going and progressing quickly. A version of this paper is being considered at the Primary Care Joint Commissioning Committee on 5 April and a verbal update on any new developments will be given at the meeting

2 NEW MODELS OF CARE

2.1 Primary Care Home

This model is a collective of eight practices dispersed across the city providing services for around 47,000 patients who have come together to offer services in new ways. They responded to a national call to form new models of care from the National Association of Primary Care and are one of 14 Rapid Test Sites across England. The member practices are:

- Church Street Medical Practice (Drs Saini & Mehta)
- The Newbridge Surgery (Drs Pickavance, Nazir & Badr)
- Caerleon Surgery (Drs Asghar & Labutale)
- Tudor Medical Practice (Dr Agrawal & Partners)
- Fordhouses Medical Centre (Dr Kharwadkar)
- Keats Grove Surgery (Drs Kehler, Aung & Naz)
- Whitmore Reans Health Centre (Drs Vij, Vij, Mohindroo & Handy)
- East Park Medical Practice (Drs Majid, Malhi, Ravindran & Ravindran)

The programme has three initial stages:

- Stage 1: November - January 2016 – establishing the programme and selection of Rapid Test Sites

- Stage 2: January – March 2016 – support the learning and development of the Rapid Test Sites based on identified needs and share learning and innovation with other interested organisations

- Stage 3: April 2016 – Mar 2017 – shadow running of Rapid Test Sites to test and implement the PC model on an incremental basis. Support to other interested parties by sharing learning across multiple sites as the Rapid Test Sites develop, in conjunction with the NHS Confederation.

- The model of care proposed as part of the PCH is very similar to the Multispecialty Community Provider (MCP) and focuses on drawing together a wide range of health and social care professionals to work together and provide integrated out-of-hospital care. This aims to provide care to patients that is significantly more person-centred, joined-up, proactive and convenient through:- Provision of care to a defined, registered population of between 30,000 and 50,000;

- A combined focus on personalisation of care with improvements in population health outcomes;

- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and

- Aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards. The key and unique benefits of the PCH model and programme is realised by focusing on:

- A defined registered population proportioned to maintain personalised care from an inclusive interprofessional team;

- Delivery of high quality clinical care across local organisations; and

- Driving behavioural and cultural change.

The pilot project is in the very early stages, with a key focus on identifying areas where joint working would be most beneficial. This includes working with the CCG to share data analysis work so that models of integrated working can be most effectively targeted. The homes are also looking at other forms of partnership working; including an innovative project with the Fire Service to share intelligence about vulnerable people in need of support. Whilst it is unlikely that patients will see significant changes to the way services are delivered in the short term, the intention is that the lessons from these pieces of work will then be used to support service development in future years.

2.2 RWT Vertical Model

There are three practices (providing services for around 22,000 patients) involved in a pilot scheme with the Royal Wolverhampton Trust. These are:

- Lea Road Medical Practice (Drs Sidhu, Bird & Maarouf)
- MGS Medical Practice (Dr Bagary)
- Alfred Squire Medical Practice (Dr Parkes & Partners)

The proposal is intended to improve working between the Trust and the GP practices to remove perceived barriers between GPs and the hospital and improve the use of staffing resources. This is intended to improve patient experience by reducing waiting times for GP appointments, faster referrals into secondary care services via improved flows of information. Discussions continue around potential metrics to measure the project's success but key themes include:-

- Access to primary care
- Patient experience
- Primary care workforce
- Linking to the NHS Outcomes Framework
- Care Transition Measures

As current legislation does not permit the Trust to hold GMS contracts, the intention is for the practices to 'sub-contract' the delivery of the services to RWT. To support this, the existing practice staff will then be employed by RWT within a new Directorate of Primary Care to ensure continuity of service for patients. As a sub-contractor, RWT will then be responsible for managing the service on a day to day basis (including paying and supporting staff, arranging locum cover when required, supervision arrangements for staff etc.) with the partners maintaining responsibility for the premises and delivery of the service. There are still lots of questions to be answered regarding the governance arrangements for this model, in particular the management of potential conflicts of interest associated with the partners' dual role as holders of the contract and employees of the trust. Discussions with the practices and RWT continue to ensure assurance can be provided that the arrangements will meet NHS England requirements for the delivery of GMS contracts.

3. RISKS AND IMPLICATIONS

Key Risks

3.1 The discussions around the new models of care are at an early stage so the full implications have yet to emerge. The initial discussions have highlighted a number of risks, particularly around actual and perceived conflicts of interests in relation to the Vertical Integration model.

Financial and Resource Implications

3.2 There are no immediate resource implications however, the aspiration of both projects is to move towards capitated budgets at some stage and any implications that arise from this work as it progresses will be analysed.

Quality and Safety Implications

3.3 There are no immediate quality or patient safety implications arising from this update report.

Equality Implications

3.4 There are no immediate equality implications, however a key consideration for the CCG will be ensuring that the benefits from New Model of Care are passed on to all patients across Wolverhampton.

Medicines Management Implications

3.5 There are no immediate medicines management implications.

Legal and Policy Implications

3.6 The Governance arrangements related to New Models of Care are being discussed and designed to ensure that they meet relevant legislative requirements.

4. RECOMMENDATIONS

4.1 The Governing Body is asked to note the two main new models of care emerging within Wolverhampton, along with any update from the Primary Care Joint Commissioning Committee.

Name: Mike Hastings
Job Title: Associate Director of Operations
Date: 29 March 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)	**Mike Hastings**	**29/03/2016**

NHS
Wolverhampton
Clinical Commissioning Group

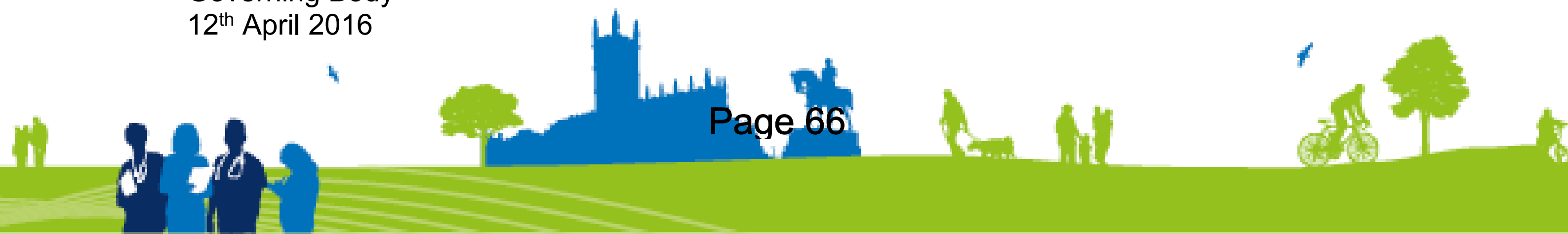
WOLVERHAMPTON CCG

Governing Body Meeting – 12th April 2016

Agenda item 12a

Title of Report:	**Commissioning Committee – Reporting Period March 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 March 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 March 2016.

2. MAIN BODY OF REPORT

2.1 Contracting & Procurement Update – Month 10 January 2016

Contract offers received to date include:

- Birmingham Children's NHS Trust
- Birmingham Women's NHS Foundation Trust
- Dudley Group Foundation NHS Trust
- Robert Jones and Angus Hunt NHS Trust
- Dudley and Walsall Mental Health Trust
- University of Birmingham Trust
- West Midlands Ambulance Trust

Progress continues to be made with the negotiations with Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust. A financial envelope has been agreed and it is anticipated that contracts will be signed off by 31st March 2016.

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 improved slightly since December to 89.31%, however the RAP trajectory of 92% was not achieved and commissioners have been asked to withhold 2% of the A&E payment, in line with General Conditions (GC) 9 of the contract.

Cancer Targets

Three cancer wait targets did not achieve their targets in January.

The percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer has dipped to 71.34% with an overall Q3 breach of 80.48%. This is directly linked to patients choosing not to have appointments during the holiday period.

The validated UNIFY January cancer wait data is not yet available so no action has been undertaken this month.

New breaches occurred in the following two areas:

- Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery
- Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. This was due to bed capacity issues.

Referral to Treatment (RTT) 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 in December. Overall the Trust has been achieving against this target throughout the year, however performance has been declining. At a speciality level the Trust is failing to achieve in the following areas:

- General Surgery
- Oral surgery
- Trauma and Orthopaedics
- Urology

A Recover Plan is in place.

E- Discharge - RWT

The Trust acknowledges that they will not achieve this target for the year. Monitoring will continue to take place through the Quality and Contract meetings.

Performance/Sanctions

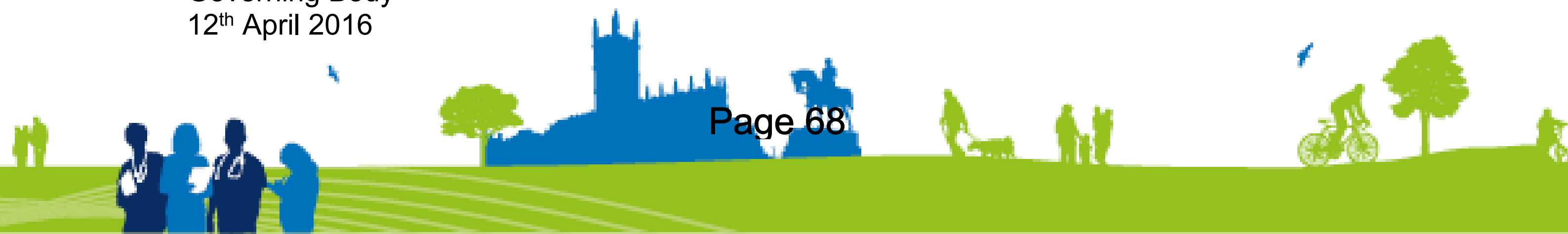
2015-16 total sanctions levied to RWT to date equates to £1,402,080.00 across the whole contract.

RWT have submitted a number of bids to the CCG which are currently being reviewed.

Activity & Finance

Overall Position by Commissioner

- Over performance is currently at £7.3m with Cannock equating to £8.5m.
- Stafford & Surrounds is the biggest under performer at £2m with Wolverhampton at £1.4m below plan.



Speciality Performance

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

Community Services by Commissioner

- As at month 9, the Community element of RWT contract is £136k under plan.
- Dudley CCG is currently £14k above plan
- Wolverhampton CCG remains “break even”

Community Over-Performing Specialities

- Community Matrons continue to be the top over performing specialty, and is now £188k above plan YTD
- District Nursing is now £172k over plan
- CICT Rehab also continues to over perform and over performance has increased to £72k in month 9
- 14 specialties are under plan equating to £694k of under-performance.

Contract Negotiation Update

Weekly escalation meetings are in place and there are a number of key issues/ significant gaps to be resolved relating to the following areas:

- Clinical Decision Unit tariff
- Urgent Care Centre (percentage reduction of A&E activity)
- End of Life block payment
- Chest Pain pathway
- WUCTAS – change in medical triaging process
- Critical Care local price
- Level of growth to be applied

Black Country Partnership Foundation Trust

Action plans are in place for the following areas which 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.

Two open Contract Performance Notices were discussed at the January Clinical Quality Review meeting and action plans are being monitored.

Contract Negotiation Update

The following issues/gaps exist which were reviewed at an Escalation Meeting:

- IAPT funding
- Non-recurring funding
- Bed day costs for WCCG patients

Other Contracts

Nuffield – contract negotiations are progressing well and a draft contract has been issued.

Vocare (Urgent Care Centre provider) – A draft contract has been issued. Step in arrangements have now been established for the period 9th to 31st March, as requested by RWT via the System Resilience Group.

Non-Emergency Patient Transport (NSL) – this contract is due to run through until September 2016. On-going problems exist with non-payment of invoices from certain associate commissioners which the CCG is helping NSL to resolve.

2015-16 Procurement Schedule

The procurement schedule is on target. However, there is some slippage with procurement for the Non-Emergency Patient Transport procurement. If a start date is delayed an interim provider will be sought.

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

2.2 Community Team Neighbourhood Specification

The Committee were presented with a report that sought approval of a Service Specification for the implementation of new Community Neighbourhood Locality Teams based around Primary Care. The teams will be the foundation for further development of new models of care closer to home and will work in partnership with patients to develop goals and outcomes which optimise their health and social wellbeing.

Currently all Community Nursing Teams operate in silos and services are fragmented with duplicated activity. This results in unacceptable professional 'traffic' in people's homes and people 'falling through the gaps' during transition between service providers. The proposed new service has been agreed and co-produced through the BCF work stream for Intermediate and Community Care. It is anticipated that it will realise a number of benefits and opportunities for efficiencies, but the main driver for

this initiative is to provide local, person centred care and support for Primary Care in the case management of high risk patients.

The Service Specification was approved in principle and it was requested that a more detailed specification, identifying how the specific teams function and what the demand profiles are, is submitted to the next Committee in May.

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

2.3 Draft Commissioning Committee Annual Report

The Committee are invited to consider the Annual Report and suggest any appropriate amendments prior to submitting it to the Governing Body for assurance. In particular, the Committee are asked to confirm what conclusions they can draw from the Annual Report around whether the Committee has been effective in meeting its duties set out in the Terms of Reference.

Action – The Committee request that Governing Body note the content of the report sign off the formal version of Commissioning Committee Annual Report.

3. RECOMMENDATIONS

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

Attached ~ Community Neighbourhood Specification

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

This page is intentionally left blank

Service Specification

Service	Community Neighourhood Teams
Commissioner Lead	Wolverhampton CCG
Provider Lead	Royal Wolverhampton Hospitals NHS Trust
Period	1st April 2016 – 31st March 2017
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Background

The NHS and Social care are faced with the major challenges of using resources more efficiently and of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent. The key task therefore is to implement a new model of care in which clinicians and Social Care professionals work together more closely to meet the needs of patients and to co-ordinate services. This model of integrated care would focus much more on preventing ill health, supporting self-care, enhancing primary care, providing care in people's homes and the community, and increasing co-ordination between primary care teams and specialists and between health and social care.

The Keogh review of Urgent and emergency care services in England published in 2013[1] recognised that the current system is under intense, growing and unsustainable pressure that is driven by demand from an ageing population.

He advocated a system wide transformation was the only way to find a sustainable solution.

Highlighting opportunities to 'move care closer to home', Dr Keogh states that 40% of A&E patients are discharged requiring no treatment, up to one million emergency admissions were avoidable in the previous year and up to 50% of 999 calls could be managed on scene.

In the updated report published in 2014, Dr Keith Willetts, Director for acute episodes of care NHS England, stated that "*we must not be fooled into thinking change isn't necessary. The pressures we highlighted last November still exist, and the challenges that the health and social care system faces in delivering urgent and emergency care remain*"[2]

In this report update, Dr Caron Morton, Accountable Officer, states that nationally there is a recognition that 'one size doesn't fit all' to a solution to this problem and that CCGs need to be supported and encouraged to develop local bespoke solutions for their populations.

In order to move from the current to the future system the report update proposes five key elements of change. These should apply to all patients, regardless of their age, location, co-morbidities or physical and mental health needs:

- Providing better support for people to self-care

[1] The Keogh Report on Urgent and emergency services – 1st stage report. Nov 2013
[2] Transforming urgent and emergency care services in England Update on the Urgent and Emergency Care Review. 2014

- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services so the overall systems becomes more than just the sum of its parts

The NHS Confederation report 'Ripping off the sticking plaster'[3] advised that the NHS needs to find practical whole-system solutions to address current pressures and that failure to find such solutions, and to act on them quickly, could have dire consequences for patients, and for the NHS as a whole.

The report recognizes that the sheer scale of the challenge means that it cannot be tackled by NHS organisation's working in isolation. Solutions hinge on change happening across the system, and leadership and shared responsibility that unites all parts of the service.

To this end, a whole-system approach that involves all commissioners and providers of hospital, ambulance, primary, community, mental health and social care services working effectively together is required.

Local Context

Wolverhampton is one of the most densely populated local authority areas in England with a population of approx. 262,000 (registered population). The average age of residents in Wolverhampton is 39 similar to the national average; however broken down by specific age groups Wolverhampton has a slighter higher proportion of children aged less than 16. The older population is predicted to increase over the next 10 years in line with the national average.

Population forecasting undertaken indicates that the number of males and, to a lesser extent females aged 85 and over is to increase significantly by 2018. The Wolverhampton Joint Strategic Needs Analysis (JSNA) supports this with population projections showing increases across both 65 to 84 and 85 and over age groups for males and females.

The CCG has developed operating plans that cover two and five year periods and detail that strategic objectives and priorities.

This service will contribute to three of these objectives:

Strategic Objective	
Transferring and integrating services to maximise the quality of care	✓
Development of services and capacity outside of hospital	✓
Assurance, monitoring and development ensure quality and access to services	✓

The shift to the implementation of multi disciplinary, integrated Community Neighbourhood teams will realise a move from commissioning episodic care to a more outcomes based approach focussing on patient holistic needs.

Community Neighbourhood Teams

The development of Community neighbourhood teams is part of a large programme of work

[3] Ripping off the sticking plaster Whole-system solutions for urgent and emergency care

being delivered under the umbrella of the Better Care Fund. The Better Care Fund, consists of all health and social care organisations in Wolverhampton who have agreed to work better together to commission and provide safe, high quality and financially sustainable services for the residents of Wolverhampton.

By adopting a more integrated approach the aim is to prevent people having unnecessary stays in hospital, reduce demand on emergency and urgent care services, and improve health and social care outcomes for everyone in Wolverhampton.

The delivery of Community Neighbourhood Teams is underpinned by the following underlying principles:

- Services should be safe, accessible, convenient and responsive
- Patients should receive high quality care person centred care
- Health and Social professionals see a shift from delivering episodic care to a more integrated, person centred model of care
- Patients should be empowered and supported to manage their own care and self-care where clinically appropriate.
- Services should be local wherever possible
- Services should be centralised where necessary (to ensure clinical safety).
- Care should be seamless across health and social care. Patients shouldn't be impacted by silo working
- Information and communications should be centred on the needs of the patient not the organisation or professional taking into account the diverse population of Wolverhampton

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

2.1.1 Adult Social Care Outcomes Framework

Domain 1	Enhancing quality of life for people with care and support needs	✓
Domain 2	Delaying and reducing the need for care and support	✓
Domain 3	Ensuring that people have a positive experience of care and support	✓
Domain 4	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	✓

2.1.2 Public Health Outcomes Framework

Outcome 1	Increased healthy life expectancy	✓
Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities	✓

2.2 Locally defined deliverables

- A progressive increase in Improved customer experience, satisfaction
- A progressive increase in a real shift of appropriate activity into appropriate services within the Community neighbourhood team
- Improved partnership / shared care working with Primary Care
- Improved access to services that are able to swiftly support early discharge from hospital
- Access to flexible services that are able to swiftly react to emergency situations that include exacerbation of chronic conditions
- Improved access to flexible services that support the holistic needs of patients through delivering seamless care at the appropriate time, place and delivered by the most appropriate professional(s)
- A progressive reduction in A&E attendances and emergency admissions
- Improved clinical outcomes for patients through the implementation of seamless, risk managed, safe pathways of care
- Reduced duplication of assessment (health only)
- Appropriate sharing of information between professionals and organisations enabling effective joined up care
- Delivery of efficient and effective services based on the holistic needs of the identified patient population
- Improved health and social quality of life for patients with LTC's or life limiting conditions
- Adopt a preventative and proactive approach to the delivery of services focusing on supporting patients with the knowledge and skills to facilitate self-care, improve general wellbeing and promote independence
- Patients identified as at risk or with increased risk score identified and proactively case managed with appropriate and timely interventions to maintain their care within a community based setting.
- The delivery of care co-ordination for all patients with a nominated lead professional for their care
- An effective risk management approach to delivery of care closer to home and enabling patients to self- manage their condition within their usual place of residence
- Evidence of learning from untoward incidents and action planning being core to the operational delivery of the services

3. Scope

3.1

Service Description

Each Neighborhood Team will wrap around a number of GP practices and their populations. The teams will be made up of district nurses, community matrons, intermediate care professionals and social workers along with the existing GP practice staff.
People who use services, along with their family and carers, will be at the heart of these teams.

Linking in with the neighborhood teams will be a whole range of specialist and other services, including services provided by the voluntary sector for example :

- Age UK

The teams will provide a service in a variety of settings, primarily the persons own home but delivering some interventions in other locations such as GP practices, community clinic locations or residential/care homes.

The skill mix and capacity of the teams within the localities will vary to meet the particular health needs of each locality and allow maximum flexibility in resource allocation.

As a minimum, the team will consist of:

- Advanced Nurse Practitioner
- Community Matron
- District Nurses
- Therapists
- Social Care professionals

3.2 Aims of the service

The aim of the Community Neighborhood teams is to provide multidisciplinary, seamless care closer to a patient's home, reducing admission to hospital and facilitating speedier and timely discharge.

70 per cent of premature deaths are caused by detrimental health behaviors, it is vital that people engage more with improving their own health.[4]

What people do in their everyday lives – what they eat, how much they exercise and how far they follow medical advice – largely determines their health and their need for health care (World Health Organization 2005).

The Community Neighborhood Teams will deliver a wide range of interventions including working with patients to achieve better self-management of their long term conditions. It will incorporate clinical intervention when needed however it is also about working with and supporting patients to develop a personalized approach to their conditions

One of the aims of the Community Neighborhood teams is to increase 'Patient Activation'. The influence of patient behavior on health outcomes can be seen in everything from preventing illness in the first place through to the management of long term health conditions.

Patient activation refers to a person's ability and willingness to take on the role of self-management of their health and health care needs. The higher the level of activation the higher the patient's engagement in healthy behaviors, self-management and knowledge regarding their conditions.[5]

Activation focuses on embedding the skills and knowledge required for day-to-day management of health. The service will aim to increase patient's engagement with their own health it will support patients to manage their conditions reducing the need for avoidable admission to hospital and reducing dependency on community health services.

The Community Neighborhood team will include Community Matrons, Advanced Nurse Specialist, District Nurses, Occupational and Physiotherapists, calling on support where needed from other professionals.

3.3 Service Objectives

- Increased patient satisfaction with clinical and social care services
- Reduce the fragmentation of care provision so that there is seamless, integrated

[4] Supporting people to manage their health. The Kings Fund May 2014
[5] Supporting people to manage their health. The Kings Fund May 2014

and personalised care, when and where people need it, ensuring that patients do not get lost in a complex system

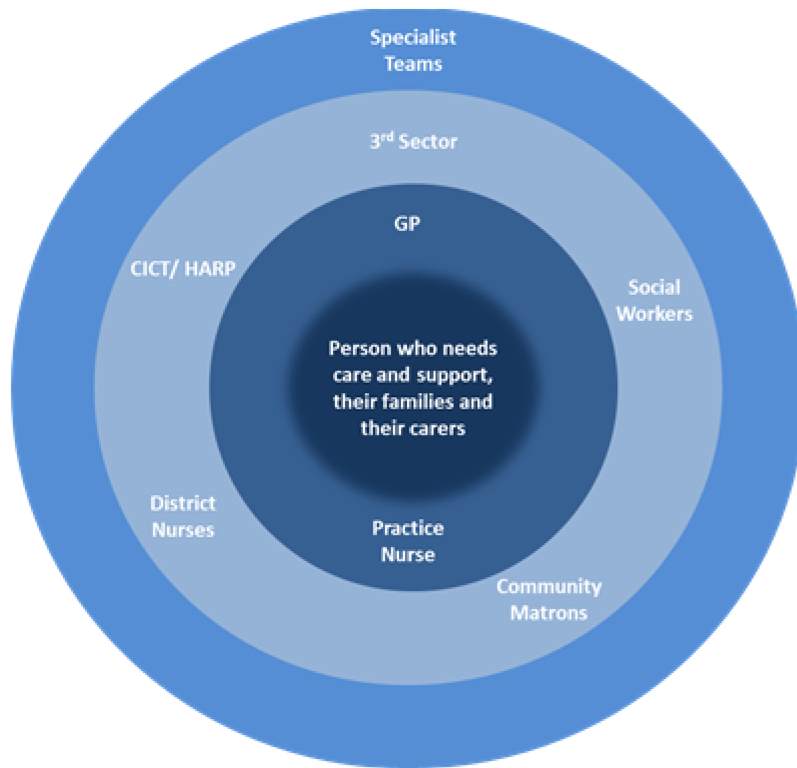
- Provision of services that encompass the whole patient journey, are fully integrated and centred on patients' needs
- The provision of integrated care , centred around the patient with access to local services, providing continuity of care;
- Provide a coordinated quality focussed service to receive referrals from health and social care professionals within the community
- Facilitate and co-ordinate the provision of holistic care required to support the patient (health and social care)
- Monitor the delivery of care to ensure that the agreed health and social input is received in a timely manner/to the timescales agreed
- Improve accessibility to community based services (health and social care)
- Less time spent by referrer navigating services in an urgent, intermediate or longer term situation
- Pathways to other support services will be jointly developed to facilitate smoother referral processes
- Communication between services (health and social care) will be appropriate to ensure timely treatment and/ or discharge from services
- Reduction in unnecessary admissions to hospital of patients who could be cared for at home, in crisis,
- Increase early discharge of patients from hospital who no longer require acute medical intervention
- Delivery of safe, robust clinical & social outcomes
- Delivery of seamless care with reduced duplication of assessment and diagnostics (health only)
- All professionals will facilitate and the sharing of necessary information to provide holistic, person centred care
- Community Neighbourhood Teams will be locality based and aligned around a number of GP practices and their populations
- All professionals will work in a collaborative manner delivering a shared care approach to the identified patient population
- Locality based teams will the development of the workforce to meet the changing health and social needs of the identified population

3.4 Service Model

The community neighborhood teams will have a single access point which will receive all referrals from health and social care professionals that meet the criteria of each team. Referrals will be directed to the most clinically appropriate service for the identified need of the patient.

The different functions of the Community Neighborhood Team include:

- Rapid Response (which will include Home In reach Team, service specification to be developed following end of pilot in March 2016)
- Intermediate Care (CICT)
- Community Delivery Team (Service Specification under review)
- Delivery of Core District Nursing Service (Service Specification under review)



Functions of Community Neighborhood Teams:

Risk stratification

Community matrons will work closely with GP practices to risk stratify and identify patients who have either complex needs or at risk of admission and would benefit from a case management approach or would benefit from multidisciplinary team discussion. Patients at risk of admission to hospital will be identified through the use of a risk stratification tool (Aristotle).

The purpose of this is to agree with the person a planned 'shared care' holistic person centred approach which stabilises the person's condition and prevents further unnecessary admissions and/or supports earlier discharge. Management of the patient will include designation of a case manager who will co-ordinate the provision of care. The case manager will be the most appropriate health or social care professional depending on the patient's assessed clinical or Social needs

Integrated Case Management

Community Matrons will proactively case manage patients referred by their GP for complex care needs.

Intermediate care (CICT)

Neighbourhood community teams will work with patients to achieve their optimum potential and maintain them in their own home or residence of choice. This service element will facilitate the delivery of all forms of intermediate care, providing an interface between primary and secondary care and working closely with the rapid response team.

The patients who are the focus of this care include those who:

- require further rehabilitation following an acute medical or surgical episode;
- require further rehabilitation following a fall, once their medical treatment is in place;
- Following an acute care episode, patients with long term conditions such as stroke, Multiple Sclerosis, Parkinsonism, head injuries, obstructive airways problems requiring additional support or rehabilitation.

In all cases each individual will be assessed and their care will be tailored to meet their individual needs.

Facilitated Discharge from acute care to intermediate care

The Neighborhood Community Teams will assist patients who are medically stable in an acute setting by providing a short term rehabilitation intervention designed to enable a timely, coordinated discharge from hospital.
The objective is to improve an individual's level of independence, help build confidence and to re-equip them with the skills to remain in their usual place of residence.
This approach is appropriate for people who are in hospital and can continue to regain their independence in the community (e.g fractured neck of femur).

Rapid Response

The aim of the Rapid Response function is to primarily prevent unnecessary hospital admissions by providing a multi-disciplinary team approach for those experiencing an acute episode of illness or injury that are in a health and social care crisis. The rapid response service utilises varying levels of interventions in order to prevent avoidable hospital admission and incorporates rapid response and assessment, crisis support and support/intervention during acute illness.
The service will provide care for a maximum of 2 weeks (exception by agreement based on clinical need).

Core District Nursing

Core District nursing provision will be delivered in line with current service specification

3.5 Care Pathways

The Community Neighborhood teams will be expected to utilise relevant care pathways to deliver integrated care including but not limited to:

- Rehabilitation and maintenance
- End of life care
- Urgent care services
- Falls
- Community beds (step up/step down)

3.6 Days/Hours of Function

- Rapid Response - 8am to 8pm, seven days a week (this will be a phased implementation following completion of a pilot)

- Intermediate Care (CICT & HARP) – 8am to 10pm, seven days a week

- District Nursing Service – Operational Monday to Sunday, 24 hours a day, 365 days a year including bank holidays)

- Integrated Case Management Team – will be provided from 8.30am to 5pm,

Monday to Friday, only exception is on Friday where core hours for social care team are 8.30am to 5.30pm with the intention to move to seven days a week

3.7 Referral Route

Health related referrals will be received via the locality single point of access.

Social Care referrals will be received via locality single point of access

3.8 Response time and prioritisation

- **Rapid Response** - The rapid response multi-disciplinary team see, assess, diagnose and treat the patient within two hours of referral to the service.
- **CICT** patients will be assessed and prioritized based on clinical need
- **Integrated Case Management Team** Referrals will be prioritized based on clinical need Outlined within Service Specification

3.9 Transfer of patent data

Providers must establish and maintain clearly documented responsibilities and procedures in relation to the transfer of patient identifiable and clinical information to services in line with current information governance standards.

3.10 Population Covered

The service is available to anyone aged 18 and over who is registered with a Wolverhampton CCG GP practice (health & social care), or, is resident within Wolverhampton and are registered with a non Wolverhampton CCG GP (social care only).

3.11 Accessibility/Acceptability

- The Community Neighborhood Teams will ensure that all individuals presenting with a health or social care need that can be appropriately & safely managed in the community are accepted for assessment and triage
- In addition case management, the team will focus on Long Term Conditions and Complex Case individuals selected by using a nomination criteria tool, secondary assessment and also a risk stratification tool

3.12 Referral Criteria and access

Referrals into the integrated care service will be accepted from the following professionals:-

- GPs
- Practice Nurses
- Consultants
- Specialist teams
- Secondary Care
- Patients (self-referral) only if previously known to the service via the message handling service within agreed protocols/timescales
- Social Care
- Social Care
- District nurses
- Community Matrons
- *Residential/Care Homes (referrals only accepted for rapid response service)

The provider will be responsible for the marketing and promotion of the service to the list of referrers as above

3.13 Whole System Relationships

The service will support effective, seamless patient flow across the health and social care system and reduce the number of non-elective admissions into an acute hospital which could be appropriately managed within a community setting.

The service will also support and enable timely discharge from an acute setting to a patients usual place of residence/step down beds where appropriate

3.14 Interdependencies

- Primary In Reach Teams (Residential Home support)
- Frail Elderly Pathway (In development)
- Dementia Pathway (In development)
- Any other service development applicable to this patient cohort

3.15 Service Development

All future service developments will be in line with delivering care closer to home and align with the CCG Strategic objectives.

4. Applicable Service Standards

4.1 Applicable national standards

- National Service Framework for older people DH 2001
- Intermediate Care – Halfway Home DH 2009[6]
- One chance to get it right The Leadership Alliance for the care of the dying person 2014[7]
- The six C's of delivering compassionate care[8]

4.2 Applicable standards set out in Guidance and/or issued by a competent body

- NHS Five year forward view[9]
- NHSE Using case finding and risk stratification: A key service component for personalised care and support planning[10]
- NHSE West Midlands 5 year plan[11]

4.3 Applicable local standards

[6] DoH July 2009
[7] Leadership Alliance for the care of the dying person – June 2014
[8] The Royal College of Nursing – Dec 2012
[9] NHS Five year forward view. NHSE October 2014
[10] Using case finding and risk stratification – NHSE January 2015
[11] NHS England West Midlands Five Year Plan on a Page - February 2015

5. Applicable quality requirements

5.1 Applicable Quality Requirements

These outcomes will require a baseline assessment prior to ongoing monitoring.

Outcome	Indicator
Patient Experience	Improve the experience of all patients in receipt of the specified services
	A reduction in the number of people experiencing delays in being transferred from hospital
	A reduction in the number of patients attending emergency care portals in an emergency
	An increase in the number of carers reporting that the care received was excellent
Patient Choice	All providers of care enable choice and promote preferred place of care at all times in line with their jointly developed care plan
	An increase in the number of patients who report being supported to remain in their usual place of residence if clinically appropriate
	An increase in the number of patients being offered a personal health budget and supported to access should they wish to
Treatment	All staff deliver optimal symptom control in line with the personalised care plan
	All patients report receiving advice, guidance and support on achieving optimal quality of life
Carers	All carers are made aware of and supported to undertake a carers assessment in line with National policy
Care Planning	There is evidence of person centred care being delivered at all times
	Systems and process are established across care givers to ensure effective and timely sharing of information and care plans
	All patients and carers(in line with the patients wishes) are involved in the development of a holistic care plan
	An increase in the number of people who state that they know who to contact in a time of crisis
	A reduction in the number of patients admitted to hospital as an emergency

	For patients who do not have capacity to express their wishes – carers report that the care received is in line with the care plan
Information & Education	Patients and carers (in line with the patients wishes) report that they are fully informed about the progression of the illness
	Patients and carers report that they are fully informed about what to do in the event of a crisis
	All information and communication is delivered taking full account of a patients individual needs

Reporting Requirements:

The following minimum data set will be required on a monthly basis :

Order	Name
1	Fiscal Year Month
2	Provider Code
3	Local Patient Identifier
4	Group Activity
5	Organisation Code (Local Patient Identifier)
6	Organisation Code (Residence Responsibility)
7	NHS Number
8	NHS Number Status Indicator Code
9	Age On Treatment
10	Lower Super Output Area
11	Person Gender Code Current
12	Ethnic Category
13	Language Code (Preferred)
14	Person Death Date
15	Death Location Type (Preferred)
16	Death Location Type (Actual)
17	General Medical Practice Code (Patient Registration)
18	Organisation Code (Code of Commissioner)
19	Service Request Identifier
20	Referral Request Received Date
21	Referral Request Received Time
22	NHS Service Agreement Line Number
23	Service Type Referred To (Community Care)
24	Source of Referral for Community
25	Referring Organisation Code

26	Referring Care Professional Staff Group (Community Care)
27	Priority Type Code
28	Primary Reason for Referral (Community Care)
29	Other Reason for Referral (Community Care)
30	Referral Closure Date (Community Care)
31	Referral Closure Reason (Community Care)
32	Discharge Date (Community Health Service)
33	Discharge Letter Issued Date (Community Care)
34	Community Care Contact Identifier
35	Care Contact Date
36	Care Contact Time
37	Administrative Category Code
38	Clinical Contact Duration of Care Contact
39	Care Contact Type (Community Care)
40	Care Contact Subject
41	Consultation Medium Used
42	Activity Location Type Code
43	Site Code (of Treatment)
44	Attended or Did Not Attend Code
45	Care Professional Staff Group (Community Care)
46	Earliest Reasonable Offer Date
47	Earliest Clinically Appropriate Date
48	Care Contact Cancellation Date
49	Care Contact Cancellation Reason
50	Replacement Appointment Booked Date (Community Care)
51	Replacement Appointment Date Offered (Community Care)
52	Community Care Activity Type Code
53	Group Therapy Indicator (Community Care)
54	Unique Booking Reference Number (Converted)
55	Patient Pathway Identifier
56	Organisation Code (Patient Pathway Identifier Issuer)
57	Waiting Time Measurement Type
58	Referral to Treatment Period Start Date
59	Referral to Treatment Period End Date
60	Referral to Treatment Period Status
61	Group Session Identifier (Community Care)
62	Group Session Date Time
63	Clinical Contact Duration of Group Session
64	Group Session Type Code (Community Care)
65	Number of Group Session Participants (Community Care)
66	Discharge Destination Code
67	Treatment Function Code

6. Location of Provider Premises

The Integrated Community Neighborhood Teams will be co-located in the following geographic localities:

- South West
- North East
- South East

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 12th April 2016

Agenda item 13

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

Ledger

Colour	Level
Red	**Level 2 RAPS breached escalation to executives and/or contracting**
Orange	**Level 2 RAPs in place**
Amber	**Level 1 close monitoring**
Green	**Level 1 business as usual**

Key Issue	Level	Comments	Detail on page
Board Assurance Framework and Risk Register	1	No Concerns, all risks are managed as per requirement. Managed at SMT for issues. Staff training currently being planned to use Datix and update risks	
Adverse media or exception reporting	1	Walsall Hospitals Sustaining Maternity Services	23-25
Escalated issues	2	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, improvements not sustained. Pressure Ulcers – increase in hospital and community grade 3 & 4s - close observation Monthly assurance sought at monthly CQR Meetings	6 7 8

Health Acquired Infections- CDiff	2	Increasing incidence of Cdiff, trust has failed its 2015/16 target- close observation January and February improvements have been sustained. – close monitoring continues	10-11
Performance Improvement notices impacting on Quality	2	Meetings with RWT held regularly and action plans agreed. More detail will be covered by the Finance and Performance paper.	
Workforce- RWT Risk Register	2	RWT Nursing and consultant recruitment issues are impacting on Quality and Patient Safety and A&E performance.	17-18
Sustaining Maternity Services at Walsall impact	2	Full Risk Assessmnet completed, go live 21st March. Needs close scrutiny of impact on W'ton commissioned residents.	22 -23
LAC	2	Wolverhampton remains an outlier for number of LAC. There is a city wide strategy in place with improvements seen.	21-22
NHS Safety Thermometer	2	Close monitoring and correlation with wider intelligence in progress- awaiting assurance	12
BCP Provider Performance:- Safeguarding training Early Intervention Service CPA Mandatory training	 2 2	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.	13 - 14

CQC Inspection Report	2	Rating 'requires improvement' for RWT. Action Plan completed March 2016; however the Trust is still awaiting the final report.	14
CQC General Practice	1	Practice has had a re inspection, have achieved good overall.	12
Mortality	1	Within expected limits, some data cleansing and audits being conducted.	14-16
Never Events	1	NE RCAs received and reviewed, assurance on actions taken received and a triangulation visit planned for Spring 2016.	7
Falls	1	Improvements seen in number of falls causing serious harm. CCG will maintain focus	8

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 March 8th, 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:

- No issues were identified to be escalated to the Governing Body at the Q&SC meeting held on March 8th 2016.
- 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 sustaining maternity services – full report included in this paper. Pages 22-23.
- Junior doctor's strike was managed by RWT with minimum disruption to services.
- Pressure Ulcers reported- scrutiny increased in line with actions.

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.

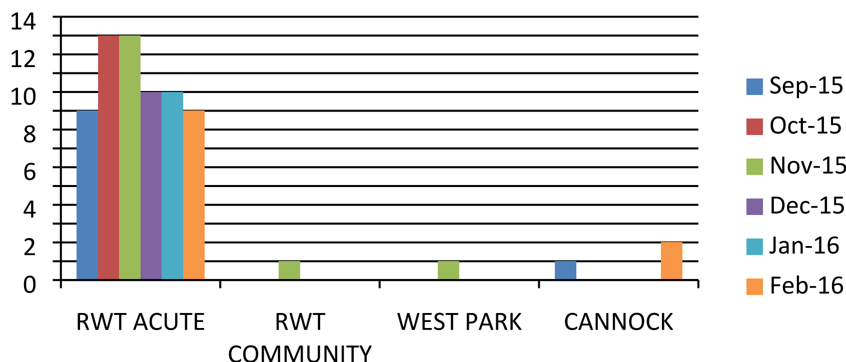
4. THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

A total of 11 new Serious Incidents were reported by RWT in February 2016 (this includes 1 Never Event, wrong tooth extracted).

Of these, 2 of the incidents were reported by Cannock Hospital

RWT All SI's (Excl PU's)



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

- 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.

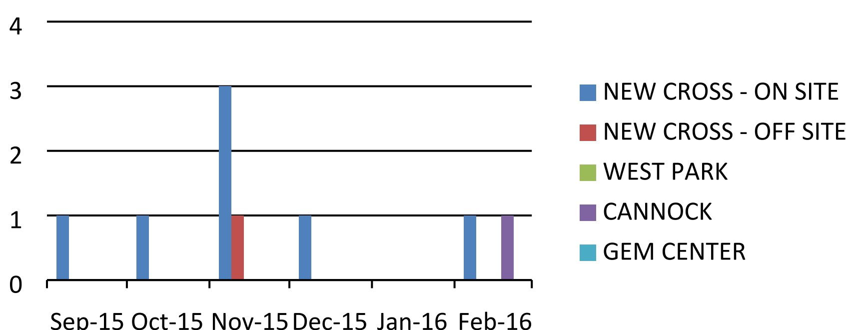
Actions agreed:

- 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.
- A full report will be discussed at May CQRM.

4.2.1 Confidential Breaches

Following a disappointing surge in November, there were zero incidents reported in January and 2 reported in February, of which one was at Cannock site. 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.



Planned action is to observe March and April data to monitor improvements, if improvements are not made or sustained, this issue will be escalated via CQRM for urgent action.

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 February 2016, detailed below. 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.

Reported	Open		Summary
04.02.16	3315	Surgical/invasive procedure incident meeting SI criteria	Patient attended clinic on 29th January 2016 following referral from GDP. Letter from GDP requested extraction of LR8 (lower right wisdom tooth) if in agreement. However, letter stated that the patient had previously been referred for the same and had undergone dental extraction. On examination of patient LR8 was in situ. It would therefore seem that during the operation for dental extraction (04/04/14) that the incorrect tooth had been removed.

Assurance will be sought at a planned Quality visit to the eye department in the near future.

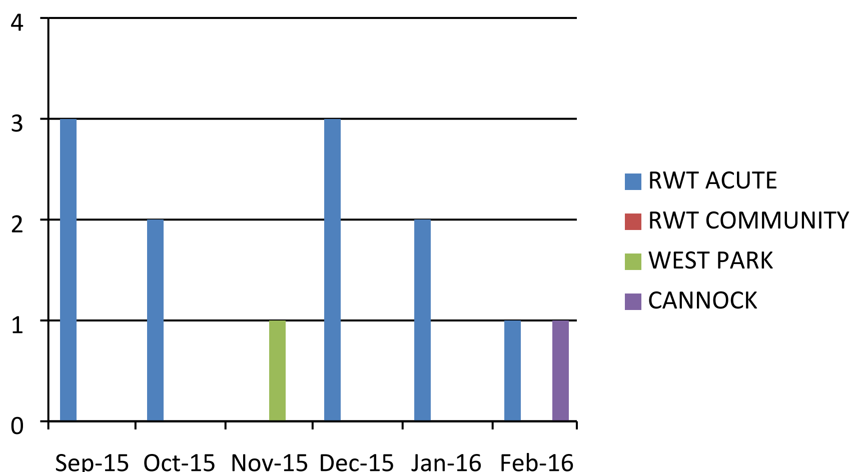
4.4 Slips Trips and Falls

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 at Cannock site in February 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.



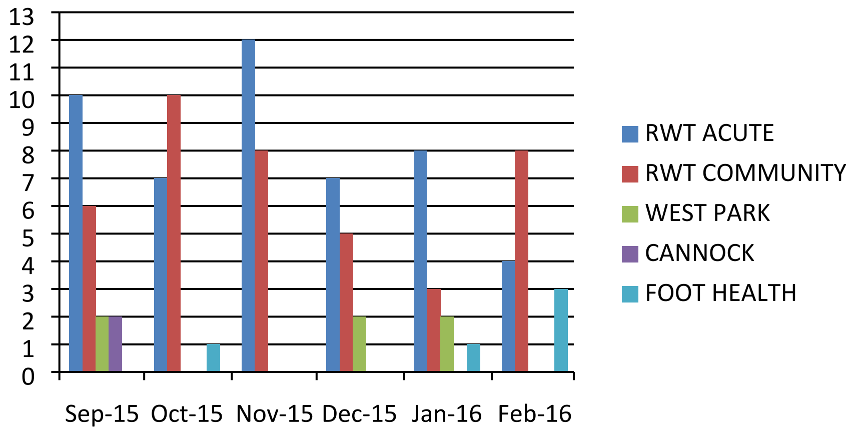
4.5 Pressure Ulcers Grade 3

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 took place 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. A gap analysis is being undertaken to inform the work and focus. The CCG Q&SC will receive regular updates and Governing Body will be appraised of any exceptions.

15 Grade 3 pressure ulcer incidents were reported by RWT in February 2016.

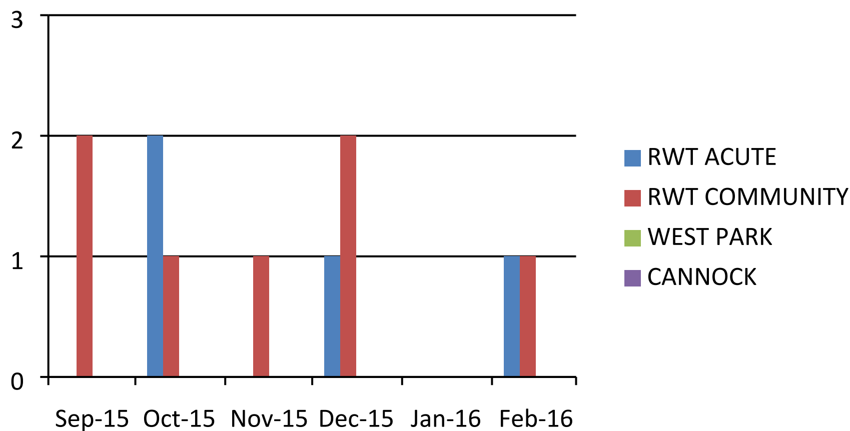
8 Grade 3 pressure ulcer incidents were reported by the Community and 4 reported by the Acute Trust. A trend has been observed in foot health services and this is currently being investigated.

Overall there is a deteriorating picture for pressure ulcers and the CCG has escalated this to the Trust Executives to take urgent action.



4.5.1 Grade 4 Pressure Ulcers

Two Grade 4 Pressure Ulcers were reported by RWT in February 2016:



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 - February assurance meetings include:

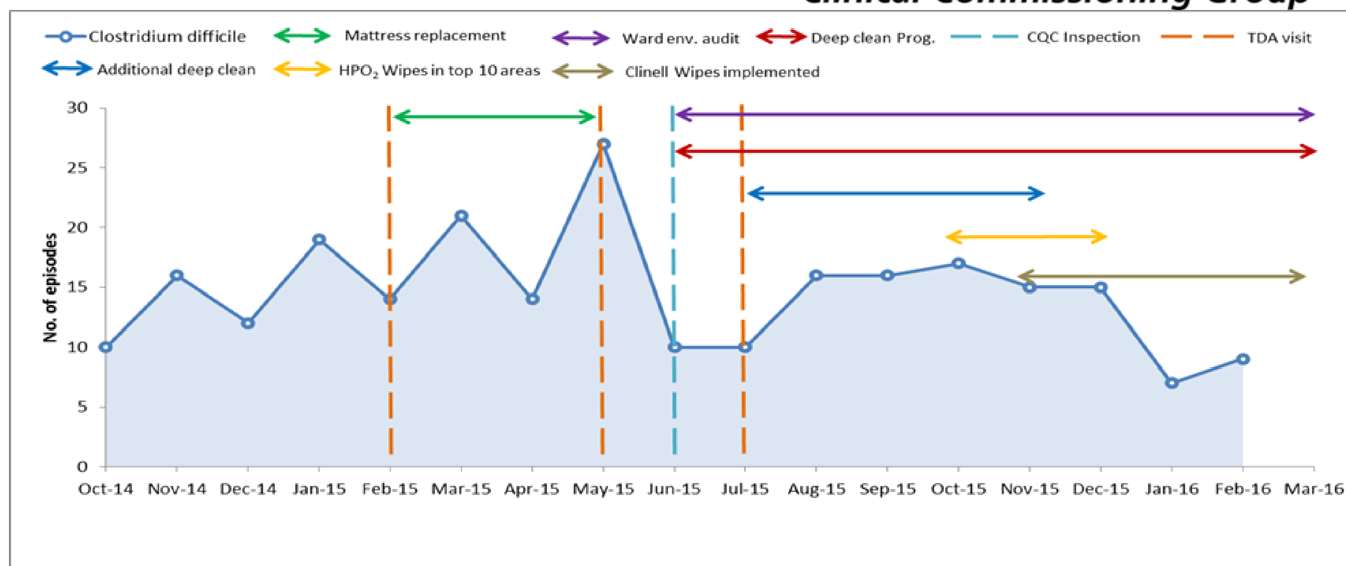
- There have been no MRSA Bacteraemia cases reported within the quarter.
- C Difficile objectives are challenging for Wolverhampton and the Trust have breached its yearend target; 65 actual V target of 35. However, the concerted efforts have resulted in a reduction in the number of cases of CDiff in February which was 9. All were externally unavoidable i.e. met the national minimum standards of care for hand hygiene, environment hygiene and no breaches in prescribing. As seen on page 10 chart, January and February 2016 have 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.



4.6 West Midlands Quality Review Service

WMQRS undertook a review of theatres and anaesthetics early March 2016. There were two immediate issues concerning availability of sterilized supplies at Cannock Hospital and availability of equipment at RWT. The Trust was asked to address and the CCG is awaiting formal response from RWT with assurance that these have been resolved and or the risk has been mitigated. As required, the CCG has shared this with NHSE Director of Nursing and will follow on with the action plan as soon as we are in receipt.

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 February 2016 was 94.65%. This is a sustained 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. The Trust is reviewing their ward dashboards to identify key themes. This remains amber for close scrutiny at present until as step change is seen and sustained.

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 also 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 has considered what other support we can give and how this will be delivered and monitored. A Primary Care Nurse role has been approved and will be advertised shortly.

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 and the March meeting is scheduled for 29th March. 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.

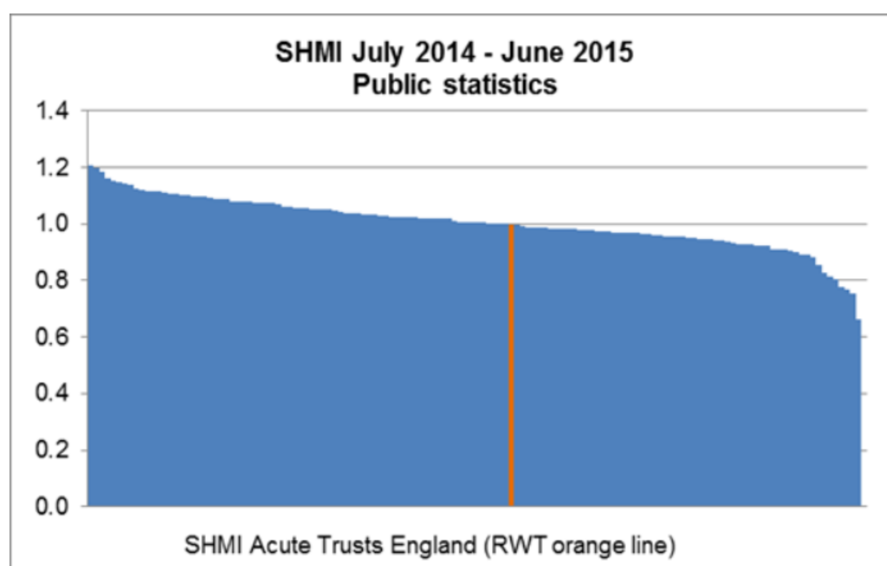
  Assurance - In 2013 an Infant Mortality Scrutiny Panel Review was setup in Wolverhampton with membership from the local health economy; this was presented to WCC Cabinet in July 2015 and favourably received by Councillor Darke. WCCG profiles for 2015 are

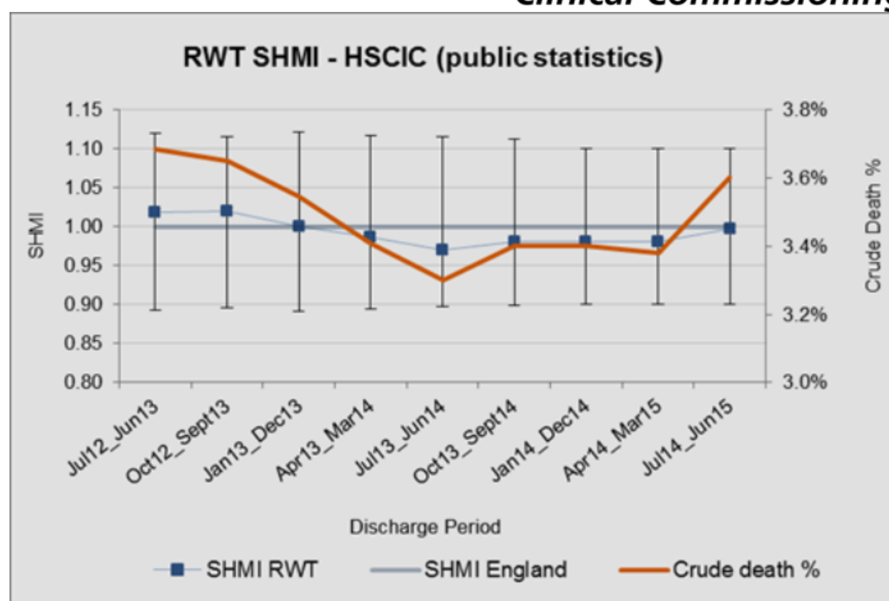
now available and a further piece of work is planned. In the meantime to strengthen the work already undertaken at RWT, an external audit was supported to be undertaken.

The SHMI* published by the HSCIC for July 2014 to June 2015 is 1 (England average is 1) and banded "as expected".

RWT has the 18th lowest SHMI value in England for this period (out of a total of 136 acute trusts; value ranked rounded at 2 decimals).

The charts below represent the SHMI trend for RWT showing the consistent performance in the last year and RWT's position in the national picture for the reporting period.(source: HSCIC, figures released quarterly, next release at the end of April 2016).





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.
- Recruitment fairs

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 is under on-going scrutiny at monthly CQRMs and QSGs.

Further discussions have been held with Chief Nurse at RWT to review use of agency nurses at times of extreme difficulty in maintaining safe staffing numbers. Currently the Trust is not considering this as an option but have increased payments for bank nurses on some specialist areas.

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 on 7th April 2016. This meeting will address recruitment of local students, changes with Health Education England rules for bursaries, overseas recruitment, the high failure rate of overseas nurses passing the IELTS test requirement which is impacting on immigration and the effect of the agency cap coming into force from 1st April 2016.

The CCG Primary Care Workforce Analysis has commenced in March. This work is due to conclude in July 2016 therefore a regular update will be provided.

5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

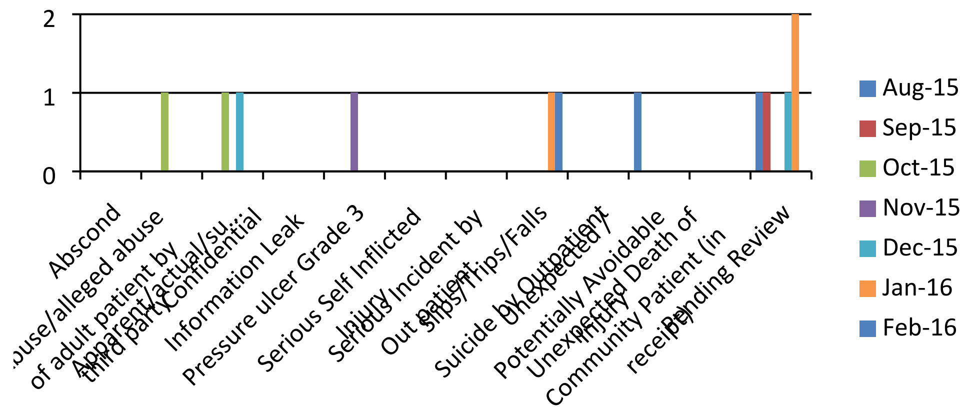
Level of Concern as of 31st January 2016

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

5.1 Serious Incidents

One new SI was reported by BCPFT in February 2016: a slip trip and fall.

BCPFT All SI's - Last 6 Months



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 January 2016 was 98.81%. This is in line with previous performance.

5.3 Items to Note from Clinical Quality Review Meeting

The theme of the quality review meeting which took place in February 2016 was CAMHS and the agenda covered:

- Serious incidents – all are scrutinised individually
- Safeguarding
- Performance
- CQUINS
- Sickness
- Workforce

During December 2015 the final report from the West Midlands Quality Review Service (WMQRS). The review included a focus on Early Intervention Services in Wolverhampton and noted the following areas of good practice:

a) The relapse prevention plans were very clear, with the risks marked using a traffic light coding system. The service users who met the visiting team felt that they really benefited from defining and agreeing their relapse prevention plans.
b) The team was very accessible to clients, who said they could easily speak to someone if they needed help during office hours. Service users who met the visiting team all knew who their care coordinator was and had contact details for them.

There were no areas identified for escalation to Q&S Committee.

5.4 Safeguarding

Wolverhampton Children MASH went live on 5th January 2016 as planned. Currently there are representatives from Children's Social Care, Early Help, Police and Recovery Near You. A number of other organisations have recruited individuals to work in the MASH – these include Housing and Probation. RWT, BCPFT and CCG are currently going through the reprocess to recruit individuals who will make up the team of health representatives. RWT have now recruited and BCP are pursuing.

The MASH Operational Group continue to meet bi weekly with a Dip sampling exercise taking place alternate weeks to review the implementation of process and thresholds. Findings are reported to the MASH Strategic Board which meets monthly. There have been a number of initial problems with the IT system purchased to manage the MASH process. This added to the fact that not all partners have a representative in the MASH at this point has led to a small number cases being reviewed following the Dip sampling. It is expected that issues will be resolved as the MASH develops and all key personnel are in place.

An Adult Work steam is currently working to identify resources required for the Adult MASH planned to commence in August 2016. WCCG is represented on this group.

In order to support the workforce across the city to understand thresholds for intervention, WSCB organised a number of Multi-agency Threshold Briefings. Attendees were provided with the WSCB resource – Thresholds of Support to Children and Families in Wolverhampton. This is also available from the WSCB website www.wolvesscb.org.uk. WCCG designated professionals were involved in the delivery of a number of the sessions.

The WCCG safeguarding team are currently reviewing the CCGs compliance against its statutory requirements identified in the refreshed Safeguarding

Vulnerable people in the NHS – Accountability and Assurance framework (2015).The findings will be included in the Annual report due to be presented in May 2016. Any actions required to ensure compliance will be include in the Quality Team action plan 2016/17.

5.4.1 Looked After Children

At the time of writing this report there are 659 children who are Looked After. This number continues to improve slowly but is still high and Wolverhampton is a national outlier.

This time last year, Wolverhampton had 800 looked after children (LAC), one of the highest numbers in the country? In light of this, the City council and partners developed The Families R First programme, which came into fruition in July 2015, its main aim being to target early help at the lowest level, supporting children to remain with their families safely. It focused on ensuring that only the right children should be in care and in achieving permanence (adoption) in a timelier manner.

As a result, the number of LAC in Wolverhampton has slowly but steadily decreased, and continues to do so, with the current numbers standing at 669 as shown below. WCCG are active partners within this as part of core corporate parenting duties and responsibilities. It remains that almost 60% of our children are placed outside of the City; this has been consistent throughout the year.

	Number	%age
Wolverhampton City Council	**275**	**41.1**
Dudley Metropolitan Borough Council	43	6.4
Sandwell Metropolitan Borough Council	38	5.7
Walsall Metropolitan Borough Council	63	9.4
South Staffordshire Council	37	5.5
All in Adjoining LAs	181	27.1
Anywhere Else - not in W'ton or in Adjoining LAs	213	31.8
TOTAL LAC	**669**	**100**

External placements are sometimes necessary where the holistic (social, educational and health) needs of a child/young person require specialist support and provision that is not available within Wolverhampton or within CAMHS Tier 4 provision. These are children/young people who may present with the most complex of health (including physical and/or psychological i.e. mental health needs), educational and social care needs and where local service provision to meet these needs has been exhausted.

Another reason is because Wolverhampton City Council do not have the number of foster carers it needs to place all looked after children within its own foster placements. The split at this time shows around 40% of children with in house foster carers, and 60% are placed externally.

The Fostering Recruitment Strategy and the City Council Sufficiency Strategy 2014-17 aim to tackle this, the key targets being;

- Reduce the numbers of children placed in external foster care placements. This will be achieved by increasing internal capacity by creating additional new placements (for new and existing carers) and “stretching” existing carers in terms of numbers of children placed, age and complexity of need.
- Contribute to the reduction in the numbers of children who are looked after through increasing the numbers of permanence orders secured (Special Guardianship and Residence Orders). This will also be supported through the re-launch of the permanence strategy, including the amended permanence financial support policy.
- Recruit to foster carers to Specialist Fostering Scheme (specialist carers).
- To embed the new fees and allowances payments structure that will engage and
- reward foster carers for the work they do.

The Fostering Annual Report Jan 2016 indeed shows continuity and improvements in the recruitment process of fosters carers through targeted marketing activity, and whilst the split remains the same, it is hoped that this will have a positive impact moving forward.

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.

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.

5.4.2 Care Homes

The QNAs continue to conduct STEIS investigations and support the Local Authority with quality concerns. Four nursing homes remain suspended under partial or full suspension within the city. One of the homes is being managed under the Local Authority's Failing Home Policy.

SUSPENSIONS	Full – F Partial – PL
Anville	F
Sycamores	PL
Wrottesley Park	PL
Parkfields	F

Assurance – there is a robust system in place whereby safety concerns as safeguarding, care home acquired pressure ulcers, fall and frequent attenders to A&E are monitored. The Quality Nurse Advisors have a schedule to planned and unplanned visits to monitor compliance and improvements. The process by which care homes are suspended works very well and homes are not permitted to take on new residents until a sustained improvements are made and can be evidenced.

6.0 Additional assurance information to note

Sustaining Maternity Services at Walsall Hospitals NHS Trust and impact on Royal Wolverhampton NHS Trust

6.1 Background

In conjunction with both Wolverhampton and Walsall Clinical Commissioning Groups, Royal Wolverhampton Hospitals NHS Trust has agreed to increase its delivery capacity to ensure the sustainability of maternity services at Walsall Manor Hospital.

The recent CQC inspection of Walsall Manor Hospital has rated the maternity services as inadequate. There are a number of factors that have had an impact on the quality of the maternity services that the Trust has been able to provide. These include;-

- ***An inadequate estate***
  The Maternity unit was developed to deliver up 4000 births and has 15 neonatal cots. Over the past few years there has been an increasing birth rate which last year meant nearly 5000 babies were born in the hospital and approximately 18-19 neonatal cots required per day.
- ***Reconfiguration of maternity services in neighbouring area***
  An increase in activity from surrounding areas has been seen over the last few years which is putting more pressure on the maternity unit.
- ***Staffing levels***
  Walsall have been doing everything possible to maintain safe staffing levels on a 24/7 basis in the neonatal services and maternity, despite very real challenges with recruitment. Even with recent recruitments, staffing levels have not kept pace with the increase in activity.

6.2 Proposed changes to maternity services at Walsall Manor Hospital

NHS Walsall Clinical Commissioning Group (CCG) and Walsall Healthcare Trust are proposing to put in place measures to ensure the safety and stability of maternity services at Walsall Manor Hospital.

Following careful consideration NHS Walsall CCG and the Trust are taking steps to reduce the number of births at the hospital in the short to medium term.

This decision has been jointly agreed by health partners in Wolverhampton, Walsall, Stafford, Sandwell and Birmingham with clinical advice from the Maternity Networks, local GPs and midwives.

Walsall Manor Hospital is proposing to reduce their current activity from 4900 births per year to 4200. The 700 deliveries will be transferring to RWT, Sandwell and West Birmingham and Staffordshire. This will stabilise the maternity service and ensure that every Walsall mother and baby gets effective high quality care; the number of births at the hospital will be reduced.

The proposed changes are expected to take place week commencing 21st March 2016 and will initially affect newly expectant women who are registered within a specific geographical area in Staffordshire and Walsall. Those women affected in Walsall, will be those patients registered with a Walsall GP to the west of Walsall. On booking with their GP, newly expectant women will be signposted to maternity care services at The Royal Wolverhampton NHS Trust instead of Walsall Manor Hospital.

A joint quality impact assessment has been undertaken with RWT and Walsall Manor Hospital clinicians and managers. Assurances have been acquired regarding:

- Staffing on maternity
- Staffing and consultant cover for neo natal services
- Current vacancies and recruitment timelines
- Sonographer capacity

Antenatal and Post natal care will continue to be provided by Walsall Community Midwives in most cases.

A very comprehensive communication plan has been mobilised across all the affected areas.

The Governing Body will be kept appraised of progress.

7.0 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.

8.0 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.

9.0 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.

10.0 Risks and Implications

10.1 Key Risks

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

11.0 Quality and Safety Implications

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

12.0 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.

13.0 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.

14.0 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.

15.0 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**

NHS
Wolverhampton
Clinical Commissioning Group

Date: **16th March 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**	**27/03/2016**
Public/ Patient View	**Pat Roberts**	**NA**
Finance Implications discussed with Finance Team	**NA**	**NA**
Quality Implications discussed with Quality and Risk Team	**Report of Q&RT**	**March 2016**
Medicines Management Implications discussed with Medicines Management team	**David Birch**	**NA**
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliet Herbert**	**NA**
Information Governance implications discussed with IG Support Officer	**Michelle Wiles**	**NA**
Legal/Policy implications discussed with Corporate Operations Manager	**NA**	**NA**
Signed off by Report Owner (Must be completed)	**Manjeet Garcha**	**29/03/2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12th April 2016

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Finance and Performance Committee- 29th March 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 M11	Achieved M11	Variance	RAG
Programme Cost £'000*	299,139	300,044	904	G
Reserves £'000*	3,013	910	-2,103	G
Running Cost £'000*	5,487	4,984	-503	G
Maximum closing cash balance £'000	271	123	-148	G
Maximum closing cash balance %	1.25%	0.57%	-0.68%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	96%	-1%	G

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

		YTD Performance M11			
	Annual Plan £'000	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Var %**
Acute Services	175,099	160,351	162,040	1,689	1.05%
Mental Health Services	34,060	31,221	31,051	-171	-0.55%
Community Services	33,108	30,349	30,315	-34	-0.11%
Continuing Care/FNC	13,198	12,167	10,845	-1,322	-10.87%
Prescribing & Quality	49,936	45,775	44,456	-1,319	-2.88%
Other Programme	21,028	19,277	21,337	2,060	10.69%
Total Programme	**326,428**	**299,139**	**300,044**	**904**	**0.30%**
Running Costs	6,120	5,487	4,984	-503	-9.17%
Reserves	3,244	3,013	910	-2,103	-69.80%
Total Mandate	**335,792**	**307,640**	**305,937**	**-1,702**	-0.55%
Target Surplus(deficit)	5,905	7,535	-	-7,535	-100.00%
Total	**341,697**	**315,175**	**305,937**	**-9,237**	-2.93%

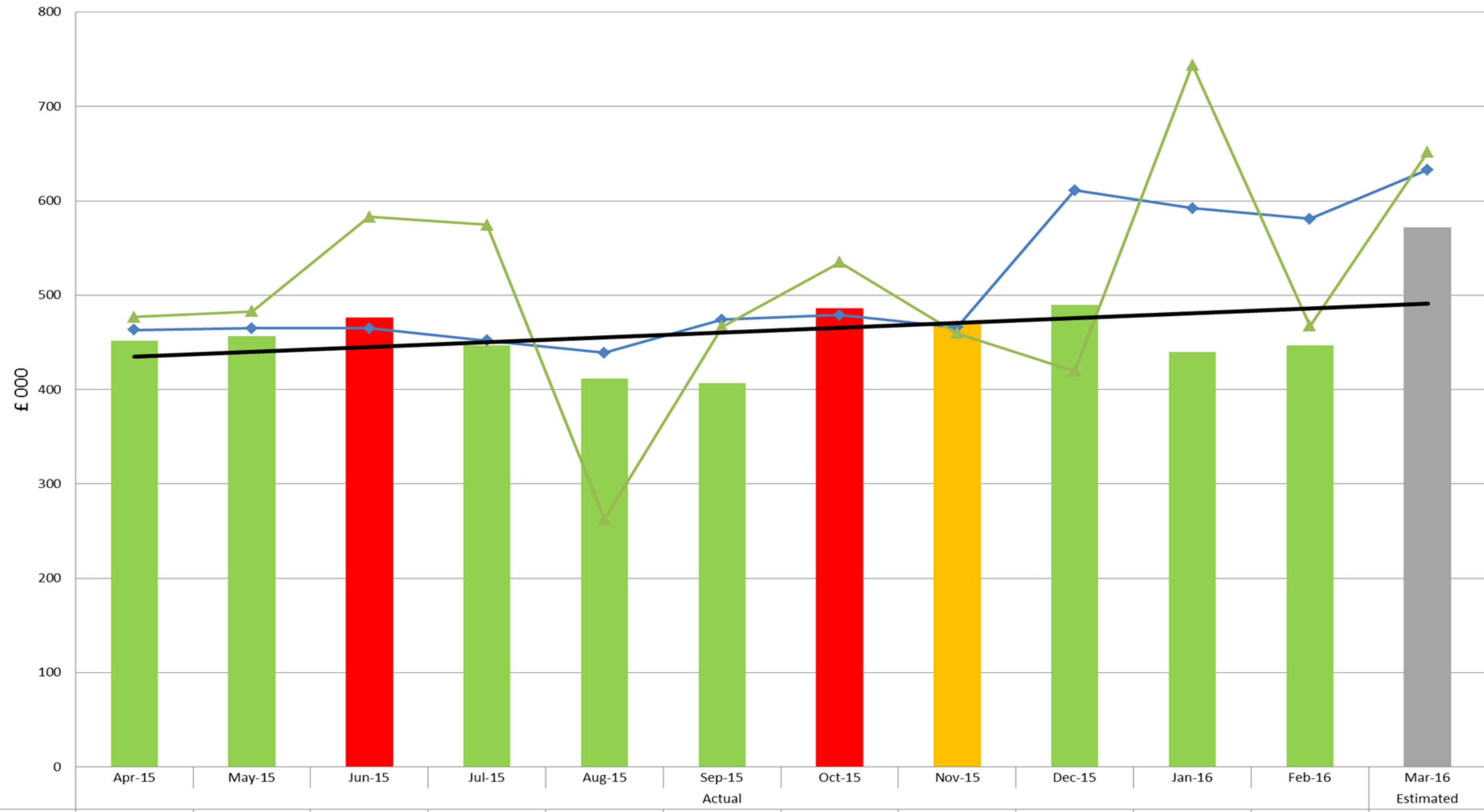
The table below details the forecast out turn by service line

	Annual Plan £'000	Forecast Outurn at M11		
		Actual £'000	Variance £'000	Var %
Acute Services	175,099	176,945	1,846	1.05%
Mental Health Services	34,060	33,892	-168	-0.49%
Community Services	33,108	33,108	0	0.00%
Continuing Care/FNC	13,198	11,937	-1,261	-9.56%
Prescribing & Quality	49,936	48,578	-924	-1.85%
Other programme	21,028	23,283	1,821	8.66%
Total Programme	**326,428**	327,743	**1,315**	**0.40%**
Running Costs	6,120	5,556	-564	-9.22%
Reserves	3,244	1,493	-1,751	-53.98%
Target Surplus	5,905	5,905	0	0.00%
Total Mandate Spend	**341,697**	**340,697**	**-1,000**	-0.29%

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15 Actual	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16 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	27,213,192	27,213,192
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	27,608,390	27,519,377

NHS
Wolverhampton
Clinical Commissioning Group

Monthly Planned vs Monthly Actual Running Cost Expenditure £000's



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15 Actual	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16 Estimated
Monthly Spend / Profile 15/16	452	457	476	447	412	407	486	470	490	440	447	572
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

Monthly Spend / Profile 15/16 — Monthly Budget 15/16 — Monthly Spend / Profile 14/15 — Linear (Monthly Spend / Profile 15/16)

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 11.

2015- 16 M11

Delivery Board	Current Mth Plan	Current Mth Savings	Variance from Plan	Annual Plan	FOT	FOT Variance from Plan
Modernisation and Medicines Optimisation	2.809	2.867	0.058	3.063	3.070	0.007
Integrated Care	1.830	2.977	1.147	2.050	3.325	1.275
Primary Care	2.482	2.219	-0.263	2.771	2.455	-0.316
Better Care Fund	1.673	1.209	-0.464	1.914	1.429	-0.485
Unallocated	1.665	0.000	-1.665	2.000	0.000	-2.000
Other	0.000	0.000	0.000	0.000	0.000	0.000
Total	10.459	9.273	-1.186	11.798	10.281	-1.517

Details of the Savings Plans

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

4. PERFORMANCE

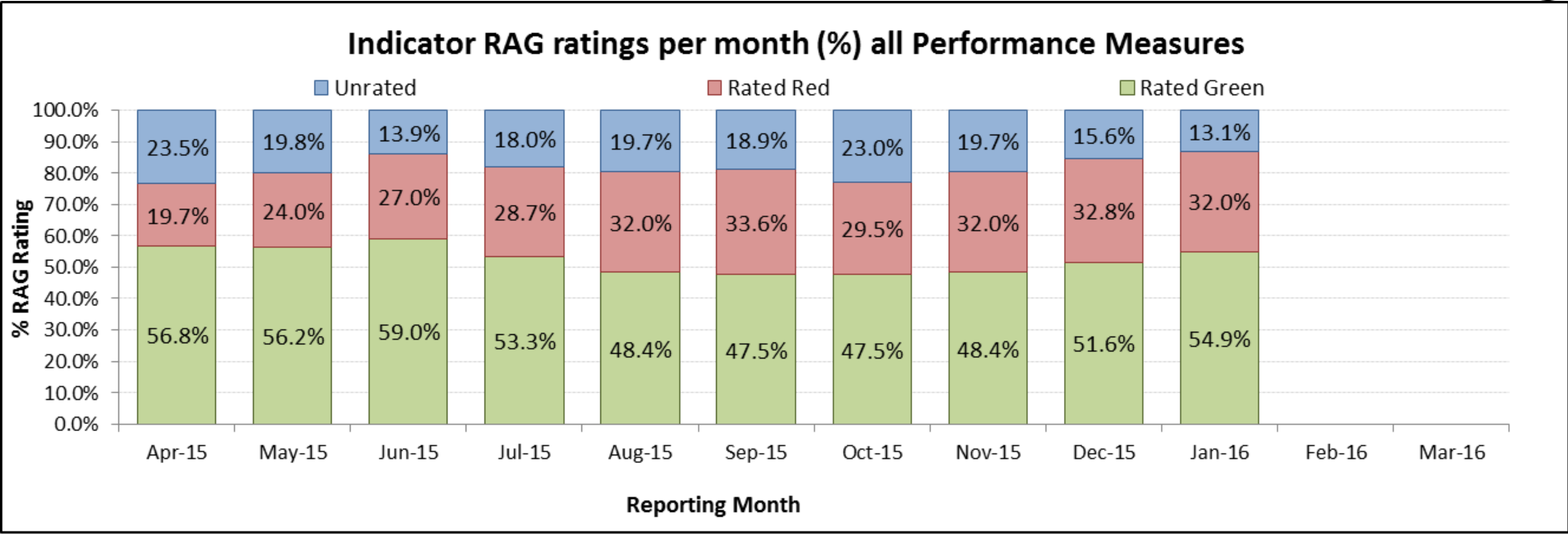
The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Jan-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	17	18	11	10	0	0	28
Outcomes Framework	17	18	13	11	7	8	37
Mental Health	29	30	16	19	12	8	57
Totals	63	**66**	40	**40**	19	**16**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	61%	64%	39%	36%	0%	0%
Outcomes Framework	46%	49%	35%	30%	19%	22%
Mental Health	51%	53%	28%	33%	21%	14%
Totals	52%	**54%**	33%	**33%**	16%	**13%**



Exceptions were highlighted as follows;

Jan-16

NHS Constitution

18 of the 28 Indicated areas are rated green. There were 0 unrated indicator(s) -eg. data not received. The 10 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 7th consecutive month (80.21% - SQPR report and unconfirmed) against the 90% target. This is a 1.65% 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 January at (92.03%). 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 6th consecutive month (92.70% - SQPR report and unconfirmed) against the 95% target. This is a 0.48% 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 January at (92.03%). 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 remains under 90% and has breached both in month (89.31%) and Year End (92.69%). Attendances have continued to increase with an additional 2,050 (17.85%) attendances in January compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. The Remedial Action Plan trajectory has been missed for January and provisional data indicates failure in February. Due to the continued failure of the A&E target and in line with General Conditions (GC9) the Trust were notified that 2% of the Actual Monthly Value of the Trust contract is to be withheld (as of 1st March 2016). Negotiations for an alternative action plan are on-going and will feed into the sustainability and transformation fund plans for 2016/17. The Vocare Urgent Care Centre is due to fully open from 1st April 2016, however in light of the increase in attendances and the decline in recent performance, the Phase One opening has been brought forward to 9th March 2016 (currently a skeleton service) to support A&E.
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 3rd consecutive month (82.93%) and YTD (92.34%). There were 7 patient breaches in January 2016, of which 6 were due to Urology capacity issues and 1 patient was a joint operation between Gynaecology and Lower GI surgeons which was not able to be scheduled within the standard. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 93.33% and under target.

Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Following the previous months in month achievement of the 85% target (85.71%), this indicator has seen a -14.38% decrease to 71.34% and the lowest performance since August 2015 (70.86%). There were 29 patient breaches during January (9 x Tertiary Referrals received between days 30 and 112 of the patients pathway, 8 x Capacity Issues, 6 x Patient Initiated and 6 x Complex Pathways. The Trust have provided a breakdown of performance by specialty for information with the high breaches as follows (% seen within standard): Head & Neck (33.33%), Colorectal (46.67%), Urology (51.16%), Gynaecology (54.55%), Upper GI (66.67%), Breast (91.67%), Lung (94.12%) and with both Haematology and Skin achieving 100% of patients seen within standard. A Remedial Action Plan (RAP) has been agreed and includes the following actions : Improved tracking of Cancer patients and escalation to ensure all cancer pathways are being reviewed and managed appropriately, a review of Cancer Services to ensure staffing levels and skill mix are available across the cancer services team, weekly escalation meetings to Divisional manager to review performance with a view to identify process bottlenecks, Hysteroscopy sessions increased at Cannock to provide additional capacity. The RWT quarterly report on Cancer Services has been presented to Trust Board and highlights an impending peer review which involves an external visit to the Head & Neck team. RWT Trust Management Committee has noted that the Head & Neck team treat almost as many patients as Birmingham's team despite being half the size of it's neighbour. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 64.52% and under target. As per the January CRM meeting the Trust confirmed that they will not have met the RAP trajectory for January and the CCG has initiated discussion of GC9 initiation with the process to start on the basis of failing January.
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 failed to achieve the 90% for January (83.78%) and YTD (88.66%). There were 4 patient breaches (1 x Complex Pathway, 2 x Capacity Issues and 1 x Patient Initiated). A Remedial Action Plan (RAP) has been agreed and includes the following actions : Improved tracking of Cancer patients and escalation to ensure all cancer pathways are being reviewed and managed appropriately, a review of Cancer Services to ensure staffing levels and skill mix are available across the cancer services team, weekly escalation meetings to Divisional manager to review performance with a view to identify process bottlenecks, Hysteroscopy sessions increased at Cannock to provide additional capacity. The performance for this indicator is affected by small numbers. Performance had previously seen significant improvement (with December reporting 100%), however performance continues to fluctuate. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 80.95% and under target.

Rates of Clostridium difficile	The C-Diff performance in Month 10 brings the Year to Date number of breaches to 65 and has already breached the full year threshold set for RWT by NHSE of 35. There were 6 positive cases by toxin test, 3 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 are attended by the CCG and an action plan is in place (Trust Wide) and CCG contribute to Infection Prevention Control Group meetings. 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. A C-Diff Action Plan is in place (Trust wide) and the CCG contribute to the Infection Prevention Control Group meetings (48 hour reports awaited). It has been noted that data for August 2015 has been amended due to positive toxin test admin issue. Following the advice of the National Mandatory Surveillance Database, this patient has not been attributed against RWT. The SQPR figure for August has been amended to reflect the change (from 11 to 10 cases). The RWT C-Diff total for January comprises of 2 x Wolverhampton CCG patients and 1 x South East Seisdon Peninsula CCG patient.

All handovers between ambulance and A & E must take place within 30 minutes	Month 10 breached the zero target with 50 breaches (within 30-60 minutes) and although this is a significant improvement from the previous months performance of 128, January has seen a deterioration in the >60minute with 10 breaches. The cumulative position for 15/16 is still ahead of last years position (144 fewer breaches overall this year). There were no patients who breached the 12 hour target during January. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency DepartmentIt 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 CCG have commissioned Vocare to commence Phase 1 (ED diverted patients only) of the new co-located Urgent Care Centre, 4 weeks earlier than planned . The aim is to redirect ED patients to a GP based service on 1st floor above ED between 10:00 and 22:00. Phase 2 (ED diverted patients, Walk in Centre facilities and GP OOH provision) will commence as planned on 1 April 2016. The total fine for ambulance handover during January is predicted at £20,000. This fine is calculated on 50 patients between 30-60 minutes @£200 per patient and 10 patients >60 minutes @£1,000 per patient.

All handovers between ambulance and A & E must take place within 60 minutes	Month 10 breached the zero target with 10 breaches (50 within 30-60 minutes, 10 >60 minutes) and although this is a significant improvement from the previous months performance within 30-60 minutes (128), January has seen a deterioration in the >60minute. The cumulative position for 15/16 is still ahead of last years position (34 fewer breaches overall this year). There were no patients who breached the 12 hour target during January. Data has been extracted direct from the WMAS publication website to look at benchmarking conveyance destinations and handover periods. The results for January 2016 activity has been included as part of this report. For January, New Cross ranked 7th (1.1% of conveyances over 60 minutes) and Worcestershire Royal ranking 1st with highest proportion (4% of conveyances over 60 minutes). The total fine for ambulance handover during January is predicted at £20,000. This fine is calculated on 50 patients between 30-60 minutes @£200 per patient and 10 patients >60 minutes @£1,000 per patient.
Trolley waits in A&E	There were no 12 hour trolley breaches for January, 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

18 of the 37 Indicated areas are rated green. There were 8 unrated indicator(s) - eg. data not received. The 11 red rated areas are :

Description	Commentary
Falls per 1,000 occupied bed days	The performance for this indicator has achieved target for the 7th consecutive month. The number of falls (by occupied bed days) remain under the 5.6 threshold. January performance has seen a slight increase but is still within threshold at 4.44. A rapid improvement model undertaken on one of the wards is being reviewed with the intention to roll out. The RWT Falls Steering group will look at three work streams regards to current policy/process, training and awareness raising in line with National events. 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.

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). January data indicates a 0.04% decrease in performance to 95.34% for all wards (excluding assessment units), however this is the 4th month standard has been achieved for this indicator. It should be noted that the assessment units (see LQR2b) saw a 4.76% decrease from the previous month (80.79%) and is still below target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the February CRM meeting at RWT, it has been confirmed that base wards are achieving, although assessment areas are failing. There is a Remedial Action Plan in place with a recovery trajectory; however, the trajectory is not being met. RWT have confirmed that following further investigations, further issues have been identified and Internal Governance is addressing these issues. The Commissioner has informed the Trust of its intention to initiate a GC9 process in relation to the failure to meet the RAP trajectory.
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). January data indicates a 4.76% decrease in performance to 80.79% for assessment units. It should be noted that the all wards (see LQR2a) saw a 0.04% decrease from the previous month (95.34%) and is still above the 95% target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the February CRM meeting at RWT, it has been confirmed that base wards are achieving, although assessment areas are failing. There is a Remedial Action Plan in place with a recovery trajectory; however, the trajectory is not being met. RWT have confirmed that following further investigations, further issues have been identified and Internal Governance is addressing these issues. The Commissioner has informed the trust of its intention to initiate a GC9 process in relation to the failure to meet the RAP trajectory.
Serious incidence reporting - Report incidences within 48 hours	This indicator breached in January with 1 Serious Incident, categorised as a Slip/Trip/Fall (STEIS reference 2016/1830). This brings the YTD Total to 4 breaches. It has been noted that the Trust SQPR January submission included incorrect data - submission utilised decimal places (1.2) rather than full figures (1 breach). Both the Trust and the Quality and Risk Team have verified that January figure as 1 breach. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings.

Serious incidence reporting - Update on immediate actions of incident within 72 hours	This indicator breached in January with 3 Serious Incidents, categorised as follows : 2016/243 - Pressure Ulcer (Grade 3) 2016/255 - Sub-optimal care of the deteriorating patient 2016/2327 - Pending Review (awaiting formal STEIS category following investigation, currently on Stop Clock with Coroner). This brings the YTD Total to 11 breaches. It has been noted that the Trust SQPR January submission included incorrect data - submission utilised decimal places (3.1) rather than full figures (3 breaches). Both the Trust and the Quality and Risk Team have verified that January figure as 3 breaches. 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 did not breach in month however, the Year End total has breached the zero target (currently reporting at 9 breaches for 15/16). Each breach is reviewed at the Contract Review Meeting and the Clinical Quality Review Meeting.
% 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 January performance has seen significant improvements and acheived 100%, however the Year End performance is below the 98% target (94.29%). 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 84.81% for January (a 0.90% increase from previous month). Attendances have continued to increase with an additional 2,050 (17.85%) 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 Remedial Action Plan trajectory has been missed for January and provisional data indicates failure in February. Due to the continued failure of the A&E target and in line with General Conditions (GC9) the Trust were notified that 2% of the Actual Monthly Value of the Trust contract is to be withheld (as of 1st March 2016). Negotiations for an alternative action plan are on-going and will feed into the sustainability and transformation plans for 2016/17. The Vocare Urgent Care Centre is due to fully open from 1st April 2016, however in light of the increase in attendances and the decline in recent performance, the Phase One opening has been brought forward to 9th March 2016 (currently a skeleton service) to support A&E. Provisional data for February indicates a continued increase in A&E attendances and has failed to meet the daily 95% target every day since 16th January 2016 (as of 10th March). The Trust are working on actions as detailed within the remedial action plan. The predicted fine for the A&E December breaches is £111,480.
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 has met the 95% target for January (99.75%), however the Year End continues to breach (98.99%) due to below target performance during April, May, September and October. The indicator for 10 day Radiology reporting indicator (LQR27a - 95% of direct access imaging provided within 10 days) has met both in month (97.67%) and for the first time the Year End (95.25%) has also met the 95% target.
The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time	There were no Never Events reported for January, however, 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

30 of the 57 Indicated areas are rated green. There were 8 unrated indicator(s) - eg. data not received. The 19 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 January 2016 performance and reported 95.12% of CPA follow ups within 7 days. However, the indicator is breaching the 95% Year End target (93.37%). 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.
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 January achieving the highest performance so far at 40% (numerator = 2, denominator = 5). 22 initial assessment appointments were offered in January and there were 13 DNAs during the month. The EI service continue to experience high DNAs and the service continue to explore ways to reduce them. The team offer 100% of referrals an appointment for assessment to meet the 5 day target. The Trust are to meet with the CCG to discuss EIS with a view to put an action plan in place.
EIS Meeting commitment to serve new psychosis cases by early intervention teams. Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance rounded down. (Monitor definition 11)	This indicator is based on a year end target of 44, current performance is at 35 (if target and performance is split over 10 months this indicator is rated as RED). Performance has been discussed at CQRM, with an action plan in place and monitoring will continue.

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed both in month (11.11%) and Year End (33.49%) against a target of 95%. The Trust are to meet with the CCG to discuss EIS with a view to put an action plan in place. There were 22 initial assessment appointments offered in January, with 13 DNAs during the month. The team is continually reviewing the high number of DNAs and exploring ways to reduce them, including contacting clients who DNA to establish the reasons why. If the team are able to address the reason for the DNA then alternatives can be offered to meet the need e.g travel cost identified as reason for DNA - client can be offered assessment at GP surgery if room available and closer to clients home. The standard initial assessment letter has been amended to include the reason for offering early appointments to assist recovery as a lack of understanding regarding a quick initial appointment time may have impacted on DNA rates. Team are texting and calling new clients to remind them about their appointments (as well as sending out appointment letters) and letting referrers know the details of initial assessments so that they can pass the information to the clients if they are seeing them again before the Team. The team actively reviews reasons for DNA and will make every attempt to address any new issues with attendance if raised by clients. The team makes every attempt to offer 100% of referrals an appointment for assessment to meet the 5 day target if staff are available.
Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for January 2016 (14.17%) and 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 submissions have been received from the Trust and they have confirmed that these are due to data quality improvements. The Trust continue to promote active management of delays but struggle with moving some "hard to place" patients outside the Trust (due to an arson conviction or awaiting funding) and those patients who have no recourse to public funds (illegal immigrants) who do not get health or housing monies. Buy-in from the Local Authority is not consistent and has been requested. Discussions have taken place at the CQRM meeting regarding escalation of issues to the Local Authority. 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 January (based on 9 patients with a Care Plan on discharge). However due to the under performance in April and May, the Year End is below target (88.57%). 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 4th consecutive month this year (56.98%) 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 (47.09%). 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 4 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 (96.67%).
SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for January 2016, however the YTD has breached the 100% target (96.67%) 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 since April 15. The Trust have confirmed via the CQRM meeting that the IPC training is meeting target, however, the data on the SQPR includes other mandatory training. This issue should be resolved by M11 submission.

MEDS MGMT Memantine - Trust to give assurance that 95% of patients on Memantine have either moderate Alzheimer's Disease and a record of intolerance/contraindications to Ache or have severe Alzheimer's Disease.	This is a new performance indicator for 15/16. The Provider requested further development time to implement reporting and it was discussed that data should be available by end of Q1, the first performance submission has been received for January 2016 as 77.8% against the 95% target. Meds Management indicators were discussed at CQRM and a further meeting is to be arranged to discuss best way forward. Additional Commentary has been received from the Trust "This is being carried out as a rolling audit and data collection for all inpatient areas. This will reported end Quarter 2 following a data cleansing exercise. EPACT data can be supplied if required however, data will lag behind 3 months".
SAFEGUARDING CHILDREN % compliance with provider protocol for clinical supervision (for frontline staff who work with adults who have responsibility for children and those who work directly with children).	This is a new performance indicator for 15/16. Performance data for October - December was received at M10 and although achieved 100%, due to the null submissions in previous months the Year End performance is calculating at 50%. Comment from Children's Safeguarding Lead - "We only offer supervision to those who are holding children on a plan – this changes from one day to this next. Not all practitioners therefore are in need of CP supervision if they are not holding any cases- it is therefore difficult to give a percentage as we do not have a consistently whole amount to draw one from. CCG to liaise with Quality and Risk Team regarding the reporting of this indicator. The issue of non reporting has been raised at the CQRM as these indicators have been confirmed as required. The Trust have confirmed that they will investigate options".
SAFEGUARDING CHILDREN % compliance with Safeguarding supervision for Named Professionals from Designated Professionals.	This is a new performance indicator for 15/16. The M10 SQPR submission has been queried with the Trust as 100% has been submitted but with zero numerator and denominator. The backing data also indicates a denominator figure of zero submitted for 7 out of the 9 months, this has been queried with the Trust. The Trust have confirmed that the supervision for named professionals by designated professionals only applies to 2 members of staff and they have supervision a set number of times per year so you get some months when they were both due to have a supervision session, and other months neither is due to have a supervision session. The numbers the Trust have been supplying is whether they were due supervision in month, and if so did they have that supervision. The 0% January submission relates to neither were due supervision.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and January has achieved the 85% target for the fourth consecutive month (92.78%). The Year End performance is below target at 82.17% 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.	This indicator has maintained its improved performance level against the 85% target (85.98%) however the Year End performance is below target at 70.79% and the Remedial Action Plan is still in place as this covers other Safeguarding indicators.
SAFEGUARDING CHILDREN (WCCG Only) % compliance with staff safeguarding training strategy at Level 4 - Named Professionals.	This indicator has achieved the 100% target for the fourth consecutive month; however the Year End is still below target (84.86%) 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 reported 67.75% for January, and although the best performance so far this year, is still below the 85% target. The Year End performance is also below target at 46.77% 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 88.87% for January 2016. 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 49.08% 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 received an update on progress with the draft financial plan for 2016/17, noting adherence to the 2016/17 planning rules and discussed risks to the financial position.

A further budget paper is provided alongside this report for consideration and ratification.

6. Better Care Fund Accounting Treatment

The Committee noted the accounting treatment for the Better Care Fund.

7. Finance and Performance Committee Annual Report

The Committee considered and agreed the draft report and took assurance that the Committee has discharged it's duties as set out in its terms of reference.

8. KEY RISKS AND IMPLICATIONS

Financial Risk - 2015/16 Risk

The tables below details the current assessment of financial risk for the CCG.

Risks	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %
CCGs				
Acute SLAs	0.50	50.00%	0.25	100.00%
Community SLAs			0.00	0.00%
Mental Health SLAs			0.00	0.00%
Continuing Care SLAs			0.00	0.00%
QIPP Under-Delivery			0.00	0.00%
Performance Issues			0.00	0.00%
Primary Care			0.00	0.00%
Prescribing			0.00	0.00%
Running Costs			0.00	0.00%
Other Risks			0.00	0.00%
TOTAL RISKS	**0.50**		**0.25**	**100.00%**

Mitigations	Full Mitigation Value £m	Probability of success of mitigating action %	Expected Mitigation Value £m	Proportion of Total %
Uncommitted Funds (Excl 2% Headroom)				
Contingency Held			0.00	0.00%
Contract Reserves			0.00	0.00%
Investments Uncommitted			0.00	0.00%
Uncommitted Funds Sub-Total	**0.00**		**0.00**	**0.00%**
Actions to Implement				
Further QIPP Extensions			0.00	0.00%
Non-Recurrent Measures			0.00	0.00%
Delay/ Reduce Investment Plans			0.00	0.00%
Other Mitigations	0.25	100.00%	0.25	100.00%
Mitigations relying on potential funding	0.00		0.00	0.00%
Actions to Implement Sub-Total	**0.25**		**0.25**	**100.00%**
TOTAL MITIGATION	**0.25**		**0.25**	**100.00%**

- M11 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.
- The mitigations have reduced from last month and the CCG continues to identify sufficient mitigations to cover its risks.
- In delivering the financial surplus in M11 the CCG has already committed its Contingency reserve of £1.714m therefore this cannot be considered as mitigation.

Other Risk

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

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

9. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **30th March 2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 April 2016

Agenda item 15

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 1 March 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 1 March 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 1 March 2016. This was the first formal public meeting of the committee and this report provides a summary of the issues discussed and the decisions made.

2. WEST MIDLANDS PRIMARY CARE HUB MEMORANDUM OF UNDERSTANDING (MOU)

2.1. As previously reported to the Governing Body, the CCG has been in discussion with NHSE England about the arrangements for the Primary Care Hub and a MOU has been developed based on these discussions. The Primary Care Hub will provide transactional support for primarily contract management and financial purposes to support Primary Care Commissioning.

2.2. The hub has been developed from existing NHS England Primary Care staffing teams to ensure that, as responsibilities and CCG involvement in Primary Care Commissioning develops, day to day services continue as seamlessly as possible. This also reflects the aims of the approach to Co-Commissioning to ensure all CCGs received a ‘fair share’ of central resources including staff time.

2.3. The Committee noted that the MOU was focussed on contracting and finance and did not include detail around how the CCG and NHS England would work together on quality improvement matters. Discussions have taken place with NHS England on this matter and will be considered further in the development of the Hub. It was also noted that the front sheet draft agreement incorrectly identified the CCG as ‘ Level 1’ Co-Commissioning rather than joint commissioning and NHS England have been asked to amend this. The committee approved the MOU (subject to these on-going discussions) and it was formally signed off in March.

3. PRIMARY CARE OPERATIONS MANAGEMENT GROUP

3.1. The Committee were updated following the first meeting of the Operations Management Group in February 2015. Key issues discussed had included dialogue between the CCG, NHS England and the Care Quality Commission in respect of work around primary care and the CCG’s on-going programme of practice support visits.

3.2. The committee discussed the most effective way for the group to report into the committee and noted that no specific issues had been escalated from the meeting. The committee also suggested that it would be appropriate for a representative of the Local Pharmaceutical Committee to attend meetings of the group.

4. PRIMARY CARE ESTATES AND INFRASTRUCTURE

4.1. The Committee noted that work continued to develop the CCG's Primary Care Estates Strategy with support from NHS England. The overarching aims of the strategy will be a key factor in assessing bids for the Primary Care Transformation Fund for which further national guidance is awaited.

4.2. Brief details were also given of investment by the CCG into Primary Care IM&T to improve the infrastructure across Primary Care in Wolverhampton. Most significantly, this investment will allow the rollout of free Wi-Fi for patients in public areas of GP surgeries. As well as providing this connectivity, this will open new communication streams with patients via connected devices in the surgery. This could be used to share key messages and to encourage participation in engagement work such as the Friends and Family Test. The planned rollout of other new equipment, including PCs and monitors is currently being finalised.

5. OTHER ITEMS DISCUSSED

5.1. Brief updates were provided by NHS England and the CCG on on-going and upcoming work. This included an update on the work of the Primary Care Delivery Board and on the negotiations on the details of the new contract for GP services. It was noted that until the contract was finalised financial modelling could only take place on an estimated basis. The GP services budget was forecast to breakeven for 2015/16 and plans for 2016/17 were being developed to meet business rules within the notified allocation, subject to the issues outlined above in respect of the contract.

5.2. The Committee also met in private session to consider a recommendation to award a contract for the GP practice at Showell Park. The contact has been awarded to the current provider, Wolverhampton Doctors Limited.

6. CLINICAL VIEW

6.1. Not applicable.

7. PATIENT AND PUBLIC VIEW

7.1. Not applicable.

8. RISKS AND IMPLICATIONS

8.1. As highlighted above, the Committee noted that until the GP contract is finalised, it will not be possible to finalise the financial plan for 2016/17.

9. RECOMMENDATIONS

That the Governing Body Note the Report

Name	Pat Roberts
Job Title	Lay Member for Public and Patient Involvement, Committee Chair
Date:	March 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**	**17/03/2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – 12 April 2016

Agenda item 16

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 March 2016. The key points to note from the report are: 2.1.2 **Junior Doctors strike** 2.1.3 **Urgent Care Centre communications** 2.3.2 **Appointment of Primary Care Joint Committee patient representatives**
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

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

2. MAIN BODY OF REPORT

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 9 – 11 March. 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. Posters, leaflets and banners have been distributed across the borough in public places such as GP surgeries and local shops. Showell Park also is displaying large format banners on its site to communicate the changes. Social marketing campaign and proactive press releases also running to complement the campaign.

Communication and Participation framework

2.2.1 **GP Locality meetings** - The following items were discussed:
- Peer Review programme
- Health Child Programme
- Manpower Planning
- Clinical networks development
- Primary Care in reach teams

2.2.2 **PPG Chairs and Citizen Forum Groups**
These groups will meet in future as a Joint forum and the majority of Citizen Forum Members will act in a virtual capacity.

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

2.2.4 **Practice Nurse Bulletin**
The second edition of the Practice Nurse bulletin went out in early March. Topics covered included, revalidation tool kit training, student nurse placements and other training opportunities available.

2.2.5 **Practice Managers Forum - concentrated on the following:**
- workforce planning training
- patient online updates
- update training on the friends and family test
- update from BCF and commissioning teams

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.

2.3.1 **Grant Policy applications**
Three grants have been awarded via the grant policy to date. The second round of applications have been advertised and there is a workshop on Tuesday 19 April to help facilitate applications.

2.3.2 **Primary Care Joint Committee – Patient Representatives**
Two Lay patient representatives for this committee have been successful at interview and appointed to the committee as full members

- ## Lay member's report of key meetings

2.4.1 The Lay Member attended a drop in launch event hosted by Wolverhampton County Council (WCC), to give an overview of the arrangements for the transition to Engaging Communities Staffordshire (ECS) the company awarded the contract by WCC for Wolverhampton Healthwatch from 1st April.

2.4.2 The Lay member and team have now established contact with the University of Wolverhampton and look forward to encouraging more young people to be involved in many ways with WCCG

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: 18 March 2016

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)

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	**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	18 March 2016

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
QUALITY & SAFETY COMMITTEE

Minutes of the Quality and Safety Committee Meeting held on 9th February 2016
Commencing at 10.30am in the Main CCG Meeting Room, Wolverhampton Science Park

Present:

Jim Oatridge	(JO)	Lay 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
Geoff Ward	(GW)	Patient Representative
Sarah Southall	(SS)	Head of Quality and Risk, WCCG
Laura Russell	(LR)	Administrative Officer, WCCG

Part Attendance:

Lorraine Millard	(LM)	Designated Senior Nurse for Safeguarding Children
Sharon Sidhu	(SS)	Head of Strategy and Transformation
Juliet Herbert	(JH)	Equality and Inclusion Business Partner

Apologies:

Dr Rajcholan	(RR)	Board Member, WCCG
Mr Tony Fox	(TF)	Surgeon/Secondary Care Consultant, WCCG

Declarations of Interest

QSC461 There were no declarations of interest raised.

RESOLVED: That the above is noted.

Minutes, Actions from Previous Meetings

QSC462 The minutes of the Quality and Safety Committee held on Tuesday 12th January 2016 were accepted as a true and accurate record.

The Action Log from the Quality and Safety Committee held on Tuesday 12th January 2016 were discussed, agreed and an updated version will be circulated with the minutes.

RESOLVED: That the above is noted.

Matters Arising

QSC463 There were no matters arising.

RESOLVED: That the above is noted.

Feedback from Associated Forums

QSC464 **a) Draft Governing Body Minutes**

The minutes were provided for information, it was noted that a further report on Review of Procedures of Limited Clinical Value (PoLCV) needs to be provided at the Committee Meeting. LR to ensure this is included on the action log.

b) Health and Wellbeing Board Minutes

The next meeting of the Health and Wellbeing Board is taking place tomorrow (10th February 2016).

c) Quality Surveillance Group Minutes

A meeting had taken place in January and both Royal Wolverhampton Trust and Black Country Partnership Foundation Trust remain on routine surveillance. There were actions for the CCG around CQC, Healthwatch and Complaints which are being progressed and assurance will be provided by the CCG at the next meeting.

d) Primary Care Operational Management Group

The Primary Care Operational Management Group first meeting is due to take place on the 16th February 2016.

e) Draft Clinical Commissioning Committee Minutes

The minutes from the January Meeting were not available.

f) Clinical Mortality Oversight Group

The next meeting will be taking place no 23rd February 2016. SS reported links have been made with the Coroner and work has started around reviewing unexpected deaths and suicide deaths of patients who were not in receipt of secondary care (RWT/BCPFT) to ensure correct needs are in place.

MG informed the group NHS England are in the process of rolling out the scrutiny principles used by acute providers into Primary Care for unexpected deaths.

RESOLUTION: LR to ensure the action from the Governing Body regarding a report on the Review of Procedures of Low Clinical Value (PoLCV) is included on the action log.

Assurance Reports

QSC465a **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 31stJanuary 2016 the Trust were at concern level 2, the areas of concern include;

- Infection Control (Cdiff)
- Pressure Ulcer Prevalence
- Recurring Serious Incidents (treatment delays)
- Never Event(s)
- Quality Indicators (A&E/Cancer)
- Workforce/Safer Staffing

- There have been no new Never Events reported during January 2016.
- There had been 10 new serious incidents reported in January 2016.
- The Trust indicators for A&E and Cancer Targets are a concern and mitigating actions have been provided by the Trust via Remedial Action Plans.
- The number of Cdiff cases has reduced in January with only 1 case being reported, final figure to be confirmed. This demonstrates the positive impact that has been made by the Trusts action plan.

Black Country Partnership Foundation Trust

- As of the 31st January 2016 the Trust were reporting at concern level 1.
- There were 3 serious incidents reported in January 2016 and a breakdown of incidents types can be found on page 18 of the report.
- The NHS Safety Thermometer harm free care rate for December reported at 99.39%.
- The theme of the Clinical Quality Review Meeting in January was Mental Health Services. The main discussions at the meeting were around medication errors and sickness levels and the work being undertaken in order to retain band 5 staff nurses. There has been 2 incidents graded as level 4.

Private Sector/Other Providers – Clinical Quality Review Meetings

- NSL (NEPTS) - reporting as level 2 concern.
- Poplars Medical Practice - reporting concern level 1. The CQC overall rating in 2015 was inadequate and following a CQC revisit on the 18th November 2015 they have now been rated as Good overall with 'safety' requiring improvement.
- Compton Hospice – reporting as level 1 and they are expecting a CQC visit.

- Nuffield – The CCG are now working towards a separate contract from April 2016.

Care Quality Commission (CQC) Notification or Advice from Monitor

- Black Country Partnership Foundation Trust – still awaiting the first draft report following inspection in November 2016.

Care Homes

- The Quality Nurse Advisors have been involved in 3 STEIS investigations in month and working well the Local Authority where these cases have taken place.
- There are currently no Care Homes in Large Scale Strategy, however 4 remain suspended under partial or full suspension.
- There were only 6 homes participating in the NHS Safety Thermometer during December.
- 27 Homes provided dated for the quality indicator Survey Monkey questionnaire, which is an improvement on last month when 24 Homes submitted data. JO asked if it was voluntary to submit the data and if not do the Homes that submit the data have any benefits from doing so. SS highlighted those Homes who choose to make improvements would benefit from submitting this information as it helps to identify areas where support and improvements can be made. At present the CCG are working towards implementing a model in which the CCG will be supporting those Care Homes that are NHS Commissioned who will have to submit to the quality indicator Survey Monkey questionnaire as part of their contract. Discussions took place around those Homes who do not have NHS Commissioned patients as the CCG will still have responsibility to undertake pressure ulcer and serious incidents investigations with the Local Authority.

User and Carer Experience

- There have been 2 new complaints received in January 2016, which have been reported on Datix and investigations are taking place. A further complaint had been received in January where there had been delay in responding regarding access to IVF treatment, this compliant has now been closed.
- 1 complaint remains on-going and a meeting will be taking place in January with the complainant.
- 1 exiting complaint has been closed in relation to refusal to fund laparoscopic surgery.

Quality Matters

- There have been 21 new Quality Matters raised during January 2016. The CCG continue to encourage Primary Care, BCPFT and RWT to raise issues and concerns through Quality Matters.

Item Escalated to Contract Meetings

- Mental Health – Safeguarding training compliance breach and IAPT.
- RWT – 62 day cancer performance and A&E performance.
- NEPTS – Staffing issues.

Quality Visits

- The visit programmes for RWT and BCPFT were shared and the programmes for 2016/2017 are being prepared. There are links being made with Healthwatch to undertake joint visits during 2016/2017.
- A visit to Compton Hospice Community Nursing has taken place on the 5th January 2016, which was extremely positive and formal feedback has been shared.

Primary Care

- A number of quality visits to GP practices have taken place during January 2016.
- The Primary Care Development Manager has drafted an objectives and guidance summary along with a scorecard. This information will feed into the Primary Care Operational Management Group. JO asked how the practice visits were followed up. SS confirmed that each practice will be followed up with a second visit and supported by a named person from the Quality Team and Strategy and Solutions Team.

CCG Risk Register

- The Risk Register entries as of the 4th November 2015 were as follows;
  - Number of Open Risks was 110
  - Number of Red Risks was 10
  - Number of Amber Risks was 60
  - Number of Green Risks was 40
  - Number of Risks where an update is due in February was 43
  - Risks that have past their review date is 6

RESOLVED: That the above is noted.

QSC465b **Community Dermatology Service (Concordia)**

SSidhu advised the Committee the CCG undertook a procurement exercise in 2014 which resulted in the Community Dermatology Service contract was awarded to Concordia. The service went live on the 1st December 2014 and is being delivered across five sites. The service accepts all dermatology referrals for patients aged 16 over apart from two week waits.

SSidhu provided the following summary of the current performance and the expected benefits;

- Reduced waiting times – currently meeting the waiting times and the average time varies from three to four weeks.
- One stop see, treat and discharge model – currently achieving 1:2 new to review ratio.
- High quality service - response rate to the patient questionnaire reported at 10% which is very low and the Provider is working towards increasing the response rate. The responses received indicate that patients would be extremely likely or likely to recommend the services to friends and family. There were initially some concerns raised through Quality Matters in relation to prescribing and blood tests. These issues have now been addressed.
- Value for Money – overall there has been a 20% decrease in GP referrals to the hospital with patients being transferred to the community service. It was highlighted that the decision on where to refer the patients is the GP choice and the Provider are undertaking targeted work with GP Practices who are reporting the low referring practices.

RESOLVED: That the above is noted.

QSC465c Equality and Diversity Quarter 3 Update Report

JH provided to the Committee an update on the equality and inclusion work and activities undertaken during quarter 3. The biggest challenge is ensuring the impact assessment have been completed and the issue that people need to take more ownership in completing them. Equality impact assessment training has been scheduled for the 24th February with two sessions being held and a further a mop up session will be provided.

JH highlighted the outstanding activity which included meeting with SMT and Governing Body to out forward the proposal of incorporating the 'Brown Principles' into the decision making. The 'Brown Principles' were shared with the Committee, these principles will support and cover the CCG in the situation of litigation as the courts will review the decision making process.

Another area keen for the CCG to introduce is equality training and hoping to introduce an online module. A discussion took place as whether equality training should be mandatory and how new starters will be managed.

RESOLVED: That the above is noted.

QSC465d Infection Prevention Quarterly Update

SS reported the service provision is jointly commissioned with Public Health and a review of the service specification has been undertaken on readiness for 2016/2017.

SS reported that both RWT and WCCG are over trajectory at the end of Quarter 3 (2015/2016) for Cdiff. It was noted there has been problems with a Wolverhampton Patient being affected by Cdiff at Dudley, this information had not be shared. Since this incident communication between the two CCGs has been strengthened.

The key risks for the Committee to note are;

- The risk of infection continuing to rise above trajectory due to the number of patients who test positive for Cdiff.
- Risk of HCAI prevalence trajectories being exceeded by the CCG that will result in a negative impact on payment of the Quality Premium 2015/2016.

RESOLVED: That the above is noted.

QSC465e **Business Continuity Update Report**

The item has been deferred to the March meeting.

RESOLVED: That the above is noted.

QSC465d **Quality Assurance in CHC**

This item has been deferred to the March meeting.

RESOLVED: That the above is noted.

QSC465f **Safeguarding Children and Looked After Children Quarterly update**

LM provided assurance to the Committee on Safeguarding and Children and Looked after Children performance during quarter 3 and highlighted the following key points;

- The current position for WCCG representatives is that the Designated Nurses for both Safeguarding Children and Looked After Children receive supervision from a peer with extensive experience in their particular speciality. The designated Doctors are currently considering how to access appropriate support and supervision.
- Family Nurse Partnership (FNP) held its first Annual Review on 8th December 2015. The purpose of the annual review is to ensure the programme is delivered appropriately and to review the progress of the previous 12 months. The review identified that the outcomes for FNP in Wolverhampton are better than the FNP national average as seen from the data.

- MASH service for children and young people went live as of the 5th January 2016. The vulnerable adults will be introduced within 6 months of this date.
- Wolverhampton City Council (WCCG) is still awaiting an OFSTED inspection.
- The numbers of LAC and their placements can vary month to month, however it highlights that 60% of Wolverhampton LAC are placed out of area. Discussions took place around the number of children placed in Wolverhampton and by Local Authorities, it was explained there are national problems regarding the notification process when children are placed in or out of area. The Designated Nurse has raised this during her work locally to make improvements in (term so) terms of lack of consistency and plans to be raising it further at the regional/national LAC forums. The Designated Nurse is currently reviewing the service for Looked After Children and the Committee asked if she can attend the next committee meeting to discuss findings to date in further detail.
- The CCG continue to work with the Local Authority in relation to all cases that may reach the criteria for serious case reviews.

RESOLUTION: Fiona Brennan, Designated Nurse for Looked After Children will be invited to attend a future Quality and Safety Committee to discuss further findings to date in further detail.

Items For Consideration

QSC466a **Improving Safety in Care Homes Programme**

MHD attended the Committee to seek approved for the CCG to participate in the West Midlands Patient Safety Collaborate Improving Safety in Care Homes Programme. The CGG attended an event in November 2015 to review an existing care homes programme called PROSPER (Promoting Safer Provision of Care for Elderly Residents) based in Essex. The PROSPER programme will be aimed at evaluating if up-skilling care homes staff in basic service improvement techniques can:

- Improve the quality of care delivered to residents in care homes
- Reduce the incidence of harm
- Reduce avoidable hospital admissions.

The progamme will be directly funded for two years by WMPSC and an allocated budget will be delegated to the CCG. The Committee approved the CCG proposal and involvement in Improving Safety in Care Homes Programme

RESOLVED: That the above is noted.

QSC466b **Terms of Reference Review**

SS presented the Terms of Reference for review and outlined the amendments to the Committee. The Committee reviewed the amendments and formally agreed the Terms of Reference.

RESOLVED: That the above is noted.

Polices for Consideration

QSC467 There were no polices for consideration.

RESOLVED: That the above is noted.
Items for Escalation/Feedback to CCG Governing Body

QSC468 There were no items for escalation.

RESOLVED: That the above is noted.

Any Other Business

QSC469 **There were no items for any other business**

RESOLVED: That the above is noted

Date and Time of Next Meeting

QSC470 Tuesday 8th March 2016 at 10.30am – 12.30pm, CCG Main Meeting Room

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 25 February 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	No

Management ~

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

In Attendance ~

Vic Middlemiss (VM)	Head of Contracting & Procurement	Yes
Hemant Patel (HP)	Deputy Head of Medicines Optimisation	Yes (Part)
Ranjit Khular (RK)	Development Manager	Yes

Apologies for absence

Apologies were submitted on behalf of Viv Griffin and Cyril Randles.

Declarations of Interest

CCM457 JM declared an interest as a GP.

RESOLVED: That the above is noted.

Minutes

CCM458 Minutes of Commissioning Committee held on Thursday 28th January 2016 were accepted as a true record with the following amendment to be made:

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

RESOLVED: That the above is noted.

Matters Arising

CCM459 Agenda Membership – John Ray to be replaced with Cyril Randles.

RESOLVED: That the above is noted.

Committee Action Points

CCM460 There were no action points to review.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM461 The Committee was presented with an overview of contract performance for Month 9 (December 2015).

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.

2015-16 Procurement Schedule

The schedule was reviewed and it was agreed that going forward, a schedule of all contract expiry dates will be included as part of the Contracting and Procurement Update report.

RESOLVED: The Committee noted the contents of the update report.

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

CCM462 The Committee was presented with an assurance report and an RWT Business Case.

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.

RESOLVED: The Committee was assured by the contents of the report and acknowledged the mandatory requirement to introduce the use of Eltrombopag.

It was agreed that:

- A quarterly update report would be submitted to the Committee to inform of any mandatory NICE TA requirements.
- For any future mandatory NICE TA's, an Implementation Plan should be submitted to the CCG by RWT instead of a Business Case.

Public Health Commissioning Intentions

CCM463 The Committee was informed about the Public Health commissioning intentions for 2016/17.

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.

RESOLVED: Commissioning Committee noted the contents of the report.

Any Other Business

CCM464 None discussed.

Date, Time & Venue of Next Committee Meeting

CCM465 Thursday 24th March 2016 at 1pm in the CCG Main Meeting Room.

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 23rd February 2016
Science Park, Wolverhampton

Present:

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

In regular attendance:

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

1. Apologies

Apologies were received from Mr Marshall and Mr Mincher

2. Declarations of Interest

FP.16.14 There were no declarations of interest.

3. Minutes of the last meeting held on 26th January 2016

FP.16.15 The minutes of the last meeting were agreed as a correct record with the caveat that the following amendments are made:

- Item FP.16.08 – External Placements Panel (Children) update – the sentence ‘Mr Oatridge commented that whilst the previous report to the Committee gave clinical and quality assurance this report was relating to finance’ to be changed to ‘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’.
- FP.16.10 – title of Public Health work to be change to Immigration Population Project.

4. Resolution Log

FP.16.16 There were no open actions at this time.

5. Matters Arising from the minutes of the meeting held on 26th January 2016

FP.16.17 There were no matters arising from the minutes of this meeting.

6. Finance Report

FP.16.18 Mrs Sawrey informed the Committee that at Month 10 there were no major changes in the position to be reported. The following key points were highlighted:

- During January the CCG agreed with NHS England (NHSE) that it would extend its year end surplus by £1m. This has been reflected in reporting and the revised surplus is £6.905m.
- The forecast overspend on the Healthcare contracts portfolio has reduced as a result of a reduction to the RWT forecast outturn and a favourable resolution to queries with Heart of England Foundation Trust. A repayment will also be received from Nuffield following the identification of coding issues.
- QIPP forecast outturn delivery has increased slightly from last month as a result of validation of activity levels.
- A full review of the Better Care Fund (BCF) risk has been undertaken, including the CCG's share of risk on Local Authority (LA) Budgets. The forecast outturn net risk for the CCG has increased significantly, however, the proportion of risk has reduced for the CCG due to the nature of the increased spend and risk share arrangements. The main drivers for the increase has been the LA spend in Adult Nursing Residential placements. The CCG has challenged the LA through the BCF Finance and Information Group. The LA have confirmed this is the worst case scenario and do not expect any further deterioration in the remaining months.

Dr Bush asked for clarification regarding the over performance of Dermatology - Out Patient Procedure which continues although a community dermatology service has been commissioned. It was clarified that the modelling for 15/16 was based on figures from RWT and it appears that too much was taken out of the plan. This has been rectified for 16/17.

Dr Bush raised a concern relating to the reducing numbers of Continuing Health Care patients and whether this is causing suffering for patients. It was reported that the Team responsible for this were adhering to the policy and that the protocol in place should protect patients who need the care. Dr Bush stated that there were concerns relating to the criteria and how these are interpreted. Whilst the reduction of patients is financially beneficial there are clinical concerns. Assurance was given that it is anticipated that the patient numbers have plateaud to a normalised level. It was also noted that if a patient's health changes they can be reassessed.

Resolved: The Committee;

- noted the contents of the report.

6. QIPP Report

FP. 16.19 Mrs Sawrey presented the QIPP report. The annual QIPP plan is £11.8m. The QIPP Forecast Delivery at Month10 is reported at £8.2m against the target of £9.1m.

It was reported that the focus is now on 16/17 projects.

Resolved: The Committee;

- Noted the contents of the report and the current position.

7. Monthly Contract/Performance Report

FP.16.20 **Contract and Procurement**

Mr Middlemiss provided the Committee with a summary of the current procurement register. There are currently 6 procurements at various stages of the process; Step Down/CHS Framework, MSK, Translation Services, AQP Audiology, Non-Emergency Patient Transport and Independent living equipment services.

Mr Middlemiss reported that along with Mr Hastings he has met with the Arden and Gem CSU Manager responsible for procurement to discuss mitigation of the risk during the transition period during the change of CSUs. Assurance has been taken from this meeting.

Mr Oatridge asked that the procurement schedule be amended to also show when the contract is due to be awarded.

Resolved: The Committee

- noted the contents of the report
- procurement schedule to be amended to show when the contract is due to be awarded.

FP.16.21 **Performance**

Mr Bahia reported that at Month 9, of the indicators, 63 are green and 40 are red. There are in total 122 indicators, 19 of which are for information only. The following key points from the report were highlighted;

- A&E 4 hour waits – RWT have failed to achieved target for the month. The CCG have agreed a Remedial Action Plan(RAP) with the Trust focussing on the key drivers for failing to achieve targets, e.g. high levels of staff sickness, bed availability, patient flow, delays in patients having first assessment, patients and ambulances arriving in batches, process issues. Several actions have been identified to resolved issues. RWT has submitted a recovery trajectory for January, February and March, however as the target

has not been met in January the CCG will withhold 2% in line with the contract.

The System Resilience Group has supported plans for a GP in the Emergency Department, to Extend HALO and seek to bring forward the start date for phase 1 of the Urgent Care Centre (UCC).

The Trust has requested, through the RAP, to change to the trajectory figure, however, the CCG have not supported this request.

- Referral to Treatment 18 Weeks (RTT) – the target is being achieved; however, this is close to the threshold. Concerns remain in areas as previously reported General Surgery, T&O and Urology. NHSE funding has been received by the Trust to carry out validation work around waiting lists. A plan has been submitted by the Trust as to how they will meet number. It was noted that the CCG has offered the Trust £400k to support in reducing waiting lists, however, an activity plan has not been received from them.
- Cancer Waits – in December standards were hit as patient numbers were slightly lower. The same issues are affecting performance as previously reported. Recent figures received indicate that performance has decreased in January and the Trust has failed to meet the threshold once more.
- C. Diff – the Trust is performing below threshold. Work is onging to eradicate Avoidable cases and a full investigation is underway.
- Ambulance Handover breaches – these have increased. Discussions have taken place with WMAS. The issues are due to the high volume of activity.
- Delayed Transfer of Care (DTOC) - the target has been achieved. Tripartite work with PricewaterhouseCooper continues and support work has commenced.
- Mental Health IAPT – all access targets are being achieved with patients actively being moved to recovery. Year to date threshold is still below target.

Resolved: The Committee;

- Noted the contents of the report.

Mr Middlemiss left the meeting.

8. 16/17 Financial Plan and Budget

FP.16.22 Mrs Sawrey presented to the Committee the draft financial plan for 2016/17, noting adherence to the 16/17 planning rules and flagging risks to the financial position.

It was reported that in December 2015 NHSE confirmed that it has set firm three year allocations for CCGs. Followed by two indicative years. NHSE also confirmed that CCG admin allowances (Running Costs) will remain flat until 2020/21. The CCG has now received recurrent allocations.

The Committee was reminded that a paper was presented to the last meeting setting out the planning process and this was reiterated.

It was highlighted that growth modelledhas been based on demographic (ONS) projections provided by Public Health and non ONS projects derived from trend analysis and local knowledge. CHC spend for 16/17 has risen recognising the impact of the living wage and pension increases and also more patients with higher cost packages.

When the Long Term Financial Model (LTFM) was being developed a draft National Tariff had been published which includes the efficiency and inflation assumptions issued. The CCG has applied such 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 will 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 1% in the next 3 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 (3.56% for the CCG).

Within the plan for 16/17 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.

The Long Term Financial Model involves calculating budgets and comparing this against allocation. In order to submit a balanced plan in February the model included a QIPP programme of £11.9m, 3.4% of allocation. This is a stretching target when considering the achievement of QIPP in 15/16 included more readily available savings. The current QIPP position is;

- £5.8m of schemes well progressed in development and will deliver
- £2.3m of schemes either at outline stage or subject to contract negotiations
- £3.0m of schemes which are being worked up
- £800k without schemes identified

Budget Holders have been fully engaged in setting budgets, confirming their establishment and non-pay requirements.

It was noted that following an exercise undertaken as part of the strategic alignment of roles and, as a result more focus on co-commissioning, further changes to the staffing structure have been agreed at executive level. Running cost budgets therefore reflect the CCG requirements for 2016/17. Programme budgets have been calculated based on the planning assumptions and known changes.

The CCG has 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. The key areas of concern are:

- £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 practices.
- £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.

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).

Mrs Skidmore reminded the Committee that at this time she would normally be asking the Committee to consider recommending to the Governing Body to sign off financial plans and the CCG budget for the following year. However, at this stage there are too many variables and risks in the plan for her to be able to recommend to the Committee to do this.

Resolved – The Committee,

- noted the content of the report
- noted the budgets and the associated risks
- recommends to the Governing Body that it should note the financial plan as presented but also the risks still to be resolved. Hence it should not sign off the finance plan and budgets until the risks have been addressed.
- a further update will be brought to the March meeting with a view to recommending sign off at the April Governing Body meeting.

9. 16/17 QIPP Plans

FP.16.23 Mrs Sawrey reported that since the report presented was written the unallocated QIPP has been identified as £800k. Further detail is contained in the budget report discussed earlier in the meeting.

Mrs Sawrey reminded the Committee that there are two categories for QIPP Schemes, either Transactional (pricing, contractual or technical changes) or Transformational (service redesign, pathway changes etc.).

It was highlighted that each QIPP scheme has been RAG rated based on the NHSE scale and a table of the schemes was included in the report.

Resolved – The Committee;

- Noted the contents of the report and the ongoing work of the CCG to address the 'QIPP gap'.

10. 16/17 National Tariff Payment System

FP.16.24 The HFMA – 16/17 National Tariff Payment System document was circulated for information.

11. Any other business

FP.16.25 There were no items raised under any other business.

12. Date and time of next meeting

FP.16.26 Tuesday 29th March 2016 at 2.00pm, CCG Main Meeting Room

Signed:

Dated: