NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 12th July 2016 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

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			Date and time of next meeting ~ Tuesday 13 September 2016 ~ Governing Body Board Meeting		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Extraordinary Governing Body Meeting held on Tuesday 24 May 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
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
Mr M Hastings	Associate Director of Operations
Mr D McIntosh	Healthwatch representative
Mr P McKenzie	Corporate Operations Manager
Dr S Reehana	Interim South East Locality Chair
Ms M Tongue	Head of Financial Resources

Apologies for absence

No apologies were received.

Declarations of Interest

WCCG.1497 Dr D De Rosa reported there are no declarations of interest.

RESOLVED: That the above is noted

Minutes

WCCG.1498 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 10 May 2016 be approved as a correct record.

Matters arising from the Minutes

WCCG.1499 There were no matters arising from the minutes.

RESOLVED: That the above is noted

Committee Action Points

WCCG.1500 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Sign off the accounts and annual report

WCCG.1501 Ms C Skidmore drew the Governing Body's attention to the Annual Report and Accounts – statement as to disclosure to auditors.

"For each Governing Body member at the time the report is approved:

- So far as the Governing Body member is aware, there is no relevant audit information of which the CCG's auditor is unaware.
- They have taken all the steps they should have taken to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information."

Members of the Governing Body confirmed their agreement with the statement.

Ms Skidmore stated that the Annual Report and Accounts presented is the final version with only a few minor cosmetic amendments still required. She also pointed out a revised page 76 included within the document.

As far as the accounts are concerned no changes have been made to the numbers which have previously been reported to the Governing Body. We have nothing fundamental to note to Governing Body members. She pointed out the performance against targets table on page 7 of the report and accounts. The Clinical Commissioning Group (CCG) has achieved all of its statutory duties and three of its four local targets, (the exception being Quality, Innovation, Productivity and Prevention (QIPP) which was 87% achieved).

Mr D McIntosh highlighted that the annual report refers mainly to the Royal Wolverhampton Hospital Trust (RWT) as our main providers. Mrs Skidmore noted Mr McIntosh's request for information on other providers and suggested that this could be shared as part of the Annual General Meeting (AGM) presentation. He also pointed out that the practice list is not up to date and the list does not include branch practices. Ms Skidmore confirmed this will be checked before final submission and publication.

Dr J Morgans and Dr G Mahay arrived

Mr J Oatridge informed the Governing Body that an Audit and Governance Committee meeting had taken place this morning where the Annual Report and Accounts had been scrutinized enabling the Governing Body to be provided with assurance. Dr De Rosa and Dr Hibbs also attended the meeting. He highlighted the chief internal auditors opinion ~

"The internal auditors for 2015/2016, West Midlands Ambulance have formally produced their report and they have given significance assurance regarding controls operating within the organisation."

A formal report was also received from the external auditors Ernst and Young. They reported no issues regarding value for money and are able to issue a clean audit certificate. The Management representation letter will also be signed off.

Mr Oatridge stated one risk raised by the auditors was the way agendas are moving forward and how the Governing Body will receive assurance that governance remains robust as things like the Sustainability and Transformation Plan (STP) and combined Local Authorities develop. This will be reported back to the Governing Body through the Audit and Governance Committee in future.

The Governing Body noted the complimentary feedback from both the internal and external auditors and recognised the hard work from the CCG staff to produce the Annual Report and Accounts.

RESOLVED: That the Governing Body agreed with the statement which was read out. That the Governing Body approved the Annual Report and Accounts subject to the cosmetic changes occurring as noted.

Committee Annual Reports

WCCG.1502 Mr P McKenzie stated this report introduces the annual reports of the Governing Body Committees that demonstrate how each of them has met their terms of reference as set out in the CCG's Constitution. Ms Roberts asked if the percentage of attendance and quoracy could be included within the attendance at meetings. Dr De Rosa confirmed this was a good idea. Mr McKenzie will pick this up.

RESOLVED: That the Governing Body accepted the report presented by its Committees as a record of their continued delivery of their terms of reference.

Any Other Business

WCCG.1503 There were no items.

RESOLVED: That the above is noted.

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

WCCG.1504 No questions were raised by the Public/Press

RESOLVED: That the above is noted

Date of Next Meeting

WCCG.1505 The Board noted that the next meeting was due to be held on **Tuesday 12 July 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 1.45 pm

Chair……..

Date ……

Wolverhampton Clinical Commissioning Group Governing Body

12 July 2016

Date of meeting	Minute Number	Action	By When	By Whom	Status
10.5.16	WCCG.1465	Emergency Preparedness, Resilience and Response (EPRR) – • A further report is presented to the Governing Body. • How can Prevent requirements be delivered to GP practices	July/September 2016	Andy Smith Dr Dan De Rosa	
10.5.16	WCCG.1474	Communications and Engagement – Stakeholder letter and invitations to public events are distributed to Governing Body members	June/July 2016	Pat Roberts	
10.5.16	WCCG.1482	Members of the Public Questions – • Invitations to public events are distributed in a timely manner to the public • Up to date directory of services for GP practices	June/July 2016	Pat Roberts Mike Hastings	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING

12 JULY 2016

Agenda item 6

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 – Business As Usual (BAU)

The procurement and mobilisation stages of the Lead Provider Framework re-procurement of CSU services are now complete. The collective CCG's have now transitioned to the BAU stage and Wolverhampton CCG is monitoring delivery of services on a line by line basis.

Customer feedback is sought from all CCG staff members that work directly with CSU services on a monthly basis and this is fed back to the CSU and forms part of the monthly Contract Review Meetings. At these meetings the CCG and the CSU review the customer feedback, the performance against agreed Key Performance Indicators (KPI's) and discuss emerging risks, under-performance or system and process redesign requirements. The KPI's are being constantly monitored however, there is an agreement that there is a three month grace period for the CSU where financial penalties will not be levered against them whilst new services are 'bedding-in'. This comes to an end on 30th June.

Highlights from this month in terms of delivery include; the joint work to agree reporting formats for contract management. The latest feedback from the collective CCGs was good with good feedback about the Human Resources function particularly regarding their proposals for Organisational Development; with recent changes in the contracting team, Interim staff are in place and this is working well. Both CSU's are completing their collation of Statements of Work which define their commitment of support to each service line in detail which will help with contract management.

2.2 West Midlands Accountable Officers Workshop CCGs in the commissioning landscape: A forward look

A workshop took place on 9 May 2016 to offer CCGs an opportunity to consider the influences which are shaping the future of commissioning nationally and locally and the impact they are having on CCGs. The workshop provided a forum to enable CCGs to identify changes they may wish to make to ensure they are as fit as possible for that future.

2.3 Sustainability and Transformation 2021 - Delivering Success in the West Midlands - Peer Review – Sustainability and Transformation Plan (STP) Development Day

Further to the initial workshop on the 20 January 2016 outlining the operational planning guidance and the STP guidance for 2021, a system wide event to provide an on-going opportunity to work on a West Midlands wide footprint across the STP's and with key partners and advisors took place on 5 May 2016.

The event provided input on a number of key planning areas, the latest information to support STPs and the opportunity to meet and discuss issues with Regional Directors and representatives from:

- Care Quality Commission
- Health Education England
- Local Government Association
- NHS England
- NHS Improvement
- Public Health England

The event was supported by Simon Stevens – Chief Executive Officer NHS England, Bob Alexander - Executive Director of Resources / Deputy Chief Executive, NHS Improvement and other national leaders.

2.4 Wolverhampton CCG Visit to Bromley-by-Bow Centre – 19 May 2016

Members of Wolverhampton CCG's Executive Team met with Sir Sam Everington, Chair of NHS Tower Hamlets Clinical Commissioning Group and lead GP of the Bromley by Bow Health Centre. The Centre offers a full range of services to help to improve health and wellbeing alongside traditional primary care services.

Of particular interest was the extensive community work that is being done including a well-developed social prescribing model.

2.5 Immediate Solutions to Address Demand and Capacity Pressures in the Hospital Eye Service Event

NHS England hosted an event in London on the 7 June 2016 entitled "Immediate solutions to address demand and capacity pressures in the Hospital Eye Service". NHS England, in cooperation with key partners such as the Royal College of Ophthalmologists, The Optical Confederation and the Clinical Council for Eye Health Commissioning produced a comprehensive programme for this event.

I was asked to attend and present on behalf of Wolverhampton CCG as we have commissioned a number of enhanced eye care services through a Primary Eye-care Assessment and Referral Service (PEARS) model from local optometry practices using an Any Qualified Provider (AQP) contract. There is a good body of evidence that this has had a positive effect on demand at local acute trust eye departments.

2.6 NHS Confederation Annual Conference and Exhibition 2016

The NHS Confederation Annual Conference and Exhibition took place over 15 – 17 June 2016. The focus of this year's conference was the huge effort that is underway in the NHS, and wider health and care system, to transform care for patients and ensure system sustainability for the future. Speakers included Rt Hon Jeremy Hunt MP - Secretary of State for Health, Simon Stevens – Chief Executive Officer NHS England and Jim Mackey - Chief Executive, NHS Improvement.

2.7 Wolverhampton City Board Meeting – 21 June 2016

The City Board is made up of Wolverhampton's key public, private and voluntary sector partners who are working together to create opportunities that encourage enterprise, empower people and re-invigorate the City. A meeting took place on 21 June 2016 to discuss the on-going work plan.

2.8 Health Scrutiny Panel

A meeting of Wolverhampton Health Scrutiny Panel took place on 23 June 2016. Items discussed included Royal Wolverhampton NHS Trust (RWT) - Quality Account, RWT CQC Inspection Improvement Plan, update on the Accident and Emergency Department RWT and Wolverhampton CCG Primary Care Strategy Update.

2.9 West Midlands Accountable Officers Meeting

A meeting of the West Midlands Accountable Officers took place on 27 June 2016. Claire Skidmore attended to represent the CCG. Discussion took place around the CCG role, programme development including defining the CCG role – the need for joint values, ambition, leadership, effective relationships and the management of change.

Dr Helen Hibbs
Chief Officer
Date: 30 June 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**	**30/06/16**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting

12 July 2016

Agenda item 7a

Title of Report:	**Presentation of Joint Carer Strategy**
Report of:	Maxine Danks
Contact:	Maxine Danks
Governing Body Meeting Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To provide the Governing Body with the final draft Wolverhampton Joint Carer Strategy '*Who Cares? We do*' To request the Governing Body approve and endorse the Strategy in order that it can be implemented once approved by Wolverhampton City Council on 20.07.2016
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	The strategy has been developed in partnership with Wolverhampton City Council and has included consultation with carers of all ages in the city
• **Domain 2a:** Performance – delivery of commitments and	The strategy will ensure the obligations identified in The Care Act and other directives are addressed.

improved outcomes	This will, in turn, benefit carers locally
• **Domain 2b:** Quality (Improved Outcomes)	The strategy should assist in delivering improved health and well-being outcomes for individuals undertaking the role of a carer
• **Domain 3:** Financial Management	The CCG already contribute financially to the support provided for carers by WCC via the Better Care Fund. The strategy should assist in establishing transparency as to the utilisation of these funds to meet the outcomes identified in the implementation plan
• **Domain 4:** Planning (Long Term and Short Term)	The Strategy is for a four year period until 2020 and the aim is to deliver short, medium and long term improvements
• **Domain 5:** Delegated Functions	There are no identified delegated functions

1. BACKGROUND AND CURRENT SITUATION

1.1. Nationally it is recognised that the number of people delivering unpaid care is rising.

1.2. It is estimated that in the UK as a whole some 6.8 million people deliver unpaid care which is valued at £132 billion.

1.3. In the 2011 census 27,000 carers were identified in Wolverhampton and provided support to the value of £594 million

1.4. There is a recognition, both nationally and locally, that undertaking the role of a carer has the capacity to impact on the health and wellbeing of an individual

1.5. A number of Government directives, along with The Care Act 2014, have highlighted the areas that health and social care need to address in order to support carers in the valuable role they deliver.

2. MAIN BODY OF REPORT

2.1. The CCG are required to provide support for carers as part of The NHS Commitment Carers. The Care Act has also impacted and there are specific actions that must be taken to meet the needs of carers.

2.2. In the spirit of good partnership working and to maximise the impact of the strategy a joint approach was agreed. Wolverhampton City Council have an established carer support service in place and therefore it was appropriate that they lead on this strategy

2.3. The Better Care Fund encompasses carer support and WCCG have committed funds to support this important work via the pooled budget

2.4. The strategy and associated implementation plan reflect the views and feedback from a range of carers living in Wolverhampton

2.5. The strategy will provide a framework to underpin the changes necessary to ensure, both WCCG and WCC, are compliant with legislation and government directives

2.6. Carers of all ages will benefit from targeted, appropriate provision and support to allow them to continue with their valuable contribution to the health and social care economy in Wolverhampton

3. CLINICAL VIEW

3.1. Not required for this strategy

4. PATIENT AND PUBLIC VIEW

4.1. There were a number of widely published events held for carers, of all ages across the city, during the consultation period from 10.03.2016 until 21.04.2016.

4.2. Additionally events were held that focused on young carers, their opinions were also gathered by an electronic survey.

4.3. Feedback gathered from the consultation events identified 6 key themes

- Being acknowledged and valued as a carer
- The personal impact of caring
- Services are not always responsive and flexible to meet the needs of carers
- Employment – issues experienced
- Direct Payment options
- Information available

4.4 This feedback was used to develop the strategy and the implementation plan

5. RISKS AND IMPLICATIONS

Key Risks

5.1. The main risk would be reputational as WCCG would be identified as a partner responsible for delivering this strategy

Financial and Resource Implications

5.2. There have been no additional financial or resource implications identified.

5.3. Wolverhampton CCG already contribute, directly via BCF, specific monies to support the services delivered to carers

5.4. In addition Wolverhampton CCG provide support for carers ,via respite funding, for individuals who receive NHS Continuing Healthcare at home

Quality and Safety Implications

5.5. The strategy has no specific areas which require input from a quality and safety perspective

5.6. Reports will be provided on a 6 monthly basis to inform the Quality and Safety Committee as to the progress of the implementation plan

Equality Implications

5.7. An Equality Impact Assessment has been completed following discussion and liaison with Juliet Herbert. This is attached in appendices for information

5.8. It is anticipated that the implementation of this strategy will lead to improved equality outcomes

Medicines Management Implications

5.9. Not applicable

Legal and Policy Implications

5.10. There have been several directives and 2 legislative changes which are listed below:

- The Care Act 2014
- NHS Commitment to Carers 2014
- The Children and Families Act 2014
- The National Vision and outcomes for Carers 2014
- Equality Act 2010

6. RECOMMENDATIONS

6.1 That the Governing Body receive and discuss the draft strategy, implementation plan and equality impact assessment

6.2 That the Governing Body endorse the strategy in order that is can then be adopted following ratification at WCC cabinet on 20.07.2016

Name: Maxine Danks
Job Title: Head of Individual Care
Date: June 22nd 2016

ATTACHED:
Draft Joint Carer Strategy
Implementation Plan
Equality Impact Assessment

RELEVANT BACKGROUND PAPERS

https://www.england.nhs.uk/ourwork/pe/commitment-to-carers
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
https://www.gov.uk/government/publications/carers-strategy-actions-for-2014-to-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**	**22.06.2016**
Public/ Patient View	**See report for detail**	**22.06.2016**
Finance Implications discussed with Finance Team	**N/A**	**22.06.2016**
Quality Implications discussed with Quality and Risk Team		
Medicines Management Implications discussed with Medicines Management team	**N/A**	**22.06.2016**
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliet Herbert**	**21.06.2016**
Information Governance implications discussed with IG Support Officer	**N/A**	**22.06.2016**
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	**22.06.2016**
Signed off by Report Owner (Must be completed)	**Maxine Danks**	**23.06.2016**

Appendix 1

CITY OF WOLVERHAMPTON COUNCIL

Joint All Age Carer Strategy

2016 – 2020

NHS
Wolverhampton
Clinical Commissioning Group

Forward

Carers play a critical role in supporting someone who would otherwise be unable to look after themselves; often putting the needs of the cared for before themselves. There is no age barrier to becoming a carer; some become a carer for the first time at an earlier age, whilst for others it can be later in life.

We know from national research, and more locally from talking to carers, that caring impacts on their quality of life.

Carers are unique individuals and how their caring role impacts on their life will differ from person to person. Some carers will find that caring for someone is a positive experience, whilst for others it means putting their life `on hold'.

The Care Act brings significant advances in the rights of carers and for the first time places carers on the same legal footing as the person they care for.

We have no doubt that this piece of legislation will have a positive impact on the health and well-being of carers, supporting them to have a life alongside their caring role. We are committed to ensuring carers continue to be made aware of their legal rights as part of the delivery of this strategy.

We would like to thank all the carers that have contributed to the development of this Joint All Age Carer Strategy, and offer our assurances that we will work with carers to help reshape our services around the things that Wolverhampton carers told us was important to them.

Contents

Who Cares? We do.

A carer is a person of any age who, on an unpaid basis, helps to look after a relative, neighbour or friend who could not manage at home without their help. The Care Act 2014 defines a carer as `an adult who provides or intends to provide care for another adult'[1]

The term `young carer', applies to anyone under the age of 18 who provides care. They may be the main carer, or provide partial care for an adult or sibling.

Why do carers matter?

There were over 27,000 carers in Wolverhampton identified in the 2011 Census[2], so their caring contribution makes a big difference to the lives of the people they care for.

Often carers will help the person they care for with everyday tasks such as helping someone to bed, getting them to up in the morning, helping them to wash and dress, making of meals and help with toileting.

Often the caring role will extend to include shopping, household cleaning and laundry. In additional to these practical tasks the caring role can also extend to providing emotional support and childcare responsibilities.

Many carers take on the role of caring without thinking twice, or noticing the effect it has on their own lives because of the close relationship they have with the person they care for.

Adult carers often experience loneliness and isolation, poor health and financial hardship. Younger carers may find it harder at school and beyond.

A carer's contribution means the person being cared has a better quality of life enabling them to:

- continue to live in a family environment;
- contribute and be included in family life;
- be more able to be included in the everyday life of their community.

While caring can be a very positive and enjoyable experience it can also mean the carer may:

- experience a greater level of stress and emotional strain that may harm their own health;
- find that they cannot keep up their social networks or other relationships and become more isolated as a result;
- become unable to continue working full- time and their income and future pension can be harmed.

The report `Valuing Carers 2015 – The Rising Value of Carers' Support' published by Carers UK sought to quantify the value unpaid carers contributed to the national and local economy. The report estimated that:

- in 2011, 12% of the UK population – in 2015 equal to 6.8 million people – provided unpaid care;
- the annual value of support provided by unpaid carers nationally is now £132 billion. To put this in context the annual

[1] Clause 10 (3) The Care Act 2014
[2] Office of National Statistics 2011 Census

cost of health spending stood at £134.1 billion in 2014 - 15 ;
- in Wolverhampton unpaid carers provided support to the value of £594 million per annum.

The report also noted that that the number of carers would increase as people are living longer.

The Wolverhampton Picture

27,136 people identified themselves as carers in the 2011 Census, which represents 10.8% of the whole population (249,470).

The numbers of hours that people provide care is given as:

- 15,450 provide 1 to 19 hours p/w (6.2% of the population)
- 4,278 provide 20 to 49 hours p/w (1.7% of the population)
- 7,408 provide 50 hours or more p/w (3% of the population)

The peak age for providing care is 50-64; almost 1 in 5 people in this age group provide care.

1 in 7 people aged over 65 provide care and this group provides the largest percentage of care at over 50 hours each week

The Census recorded the ethnicity of those that that identified themselves as carers:

- 12% of White British people identified themselves as carers;
- 9.9% of Asian/Asian British people identified themselves as a carer;
- 9.6% of Black/African Caribbean/Black British people identified themselves as a carer;
- 4.6% of people from a Mixed/Multiple ethnic group identified themselves as carers.

594 children and young people under 15 were identified as carers by the adult who completed the census form. Of these 52 were said to be providing 20-49 hours per week, and 69 providing in excess of 50 hours per week.

An ageing population[3]

As people live longer the number of older carers is almost certain to increase as will older people's need for care.

In 2015 it was estimated that that were 42,700 people aged 65 and over. This figure is estimated to increase to 45,200 by 2020 (5.8%).

Behind this headline figure rests much more significant increases in population across certain age bands, for example people aged:

- 70 – 75 is expected to increase from 9,800 to 10,800 an increase of 10.2%;
- 80 plus is expected to increase from 12,700 to 14,100 (11%) Most notable in this age group is the number of people aged 90 and over which is expected to increase from 2,200 to 2,800 an increase of 27%.

[3] Projecting Older People Population Information System 2016

Self Care -limiting long term conditions

Within the life time of this strategy the number of older people aged 65 and over unable to manage at least one self- care activity is forecast to increase by almost 1,000[4].

Self- care activities include ability to: bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails or take medication

Whilst the number of adults aged 18 – 64 with a moderate or serious personal care disability is estimated to increase by almost 200 over the course of this strategy[5].

These statistics together with increasing numbers of people with dementia strongly suggests that more people will become carers in the future.

The Care Act 2014

The Care Act has bought about significant advances in the rights of carers to be recognised and, for the first time places carers as an equal to the person they care for – putting them at centre of the law and on the same equal footing[6]

The Care Act 2014 means important changes for carers, from 1 April 2015:

- Carers have the same legal rights as those for whom they care;
- Local authorities have a duty to assess all carers that have appearance of need;
- Local authorities must consider a carer's overall well-being, which includes physical, mental and emotional well-being; participation in work, education and training, and social and economic well-being;
- Carers who meet the eligibility criteria have a right to support to meet any eligible unmet needs;
- Carers have the right to be involved in the assessment of the person they care for;
- Local authorities will have a duty to recognise that carers may have their own specific information needs.

The Act requires local authorities to provide information and advice relating to care and support locally, to include:

- **Training** – learning and skills for caring;
- **Coping** – with routine caring responsibilities;
- **Managing work** – how the workplace takes into account carer's responsibilities;
- **Local support and services** – knowing where to go close to home;
- **Benefits and finance** – assistance and independent advice available;
- **Information on assistive technology** – devices and equipment that improve daily living.

[4] Projecting Older People Population Information System 2016
[5] Projecting Adult Needs and Service Information 2016
[6] The Care Act 2014

The Children and Families Act 2014

This Act updates the 1989 Children Act, which remains in force, as it extends the right to an assessment of needs to support all young carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it.

All local authorities in England must assess whether a young carer within their area has needs for support and, if so, what those needs are, if[7]:

- it appears to the authority that the young carer may have needs for support, or
- the authority receives a request from the young carer or a parent of the young carer to assess the young carers' needs for support.

The needs assessment, which can be requested by the young carer themselves, is an important tool to ensure the young carers own needs are being met and not neglected as a result of their caring role.

The assessment must include how appropriate it is for the young carer to provide, or continue to provide, care for the person in question, in the light of the young carers' needs for support, other needs and wishes[8].

A local authority, in carrying out a young carers' needs assessment, must have regard to the extent[9]:

- the young carer is participating in, or wishes, to participate in education, training or recreation, and to;
- which the young carer works or wishes to work.

In addition to bringing in rights for young carers to request and receive a care needs assessment the Care Act 2014 and Children and Families Act 2014 also:

- requires the development of a "whole-family approach" to assessment and support, so that young carers and their families can access appropriate assistance;

- requires councils to consider the support disabled parents and carers may need in carrying out their responsibilities to care for a child (who may potentially be a young carer);

- specify that adult services must, while carrying out assessments, identify children in the household and consider whether they are young carers and if so whether they are children in need;

- support for young carers 'in transition' to adulthood. The Care Act requires that an assessment, of a young carers needs, if it considers that they are likely to have needs for support after becoming 18 and that the assessment would be of significant benefit to him / her;

[7] Children and Families Act 2014 S96 (1a & 1b)
[8] Children and Families Act 2014 S96 (7)
[9] Children and Families Act 2014 S96 (8a & 8b)

- locally ensure there is clarity about who has responsibility for supporting young adult carers aged 18 -24 preventing needs and support.

Strategic Context

The strategic context of this strategy is set within:

The National Vision and Outcomes for Carers

The UK Government published the first National Strategy for Carers in 1999, which has subsequently been revised (2008) and updated (2010 and 2014) The needs of carers have also been recognised and strengthened in related employment and health policy, while advocating closer working between Health and Social Care.

In 2014, the Government continued its recognition of the importance of carers by releasing the 'Carers Strategy: Second National Action Plan 2014-16'. The plan identifies four priority areas for action:

Priority Area 1: Identification and recognition

- Supporting people with caring responsibilities in order to identify themselves as carers, so they can access the information, advice and support is available;
- Carers feeling their knowledge and experience are valued by health and social care professionals;
- Involving carers in planning individual care packages and in developing local strategies.

Priority Area 2: Realising and releasing potential

- Support for young carers and young adult carers;
- Support for carers of working age.

Priority Area 3: A life alongside caring

- Personalising support for carers and the people they support;
- Availability of good quality information, advice and support.

Priority Area 4: Supporting carers to stay healthy

- Impact of caring on health and wellbeing;
- Prevention and early intervention for carers within local communities;
- Supporting carers to look after their own health and wellbeing.

NHS Commitments to Carers

In 2014, NHS England published a 'Commitment to Carers' which identified eight priorities:

1. Raising the profile of carers
2. Education, training and information
3. Service development
4. Person-centred, well-coordinated care
5. Primary care
6. Commissioning support
7. Partnership links
8. NHS England as an employer

Regional Commitments to Carers

Wolverhampton Council has been working as at a regional level, through the Association of Directors of Adult Social Services (ADASS), to develop a shared commitment to carers.

In total 14 local authorities have worked collectively to put together a set of regional commitments for carers[10]. Wolverhampton Council is committed to working to meet these commitments.

These commitments, and those made by NHS England, form part of an on-going work programme.

Wolverhampton Council Corporate Plan

Supporting carers has a significant role to play in helping the Council achieve its' strategic priorities for the city[11]. Where carers are supported:

- to live longer healthier lives;
- in times of need;
- to achieve their full potential.

These strategic drivers are clearly identified within the Implementation Plan that will deliver this strategy.

The Impact of Caring

Carers are unique individuals and therefore it is impossible to `profile' a typical carer. However the 2011 Census helps us understand some common characteristics of caring and how this can impact on the lives of carers and their well-being.

Inequality of caring in England[12]

Women are more likely to be carers than men. Nationally 3.12m females provided one of more hours of care ~~each week compared to 2.2~~9m of men. This represents 11.8% of the female population and 8.9% of the male population.

Women are 2.7 times and men 2.4 times more likely to report `not good' health if working full time and providing 50 or more hours of care each week.

The greatest health divide between unpaid carers and those providing no unpaid care is among students. Male and female students are more than 4 times more likely to have `not good health' if they are providing 50 hours or more unpaid care each week compared those that provide no unpaid care.

The possibility of becoming a carer increases up to the age of 64. More men and women are most likely to become carer when they are aged 50 – 64, as this group are most likely to have an elderly parent to care for.

Becoming an unpaid carer in your 50's increases the chances of leaving the labour market for good, is associated with health problems and restricts social and leisure activities.

The impact of caring – a lonely experience

Providing care can have a significant impact on relationships with others; a report by Carers UK[13] found that:

- 8 in 10 carers felt lonely or socially isolated;
- 49% of carers have experienced difficulties in their relationship with their partner;
- 57% of carers had lost touch with friends and family;
- 38% of carers in full time

[10] Implementing the Care Act 2014 – A Commitment to West Midlands Carers
[11] Wolverhampton Corporate Plan 2016-2019
[12] Office for Nation Statistics: Headline information for Carers Week 10-16 June 2013
[13] Carers UK: Alone and Caring – isolation, loneliness and the impact of caring

employment have felt isolated from other people at work.

The impact of caring – health and wellbeing

In their annual survey[14] Carers UK found that:

- 82% of carers report that caring has had a negative impact on their health;
- 74% of carers find it difficult to get a good night's sleep;
- 47% struggle to maintain a balanced diet;
- 41% have experienced an injury or their physical health has suffered as a result of caring.

The report noted the consequence for carers' mental health with 84% of respondents saying they feel more stressed, 78% saying they feel more anxious, and 55% reporting that they have suffered from depression as a result of their caring role.

The impact of caring – financial hardship

The financial hardship that carers and the person they care for cannot be under estimated. This may be caused by carers giving up work entirely to carry out their caring role or take lower paid, more flexible, employment. Often a drop in household income is accompanied by higher than usual household expenditure.

Carers UK's year-long Caring & Family Finances Inquiry[15] found that carers can face higher; utility bills, transport costs and shopping bills. Nearly half (48%) of carers who responded to their survey were struggling to make ends meet. The survey also found that 41% are cutting back on essentials like food and heating.

Given that people beginning to care in their 50's are more likely to leave the labour market for good, there is an increased risk that they may continue to face financial hardship in their later years as a result of leaving private/employer pension schemes earlier than may otherwise have been the case.

Young Carers

A young carer is a child or young person under 18 who provides or intends to provide care for another person (either practical or emotional support).

In Wolverhampton there are around 600 young people under the age of 15, and 1,800 young people aged 16 - 24 who look after someone else who would not otherwise manage at home without their help[16].

The impact of caring – a positive experience

Contributing to the care of a family member or friend with a disability or illness can be a positive experience for a young person. It can be an expression of commitment and affection, which can serve to strengthen the relationship between the young person providing the care and the person receiving the care.

Providing care can also enable a young person to develop personally and to gain life skills as a result of the

[14] Carers UK: State of Caring 2015

[15] Carers UK (2014) Caring & Family Finances Inquiry: UK Report

[16] Wolverhampton children and young people mental wellbeing needs assessment 2015

caring contribution they make and the responsibilities they take on.

Young carers can:

- achieve greater maturity and resilience;
- develop problem-solving and coping skills allowing them to become more independent;
- enhance their practical skills in managing money, maintaining a home, providing child care, organising appointments and liaising with professionals.

However, there is growing evidence pointing to the adverse impact on the health, future employment opportunities and social and leisure activities of those providing unpaid care, particularly for young carers.

The effects of caring on young carers

Hidden from View: The experiences of young carers in England[17] provides a valuable insight in to some shared characteristics of young carers which not only affect their childhood and education in the here and now, but also casts a shadow forward and affect their futures and prospects in later life.

Some of the key finding from the report show that young carers are:

- 1.5 times more likely than their peers to be from a black, Asian or minority ethnic communities;
- 1.5 times more likely than their peers to have a special educational need or disability;
- more likely to belong to a family where the household income is £5000 less than families that do not have a young carer;
- more likely to miss school because of their caring responsibilities.

The report also notes that young carers have significantly lower education attainment at GCSE level than their peers.

A quarter of young carers said they were bullied at school because of their caring role. Only half had received additional support from a member of school staff[18]

Young carers' Not in Education, Employment or Training (NEET) aged between 16 and 19 years old has a significant impact on a person's outcomes later in life.

The Department for Education[19] recognises that 'Being NEET is associated with negative outcomes later in life, including unemployment, reduced earnings, poor health and depression. These outcomes have a cost for both the individual and the economy.

Impact on young carers' mental health

Children and young people's mental health can be affected by their caring role, whether the condition of the person they care for is related to physical health, mental health, an addiction or frailty in older age.

[17] Hidden from View: The experiences of young carers in England, The Children's Society 2013

[18] Young Adult Carers at School: Experiences and Perceptions of Caring and Education (Carers Trust 2013).

[19] Department for Education (2013)

A report by Carers UK[20] shows that young carers have worst mental health than their peers. The report notes that:

- young carers providing 50+ hours of care a week were up to five times more likely to report their general health as 'not good';
- A survey of 350 young carers found that 48% of them made them feel stressed and 44% said it made them feel tired;
- A survey of 61 young carers in school found that 38% had mental health problems.

Young Carers in Transition to Adulthood

Young carers can find the passage from been a young carer to a young adult carer complex and challenging.

Around 1 in 5 young adult carers are not in education, employment or training when they leave school[21]

A report by the Carers Trust[22] found that:

- Over half of young adult carers at college or university said they experienced difficulties because of their caring role and 16% were concerned they might have to drop out;
- Over three quarters of young adult carers at college or university had communicated their caring role to their college or university but nearly half still felt there was no one there who recognised them as a carer and helped them.

Wolverhampton Adult Carers – their priorities

Caring for someone is a unique and personal experience. Whilst no two caring experiences will be identical, a series of themes began to emerge through the conversations we had with carers.

These themes surrounded:

- Being acknowledged and valued as a carer. The carers we spoke to felt that they were valued and supported until something unexpected happens that interrupts the care they provide.

- The personal impact of caring; caring is a full time job, often carers have put their own life `on hold' and forego doing the things they want to do

- Services are not always responsive and flexible to meet the needs of carers; support is not always co-ordinated across health and social, resulting in carers repeating themselves, and respite care is not flexible to meet the needs of carers.

- Employment; whilst employment was seen as a `saving grace' for some, for others they were unable to

[20] Invisible and in Distress: prioritising the mental health of England's young carers (Carers Trust 2016)
[21] Young Adult Carers and Employment (Carers Trust 2014)
[22] Young Adult Carers at College and University (Carers Trust 2014)

balance their caring role with employment.

- Direct Payments; whilst some carers we spoke to were already in receipt of a direct payment, others felt they were complicated but would like to learn more.

Top 10 Priorities for the future

As part of our conversations with adult carers we asked them to list the top ten things that would support them in their caring role. They told us that they:

1. Would like the Council and NHS to work together to develop a set of promises for carers, for example through a `Carers Charter'.
2. Want employers to be `carer friendly' recognising that carers may need to work flexibly and for them to recognise the special skills and knowledge carers can bring to them, as employees.
3. Want to be recognised as a carer by professionals and my knowledge and experience taken account of.
4. Would like the Council and NHS to work more closely together to ensure so that I don't have to repeat myself.
5. Would like more opportunities to access respite care for the person I care for.
6. Would like someone to talk to, when I need it, to help me with my caring role.
7. Would like more information about assistive technology to support me in my caring role.
8. Would like to know more about local support services, close to where they live.
9. I would like to better understand their legal rights as a carer.
10. Would like to socialise with other carers for companionship and mutual support.

These priorities, identified by Wolverhampton adult carers, will form part of the Implementation Plan that will support the delivery of these priorities.

Young Carers: what they told us

Young carers were encouraged to join the conversation with carers by attending one of two workshop events, or through the completion of a paper or online questionnaire.

Impact on health and well-being

Nearly half of young carers that took part in the consultation exercise told us that caring had impacted on their health and well-being; stress and anxiety were common themes.

Some young carers reported suffering from physical pain as a result of caring for someone with a mobility problem and some told us that they feel upset and sad at times.

Most concerning is that two young carers replied anonymously "**Sad with suicidal thoughts" and "depressed, it is out of control sometimes."**

The things young carers worry about

Young carers told us that they worry about things that are connected to their caring responsibilities, examples include:

- displays of anger from siblings they care for that have a learning disability;
- the person they care for having a fall;
- what might happen whilst they are away from home and unable to assist *"My dad can have a seizure at any time. I worry more when I'm not there";*
- worrying about the health and wellbeing of the person they care for, that their illness might get progressively worse and their passing.

Young carers and school

Young carers see school as playing a significant role in identifying young carers and providing them with support and information.

Young carers told us that there are inconsistencies in how they are supported at school, "some schools are good and some aren't"

A common theme is that young carers who reported receiving information and support at school seemed to cope with their education and caring role much better than those who do not.

Some of the issues faced by young carers include:

- time management, balancing their caring role with school work, homework and exams;
- tiredness and inability to concentrate;
- attendance at school including arriving late, finishing early or not attending.

Information and advice

Young carers told us that they would like information surrounding:

- their caring role and the support that they can access;
- specialist information and advice about the condition of the person they care for and appropriate caring techniques "*Help from an autism specialist on how autism affects someone's mind."* ;
- Information around managing their own stress.

A life alongside caring

Young carers told us that caring impacted on their social life in the following ways:

- Unable to make plans to go out as they have limited time;
- Are less likely to invite friends to their home because of their caring role;
- Time to stay in touch with friends and family is limited.

They also said that they have limited time to play computer games or engage in other social media. They

tend to only be able to socialise online at night before going to sleep. By this time many of their friends are offline.

"There are new phone apps but I don't get chance to use them. I miss out on stuff young people do."

Future aspirations

Young carers have many aspirations for the future.

Some young carers told us that would like to go on to further and higher education, start a family, or find employment in health or professions.

However, young carers were also concerned about the impact of caring might have on these aspirations.

These concerns surround:

- the need to continue to care;
- having the time to pursue their aspirations;
- The impact caring will have had on their education.

Wolverhampton Young Carers – their priorities

Throughout the consultation process with young carers we can see that schools have a key role to play in identifying and supporting young carers to meet their priorities and aspirations for the future.

Young carers told us that their priorities are:

1. More education for all, particularly in schools, on the role of young carers and the impact it has on their lives.
2. Reassurance, encouragement and confidence building.
3. Time management techniques and resources to enable them to organise their lives to reduce the negative impact of caring.
4. Information, advice and support on how to balance caring and education.
5. Support with school work and homework such as a homework club and extra lessons.
6. Support to achieve their future goals, to access further and higher education and careers advice.
7. Information on how to support someone with a disability or long term condition.
8. Therapy and stress management techniques
9. More opportunities to engage socially
10. For a smoother transition from a young carer to adult carer with support for young carers aged 18 – 25 years.

These priorities, identified by Wolverhampton young carers, will form part of the Implementation Plan that will support the delivery of these priorities.

Future Commissioning Intentions

The Council's Market Position Statement (MPS) provides a comprehensive base for continued change and improvement for all

commissioned services in Wolverhampton.

The MPS outlines the common set of themes which will be embedded in all future commissioned intentions.

All future commissioned services, including those designed to support carers, will have to demonstrate that:

- they put the person first and promote independence;
- are outcome focused;
- use of assistive technologies, for example telecare, is maximised to its full potential;
- people receive the maximum support to maintain or regain skills that may otherwise be lost through a programme of reablement;
- services are co-produced with users and user led.

Developing the Strategy

We couldn't have developed this strategy without understanding what's important to carers and how we can work together to make a difference to their quality of life and the person they care for.

Carers were invited to join one of a series of round table `Conversation with Carers' events where carers were invited to share their views and experiences of being a carer and identify the things they would like to see change to improve their quality of life and in turn the person they care for.

We recognise that being a carer can be a demanding role and that people are not always available to attend organised events. To help ensure that the voice of these carers was not lost carers were invited to contact the Commissioning team direct.

Implementing the Joint All Age Carer Strategy

Throughout this document we have seen that carers play a key role in the life of the person they care for, and whilst it can be a personally fulfilling experience, their commitment can have a significant impact on their own quality of life.

Both Wolverhampton City Council and Wolverhampton Clinical Commissioning Group are committed to supporting carers in their caring role and to recognise and value their on-going commitment to the person they care for.

Accompanying this Joint All Age Carer Strategy is an Implementation Plan detailing what we will do to address the priorities of carers.

The Implementation of the strategy will be overseen by a steering group made up of representatives of both Wolverhampton Council, Wolverhampton Clinical Commissioning Group and Carers.

We recognise that in the lifetime of this strategy there will be new national carers' strategy and that other best practices will develop. The strategy will be refreshed in 2018 to ensure it reflects these changes.

Joint All Age Carer Strategy Implementation Plan – Adult Carers			
Adult Carers Priority	**The things carers want us to do to support them in their caring role**	**What we will do and Strategic Context**	**Responsible Lead Person Completion Date**
1.	I would like the Council and NHS to work together to develop a set of promises for carers, for example through a `Carers Charter'	We will work with carers to develop a Carers Charter that delivers a set of promises for carers that demonstrate both agencies are working closely to enhance the carers' experience. Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition NHS Commitment to Carers; raising the profile of carer NHS Commitment to Carers; person centred, well-coordinated care NHS Commitment to Carers; partnership links ADASS regional commitment to carers; committed to involving carers in the production and implementation of their plans and strategies ADASS regional commitment to carers; to work with health partners to promote and encourage implementation of the NHS England Commitment to Carers Wolverhampton Corporate Plan; helping people to live longer healthier lives	

2.	I want employers to be `carer friendly' recognising that carers may need to work flexibly and for them to recognise the special skills and knowledge carers can bring to them, as employees.	We will work with local employers to promote carer friendly employment practices. Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition National Vision and Outcomes, Priority Area 2; realising and releasing potential National Vision and Outcomes, Priority Area 3; a life alongside caring NHS Commitment to Carers; NHS England as an employer Wolverhampton Corporate Plan; helping people achieve their full potential	
3.	I want to be recognised as a carer by professionals and my knowledge and experience taken account of	This priority will be incorporated in the development of a Carers Charter, as detailed in Priority 1. Strategic links: National vision and outcomes; identification and recognition of carers NHS Commitment to Carers; person centred, well-coordinated care NHS Commitment to Carers; raising the profile of carer ADASS regional commitment to carers; adopt the Care Act	

		and whole family approach when carrying out assessments and care planning	
4.	I would like the Council and NHS to work more closely together to ensure so that I don't have to repeat myself	This priority will be incorporated in the development of a Carers Charter, as detailed in Priority 1. Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition of carers NHS Commitment to Carers; person centred, well-coordinated care NHS Commitment to Carers; partnership links	
5.	I would like more opportunities to access respite care for the person I care for	We will review existing arrangements for respite care and where necessary we will remodel existing service provision to ensure transparency and flexibility to meet the needs of carers. Strategic links: National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy ADASS regional commitment to carers; impact on a carers well-being is considered equally to that of the person they care for NHS Commitment to Carers; person centred, well-coordinated care	

		Wolverhampton Corporate Plan; helping people in times of need	
6.	I would like someone to talk to, when I need it, to help me with my caring role.	The remodelled carer support groups (Priority 10) will provide the opportunity for carers to offer mutual support to each other. The Council Carer Support Service will continue to offer information and advice to carers to ensure they have access to local support Strategic links: National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy ADASS regional commitment to carers; impact on a carers well-being is considered equally to that of the person they care for Wolverhampton Corporate Plan; helping people in times of need	
7.	I would like more information about assistive technology to support me in my caring role.	Wolverhampton Council is committed to increasing the take up of assistive technology as part of their preventative agenda. We will monitor the take up of assistive technology and support carers to understand the scope of equipment available and how it can help them as carers.	

		Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition of carers National Vision and Outcomes, Priority Area 2; realising and releasing potential National Vision and Outcomes, Priority Area 3; a life alongside caring National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy NHS Commitment to Carers; education, training and information ADASS regional commitment to carers; committed to improving carers' access to training, knowledge and skills ADASS regional commitment to carers; committed to supporting a range of preventative services to support carers and those whom they care for Wolverhampton Corporate Plan; helping people achieve their full potential	
8.	I would like to know more about local support services, close to where I live	We will promote local support services as part of the remodelled community based carer support groups. Strategic links:	

		National Vision and Outcomes, Priority Area 1; identification and recognition of carers National Vision and Outcomes, Priority Area 2; realising and releasing potential National Vision and Outcomes, Priority Area 3; a life alongside caring National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy ADASS regional commitment to carers; committed to improving cares access to training, knowledge and skills. Wolverhampton Corporate Plan; helping people achieve their full potential & helping people in times of need	
9	I would like to better understand my legal rights as a carer	Specialised Information and support for carers is available from the Council's Carer Support Team. The Carer Support Team has been active in promoting the legal rights of carers. We will ensure that a planned programme of events is developed to promote carers understanding of their legal rights. Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition of carers National Vision and Outcomes, Priority Area 2; realising and	

		releasing potential National Vision and Outcomes, Priority Area 3; a life alongside caring National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy ADASS regional commitment to carers; ensuing, when required, that independent advocates are available equally to carers and the adults they care for ADASS regional commitment to carers; committed to improving cares access to training, knowledge and skills.	
10	I would like to socialise with other carers for companionship and mutual support.	Wolverhampton Council is in the process of remodelling carer support groups. The remodelling will ensure that there are a range of groups to reflect the diversity and interests of carers. New groups will be supported by experienced staff from the Council's Carer Support Service. It is anticipated that the new model for carer support groups will be effective from August 2016. Strategic links: National Vision and Outcomes, Priority Area 3; a life alongside caring ADASS regional commitment to carers; committed to supporting a range of preventative services to support carers and those whom they care for.	

		ADASS regional commitment to carers; committed to improving cares access to training, knowledge and skills. Wolverhampton Corporate Plan; helping people achieve their full potential	
Joint All Age Carer Strategy Implementation Plan Young Carers			
Young Carers Priorities	**The things carers want us to do to support them in their caring role**	**What we will do and Strategic Context**	**Responsible Lead Person/Team Completion Date**
1	More education for all, particularly in schools, on the role of young carers and the impact it has on their lives.	We will engage with schools to identify ways this might be achieved Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition of carers ADASS regional commitment to carers; Improving carers' access to training, knowledge and skills. ADASS regional commitment to carers; supporting a range of preventative services to support carers and those for whom they care. Wolverhampton Corporate Plan; helping people achieve their full potential & helping people to live healthier lives	

2	Reassurance, encouragement and confidence building.	We will engage with schools to identify ways this might be achieved Strategic links: National Vision and Outcomes, Priority Area 2; realising and releasing potential Wolverhampton Corporate Plan; helping people achieve their full potential	
3	Time management techniques and resources to enable them to organise their lives to reduce the negative impact of caring.	We will engage with schools to identify ways this might be achieved Strategic links: National Vision and Outcomes, Priority Area 2; realising and releasing potential National Vision and Outcomes, Priority Area 3; a life alongside caring ADASS regional commitment to carers; Improving carers' access to training, knowledge and skills. ADASS regional commitment to carers; committed to supporting a range of preventative services to support carers and those for whom they care. Wolverhampton Corporate Plan; helping people achieve their full potential & to lead healthier lives	

4	Information, advice and support on how to balance caring and education.	We will engage with schools to identify ways this might be achieved Strategic links: National Vision and Outcomes, Priority Area 3; a life alongside caring National Vision and Outcomes, Priority Area 3; a life alongside caring ADASS regional commitment to carers; committed to supporting a range of preventative services to support carers and those for whom they care. Wolverhampton Corporate Plan; helping people achieve their full potential	
5	Support with school work and homework such as a homework club and extra lessons	We will engage with schools to identify ways this might be achieved Strategic links: National Vision and Outcomes, Priority Area 1; identification and recognition of carers National Vision and Outcomes, Priority Area 2; realising and releasing potential Wolverhampton Corporate Plan; helping people achieve their full potential	

6	Support to achieve their future goals, to access further and higher education and careers advice.	We will engage with schools and Wolverhampton Connexions to identify ways support could be improved Strategic links: National Vision and Outcomes, Priority Area 2; realising and releasing potential ADASS regional commitment to carers; Improving carers access to training, knowledge and skills Wolverhampton Corporate Plan; helping people achieve their full potential	
7	Information on how to support someone with a disability or long term condition.	We will engage with health professions to identify ways to improve access to information Strategic links: ADASS regional commitment to carers; Improving carers access to training, knowledge and skills Wolverhampton Corporate Plan; helping people achieve their full potential	
8	Therapy and stress management techniques	We will engage with health professions to identify ways support carers experiencing stress Strategic links: National Vision and Outcomes, Priority Area 4; supporting carers to stay healthy	

		ADASS regional commitment to carers; Improving carers access to training, knowledge and skills Wolverhampton Corporate Plan; supported in times of need	
9	More opportunities to engage socially	We will engage with Sprugeon's and `The Way' to identify opportunities for young carers to engage socially Strategic links: National Vision and Outcomes, Priority Area 3; a life alongside caring Wolverhampton Corporate Plan; helping people achieve their full potential	
10	Smoother transition from young carer to adult carer with support for young carers aged 18 – 25 years.	We will work with children and adult social care services to improve the transition process Links to: National Vision and Outcomes, Priority Area 2; realising and releasing potential Wolverhampton Corporate Plan; helping people achieve their full potential Wolverhampton Corporate Plan; supported in times of need	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting
12 July 2016

Title of Report:	**Wolverhampton Local Digital Roadmap**
Report of:	Stephen Cook
Contact:	Stephen Cook
Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	For the Governing Body to Approve the Wolverhampton Local Digital Roadmap
Public or Private:	This report is intended for Public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	Domain 1: Well led organisation – impacting on whether the CCG: • has strong and robust leadership; • has robust governance arrangements; • involves and engages patients and the public actively; • works in partnership with others, including other CCGs; • secures the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money; and • has effective systems in place to ensure compliance with its statutory functions
• **Domain 2a:** Performance – delivery of commitments and	**Domain 2a: Performance**: delivery of commitments and improved outcomes: a key focus of assurance will be how well the CCG delivers improved services,

improved outcomes	maintain and improve quality, and ensures better outcomes for patients. This includes progress in delivering key Mandate requirements and NHS Constitution standards, and ensuring standards for all aspects of quality, including safeguarding, and digital record keeping and transfers of care are met.
• **Domain 2b:** Quality (Improved Outcomes)	**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 quality and ensures better outcomes for patients. This includes progress in delivering key mandated requirements and NHS Constitution standards. Also ensure that the CCG is able to demonstrate the continuous improving quality agenda for all aspects of quality including safeguarding.
• **Domain 3:** Financial Management	**Domain 3: Financial management**: financial management capability and performance, including an assessment of data quality and contractual enforcement.
• **Domain 4:** Planning (Long Term and Short Term)	**Domain 4: Planning**: covering not only annual operational plans, and related plans such as those relating to System Resilience Groups and the Better Care Fund, but also longer term strategic plans, including progress with the implementation of the Forward View. Progress towards moving secondary care providers from paper-based to digital processes and the extent to which NHS Number and discharge summaries are being transferred digitally across care settings will be specific measures during 2015/16, towards the ambition for a paperless NHS.
• **Domain 5:** Delegated Functions	**Domain 5: Delegated functions**: When approved this will include primary care and may, in time, include other services. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed rather than delegated function

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

1. BACKGROUND AND CURRENT SITUATION

In September 2015, a three-step process began to allow local health and care systems to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020.

The first step was the organisation of local commissioners, providers and social care partners into LDR footprints.

The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps have now been completed and each LDR footprint has been asked to develop and submit its own Local Digital Roadmap by the deadline of June 2016.

2. MAIN BODY OF REPORT

NHS Wolverhampton CCG is the lead organisation for the Wolverhampton LDR. The other organisations involved are Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, Wolverhampton Council and West Midlands Ambulance Service.

The CCG has been working with our partner organisations to develop the Digital Roadmap based on the Universal Capabilities and the results of the Digital Maturity indexes that were completed by our partner organisations.

Wolverhampton CCG will present the Wolverhampton LDR to the NHS Local Area Team on the 20th July 2016 with representation form our partner organisations for review and sign off. A signed off LDR will be a condition for accessing investment for technology enabled transformation funds.

The Universal Capability Delivery Plan, Wolverhampton Information Sharing approach and the Wolverhampton Capability Trajectory are attached to this report, below overview of the key projects linked to the programme.

- The development of a shared care record across the whole health a social care economy within Wolverhampton
- The rollout of patient online services to Patients so they can access their own records, book appointments and order repeat prescriptions.

- The Continued development of e-referrals and the addition of referring to the mental health trust electronically formatting of electronic discharges along royal college headings and the introduction of electronic discharges from BCPFT.

- The expansion of e-referrals to social care

- The inclusion of Child Protection information within unscheduled care settings

- A project to initially populate Graphnet with Patients end of life preferences which will then look to develop a shared end of life plan that can be accessed by clinicians linked to a patient with read and write access.

- Continued development of the existing EPS project to increase utilization within Wolverhampton.

3. CLINICAL VIEW

3.1. Clinical engagement will be sought for each of the projects within the LDR Programme of work.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and Public engagement will be undertaken on a project by project basis dependent on the impact, scale and scope of the individual projects.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. That the current LDR footprints will be amalgamated to fit the STP footprints.

5.2. Information Governance issues will slow down the identified projects or cause them to stop.

5.3. If no additional funds are available it will lead to delays as existing resources will be stretched.

5.4. The approval process will take a long time leading to delays in starting the programme of work and thus the end date of the projects

Financial and Resource Implications
5.6. The scale and scope of the programme of work will be dependent on the allocation of funds from NHS England. The organisations have committed to carry out a number of projects from existing resources additional projects will be dependent on Central funds becoming available.

Quality and Safety Implications
5.7. There are no quality / safety implications at this present time.

Equality Implications
5.8. The Equality process will be followed via the procurement process.

Medicines Management Implications
5.9. There are no medicines management implications at this present time.

Legal and Policy Implications
5.10. There are no Legal and Policy Implications at this present time.

6. RECOMMENDATIONS

- To **Approve** the Wolverhampton Local Digital Roadmap

Name: Stephen Cook
Job Title: Senior IM & T Project Manger
Date: 28/06/16

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)	**Stephen Cook**	**28/06/16**

Footprint:	Wolverhampton

Instructions for Completion

- Please indicate your Local Digital Roadmap Footprint above
- Complete questions A to E in the subsequent pages – the same structure is used for each of the 10 universal capabilities
- For further guidance, refer to:
    - Sections 6.24 to 6.30 of the Developing Local Digital Roadmaps Guidance
    - The Universal Capabilities Information and Resources document
- This template and the documents referenced above can be downloaded from the LDR page on the NHS England website

Universal Capability:	A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
Capability Group:	Records, assessments and plans
Defined Aims:	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Wolverhampton has uploaded SCR records from all practices, allowing care professionals to access the information.

Wolverhampton CCG currently uses Graphnet Care centric solution to extract data and store GP data. This data is currently available via the Royal Wolverhampton Trust Portal which is available to authorised Clinical and non-Clinical staff within the Trust including Emergency Department.

The portal is also available in the Walk in centre and the Urgent Care Centre.

Limited access to this portal is available to clinical staff (50 accounts) working as part of the Psychiatric Liaison Services based at the Royal Wolverhampton Trust's Walk in centre and the Urgent Care Centre.

The Portal has 8000 registered user accounts with over 1 million searches conducted annually (This includes searches for Primary and secondary care and test results)

Black Country Partnership NHS Foundation Trust will use SCR data in the short term but will look to integrate into the Graphnet Care centric solution for Wolverhampton patients.

WMAS do not currently access Summary Care Record as part of normal operational practice.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	To start Project with Black Country Partnership NHS Foundation Trust to join Graphnet Care centric solution. To have SCR rolled out to all Pharmacies within Wolverhampton (Midlands and Lancs CSU Project) WMAS Deploy electronic patient record to provide platform for crew access
17/18	To include access to GP data through Black Country Partnership Foundation Trusts own portal Work with Graphnet to link the care centric portal with the Adastra solution used by West Midlands Ambulance service. To start project with Wolverhampton City Council to share information into the Graphnet CareCentric Portal WMAS SCR delivered as part of EPR solution

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Secondary care data stored in the Longitudinal Patient Record Data Warehouse Pharmacy Summary Care Briefings WMAS Deploy EPR hardware, commence training
16/17 Q2	GP's able to Access Secondary Care data through Button/Tab within EMIS Web Clinical System. Emergency Department (ED) online Hold kick off meeting with BCPFT to scope requirements Pharmacy Summary Care Briefings Pharmacies complete the SCR2 Pharmacy Form Pharmacies complete CPPE e-learning WMAS Complete EPR training
16/17 Q3	Start Information Governance meeting with BCPFT and identify required data feeds and data set.
16/17 Q4	Identify method of Integrating Care centric Portal into BCPFT's ERP
17/18 Q1	Carry out testing of BCPFT ERP access to Care Centric Portal Finalise Information Governance BCPFT Initiate project with Wolverhampton City Council to link social care to shared patient record
17/18 Q2	Go Live with BCPFT ERP access to Care Centric Portal Agree information Governance with WCC WMAS SCR available through EPR application
17/18 Q3	Organise links with WCC to facilitate data sharing
17/18 Q4	Carry out testing of links WCC

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG will supplement the use of Summary Care Records in care settings by providing access to the Wolverhampton Longitudinal Record which currently holds data from Primary Care and Secondary Care including A & E.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Royal Wolverhampton Trusts Clinical Portal has 8000 registered user accounts with over 1 million searches conducted annually (This includes searches for Primary and secondary care and test results). The portal is also an access point to the CCG's Longitudinal patient record which has information on GP- prescribed medications, patient allergies and adverse reactions.

The CCG will provide evidence of the roll out of the Longitudinal Patient record to local care providers and statistics on the roll out of Summary Care record to Pharmacies (Project being carried out by Midland and Lancs CSU).

BCPFT's Electronic Heath Record Portal will become an access point for clinicians to the Longitudinal patient record which has information on GP-prescribed medications, patient allergies and adverse reactions. Evidence of using that information will be measured by the number of registered user accounts accessing that information.

Universal Capability:	B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
Capability Group:	Records, assessments and plans
Defined Aims:	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Wolverhampton CCG with Graphnet has created a repository of data from GP Clinical Systems.

This data is extracted nightly from all EMIS Practices 37 Practices (80%) And currently Monthly from 9 TPP SystmOne Practices (20%)

This provides clinicians at ED, Urgent care Centre and Walk in centre with access to data on all Wolverhampton registered patients.

Out of Area patients information can be accessed via SCR.

This provides BCPFT clinical staff working at ED, Urgent care Centre and Walk in centre at Royal Wolverhampton Trust with access to data on all Wolverhampton registered patients.

The data from the repository is passed to Midlands and lancs CSU who run our Risk Stratification tool which then reports back to GPs on patients most at risk of presenting at A & E

WMAS 999 Command and Control System (aka CAD or Cleric) can register notes against address or patient. Typically this will be by address as this is a more robust search criteria on the 999 call however has a limitation when patient is not at home address. Notes are added manually.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	To Move TPP SystmOne practices to daily uploads. WMAS Monitor local health economy (LHE) integrated care record (ICR) programmes
17/18	WMAS Review participation in LHE ICR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points.

At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Initiate Daily uploads from TPP SystmOne into the Graphnet solution. Primary Care Data to be exported to Risk stratification tool offered by Midlands and Lancs CSU
16/17 Q2	Data Quality Check of TPP data uploads to ensure accuracy.
16/17 Q3	•
16/17 Q4	•
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG use the Graphnet Data extraction and Data warehouse solution to collect and store data which is then accessible through the CareCentric Portal. The Portal is integrated into the Royal Wolverhampton Trusts (RWT) own Clinical portal allowing RWT staff to access patient information in all care settings.

A Button/Tab is available within EMIS GP Clinical System to allow access to the CareCentric Portal for GP's to view Secondary Care Information.

This solution has the ability to be scalable and is planned to eventually include Social Care and Mental Health Data, thus providing the residents of Wolverhampton with an integrated care record.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Information is collected on all Patients with Wolverhampton excluding patients who have opted out.

Graphnet contains Primary Care records on All Wolverhampton CCG patients who have not opted out. Exact data can be provided from the Graphnet solution.

Universal Capability:	C. Patients can access their GP record
Capability Group:	Records, assessments and plans
Defined Aims:	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All practices within Wolverhampton have enable Enhanced Medical Record access.

Patients who wish to have access to enhanced records are able to request it from their GP and it will be made available subject to clinical discretion

Baseline Statistics March 2016 46 out of 46 (100%) Practices have Enhanced Patient Record access enabled on their Clinical system.

HSCIC Indicator Portal - Stats as at February 2016
Enhanced record usage for NHS Wolverhampton CCG was:

1,064 Patients enable to view record = 0.4% of the patient population
1,606 Records accessed

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All Practices provide access to Enhanced Patient records 5% of patients have access to Enhanced Patient Record

Year	Ambition
17/18	7.5% of Patients have access to Enhanced Patient Records

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Carry out analysis of current position relating to patients signed up for Enhanced Patient Record. • Identify the practices with the lowest uptake. • Contact the identified practices and arrange practice visits • Develop Patient Information Literature. • Meet with first tranche of practices with low uptakes. • Liaise with HSCIC implementation lead. • Work with care homes to review possibility of using delegated access. • Contact Local Community Groups to raise awareness
16/17 Q2	• Review latest HSCIC Stats to confirm current position • Engage practice PPG's • Engage with locality leads • Arrange meetings with all remaining practices • Hold Practice Meetings • Distribute patient information literature • Attend PPG's and raise awareness and review if patients are being signed up for enhanced GP Record • Team W Event presentation on benefits of signing up patients with long term conditions to Enhanced Patient Record • Care Home Delegated access progress • Contact Local Community Groups to raise awareness
16/17 Q3	• Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake. • Meet with PPG's to promote use of Enhanced Patient Records • Hold Practice Meetings • Attend and present at Practice managers forum • Care Home Delegated access progress

Quarter	Activities
	• Contact Local Community Groups to raise awareness
16/17 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Care Home Delegated access progress • Assess position in relation to targets and if uptake is below 5% ambition • Contact Local Community Groups to raise awareness
17/18 Q1	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings targeting practices with lowest uptake first. • Meet with PPG's to promote use of Enhanced Patient Records • Review and revise patient information literature • Care Home Delegated access progress • Carry out case study of benefits to patients and Clinicians both within Primary and Secondary care of providing access to Enhanced Patient Record • Contact Local Community Groups to raise awareness
17/18 Q2	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Distribute patient information literature • Care Home Delegated access progress • Contact Local Community Groups to raise awareness
17/18 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Team W Event presentation on benefits of signing up patients with long term conditions to Enhanced Patient Record • Care Home Delegated access progress • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record.

Quarter	Activities
	• Contact Local Community Groups to raise awareness
17/18 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Care Home Delegated access progress • Assess position in relation to targets and if uptake is below 7.5% ambition • Contact Local Community Groups to raise awareness

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Progress along the capability path will be monitored using nationally produced statistics from website below

https://indicators.hscic.gov.uk/webview/

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

The progress made by the CCG will be evidenced in the HSCIC stats produced on the website below under the Patient online heading.

https://indicators.hscic.gov.uk/webview/

Universal Capability:	D. GPs can refer electronically to secondary care
Capability Group:	Transfers of care
Defined Aims:	• Every referral created and transferred electronically • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) • [By Sep 17 – 80% of elective referrals made electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

43 of 46 practices use E-RS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Get all practices to use E-RS Royal Wolverhampton Trust to increase capacity and improve issues around TAL WCC – Procuring a new Social Care system to support integrated Working to refer to Social Workers
17/18	Black Country Partnership Foundation Trust to start using E-RS or local e-referrals service as only 5% of referrals would come via E-RS.80% of elective referrals made electronically WCC – Social Care System in Place that allows referrals to Social Workers

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Identify Practices that are not using E-RS • Engage with practices to explain benefits of E-RS and National Requirements. • Update service design improvement plan in conjunction with our main service provider Royal Wolverhampton Trust (RWT) • Start liaison process with Black Country Partnership Foundation Trust to engage them to receive referrals using E-RS • Hold monthly meetings with BCPFT to review and monitor performance. • On-going review of practices processes in relation to E-RS • Hold monthly meetings with RWT to review and monitor performance • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL
16/17 Q2	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Attend Practice Managers forum to encourage use of E-RS • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
16/17 Q3	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance

Quarter	Activities
	• On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
16/17 Q4	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • Hold monthly meetings with BCPFT to review and monitor performance. • WCC- Procurement of Social Care System Completed
17/18 Q1	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q2	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Attend Practice Managers forum to encourage use of E-RS

Quarter	Activities
	• Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q3	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q4	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • WCC- New Social Care System installation Completed

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG will use the National E-Referral solution to book appointments in conjunction with the organisations within the Local Digital Roadmap
Will use National Solution E-RS

BCPFT will use the National E-Referral solution to book appointments in conjunction with the organisations within the Local Digital Roadmap where applicable – expected uptake 5% of referrals. Remainder will use locally developed e-Referral Service.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Evidence will be provided from HSCIC produced Statistics Relating to E-Referrals

Data from Council of numbers of referrals recorded in Social Care system.

Universal Capability:	E. GPs receive timely electronic discharge summaries from secondary care
Capability Group:	Transfers of care
Defined Aims:	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Discharge summaries sent electronically from acute Hospital to the GP's within 24 hours via use of the Docman Hub.

Discharge Summaries from the Community Hospital are currently nor electronic but a project is in place to move to the solution used at the Acute site.

Black Country Partnership Foundation Trust (BCPFT) are currently developing their own solution for release in 16/17 for Discharge summaries sent electronically from acute Hospital to the GP's within 24 hours, initially via local e-mail service but BCPFT to investigate the of the Docman Hub.

WMAS - This requirement relates to secondary care so could be viewed as not applicable however there could be benefit in passing care notification to GP from ambulance. WMAS do not currently pass information to GPs

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	BCPFT - To initiate E-discharge Project RWT – To send all discharge letters electronically from Community site WMAS - Send messages to GPs for incidents where ambulance attends (and NHS number matched) using Docman relay. Dependent upon support from other Docman hubs.
17/18	BCFPFT – To send all discharge letters Electronically

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	
16/17 Q2	BCPFT to initiate talks with supplier to explore use of DOCMAN Hub. WMAS - Establish Docman relay in Staffordshire
16/17 Q3	BCPFT to design, build and test E-Discharge Module for the Trust's EHR. WMAS - Establish Docman relay in supporting LHEs
16/17 Q4	BCPFT to complete the design, build and test E-Discharge Module for the Trust's EHR. Deploy at end of Q4. WMAS - Establish Docman relay in supporting LHEs
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Messages are transmitted using the Docman hub from the Acute hospital to The Docman client on GP Clinical Systems.

BCPFT – Messages are transmitted via local e-mail service to GP's DOCMAN solution initially but BCPFT to investigate using the Docman client on GP Clinical Systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Stats will be provided from both providers Royal Wolverhampton Trust and Black Country Partnership Foundation Trust to evidence the volume and number of e-discharges sent.

Universal Capability:	F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
Capability Group:	Transfers of care
Defined Aims:	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All patients as part of admission processes on the ward are considered whether there is a likely need for social services assessment, if there is then an assessment notification is completed 24-48 from admission.

Discharge notifications are only used for out of borough local authorities as there is a local agreement for them not to be used for Wolverhampton citizens.

All notifications sent electronically unless local authority asks for a phone (<5%)

WMAS - This requirement relates to acute care so could be viewed as not applicable however there could be benefit in passing care notification to social care from ambulance especially in the case of Safeguarding referrals. WMAS currently send Safeguarding referrals by email. This approach would use Docman.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All documentation used, to be Care Act compliant. Review sending electronic notices – exploring the use of TeleTracking to automate completion and sending WMAS - Pilot safeguarding referrals to supporting social care organisation
17/18	Sending notices via TeleTracking Notices to be discharge planning notices not just to local authority i.e. District Nurses, discharge to assess WMAS - Extend social care notification to other organisations

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	
16/17 Q2	RWT - Notices reviewed and updated to Care Act compliant Initial meetings with TeleTracking regarding sending of notices and multiple use of the notices
16/17 Q3	RWT - Review meeting with TeleTracking to establish timeframes if proposal is viable.
16/17 Q4	WMAS - Pilot social care communication
17/18 Q1	RWT - Following agreed timeframe including technology changes, process change management and implementation WMAS - Roll out social care communication
17/18 Q2	WMAS - Roll out social care communication
17/18 Q3	
17/18 Q4	

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

No

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Reported and monitored by the TeleTracking lead and board.

Universal Capability:	G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
Capability Group:	Decision support
Defined Aims:	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

RWT - Current technology presents risk flags within unscheduled care settings from the Patient Administration system. This is flowed through via integration engine to receiving systems such as ED and the Electronic Patient Record system. The attributes that present within the risk flag process is handled and managed as part of joint working teams, although this is very much a manual process for data entry and ongoing maintenance of the flags. Secondary care electronic patient record system is provisioned across 100 % of GP practices within the Wolverhampton area.

WMAS do not currently access CP-IS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	RWT - To deploy automated functionality that negates the current need for manual intervention in terms of managing and maintaining current flagging process. Plans are in place to move towards full CP-IS functionality within the National SPINE, where child protection information can be recorded locally within social care. Initial upload sees the local authority uploading information on their cohort of Children to CP-IS, thereafter there will be an automatic submission to CP-IS, upon creation or amendment of status of child. Overnight updates will occur to NHS Spine when a child's information is looked up in the local health care setting and a check is made where any CP-IS information is automatically displayed. When the CP-IS record is looked at by the Health professional an audit of the event is recorded and returned to the local authority and other health workers looking at the child. This information is only held for children who are looked after or on a child protection plan, not for all children visiting unscheduled care. The above details are then made available to the local authority responsible for the child. They can also be accessed by subsequent NHS users viewing the child's child protection information. The access event log will help to highlight the children that have received unscheduled medical care across local authority boundaries. It will also help to provide clear and current indicator information to the NHS user viewing the child's details. CP-IS is not there to replace existing safeguarding policies and processes, but to support and provide up to date information which is not routinely available to aid in decision making and assessment
17/18	WMAS - Access CP-IS through SCR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	RWT - Submit confirmation to National CPIS for plans to implement connectivity for interoperable solution. : - Complete

Quarter	Activities
	RWT- Initiate discussion and agreement with Patient Administration Systems suppliers for design of solution. : - Complete RWT - Start development of solution in partnership with supplier and national / local teams : - Complete
16/17 Q2	RWT - Complete development of solution in partnership with supplier and national / local teams. RWT - Instigate testing of integrated solution and sign-off with local, National and supplier partners. RWT - Deploy solution into live service and integrate within processes and systems for unscheduled care settings.
16/17 Q3	RWT - Expand solution within live services for further integration within processes and Electronic Patient Record systems for unscheduled care settings. RWT - Access workability / benefits from Go Live in Q2, deploy issue resolution for known problems.
16/17 Q4	RWT - Continue review with partners for future scope opportunities or expansion of solution.
17/18 Q1	•
17/18 Q2	WMAS - Available through SCR
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Not applicable as all solutions deployed for universal capabilities will utilise National services. All Infrastructure and standards at local level will comply and align to those defined.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

RWT - Local, National and supplier sign-off for solution. RWT - National CPIS statistics, records called regarding protection information. RWT - Audit of events for return to local authority will be reviewed in conjunction with National team. RWT - Reference to access event logs and appropriate reviews.

Universal Capability:	H. Professionals across care settings made aware of end-of-life preference information
Capability Group:	Decision support
Defined Aims:	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Information is stored in the GP Clinical systems

The Clinical portal which will hold the information is currently used within Royal Wolverhampton Trust and by a limited number of Black Country Partnership Foundation Trust staff.

The portal is also available within Compton Hospice

WMAS 999 Command and Control System (aka CAD or Cleric) can register notes against address or patient. Typically this will be by address as this is a more robust search criteria on the 999 call however has a limitation when patient is not at home address. Notes are added manually

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Work with Graphnet to scope getting End of Life Preference shown in the Clinical Portal WMAS - Develop interface between Black Pear and Cleric. Black Pear is in use in Worcestershire, Herefordshire, Coventry & Warwickshire
17/18	Work with Graphnet to create an EPaCCs solution with a shared End of Life plan that could be accessed by RWT, BCPFT, WMAS and WCC

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Investigate data being collected via Graphnet extract.
16/17 Q2	Create new view within Graphnet Care Centric Portal to display end of life preference Carry out awareness exercise with GP's to ensure that they record end of life preferences WMAS - Development of Black Pear/Cleric Interface
16/17 Q3	Carry out testing of portal settings Carry out awareness exercise with GP's to ensure that they record end of life preferences WMAS - Deploy Black Pear/Cleric interface
16/17 Q4	Roll out new functionality within Portal Carry out awareness exercise with GP's to ensure that they record end of life preferences
17/18 Q1	Scope project to introduce shared end of life plan
17/18 Q2	Agree deliverables and finalise project plan Carry out awareness exercise with GP's to ensure that they record end of life preferences Carry out awareness exercise with GP's to ensure that they record end of life preferences
17/18 Q3	Create module and carry out testing
17/18 Q4	Go live with solution inside CareCentric Portal. Carry out awareness and training in the use of Plan

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Will Use a solution from within the CCG's existing Graphnet solution, that will build on the existing shared care record that is used within Wolverhampton

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Will provide usage statistics from Graphnet to evidence the use of the functionality.

Universal Capability:	I. GPs and community pharmacists can utilise electronic prescriptions
Capability Group:	Medicines management and optimisation
Defined Aims:	• All permitted prescriptions electronic • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic • Repeat dispensing done electronically for all appropriate patients • [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

42 of 46 Practices live with EPS

EPS April 2016 HSCIC stats for WCCG

Number of Practices Live	Practices Live %	% use in live practices
42	91.3	68.8%

HSCIC e-repeat dispensing EPS Percentage usage trends based on BSA data key = yellow actual figures

Practc Count	Live EPSr2 Practc Count	Apr-16	Apr-16 (RD)	Mar-16	Mar-16 (RD)	Feb-16	Feb-16 (RD)
46	42	64%	20.00%	57%	17.80%	60%	19.90%

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further

than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	80% of repeat prescriptions to be transmitted electronically
17/18	Roll out of Phase 4 of EPS to all GP Practices within NHS Wolverhampton CCG.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Review HSCIC Stats to identify low usage Practices Arrange Meetings with low usage practices Escalate to Locality Leads GP Practice to go live with EPS Reinvigorate Pharmacy Access Project currently being carried out with EMIS and RX
16/17 Q2	Review HSCIC Stats to identify low usage Practices GP Practice to go Live with EPS Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project CCG Pharmacy Lead to Speak at Local Pharmacy Committee about EPS and Nominations
16/17 Q3	Review HSCIC Stats to identify low usage Practices and position against 80% repeat prescription target GP Practices to go live with EPS Target GP practices who have lower than 80% repeat prescription use Attend Practice Managers forum to encourage use of Repeat Dispensing Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project
16/17 Q4	Review HSCIC Stats to identify low usage Practices Last Practice to go live with EPS Target GP practices who have lower than 80% repeat prescription use Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project
17/18 Q1	Review HSCIC Stats to identify low usage Practices

Quarter	Activities
	Arrange Meetings with low usage practices Escalate to Locality Leads Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices
17/18 Q2	Review HSCIC Stats to identify low usage Practices Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices CCG Pharmacy Lead to Speak at Local Pharmacy Committee about EPS and Nominations
17/18 Q3	Review HSCIC Stats to identify low usage Practices Attend Practice Managers forum to encourage use of EPS Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices
17/18 Q4	Review HSCIC Stats to identify low usage Practices Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Will use national EPS Solution

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress will be evidenced by Nationally Provided stats from HSCIC on EPS Script requesting stats relating to Patient online

Poplars Medical Practice EPS story Fina

Wolverhampton_Pharmacy Access_10 11 15

Universal Capability:	J. Patients can book appointments and order repeat prescriptions from their GP practice
Capability Group:	Remote care
Defined Aims:	• [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] • All patients registered for these online services use them above alternative channels

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

46 of 46 (100%) of GP Practices within Wolverhampton have enable Patient Online Access

HSCIC Indicator Portal - Stats as at February 2016
Enhanced record usage for NHS Wolverhampton CCG was:

Patients able to book online appointments
25,782 Patients 9.5% of population

Patients enabled to order Repeat prescription
24,318 Patients 9.0% of population

Patients enabled to View Letters
906 Patients 0.3% of population

Patients enabled to View Test Results
2,826 Patients 1.0% of population

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	10% plus patients registered for online services at each GP Practice 20% of patients registered for online services for CCG as a whole
17/18	20% plus patients registered for online services at each GP Practice 35% of patients registered for online services for CCG as a whole

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Carry out analysis of current position relating to patients signed up for online patient services. • Identify the practices with the lowest uptake. • Contact the identified practices and arrange practice visits • Develop Comms and scripts for reception staff to raise awareness. • Meet with initial 10 identified practices. • Liaise with HSCIC implementation lead. • Contact Local Community Groups to raise awareness
16/17 Q2	• Review latest HSCIC Stats to confirm current position • Engage practice PPG's • Engage with locality leads • Arrange meetings with all remaining practices • Hold Practice Meetings • Distribute patient information literature • Distribute scripts for reception staff to all practices. • Attend PPG's and raise awareness and review if patients are being signed up for enhanced GP Record • Contact Local Community Groups to raise awareness
16/17 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Attend and present at Practice managers forum • Review overall uptake of patient online service to identify if CCG is on track to hit 20% of patient

Quarter	Activities
	population signed up • HSCIC to attend Team W events (CCG to GP event) • Contact Local Community Groups to raise awareness • Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake.
16/17 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record. • Assess position in relation to targets and if any site is still below 10% target resources to ensure that practice hits 10% by year end • Contact Local Community Groups to raise awareness
17/18 Q1	• Review latest HSCIC Stats to confirm current position • Identify Practices with uptake below 20% • Hold Practice Meetings targeting practices with lowest uptake first. • Contact Local Community Groups to raise awareness
17/18 Q2	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake. • Contact Local Community Groups to raise awareness
17/18 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • HSCIC to attend Team W events (CCG to GP event) • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record. • Contact Local Community Groups to raise awareness
17/18 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Assess position in relation to targets and if any site is still below 20% target resources to ensure that practice hits 20% by year end.

Quarter	Activities
	• Contact Local Community Groups to raise awareness

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Progress along the capability path will be monitored using nationally produced statistics from website below

https://indicators.hscic.gov.uk/webview/

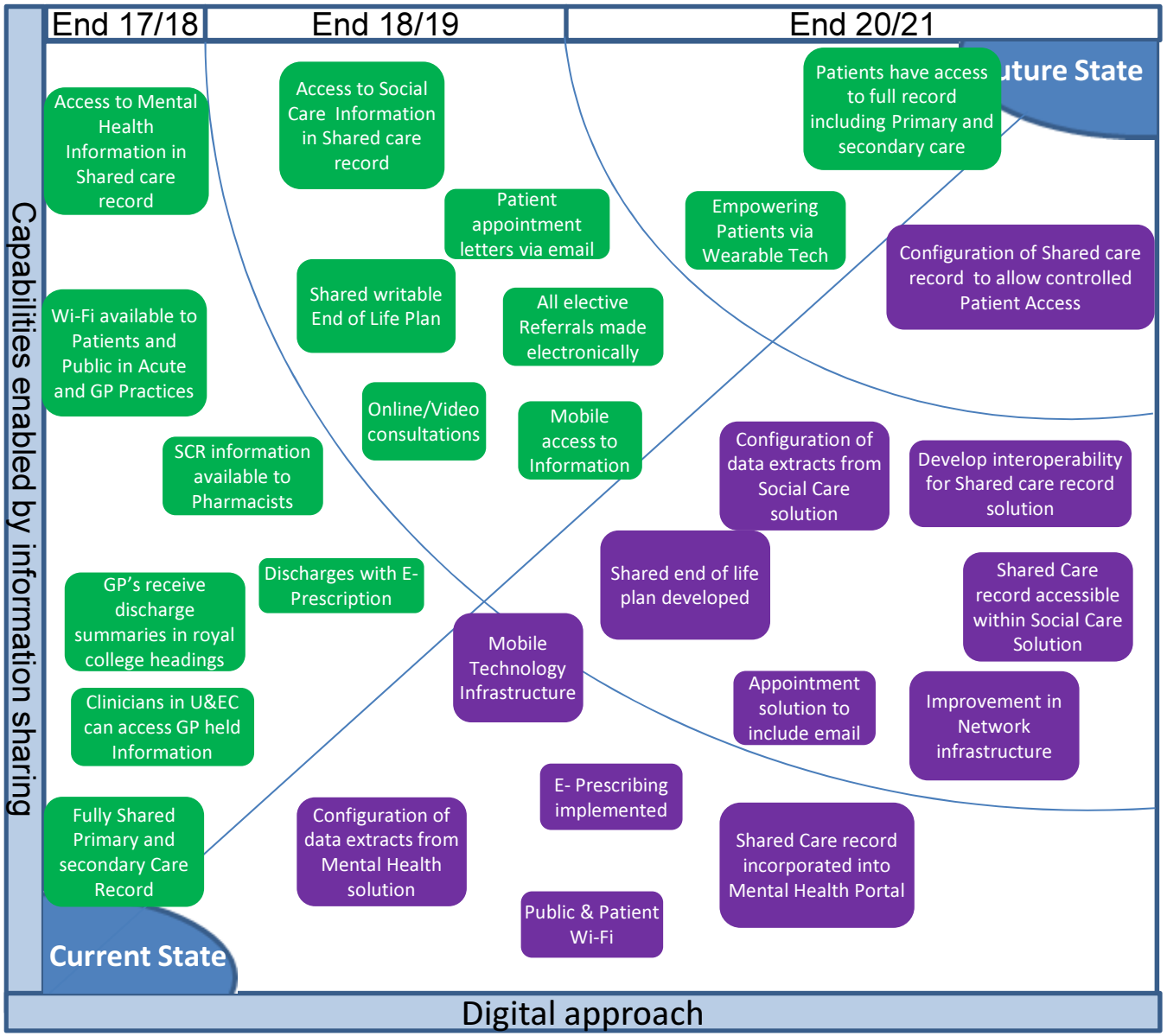
E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

The progress made by the CCG will be evidenced in the HSCIC stats produced on the website below under the Patient online heading.

https://indicators.hscic.gov.uk/webview/

Information sharing approach – Wolverhampton



- Refer to section 6.33 of the guidance for background information on this template
- Examples of completed templates will be published on the NHS England website.
- The capabilities identified should be consistent with the capability deployment schedule.

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General instructions

The summary worksheet is fed from the data in the subsequent worksheets - do not enter directly in to the sheet.

Within the subsequent worksheets, there is a sheet for each of the 7 groups of capabilities.

Within these worksheets, a row should be completed for each secondary care provider who completed a Digital Maturity Self-assessment.

An unweighted average across all providers will be automatically calculated.

The baseline score to be recorded should be taken from the results of the Digital Maturity Self-assessment, shared with providers and CCGs.

The target future scores should be set with reference to the baseline, the DMSa questions, and the capability deployment schedule.

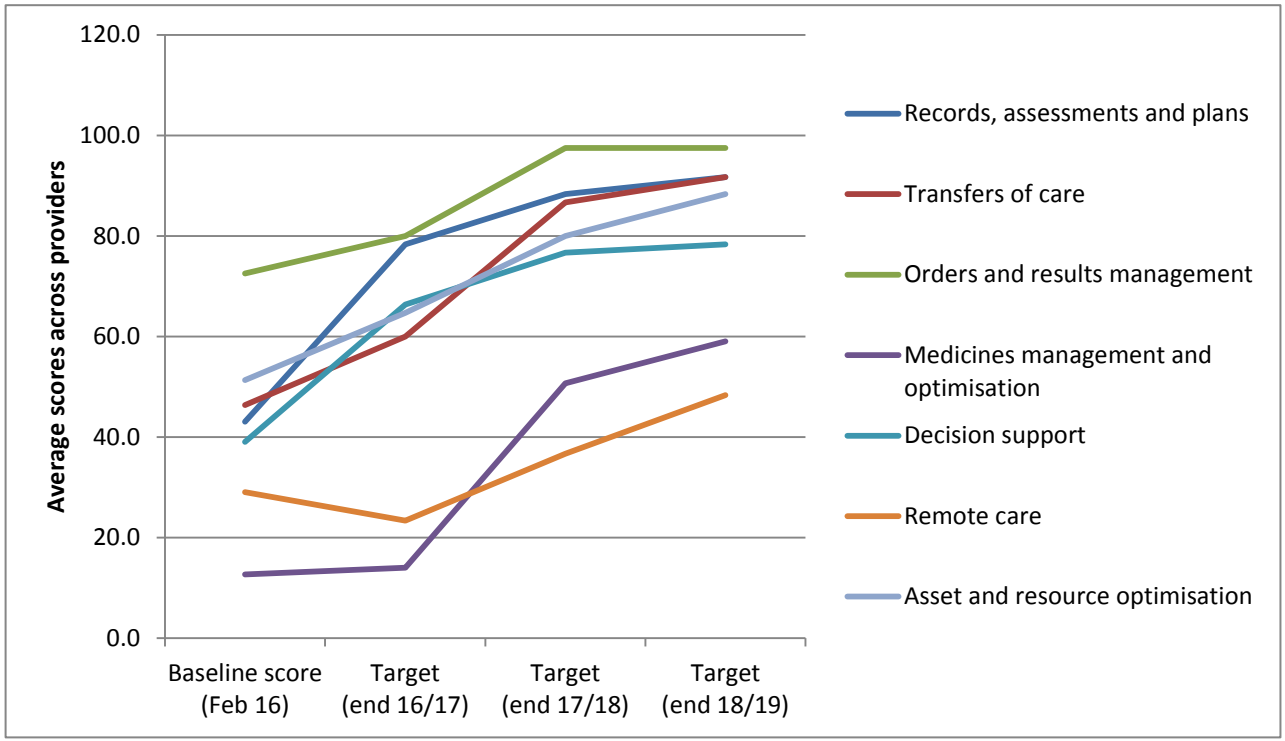
Refer to section 6.23 of the guidance for background information on the capability trajectory template.

Refer to Annex 3 of the guidance for an illustration of a capability trajectory summary.

This template can be downloaded at www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps.

Footprint:	Wolverhampton

Capability group	Average scores across providers			
	Baseline score (Feb 16)	Target (end 16/17)	Target (end 17/18)	Target (end 18/19)
Records, assessments and plans	43.0	78.3	88.3	91.7
Transfers of care	46.3	60.0	86.7	91.7
Orders and results management	72.5	80.0	97.5	97.5
Medicines management and optimisation	12.7	14.0	50.7	59.0
Decision support	39.0	66.3	76.7	78.3
Remote care	29.0	23.3	36.7	48.3
Asset and resource optimisation	51.3	64.7	80.0	88.3



Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	30	70	80	80	Deployment of Electronic Patient Record
BCPFT		13	70	90	95	
The Royal Wolverhampton NHS Trust		86	95	95	100	Move to noteless is proceeding to plan.
[Insert additional rows above if required]						
Average across providers		43.0	78.3	88.3	91.7	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	50	60	70	80	Deployment of Electronic Patient Record
BCPFT		0	30	100	100	
The Royal Wolverhampton NHS Trust		89	90	90	95	
[Insert additional rows above if required]						
Average across providers		46.3	60.0	86.7	91.7	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	N/A	N/A	N/A	N/A	
BCPFT		59	70	100	100	
The Royal Wolverhampton NHS Trust		86	90	95	95	New order Comms system to be implemented Sunquest ICE
[Insert additional rows above if required]						
Average across providers		72.5	80.0	97.5	97.5	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	8	12	12	12	SCR Access
BCPFT		10	10	100	100	
The Royal Wolverhampton NHS Trust		20	20	40	65	* Subject to Funding - Trust business case to be progressed to address Medicines Management technology capability.
[Insert additional rows above if required]						
Average across providers		12.7	14.0	50.7	59.0	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	39	39	45	45	Development of pathway automation and alerts
BCPFT		0	75	100	100	
The Royal Wolverhampton NHS Trust		78	85	85	90	
[Insert additional rows above if required]						
Average across providers		39.0	66.3	76.7	78.3	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	N/A	5	15	15	Remote clinical access through video conferencing
BCPFT		33	40	60	80	
The Royal Wolverhampton NHS Trust		25	25	35	50	*This is subject to implementation of future solutions and commercial contract agreement for remote activity, still to be scoped, hence target score is a forecast estimate at this time.
[Insert additional rows above if required]						
Average across providers		29.0	23.3	36.7	48.3	

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)	
West Midlands Ambulance Service NHS FT	RYA	69	69	75	75	Equipment tracking solution automated
BCPFT		5	40	80	100	
The Royal Wolverhampton NHS Trust		80	85	85	90	Trust is already looking at capability related to equipment tracking.
[Insert additional rows above if required]						
Average across providers		51.3	64.7	80.0	88.3	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12th July 2016
Agenda item 10

Title of Report:	**Big Lottery: Commissioning Better Outcomes**
Report of:	Andrea Smith, Head of Integrated Commissioning
Contact:	Andrea Smith
Commissioning Committee Action Required:	☒ **Decision** ☐ **Assurance**
Purpose of Report:	To discuss with members of Governing Body the business case developed through Big Lottery grant funding to propose a project of social prescribing underpinned by a Social Impact Bond, which will improve patients wellbeing and reduce emergency activity and demand on Primary Care. To inform the Governing Body of a decision by the Local Authority not to pursue this project via a Social Impact Bond model, resulting in the business case being no longer being financially viable with the CCG as sole Commissioner.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 1:** A Well Led Organisation	N/A
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	This model of delivery is a different approach to delivering improved outcomes for patients

• **Domain 2b:** Quality (Improved Outcomes)	This social prescribing model of delivery will improve the patient experience by providing low level, voluntary sector support, targeted to the individual
• **Domain 3:** Financial Management	Utilising a Social Impact Bond is a new way of Commissioning for the CCG
• **Domain 4:** Planning (Long Term and Short Term)	This model is based on a 5 year project and therefore will need to be planned on both a resource and financial basis for that period.
• **Domain 5:** Delegated Functions	N/A

BACKGROUND AND CURRENT SITUATION

1.1. In January 2016 the CCG was successful in its bid to Big Lottery to secure Grant Funding to develop a model of Social Prescribing utilising a Social Impact Bond model of funding.

1.2. Kaizen-group have been working with the CCG as an Intermediary to develop a business case that describes the operational and financial model, and demonstrates the level of potential savings to the Health and Social Care Economy.

1.3. If the business case is approved by Commissioning Committee and Governing Body and by the Local Authority, we have the opportunity to submit a Full Application to Big Lottery for funding for the project. This application needs to be submitted by the end of July 2016. *If successful, it is anticipated that Big Lottery will fund 15% of the outcomes.*

1.4. Within the current financial modelling the project would only be financially viable if it were jointly commissioning between the CCG and Local Authority as savings related to individual organisations would not be sufficient to offset the cost of the outcomes payments alone.

1.5. Since papers were presented to Commissioning Committee on 30th June, the Local Authority have confirmed that they will not pursue this project via a Social Impact Bond model.

2. MAIN BODY OF REPORT

2.1. The project itself is aimed to deliver a model of social prescribing, health messaging and training with the aim of reducing emergency activity at Secondary Care, reducing demand on Primary Care and improving patient's wellbeing.

2.2. The project would see a Care Co-ordinator working within the developing community neighbourhood teams, aligned to GP practices within a locality

2.3. Patients (those over 65 with Chronic Ambulatory Care Sensitive Conditions) would be referred to the care –co-ordinator who would assess their needs. The patients would be allocated a Well Being coach who would work with the individual in improving their well-being by identifying their needs and facilitating a package of support. This could be varied from one to one sessions, local community groups, exercise classes, bereavement counselling etc.

2.4. As the Local Authority have confirmed they will not be pursuing this delivery model, the project is no longer financially viable in its current form.

2.5. The fundamental principle of providing low level support to patients to both sign post to appropriate services and to coach them to improved well- being is still one which is considered to be a desired approach and therefore we will be exploring alternative options of delivery.

3. CLINICAL VIEW

3.1. Discussions have been held with the Chair of the CCG and the Locality Leads to gain their views during the development of the model.

4. PATIENT AND PUBLIC VIEW

4.1. A number of engagement events have been held and the approach of low level care has been supported.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. There is a significant financial risk to proceeding with this application if the subsequent service was purely commissioned by the CCG.

5.2. There may be reputational damage to not proceeding with a full application to Big Lottery following Grant Funding award. A telephone call is arranged with them on Thursday 7th July.

Financial and Resource Implications

5.3. There is a financial risk to proceeding with this application if the subsequent service was purely commissioned by the CCG.

Quality and Safety Implications

5.4. No quality and safety implications to not proceeding with this project.

Equality Implications

5.5. There are no Equality implications to not proceeding with this project.

Medicines Management Implications

5.6. There are no identified Medicines Management Implications.

Legal and Policy Implications

5.7. There are no known legal and policy implications by not pursuing a full application to Big Lottery, however we would need to justify our decision not to proceed.

6. RECOMMENDATIONS

- For the CCG not to pursue a full application to Big Lottery as the project is not financially viable with the CCG as sole Commissioners.

Name: Andrea Smith
Job Title: Head of Integrated Commissioning
Date: 4th July 2016

ATTACHED:

- Wolverhampton SIB Business Case Final

RELEVANT BACKGROUND PAPERS

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)		

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY

12th July 2016

Agenda item 11a

Title of Report:	Grant Policy/ Funding Allocations
Report of:	Vic Middlemiss
Contact:	Vic Middlemiss
Primary Care Joint Commissioning Committee Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To update the Governing Body on the outcome of grant allocations to the third sector, following the second round of bidding which concluded in May 2016.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The increase of working with Third Sector organisations will support the delivery of the Better Care Programme by helping people to remain in their own home, reducing emergency attendances and admissions and supporting early discharge
• **Domain 2b:** Quality (Improved Outcomes)	Enabling patients to have improved experience by receiving care closer to home
• **Domain 4:** Planning (Long Term and Short Term)	Third sector investment supporting the Better Care Programme Plan for 2016/17 and beyond

1. BACKGROUND AND CURRENT SITUATION

1.1. Approximately 12 months ago, the CCG developed a Grant Policy specifically aimed at supporting the Third Sector and providing a mechanism for third sector organisations to bid against allocated funding. 2016 is the first year of implementation. The policy states that funding will be determined against fixed budgets and set criteria will be updated each year at the beginning of the application process. The criteria will reflect national and local CCG strategy and priorities for commissioning as well as its statutory limitations for commissioning healthcare services to support the needs of its local population.

2. MAIN BODY OF REPORT

2.1. In January 2016, the CCG initiated the second step in the process; that of publicising the grant fund to enable organisations to prepare bids for submission. This publication was done via the CCG website, direct advertising using an existing database as well as a specific workshop event held at the science park. Organisations were advised that the CCG would consider applications that met the following criteria:

- Application for funding up to £25,000
- Provides a service or benefit within the CCG's geographical boundary of Wolverhampton
- Able to demonstrate a health impact for the population
- In line with key CCG priority areas of:
  - Right Care, Right Place, Right Time
  - Supporting Independent Living
  - Combating Social Isolation
  - Focussing on people with a Long Term Condition and/ or the Frail Elderly.

2.2. In this first round, 34 applications were received and four were approved. A further three exceeded the minimum threshold of 64 points and were designated as 'possible'. The evaluation panel determined that a second round should be undertaken and this was initiated in late March. A further interactive workshop was held in mid-April and like the first this was well attended. Unsuccessful applicants from the earlier round were invited to re-apply and a longer period was allocated for all applicants based on feedback received. 22 applications were received, some of which were revised from Round 1 but most of which were new.

2.3. The second round evaluation of the bidding process was concluded in May and a further 6 applications were approved, meaning that across both rounds a total of 10 organisations have been successful. Grant schedules (which are a form of contract agreement) have been sent out accordingly. Across the ten projects, the CCG has committed a total of £185,857. Details of the successful organisations and a summary of their projects can be found in Appendix 1.

2.4 In order to support the delivery of the Better Care programme and consequently to support Primary Care a number of steps were undertaken with the successful bidders of the first round and these will be replicated with the second round of bidders. The key objective is to introduce the third sector organisations to the community neighbourhood teams (CNTs) to begin to build relationships and to develop referral pathways. The model below demonstrates how the CNTs will be wrapped around the patients and Primary Care.

2.5 The organisations that have been awarded grants have been can be found on the CCG's Internet and Intranet sites. They will be publicised in the GP and Staff newsletters and information will be cascaded at TEAM W, GP Locality meetings and the Practice Managers Forum.

2.6 The organisations are initially invited to the Adult Community Care work stream meetings to present what their service can offer to support the work of the CNTs. They are then invited to attend the meetings on a regular basis so that discussions can be held about appropriate referrals and to monitor the progress of the projects and the impact upon the service user. Work is underway to co-locate the CNTs. Once the teams are co-located there will be more opportunity to integrate the third sector into the teams on a more effective basis.

3. CLINICAL VIEW

3.1. The senior nurses within the teams will ensure that patients are appropriately referred into the services. GPs are also able to refer directly into services.

4. PATIENT AND PUBLIC VIEW

4.1. Patient feedback and evaluation will be built into the monitoring of the services.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. There are risks that the services do not receive enough referrals to make their services effective.

5.2. There are risks that some of the services only address a very small cohort of patients and therefore it may be difficult for GPs to determine which patients meet the referral critieria.

Financial and Resource Implications

5.3. Financial Implications are covered by the CCG Grant Policy Framework

Quality and Safety Implications

5.4. The quality and safety of the services will be managed via the management of the Grant Schedule and via the evaluation process.

Equality Implications

5.5. Equality Impact Assessments have not been undertaken for these grant awards.

Medicines Management Implications

5.6. There are no medicines management implications.

Legal and Policy Implications

5.7. Any legal implications are managed through the CCG Grant Policy Framework and the contract management of the service.

6. RECOMMENDATIONS

6.1. It is recommended that the Governing Body receives and discusses this report.

Name: **Vic Middlemiss**
Job Title: **Head of Contracting and Procurement**
Date: **29th June 2016**

ATTACHED:

(Attached items: Appendix 1 - Summary of grant allocations)

RELEVANT BACKGROUND PAPERS

CCG Grant Funding Policy

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	Pat Roberts	29.06.16
Finance Implications discussed with Finance Team	Andrea Hadley	29.06.16
Quality Implications discussed with Quality and Risk Team	Sarah Southall	29.06.16
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)		

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Appendix 1 – Summary of Third Sector organisations receiving grant funding from WCCG (2016/17) and associated projects

1. **Beacon**

Project Title - Beacon Link-Line
Funding allocated - £22,714

'Our proposal is to expand current provision into the Wolverhampton area with the added element of an innovative telephone support service – Beacon Link-Line - for people living with visual impairment (VI). The Link-line will provide the vital peer mentoring support needed to VI people who have become or are at risk of being isolated from the community in order to enable them to cope with everyday living and stay independent.'

A team of mainly Visually Impaired & some sighted volunteers will provide weekly calls to clients at least once a week, whether people just want to pass the time of day; have a social chat; are feeling lonely and isolated from neighbours.

2. **Carers Group - MS Therapy Centre**

Project Title - Carers Support Group
Funding allocated - £2,819

This project is about establishing a carers' group for carers of those living with Multiple Sclerosis and other neurological conditions. It involves development of a safe regular space for carers to access peer support, advice and guidance and signpost into other services.

'The project will address the carers own support needs that will sustain the carer in their caring role and help maintain the carers own health and wellbeing through providing a safe space to discuss their own issues, offer direct support and signpost into other services.'

3. **Compton Hospice**

Project Title - Compton Hospice Isolation Prevention Service for People with Incurable Conditions and Frailty
Funding allocated - £25,000

'The project will develop a compassionate service, delivered by volunteers who will take end of life care beyond the palliative care boundaries. The service will tackle the debilitating isolation and grief that people often experience alongside physical symptoms and increasing frailty when facing an incurable illness. In collaboration with existing community service providers in Wolverhampton, it will develop a comprehensive directory of services available to service users thus acting as a gateway to other services and support.

A core group of volunteers will be recruited through the hospice to assist the coordination and development of a range of volunteer services, including befriending, to support people to remain in the place of their choice for as long as possible.

The volunteers will take on the role of community champions and will endeavour to

increase community awareness and understanding of the frailty and end of life, and to increase the community's capacity to support those who are living with its effects. '

4. **Deafblind UK (DBUK)**

Project Title - DBUK Community Services in Wolverhampton
Funding allocated - £24,480

Community services supporting deafblind people to:

- Combat social isolation;
- Live independently;
- Improve their health and wellbeing;
- Access information and services.

'Experienced Outreach Officers will be making home visits to assess needs, helping with problems and ensuring access to services. Peer support and social groups will be created for activities, friendship, information, and guidance on managing everyday tasks safely and independently. Volunteer befrienders will provide company, conversation and help with correspondence, finances, shopping and getting outdoors. There will be training/support in using accessible digital technology to stay socially connected and well informed. Provision of an Information and guidance telephone/email line is included with at least three telephone calls per year, to check welfare and help with queries/problems. The project also includes the production of a quarterly magazine in an accessible format, containing articles about deafblindness and information on services and products.'

5. **Disability Resource Centre (DRC)**

Project Title - Fit for Life
Funding allocated - £23,337

'Fit for Life is an innovative, holistic programme available to disabled people, those with long-term health conditions and people who are elderly/frail, to support them to better manage their impairments and make positive lifestyle changes to improve their health and wellbeing.

Over the course of a year, DRC will run six 10 week courses, which will include weekly 'taster' exercise sessions and Fit for Life workshops.'

6. **Gloucester Street Community Centre**

Project Title - Better Care, Together - living well and staying well for longer
Funding allocated - £25,000

'The pilot project aims to deliver a tailor-made package of support to the Elderly (primarily 65+ and from BME and migrant backgrounds) and their families – at the point of accessing NHS hospital services, with the aim of reducing subsequent need/dependency on NHS services. The project will work closely with the Health Services, in identifying those currently in regular contact and/or at risk of regular contact with NHS services. Following an assessment, a tailor-made package of support will be constructed with the involvement of both family and person in need of care (where possible). The package will involve a programme of support, including one-to-one be-friending, transport to weekly social activities (e.g. luncheon club,

exercise classes, coffee mornings and health checks) as well as faith-related activities.

The project will offer an all-round support service that places wellbeing at the centre of the living well and staying well, for longer.'

7. Hope Community Project Wolverhampton

Project Title - Angels of Hope
Funding allocated - £12,907

'The service will provide support for people over the age of 60, who have difficulty managing their lives, and the frail and elderly to enable them to live independently in their own homes and prevent early hospital admission. We will accompany people to medical appointments, provide a pre-arranged 'sitting' service to enable carers to have time to themselves during the day, help with day to day domestic duties in the home, help with shopping, fetching prescriptions and other tasks identified, as appropriate. We will offer a telephone befriending service and a regular visiting service for people who are isolated, those who are unable to leave their own homes, suffer from depression or have low self-esteem. We will arrange social activities, trips and outings to encourage new friendships outside of their home and extended peer circles.'

8. Omega, the National Association for End of Life Care

Project Title - Chatterbox, Action Against Loneliness
Funding allocated - £15,700

Chatterbox is a targeted, telephone befriending, mentoring and facilitation service aimed at clients, especially those in crisis or at risk of losing their independence.

Chatterbox extends independence, enhances wellbeing and supports family care-givers looking after someone with a complex condition to continue their caring role for as long as possible. We help to restore the self-esteem of people who would otherwise have little or no support and encourage them to re-engage with their own social network, or guide them through a difficult situation.

9. One Voice - For Disabled People

Project Title - The Next Step
Funding allocated – £16,900

Our aim is to bring together our existing expertise and work alongside Wolverhampton Homes, to address disabled people and older people's isolation, access to exercise and healthy living and to the internet.

We will begin with a telephone befriending service to identified people by WH as isolated through their vulnerabilities database. We will extend and provide opportunities to get disabled persons to talk to each other and in their communities and arrange a whole host of activities, to include:

- Community walks
- Picnics
- Teach recipes

- Share food
- Use cyber cafes to get people online and learn to use the internet
- Chairobics
- Transport to community gym/ swim facilities

10. Wolverhampton Elder Asian and Disabled Group

Project Title - Capturing Life Experiences
Funding Allocated - £17,000

'We would like to carry out a project that focuses on improving the life of disadvantaged groups by encouraging inclusion. We have found that women in particular are not taking up services and are leading lonely, isolated and unhealthy lives. We have found that women from BME backgrounds may be isolated due to religious and cultural pressures. Our project will be a positive community one approached via grass roots that will focus on raising health inequalities and developing new skills. We want to promote the wellbeing of people to make later life a fulfilling one. The project will support people to remain independent and able to deal with immediate worries and overcome loneliness and isolation. We also want to target those at risk of becoming lonely and isolated. This will involve developing engagement strategies building on capacity and mutual support.'

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body

12 July 2016

Agenda item 12a

Title of Report:	**Update on AQP Care Home Framework**
Report of:	Maxine Danks
Contact:	Maxine Danks
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To inform the Governing Body of the progress that has been made to provide quality care home provision for individuals eligible for NHS CHC
Public or Private:	This report is for the public meeting
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	• Processes support robust governance arrangements; • Involves and engages patients and the public actively • Works in partnership with others especially LA and providers • Ensures commissioning is providing the best value for money; effective systems are in place to ensure compliance with its statutory functions for NHS CHC

• **Domain 2a:** Performance – delivery of commitments and improved outcomes	• To improve outcomes for individuals who are eligible for NHS CHC and use innovative methods to achieve this improvement. • Close working with patients and providers to deliver services which address identified needs
• **Domain 2b:** Quality (Improved Outcomes)	• To improve the quality of care received by health funded individuals by supporting the work undertaken by the Quality Team, by supporting providers in meeting the needs of complex patients. • Commissioning services which have quality embedded within the contract specification.
• **Domain 3:** Financial Management	• The ICT budget is closely monitored to ensure that accurate forecasting can be made by finance colleagues. • Finance teams are notified of all significant packages prior to the funding commencing and monthly budget meetings assist with planning.
• **Domain 4:** Planning (Long Term and Short Term)	• The Framework will provide additional windows of opportunity for providers to join the Framework • Work has commenced to address the limited provision of care for young people with complex care needs in co-production with Changing Young Lives.
• **Domain 5:** Delegated Functions	• NHS CHC delivery is a statutory function of the CCG

1. BACKGROUND AND CURRENT SITUATION

1.1. The Individual Care Team undertakes the end to end NHS Funded Care statutory function for the CCG. This encompasses assessing individuals, identifying care needs, commissioning care that will meet these needs and reviewing needs and care provision on a regular basis.

1.2. Many individuals who are eligible for NHS CHC funding reside within nursing homes in Wolverhampton and receive all of the care they require in these settings, fully funded by the NHS.

1.3. Over time it has become apparent that the quality of care received within some of these homes is not of a standard that the CCG believe is appropriate to meet the needs of residents; this information has been provided from Quality Team, LA, CHC assessors and family.

1.4. At a time when families have to consider a family member moving into care they are often under considerable stress. The lack of guidance, as to which care home might be appropriate to meet their loved one's needs, can add to their distress. The ability to have access to a choice of quality assured care homes should minimise the additional stress currently experienced by families during this difficult time.

1.5. In order to address this situation and provide quality care home provision within the city it was evident that the CCG needed to commission the care differently and move away from a spot purchase model to a model which utilised the NHS Contract to improve quality standards.

2. MAIN BODY OF REPORT

2.1. The first procurement exercise undertaken by the Individual Care Team in the summer of 2015 was unsuccessful. There were several market engagement events held before this Invitation to Tender was published and amendments were made to specifications to reflect the feedback received at these events.

2.2. Despite the engagement the number of local providers was insufficient and therefore the procurement at this time was not concluded.

2.3. Feedback was gathered from a number of local providers and it was identified that the fees being offered were not at a level which reflected the needs of the individuals requiring care under NHS CHC. Providers also identified that the quality reporting requirements would require additional time from staff and that the level of fees did not take this resource into account.

2.4. A decision was made to revise the fees payable and to commission future care via an Approved Care Home Framework using the Any Qualified Provider process to identify appropriate providers.

2.5. The care fees were increased to £700 per week for physical health needs and £725 per week for care related to mental health needs. For individuals with very complex needs comprehensive assessments and care plans would provide the foundation for discussions as to the hours of additional funding required to address the individuals identified needs.

2.6. Application to be considered to join the Framework was opened on 1st February 2016 and closed on 4th March 2016.

2.7. There were 9 applicants in total and of those 8 were accepted following evaluation. (Details in Appendix 1)

2.8. The providers were informed regards the outcome of their application by the CSU.

2.9. Contracts are now complete and the Framework will become live on July 1st 2016. These are overarching NHS contracts and will be zero value; providers will be paid for each individual and the care they receive.

3. CLINICAL VIEW

3.1. The applications were evaluated and the areas related to practice were evaluated by both registered nurses and a mental health nurse.

4. PATIENT AND PUBLIC VIEW

4.1. The specifications for the provision of both physical and mental health had been reviewed and commented on by patient representatives from WCCG who had family members that were or had previously received care within nursing homes.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. The main risk would be that all of the care home provision commissioned via the Framework has no vacancies and that care would need to be purchased from providers who are not part of the Framework. This risk should be minimised as a new window of opportunity is due to be opened in October 2016 for further providers to join the Framework; at least 3 large care homes in city have indicated that they wish to be considered at the earliest opportunity.

Financial and Resource Implications

5.2. Financial modelling has been completed by the CCG finance department and the fee levels identified are affordable within the allocated budget for NHS Continuing Healthcare

Quality and Safety Implications

5.3. The quality team have been involved throughout the procurement exercise and have made significant contributions to the specification regarding the quality monitoring that providers will be required to submit.

5.4. The mandatory provision of this information will ensure any quality concerns or themes are identified in a timely manner and swift action can be taken if required.

Equality Implications

5.5. The Individual care Team currently commission care for all individuals, over 18 years of age who have eligibility for NHS continuing healthcare. The introduction of an Approved Care Home Framework will not negatively impact on any group within the local population the use of approved providers will ensure choice of quality providers

Medicines Management Implications

5.6. N/A

Legal and Policy Implications

5.7. NHS Continuing Healthcare provision is a statutory duty of the CCG. Provision of quality assured care is identified as a requirement in the NHS Continuing Healthcare Assurance Framework, as is the use of NHS Contracts when commissioning care.

6. RECOMMENDATIONS

6.1. It is recommended that the Governing Body receive and discuss the report and note the action being taken to improve the quality of care provided for individuals who are in receipt of NHS Continuing Healthcare residing in nursing homes.

Name: Maxine Danks
Job Title: Head of Individual Care
Date: 21.06.2016

ATTACHED:
Appendix 1 – Contract Award Recommendation Report

RELEVANT BACKGROUND PAPERS

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	Clinicians involved in design and project	26.04.16
Public/ Patient View	Feedback of Specifications	26.04.16
Finance Implications discussed with Finance Team	Maria Tongue provided finance input	26.04.16
Quality Implications discussed with Quality and Risk Team	Quality team involved in project	26.04.16
Medicines Management Implications discussed with Medicines Management team	N/A	26.04.16
Equality Implications discussed with CSU Equality and Inclusion Service	No change in service provision	26.04.16
Information Governance implications discussed with IG Support Officer	N/A	26.04.16
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	26.04.16
Signed off by Report Owner (Must be completed)	M. A. Danko	21.06.2016

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Arden&GEM

NHS
Arden and Greater East Midlands
Commissioning Support Unit

Contract Award
Recommendation Report

CONTINUING HEALTHCARE (CHC)
ANY QUALIFIED PROVIDER (AQP)

WOLVERHAMPTON CCG

Report Prepared By:
Craig Stephens MCIPS

Arden & GEM CSU
Kingston House
438-450 High Street
West Midlands
B70 9LD

Contents

1. Participating Commissioners

This service is being commissioned by Wolverhampton Clinical Commissioning Group (CCG) under an Any Qualified Provider (AQP) process. Arden & GEM Commissioning Support Unit managed the procurement on behalf of Wolverhampton CCG.

2. Background

This opportunity was advertised in Contracts Finder on the 01st February 2016 and closed on the 04th March 2016.

The contracts that will be awarded under AQP are zero value, zero activity; the patient determines which provider they wish to use to undertake their treatment.

All patients who meet the "referral" requirements are eligible to use the service and can select whichever Any Qualified Provider they wish.

The contracts awarded will run for an initial 3 year period from 01st June 2016 and will end on 31st May 2019. There are opportunities for the CCG to open up additional windows to allow further providers to submit applications to increase service coverage.

3. The AQP Process

3.1 Background

Thirty-two [32] organisations ("Applicants") expressed an interest in bidding for the project by registering on BRAVO during the Contracts Finder advert period. The closing date for receipt of applications was 5pm on 04th March 2016. Nine [9] organisations completed and returned an AQP accreditation questionnaire by the closing date.

Responses were received from:

	Company Name
1	Bupa Care Services Ltd
2	Caram [AH]
3	Carnoul Healthcare Agency
4	Four Seasons Health Care Limited
5	Goldthorn Lodge Limited
6	MACC Care Limited
7	The Sycamores
8	Veronica House Limited
9	Wellesley House Nursing Home Ltd

All organisations who wish to provide a service under AQP must:

- Agree to the Standard NHS Contract ;
- Agree to the tariff set by the Commissioner for the service.
- Agree to adhere to the service specification.

Responses were not received from twenty-three [23] providers. Reasons for non-response were not provided from the majority however three [3] providers cited their reason for non-response being the service being outside of their core service offer.

3.2 Tariff

The tariffs have been set at (1) EMI £725 per week (2) Mental Health £700 per week (3) Physical Disability £700 per week per patient and these tariffs were accepted by all providers that submitted an AQP response. These tariffs were presented at the market engagement event that was held by the CCG prior to the procurement commencing.

3.3 Evaluation of Accreditation Questionnaires

The AQP Offer Document sets out the minimum standards that applicants must achieve in order to qualify as an "Any Qualified Provider". The AQP Offer Document consists of a total of 8 sections. Section 7 (Service Specific) and 3 (Regulation) only were evaluated by Wolverhampton CCG. All other sections were evaluated by the CSU.

Evaluation was undertaken by the following CCG representatives

Name	Role
Maxine Danks	Commissioning Lead
Molly Henriques-Dillon	Quality Nurse Team Leader
Joanne Lake	Lead Nurse – Individual Care Team
Dorothy McIntosh	Commissioner

All "scored" questions are marked as pass\fail and in order to qualify an applicant must achieve a pass on all of the pass\fail questions.

During the evaluation process evaluators raised a series of clarification questions where the response was ambiguous or contradictory and applicants responded accordingly.

4 Evaluation Results

A summary of the results of the AQP Accreditation Questionnaire evaluation is detailed in the following table with a more detailed summary provided in Appendix 1.

	Company Name	Pass / Fail	Justification
1	Bupa Care Services Ltd	PASS	Scored a PASS on all PASS/FAIL questions
2	Caram [AH]	PASS	Scored a PASS on all PASS/FAIL questions
3	**Carnoul Healthcare Agency**	**FAIL**	**Scored a FAIL on some PASS/FAIL questions Reasons for failure are stated within the Authority Decision Report – Appendix One.**
4	Four Seasons Health Care Limited	PASS	Scored a PASS on all PASS/FAIL questions
5	Goldthorn Lodge Limited	PASS	Scored a PASS on all PASS/FAIL questions
6	MACC Care Limited	PASS	Scored a PASS on all PASS/FAIL questions
7	The Sycamores	PASS	Scored a PASS on all PASS/FAIL questions
8	Veronica House Limited	PASS	Scored a PASS on all PASS/FAIL questions
9	Wellesley House Nursing Home Ltd	PASS	Scored a PASS on all PASS/FAIL questions

5. Impact of Project on Equality & Social Values

The service will be delivered in compliance with the Equality Act 2010, the Human Rights Act 1998; and the principles, rights and pledges set out in the NHS Constitution. The service providers will be required to regularly report to the commissioning organisation on operational evidence to provide assurance that services are compliant with s149 (1) of the Equality Act 2010 – the Public Sector Equality Duty. The award of contract will have no negative impact on the Social Value assessment undertaken by Wolverhampton CCG.

6. Recommendations

6.1 That a contract is awarded to the following providers:

- BUPA Care Services Ltd
- Caram [AH]
- Four Seasons Health Care Limited
- Goldthorn Lodge Limited
- MACC Care Limited

- The Sycamores
- Veronica House Limited
- Wellesley House Nursing Home Ltd

6.2 The AQP accreditation will be the initial 3 year period.

6.3 The contract will be made under the Terms of the NHS Standard Contract 2016/17.

6.4 Whilst not obliged to, the CCG may wish to open further rounds for accreditation during the AQP accreditation period to increase the number of AQP providers available for patients to choose from or to meet any shortages in number of providers for a particular area within the region.

APPENDICES

Appendix 1 – Evaluation Outcome	Authority Decision Report.xls
Appendix 2 – Service Specifications	Service Specification CHC Physical Health 1 Service Specification Template for MH CHC

Recommendations approved by:

Name: Laraine Wooding

Signature:

Title: Senior Procurement Manager

Date: 19th April 2016

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY 12TH JULY 2016

Agenda item 13

Title of Report:	**End of Life/Palliative Care Strategy**
Report of:	Jeff Love
Contact:	Jeff Love
Integrated Care Programme Board Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide Governing Body with a timetable for the development and approval of health & Social Care economy-wide strategy for End Of Life care in Wolverhampton together with the principles underpinning the strategy and an update on progress.
Public or Private:	Public
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	The strategy covers the delivery of key components of end of life / palliative care including acute, community nursing, hospice care and third sector whilst improving service outcomes for patients
• **Domain 2b:** Quality (Improved Outcomes)	This strategy will deliver improved quality of support and improved outcomes for patients and carers experiencing end of life and palliative care services
• **Domain 3:** Financial Management	This strategy is aiming to improve the cost effectiveness and efficiency of EoL care across the whole health and care economy through development of an integrated care pathway
• **Domain 4:** Planning (Long Term and Short Term)	This project will lead to the development of an integrated End of Life care pathway co designed by

	all partners. The component parts will build on some of the Strategic developments taking place under the BCF In the short term, the strategy will inform the development and roll out of advanced care planning and support the development of Primary care in the early identification of those people nearing the end of their life.

1. BACKGROUND AND CURRENT SITUATION

1.1. To ensure delivery with the CCG priorities of care and the priorities of the Joint Health & Wellbeing Strategy, there is a need for a jointly developed, integrated health and care strategy for End of Life care in Wolverhampton. An early draft strategic approach was agreed through Commissioning Committee in 2014.Since then further policy and guidance has been published by a range of advisory bodies that needs to be taken into account.

1.2. The CCG is currently working with a wide range of partners to develop a comprehensive, co-produced strategy to deliver a whole pathway approach for people approaching the end of life. The strategy identifies how pathways need to be developed and how service providers need to coordinate their activities to ensure that the people of Wolverhampton receive the best possible care and support as they reach the end of their lives.

1.3. The strategy also addresses the needs of carers and details the importance of ensuring those needs are assessed and addressed to enable them to effectively undertake their caring role and also maintain a good quality of life themselves..

2. MAIN BODY OF REPORT

2.1. The development of the strategy and of the plan for its implementation is being managed through steering groups (one focusing on strategic issues and one on operational issues) with representation in both groups from the key partners in commissioning and delivery of end of life and palliative care, and includes a clear focus on engagement with patients, service users, carers and families and the wider public to make sure their views are recognised, considered and represented throughout the strategy.

2.2. The co production of the Strategy with all partners ensures support for both the principles and practice the strategy and implementation plan set out.

2.3. The timetable for development and approval of the strategy document is as follows :

July 2016 - Draft Strategy to CCG Integrated Care Programme Board

August 2016 – Consultation Draft circulated to Health and Wellbeing Board members
– Final Draft Strategy agreed by Strategy Steering Group

September 2016 – Final Draft Strategy to CCG Integrated Care Board

2.4. A detailed implementation plan including any proposals for service redesign, commissioning and decommissioning will be developed and agreed in conjunction with the strategy document. Decisions can then be taken on how services will be commissioned and an appropriate timetable developed.

2.5. The Strategy has adopted the definition of term "approaching the end of life" that is used in "One Chance to Get it Right"[1] :

" Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

a) *advanced, progressive, incurable conditions;*
b) *general frailty and co-existing conditions that mean they are expected to die within 12 months;*
c) *existing conditions if they are at risk of dying from a sudden acute crisis in their condition;*
d) *life-threatening acute conditions caused by sudden catastrophic events."*

2.6. The Strategy will also recommend the earliest possible implementation of advanced care planning for end of life care for people with life-limiting long term conditions where the expectation of life is longer than 12 months.

2.7. The model proposed for end of life care in Wolverhampton places the person and those closest to them, firmly in the centre. There are a number of key issues that need to be addressed to improve End of Life care in Wolverhampton, not least, the earlier identification of those approaching end of life to ensure that they have the opportunity and are empowered to plan, how their future needs will be met. The support and care they receive will be coordinated, and information about their choices, preferences and needs will be shared through a shared record across all the agencies involved.

3. CLINICAL VIEW

3.1. Clinical input into the strategy is being provided through the Steering Groups, both chaired by Dr Manny Samra, a local Macmillan GP. The Steering Groups also include a number of clinicians and health and care professionals from partner agencies involved in the provision of End of Life care including a Consultant in Palliative medicine.

3.2. Further clinical scrutiny will be provided by the CCG Clinical Reference Group as and when required.

1 One Chance to Get it Right - Leadership Alliance for the Care of Dying People, June 2014

4. PATIENT AND PUBLIC VIEW

4.1. The views of patients, carers and families and the public are being obtained through a number of initiatives. These include questionnaires, focus groups and one to one communication.

RISKS AND IMPLICATIONS

Key Risks

4.2. No immediate risks have been identified to date – any specific risks associated with service redesign or decommissioning will be identified and evaluated as the strategy work progresses.

Financial and Resource Implications

4.3. There are no immediate financial and resource implications for this strategy, the implementation planning process will identify and report these to the relevant Programme Board at the time the Strategy is agreed.

Quality and Safety Implications

4.4. The development of a whole pathway strategy for end of life care will support improved quality of care for patients. The CCG's Quality team are directly involved in the Steering Groups and will identify any key issues to be addressed as the work progresses.

Equality Implications

4.5. A full equality impact assessment will be carried out as part of the work of developing the strategy. The recent CQC Report "A Different Ending[2]" will inform part of this work.
The City of Wolverhampton has a very diverse population with a wide range of cultural differences.[3] These will be addressed within the Strategy.

Medicines Management Implications

4.6. No specific issues for medicines management have been identified at this stage.

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[2] A Different Ending – Addressing Inequalities in End of Life Care – Care Quality Commission, May 2016
[3] Hiding Who I am – The Reality of End of Life Care for LGBT People, Marie Curie, June 2016

Legal and Policy Implications

4.7. No specific legal and policy implications have been identified at this stage.

5. RECOMMENDATIONS

- **Receive** and **discuss** this report.
- **Approve** the Timetable set out at 2.3 above

Jeff Love
Development Manager
Date: 30th June 2016

ATTACHED:

RELEVANT BACKGROUND PAPERS

Commissioning Person-Centred End of Life Care –NHS England - Updated April 2016

Actions for End of Life Care - NHS England November 2014

Care of dying adults in the last days of life – NICE guideline December 2015

Understanding patterns of health and social care at the end of life – Nuffield Trust 2012

One Chance to Get it Right - Leadership Alliance for the Care of Dying People June 2014

What's Important to Me - The Choice in End of Life Care Programme Board February 2015

End of Life Care Audit – Dying in Hospital - Healthcare Quality Improvement Partnership (HQIP) March 2016

A Different Ending – CQC May 2016

"Hiding who I am" – Marie Curie May 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	**Dr Manny Samra**	
Public/ Patient View	**Lesley Fellows**	
Finance Implications discussed with Finance Team	**Not applicable at this point**	
Quality Implications discussed with Quality and Risk Team	**Molly Henriques-Dillon**	
Medicines Management Implications discussed with Medicines Management team	**Not applicable at this point**	
Equality Implications discussed with CSU Equality and Inclusion Service	**To be carried out in July 2016**	
Information Governance implications discussed with IG Support Officer	**Not applicable at this point**	
Legal/ Policy implications discussed with Corporate Operations Manager	**Not applicable at this point**	
Signed off by Report Owner (Must be completed)		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 12th July 2016

Agenda item 14a

Title of Report:	**Commissioning Committee – Reporting Period May 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 May 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 Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) for the period of May 2016.

2. MAIN BODY OF REPORT

2.1 Contracting & Procurement Update – Month 12 March 2016

The Committee was provided with an update report relating to Month 12 (March) activity and finance performance and includes commentary and key actions from the Clinical Quality Review and Contract Review meetings conducted in April 2016.

Contracting 2016-17

- The Royal Wolverhampton Trust (RWT) contract was signed in early April and 10 out of 18 of the associate commissioners to this contract have also signed.
- Black Country Partnership (BCPFT) and West Midlands Ambulance Service (WMAS) contracts are finalised and signed.
- Offers have been agreed for all other acute and Mental Health contracts to which the CCG is an associate commissioner.

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 increased since February from 85.39%, to 90.32% and the RAP trajectory of 95% was not achieved. Commissioners have been asked to withhold 2% of the A&E budget for March and to retain the 2% for the month of February, in line with General Conditions of the contract.

In addition to the Contract Review Group, continuity of performance is being monitored through the Quality Review Group and the System Resilience Group (SRG) on a monthly basis.

There is an increased national focus on A&E performance with the Sustainability and Transformation Plan also including trajectories for A&E waits for both the 4 and 12 hour targets.

Cancer Targets

- Three cancer wait targets did not achieve their targets in March.
- The percentage of Service Users waiting no more than 31 days for subsequent treatment, where that treatment is surgery, was 90.63% against target of 94%.
- The percentage of Service Users waiting no more than 62 days from urgent GP referral to first definitive treatment for cancer has decreased from 77.85% in February to 75.58% in March.
- The validated UNIFY February cancer wait data is now available and the RAP target of 80.0% was not achieved.
- The percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers in March achieved the 90% target.

Referral to Treatment (RTT) within 18 weeks (February – Unify))

Overall the Trust has been achieving against this target throughout the year. However, at speciality level the trust is failing to achieve the following areas:

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

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

E- Discharge – RWT

The Trust continues to struggle to meet this target for assessment achieving 82.5% against a target of 95% in March. The Trust has been asked to produce a revised remedial action plan.

Performance Sanctions

The 2015-16 total sanctions levied to RWT to date equate to £2,081,097.00 across the whole contract. Two targets remain unconfirmed – RTT and Cancer; these will be included in data provided for April.

Recent Issues

Orthodontic Waiting List Issue

On 7th April 2016, the Trust alerted the CCG of a problem that would impact on referral to treatment for Orthodontics. The Trust identified a consultant within the service who had been keeping a paper diary instead of logging patient activity on the orthodontics system. As a consequence there are a number of patients that have not been picked up against waiting list data, some of which are potential 52 week breaches. The CCG has written to the Trust requesting a number of specific points to be addressed as part of their internal investigation and to provide assurance that this practice is not being undertaken in any other specialty. Orthodontics is a specialised service, commissioned by NHSE so the CCG's interest in following up this issue is primarily from a quality perspective.

Junior Doctor Strike

The Trust wrote to the CCG in April 2016 regarding the two day strike, and advised of the number of elective procedures which had to be cancelled as a result of transferring consultants to cover emergency areas of the hospital. The letter requested leniency being applied to performance monitoring of affected targets. A response letter has been sent back confirming that a fair approach will be undertaken, so long as recovery can be demonstrated within a reasonable period of time.

Black Country Partnership Foundation Trust

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

- Early Intervention Services
- CPA
- Safeguarding training. A remedial plan is now in place.

Performance issues

There are two open Contract Performance Notices which were discussed in detail at the February Clinical Quality Review meeting. Remedial action plans are being monitored.

Recent Issues

Non-Achievement of CQUIN Target

One of the CQUIN targets within the 2015/16 BCP contract concerned the prescribing and monitoring of patients on Quetiapine, which is a drug used for patients with psychosis. A letter has been sent to the Trust informing them of non-achievement of the CQUIN for Quarter 2 and 4. A meeting has been requested to discuss safeguarding concerns associated with this drug and to agree an appropriate local quality target for 2016/17.

Other Contracts

Nuffield – This contract has now been finalised at a value of just under £3m and the contract signed.

Vocare (Urgent Care Centre provider) – A draft contract was issued in March but remains unsigned. This presents a degree of risk to the CCG, given the service has been delivered since 1st April 2016. The situation has been flagged to the provider and a resolution is urgently being sought.

Other contracts – other contracts are being developed for completion by end of May and there are no significant risk issues to highlight.

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

2.2 Short Breaks Provision for Vulnerable Pupils

A business case was presented to the Committee to request funding for additional nursing support at Penn Hall School and Green Park School for a period of 3 years, to allow pupils, with complex medical needs, access to a short breaks provision and after school activities.

Both schools have previously provided support for children with complex medical needs by accessing the Aiming High for Disabled Children Programme. It ensured there was nursing support available to enable this cohort of children to participate in out of school activities such as extracurricular activities, day trips and residential trips. The current service provides nursing support to allow pupils who are disabled, with complex and/or palliative care needs, to accompany their peers. The service provides the following nursing care whilst children are off school site and engaged in activities:

- Administers tube feeds and medications
- Monitors children's conditions and act to ensure their good health

- Provides suction and oxygen if appropriate

- Treats conditions such as epilepsy giving emergency first aid and rescue medication
- Provides emergency care as necessary/appropriate
- Undertakes dressings or other planned treatments.

Funding for this support is due to end at the end of summer and as a result concerns are that this cohort of children will be disadvantaged and will not be able to fully participate in school life.

An options appraisal below, with the preferred option being 4:

Option 1	Do nothing	If we choose to discontinue the programme the CCG would not be complying with legislation and would be open to discriminatory practices under the Equality Act.
Option 2	Continue the programme but opt to purchase sessional nursing support from recommended agencies.	If an incident occurred, this could put the programme at risk for all pupils under the Local Authorities Educational Visits Policy.
Option 3	Train school based staff to attend the short breaks without the support of a Nurse.	This option provides a significant risk to the pupils as they will not have a specialist health professional with the expertise and skills to monitor the changing needs of this vulnerable group.
Option 4	Recruit a Band 5 Nurse to share between the schools that are willing to offer short breaks support with a team of school staff who have enhanced medical training. To be provided by the Community Children's Nursing Team via an SLA which would provide assurance that the post holder would receive suitable clinical supervision as well provide sick leave cover. £30k of funding requested – available within the SEND budget.	This option allows the schools to comply with legislation and offer a risk reduction strategy for pupils and professionals. The Nurse would have extensive background knowledge of pupils' health needs and their preventative care procedures. Enables care plans to be kept up to date and reflective of effective practice. Enables more effective training of school staff.

The Committee welcomed the report and agreed to support the preferred option being developed into a Service Specification that addresses:

- Safety issues
- Clarity on the level of specialised training required as part of the role banding
- Confirmation that the money is not being double counted

Action – The Committee request that Governing Body note the contents of the report and support the decision taken.

2.3 Business Case Proposal: Provision of a Direct Access Diagnostic Spirometery Service (Wolverhampton and South Staffordshire GP Surgeries) – Finance Position Verbal Update

The Trust anticipates that there will be approximately 300 referrals for first diagnosis. As the CCG has a quality performance indicator to add 500 patients onto COPD registers, it is recommended that 600 referrals are commissioned.

- DZ35Z – Spirometry with post bronchodilator testing = £73.44
- DZ44Z – Simple Airflow studies = £37.24

The worst case scenario is £131,000 (QP indicator) – £44,064 (100% activity at higher rate) = £86,936 net saving. However, it was noted that negotiations are still taking place with regards to a local reduced tariff.

The Committee approved the Business Case proposal and the recommendation to commission 600 referrals working on the assumption that this is a quality premium for 2016/17 and that a review should take place in 12 months.

Action – The Committee requests that Governing Body note the update provided.

2.4 Service Specification for Designated Medical Officers Role – SEND Agenda

A Service Specification for the Designated Medical Officer role was presented to the Committee to seek approval as part of the Community Paediatrics contract held with the Royal Wolverhampton NHS Trust.

Children and young people with a Special Education Need and/or Disability (SEND), make up a significant proportion of the national childhood population, with up to 20% of school age children and young people having Special Educational Needs (SEN). Wolverhampton's Joint Strategy for Children and Young People with Special educational Needs and Disability (SEND) 2015-2020 identifies that the city has a

child population of 56,000 which includes a higher than average number of children with moderate and severe learning difficulties. Wolverhampton has 1,500 children and young people, with statements of SEN, which are currently being reviewed for transfer over to the new (September 2014) system of a single Education Health and Care plan.

The Service Specification details the requirements of the CCG to establish a Designated Medical Officer role under the Children and Families Act 2014 regarding children and young people with SEND.

The Designated Medical Officer will support the CCG in meeting its statutory responsibilities for children and young people with SEND and will be the key point of contact between the local NHS and the Local Authority and Families. Furthermore, the role will support the delivery of Supporting Pupils with Medical Conditions in Schools.

Risks if the role is not established include:

- Statutory functions not being exercised as appropriate clinical expertise will not exist within the CCG to support this function.
- Delay in delivery of assessments, planning and health support for some of the more vulnerable children, resulting in poor outcomes.

Funding for this post is available and has been agreed within the current SEND budget.

The Committee approved the Service Specification.

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

2.5 Learning Disabilities Intensive Support Service Specification

An assurance report was presented to the Committee along with the Service Specification for a learning disability intensive support service, to be provided by Black Country Partnership Foundation Trust as part of the delivery plan under Transforming Care.

The vision put forward by NHSE was for system-wide change to enable more people to live in the community, with the right support, and close to home. Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Association of Children's Social Services (ADCS) the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH), the Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

The national plan, Building the Right Support, that has been developed jointly by NHS England, the LGA and ADASS, was the next key milestone in the cross-system Transforming Care programme, and included the development 48 Transforming Care Partnerships across England to re-shape local services, to meet individual's needs. This is supported by a new Service Model for commissioners across health and care that defines what good services should look like. It is anticipated that Wolverhampton CCG will reduce their inpatient usage by 65% over the next three years.

In 2015/6 and following a previous report to Commissioning Committee, the CCG disinvested from two inpatient beds based at Pond Lane. This was in response not only to the national agenda to reduce inpatient care levels, but also because there was considerable underperformance on the contract. Negotiations have been undertaken with BCPFT regarding the reinvestment of the money attached to this level of inpatient care into a community-based alternative – an Intensive Support Service. This specification has now been agreed by the provider (BCPFT), and an implementation plan is being developed in order to implement the new service in July 2016. The Intensive Support Service is being funded through the resources disinvested from inpatient beds (£436,000).

The report was well received by the Committee.

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

2.6 GP Prescribing Incentive Scheme 2016/17

A report was presented to the Committee, with a request by the MMO Programme Board, to approve the amendments to the Prescribing Incentive Scheme 2016/17.

The Committee supported the recommendation made for the scheme to progress.

Action - The Committee requests that Governing Body note and support the decision made.

2.7 Step Up Bed Specification

A report was presented to the Committee with a request to approve a 12 week step up bed pilot at Probert Court Care Home.

The provision of step up care aligns with the local Intermediate Care Strategy and the delivery of care closer to home as detailed within the NHSE 5 year forward view.

Patients will have their condition stabilised in the community and access to beds will be strictly monitored to ensure appropriate clinical usage. The maximum length of stay will be 72 hours and a discharge plan will be developed on admission.

The current situation is that, anecdotally, a number of admissions could have been avoided if step up provision had been available. This provision will provide evidence to support this.

There are no additional costs of funding the pilot as costs will be contained within the block contract held with Probert Court Care Home.

An evaluation of the pilot will take place and will include a review of bed utilisation and the number of admissions avoided.

The pilot was approved by Commissioning Committee.

Action – The Committee request that Governing Body note and support the decision made.

2.8 Black Country Transforming Care Partnership

The Committee was presented with an assurance report and the draft Black Country Transforming Care Partnership (TCP) Plan.

The plan builds on other transforming care work to strengthen individuals' rights, to roll out care and treatment reviews across England, to reduce unnecessary hospital admissions and lengthy hospital stays, and test a new competency framework for staff to ensure we have the right skills in the right place.

The Transforming Care programme is focusing on addressing long-standing issues to ensure sustainable change that will see:

- More choice for people and their families, and more say in their care
- Providing more care in the community, with personalised support provided by multi-disciplinary health and care teams
- More innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs
- Providing early more intensive support for those who need it, so that people can stay in the community, close to home

- But for those that do need in-patient care, ensuring it is only for as long as they need it.

Since the beginning of the implementation of the Transforming Care Programme, Wolverhampton has typically had 10 patients in CCG funded care. These hospital placements range in provision and include short-term assessment and treatment, locked rehabilitation, and forensic rehabilitation. They are usually provided under the Mental Health Act, with a number of offenders subject to Hospital Orders or Ministry of Justice restrictions (with hospital being used as a more appropriate environment than prison). By 2019, the programme will require Wolverhampton CCG to have reduced its reliance on inpatient care from 10 beds to 3. Currently Wolverhampton CCG is funding 6 adults with learning disabilities in inpatient care.

The report was well received by the Committee and a quarterly progress update requested.

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

3. RECOMMENDATIONS

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

Name	**Dr Julian Morgans**
Job Title	**Governing Body Lead – Commissioning & Contracting**
Date:	**27th May 2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 12th July 2016

Agenda item 14b

Title of Report:	**Commissioning Committee – Reporting Period June 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 June 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 Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) for the period of June 2016.

2. MAIN BODY OF REPORT

2.1 Contracting & Procurement Update – Month 12 March 2016

The Committee was provided with an update report relating to Month 1 (April) activity and finance performance and includes commentary and key actions from the Clinical Quality Review and Contract Review meetings conducted in June 2016.

Contracting 2016-17

Offers have been agreed for all other acute and Mental Health contracts to which the CCG is either the host or associate commissioner. There are just 4 awaiting signature.

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 remains below the required threshold of 95% and the Trust has been formally notified of the CCG's intention to continue withholding 2% of the appropriate contract line, in line with General Condition 9.

The Trust has provided a revised Remedial Action Plan for which the CCG has requested additional information to be included regarding patient flow and the management of patients at first assessment.

Cancer Targets

The Trust continues to be challenged on delivery of the 62 day referral to first definitive treatment target and failed to meet the 85% target in May. The Trust have confirmed that this is predominantly due to the number of tertiary referrals received which exceed 42 days.

The other two cancer indicators below threshold in May were:

- Two week wait from referral to first outpatient appointment
- % of service users waiting no more than 31 days for surgical treatment

The CCG has accepted a request from the Trust to amalgamate the current Remedial Action Plan with NHS Improvement reporting requirements and this will be sent to the CCG once it has been through the Trust's internal governance processes.

Referral to Treatment (RTT) within 18 weeks (February – Unify))

The headline figure had been achieved for all of 2015/16. However, there is increasing risk of this not being maintained, taking into account the impact of the recent junior doctors' strike. The Trust has agreed to provide the CCG with cumulative data regarding cancelled activity as a result of all the strike action and to confirm an endpoint for the period that the strike will no longer impact on performance delivery.

The Trust has also agreed to the CCG's request for the recovery plan to be broadened to cover the five specialty areas of:

- General Surgery
- Urology
- Plastic Surgery
- Gynaecology

E- Discharge – RWT

The Trust has provided a revised action plan for assessment areas which highlights the reasons for current performance and shows a revised trajectory to August 2016. The CCG has accepted this revised Remedial Action Plan.

Sustainability and Transformation Fund (STF)

The Trust has advised that it is likely that it will be eligible for participation in the STF and confirmation is expected in the next few weeks. This will impact on the CCG's performance monitoring of local quality indicators and particularly the application of withholds and sanctions. A full update on this issue will be provided at the next meeting.

Performance Sanctions

Financial sanctions for Month 1 are £364,000.

Black Country Partnership Foundation Trust (BCPFT)

Performance issues

Contract Performance Notices:

- **Care Programme Approach**
  The Remedial Action Plan and performance figures were discussed and are being monitored monthly.

- **Safeguarding Training**
  BCPFT are currently meeting the trajectory in the Remedial Action Plan.

Prevent Training (Mandatory)

A contract performance notice has been issued to the Trust this month with regards to Prevent Training. BCPFT's current level of training is less than 30%, for Levels 3 and 4, against a target of 85%. Discussions are taking place to establish assurance as to how performance will be improved and maintained.

Non-achievement of CQUIN target (Quetiapine)

One of the CQUIN targets in the 2015/16 contract concerned the prescribing and monitoring of patients on Quetiapine, a drug used for patients with psychosis. A meeting took place earlier this month regarding this issue and in particular to discuss associated safeguarding concerns. The following of actions have been agreed with the Trust:

- Develop a Recovery Plan
- Produce a shared care agreement for Quetiapine by September 2016
- GPs to be given open access to pharmacy and clinicians at BCPFT for advice and guidance
- A joint assessment carried out to establish what other mental health drugs require closer monitoring for patients discharged to Primary Care

Grant Agreements

A second opportunity was given to voluntary sector organisations to apply for grant funding. 6 organisations were successful meaning 10 organisations have benefitted from the process, with a total of £185,000 allocated by the CCG. An internal communication will be issued to summarise details of the organisations/projects.

Other Contracts

Vocare (Urgent Care Centre provider) – a draft contract was issued in March but remains unsigned. This presents a degree of risk to the CCG, given the service has been delivered since 1st April. The situation has been flagged to the provider and a resolution is being sought as a matter of urgency. The CCG is aiming to achieve sign off no later than the end of June.

The Committee welcomed the report and noted its contents.

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

2.2 Big Lottery: Commissioning Better Outcomes

The Committee was presented with a report and business case that proposed a project of social prescribing underpinned by a Social Impact Bond intended to improve the wellbeing of patients, reduce emergency activity and reduce the demand placed on Primary Care.

In January 2016 the CCG was successful in its bid to the Big Lottery to secure Grant Funding to develop a model of Social Prescribing utilising a Social Impact Bond model of funding. Kaizen-group have been working with the CCG as an Intermediary to develop a business case that describes the operational and financial model, and demonstrates the level of potential savings to the Health and Social Care Economy.

Subject to approval of the business case by the CCG and the Local Authority, the opportunity exists to submit a full application to Big Lottery to fund the project. This application needs to be submitted by the end of July 2016 and if successful, it is anticipated that Big Lottery will fund 15% of the outcomes. Within the current financial modelling the project would only be financially viable if it were jointly commissioning between the CCG and Local Authority as savings related to individual organisations would not be sufficient to offset the cost of the outcomes payments alone.

The project would involve the following:

- A Care Co-ordinator working within the developing community neighbourhood teams aligned to GP practices within a locality.
- Patients (over 65 with Chronic Ambulatory Care Sensitive Conditions) would be referred to the Care Co-ordinator for assessment.

- Patients would be allocated a Well Being Coach who would facilitate a package of support.
- Delivery by local Voluntary Sector Organisations, managed by People in Partnership Consortium which is a social enterprise and community interest company underpinned by a Social Impact Bond funding model.

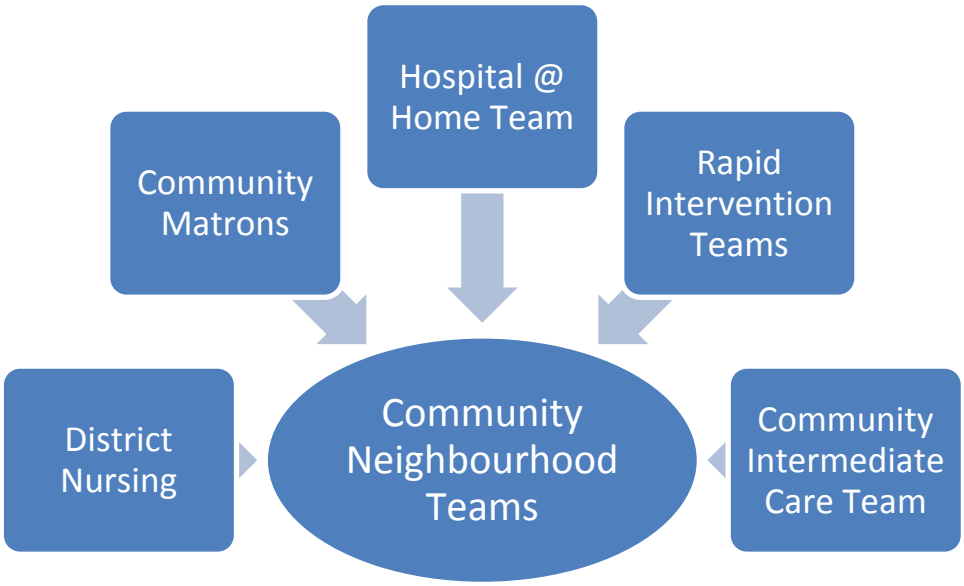
The Committee cautiously welcomed the proposed business case subject to:

- A further summary report being submitted to the Committee in July to include a formalised version of the Return of Investment and Cash Flow.
- Approval being granted by the Local Authority
- Big Lottery funding

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

2.3 Community Nursing Services Review Model

The Committee was referred to an overview of the proposed structure of Community Nursing Services following completion of review.



The above model was explained to the Committee to provide assurance of the proposal to review & redesign all Community Nursing Services and give an insight into the proposed service reviews and pathway/service re-designs.

The Committee acknowledged that it would take at least 12 months to design a full service specification and requested regular feedback on the proposals to develop Community Neighbourhood Teams.

Action – The Committee requests that Governing Body note the update provided.

2.4 Short Breaks Provision Service Specification

The Children's Commissioning Manager presented the Committee with a service specification for the Children's Community Nursing Service which includes a short breaks provision for vulnerable pupils at Penn Hall and Green Park School.

Currently the community children's nursing team provide the service to children, with complex medical needs, who attend both schools. The children with the most complex medical needs have been unable to enjoy the short break provision if nursing staff were unavailable. Previously, support has been provided in such cases by accessing the Aiming High for Disabled Children Programme. This has enabled the children to participate in out of school activities such as day trips and residential trips. The current service provides nursing support to allow pupils who are disabled with complex and/or palliative care needs to accompany their peers.

The funding for this support is due to finish at the end of the summer and as a result concerns exist that this cohort of children will be at a disadvantage and will not be able to fully participate in school life.

The service specification has been updated to enable the service to provide the additional support for the short break provision for the most vulnerable pupils attending both schools. This includes a clear indication of what the service needs to provide, to assure the CCG that the details of the business case, approved at Commissioning Committee, on 26th May 2016, are met.

The Committee approved the updated service specification which is attached as Appendix 1.

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

2.5 The Value of Using Blue Teq

A report was presented to the Committee to provide assurance on the use of the BlueTeq system.

The system clearly provides the CCG with assurances that the provider is treating patients in line with national or local commissioned criteria. It also provides us with a mechanism to check whether patients are receiving timely reviews of their treatment. The total amount refunded within year (84.4K) so far compared to the outlay (6K) provides assurance to the CCG this is also a cost effective system.

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

3. RECOMMENDATIONS

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

Name	**Dr Julian Morgans**
Job Title	**Governing Body Lead – Commissioning & Contracting**
Date:	**30th May 2016**

Appendix 1 – Children's Community Nursing Specification

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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Childrens Community Nursing
Commissioner Lead	Margaret Courts
Provider Lead	Julie Plant, Childrens Matron
Period	1st April 2016 – 31st March 2019
Date of Review	28th February 2017

1. Population Needs

1.1 National/local context and evidence base

Short term acute health problems, chronic long term health problems and/or disabilities and those who are dependent upon technology or medical equipment. The care may be provided at home, in nurseries, special schools or at the Child Development Centre. The service also aims to give support and advice for parents and carers in their difficult and often demanding caring role.

Community Children's Nursing Service (CCNS) which includes:

- Clinical Suite Nursing Team (Gem Out-patients clinic)
- Child Development Centre (CDC)
- Special School Nurses (SSN)

The teams provide the following services:

- Specialist Nursing Care for children who have acute health problems, usually on a short term basis. Care may include: wound care dressings, injections, infusions, and care during home traction, enemas, eye drops etc. This care may be given at their home, school or the Gem Centre, as appropriate

- Specialist Nursing Care for children who have chronic health problems and / or disabilities, who often remain with the service on a long-term basis. These children are supported in schools, respite centres and home. Nursing care may include assessing care needs and providing nursing/ medical equipment such as suction machines, feeding pumps, syringes etc. Advice and support is available for children who have chronic conditions such as constipation, respiratory problems etc.

- Provision of feeds and medicines via a naso gastric or gastrostomy tube. This care is for children who are dependent upon technology and is provided to enable them to access nurseries, schools, the Child Development Centre. Special school nurses are available in two special schools.

- Bereavement support and confidential counselling is available for both children and parents of children with palliative care needs.

- Assessment and management of incontinence and treatment and/ or provision of continence aids.

- A clinical suite (outpatient department) for children is available at the Gem Centre. Community children's nurses provide support to consultant clinics and hold nurse-led clinics. Other nursing care includes giving immunisations, taking blood and other samples, conducting nursing assessments, giving advice and carrying out treatments such as wound dressings etc.

- The special school nurses available at Green Park and Penn Hall School will provide short breaks support and care across the two schools to those children requiring specialist medical provision to enable this cohort of children participate in curriculum enrichment opportunities. The Short breaks nurse post supported by the Special School Nursing staff available at Green Park and Penn Hall School will support the implementation of the Coventry and Warwickshire NHS Trust web based training programme across the education workforce as well as ensuring competencies are met and maintained.

- The Short breaks nurse post who is supporting the service at Penn Hall School will be expected to provide cover where extra nursing support is needed to allow each child at school to access the residential provision, where, without this additional nursing support, the child would be unable to access the residential facilities. This will be offered in close consultation with the nursing staff to ensure the requested nights can be covered as well as other essential duties as expected by this post. Consideration to be given that Green Park School does not have this facility and the service must be used equitably and fairly across the two schools.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

3.1.1. The aims and objectives include:

- Provision of specialist nursing care for children who have acute health problems, long term conditions, complex health needs, life limiting conditions or are technology dependent
- Assessment of children who have complex care needs
- Support, advice and education for children and their families to enable them to manage their nursing care
- Assessment, treatment and management for children who have continence problems including the provision of continence aids
- Shared care with acute hospital staff for children who have oncology conditions
- Counselling support pre and post bereavement for families of children with palliative care needs
- Nursing support in the clinical suite for children attending the Gem Centre
- Special school nursing care, health surveillance and health promotion for the children in the two special schools
- Work in partnership with statutory, private and voluntary sectors in order to meet the needs of children and families.
- Safeguarding children and young people (in accordance with section 11 of the Children Act)
- Supporting special school educational workforce within Green Park and Penn Hall Schools to develop and maintain competencies for supporting young people to participate in an enhanced curriculum.

3.1.2. Expected Outcomes including improving prevention

- To improve the health and well-being of children and young people and their families
- To enable each child to reach their full potential
- To enable children to access education and the wider curriculum including supporting training of education staff within Green Park and Penn Hall Schools and providing medical support for short breaks provision.
- To prevent unnecessary admission to hospital

3.2 Service description/care pathway

3.2.1 Service Description
The CCNS provides holistic health Care for children with nursing needs and disabilities ensuring their needs are met and their parent's and carer's are supported and aware of their needs. Services include:

- A community nursing team providing home based care.
- A special school nursing team providing nursing care in two special schools and providing a training package within these schools to upskill education staff and support the short breaks agenda for this cohort of young people.
- Child development centre team working with Education

The core service includes:

- Giving specific immunisations
- Taking blood samples
- Heights, weights, urinalysis, B.P.'s and other observations.
- Special school medicals.
- Record keeping in line with record keeping policy.
- Implementation and updating of individual care plans.
- Gastrostomy/ NG tube feeding.
- Changing of mic-key buttons.
- Tracheostomy care.
- Use of suction and oxygen.
- Care of the ventilated child.
- Administration of rescue medication.
- Administration of daily medications.
- Home visits.

- Multi-agency working.
- Supporting children and their families with complex needs in main stream and special schools.
- Training and regularly updating parents and members of school staff.
- Supporting families during school holidays by providing care in the home.
- Providing holistic care for all children with special needs.
- Supporting school staff by providing appropriate training around specific nursing needs and tasks whilst developing and maintaining competencies.
- Working in partnership with other agencies statutory, private and voluntary sectors in order to meet the complex health needs of children and their families.
- To promote social inclusion for families that through disability find themselves disadvantaged.
- Acting as a key worker for children and their families
- To identify those children who are at risk of being harmed either physically or emotionally and act accordingly in line with child protection policy.
- To contribute to the Common Assessment Framework and Team around the Child process to ensure that children's additional and safeguarding needs are fully identified and communicated.
- Plan for transition to adult services
- Confidential counselling to parents and families following child deaths

3.2.2 Care Pathway

- Any care pathway applicable to the service will be followed in line with the service users needs

3.2.3 Discharge Criteria and Planning

Children and young people who have long term complex needs or disabilities usually remain in the service until transition to adult services or end of life.
Arrangements for transition include:

- A full assessment of need comprising of the appropriate assessments and care required for the individual
- Health Action Plans completed in special schools for young people who have severe learning difficulties
- Handover to adult services where required

Children requiring short term care are discharged when they no longer require care.

3.2.4 Days/ Hours of Operation

Service	Days of Operation	Times of Operation	Comment
Main CCNS service & Clinical Suite	Monday to Friday	8:30- 17:00	Later or earlier visits can be arranged if required
Weekend CCNS Reduced Service	Saturday, Sunday and Bank Holidays	8:30- 17:00	Reduced service at weekends and bank holidays for essential calls only
Special School Service	Monday to Friday	8:30- 16:30	Term time only
Special School Service – short break support	Monday to Friday	After school and nights	Term time plus 3 weeks of the summer holiday (to be agreed amongst head teachers and

			Service Lead)
CDC Service	Monday to Friday	8:30- 15:30	Term time only

3.2.5 Prevention, Self-Care and Patient and Carer Information
A health action plan for will be developed for those young people who have a severe learning disability as part of their transition planning, This will contain health information on the patients' needs.
Leaflets with information on relevant conditions will be provided to the child and their family
Advice and training on nursing care will be provided for parents/carers

3.3 Population covered

The service is offered to those children who meet the criteria with the following population restrictions:

- Children and young people aged 0 - 18 (19 years for those attending special schools)
- Children and young people who are registered with a Wolverhampton City GP or registered with a collaborative commissioner GP
- Children and young people attending the two special schools within Wolverhampton, Green Park and Penn Hall

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Referral and Acceptance Criteria

Criteria for referral and acceptance onto the CCNS are:

- Children who require advice, support or nursing care for a health problem.
- Children and young people who are diagnosed with either chronic ill health, disability, or an acute illness
- Children with nursing needs in special school/nursery
- Children requiring emergency medication or tube feeding in special or mainstream schools
- Children with life threatening/ life limiting conditions
- Children requiring end of life care
- Children Looked after in special schools in Wolverhampton with nursing needs
- Children attending the Child Development Centre who have additional nursing requirements
- Children attending the Gem clinical suite for clinics
- Bereaved parents or siblings who are referred to the family counsellor.
- Children attending Penn Hall or Green Park Special Schools who need nursing support to enable them to attend Short breaks provision at the schools.

3.4.2 Referral Route
Patients can be referred by:

- Parents
- Health Professionals
- Special school staff
- Social care staff

Referrals can be made by:

- Sending a letter directly to the Gem Centre or
- By telephone

Referrals will be assessed to determine suitability prior to access to the service.

3.4.3 Exclusion Criteria
Children whose needs can be met by universal services

3.5 Interdependence with other services/providers

The Children's Nursing Service has relationships and interdependencies with many health and local authority services including, but not limited to:

- Wolverhampton safeguarding children's board
- Wolverhampton Social Care
- Wolverhampton Education and Learning Department
- Wolverhampton CCG and neighboring CCGs where children access the special schools who live out of area.
- Special schools
- Mainstream schools
- Acute services
- Community based services
- General Practitioners
- School nurses
- Education staff based at Penn Hall and Green Park School

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

All services and advice provided should comply with the following key legislation and guidance:

- Relevant NICE guidelines
- Relevant NPSA and MHRA safety guidance / alerts
- Association for Children with Life-Threatening or Terminal Conditions and their families, ACT (2004)
- Health lives, brighter futures ¡V The Strategy for children and young people¡¦s health, DH / DCSF (2009)
- Better Care: Better Lives, DH/CNO-DCF&M (2008)
- Aiming High for Disabled Children DH/DCSF (2007)
- Making It Better: For Children and Young People, DH (2007)
- NSF for Children, Young People and Maternity Services. Transition: getting it right for young people DH (2006)
- The National Service Framework for Long-term Conditions, DH (2005)
- Commissioning Children and Young People¡¦s Palliative Care Services, DH (2005)
- NSF for Children, Young People and Maternity Services. Disabled Children and Young, DH (2004)
- People and those with Complex Health Needs. Standard 8.
- NSF for Children, Young People and Maternity Services, DH (2004)
- Children and Young People who are Ill. Standard 6.
- DH (2003) Getting it right: National Service Framework for Children. Standard for Hospital Services.
- Every Child Matters (2003) HMSO
- Children and Young Peoples Plan
- Health lives/Brighter Futures (2009)
- The Children Act (2004)
- NHS at Home: children's community nursing services (DH, 2011)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- The NMC (Nursing and Midwifery Council) Standards and Codes of Practice

4.3 Applicable local standards

- Children's Services Case Studies and Best Practice, Improvement and Efficiency West Midlands (IEWM)
- All Trust policies and procedures and clinical Practices
- Wolverhampton Children and Young People's Plan 2006-2009.

The following waiting times are applicable to the Children's Nursing Services:

Priority Level	Response Time
Urgent	Day of referral or next working day
Non – Urgent	Contacted within 10 working days

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-D)
N/A

5.2 Applicable CQUIN goals (See Schedule 4E)
N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Gem Centre - Child Development Centre and Community Children's Nursing Service
Bentley Bridge Business Park
Neachells Lane
Wednesfield
Wolverhampton
WV11 3UP

Services are also delivered at:

- Green Park Special School
- Penn Hall Special School
- Mainstream or special schools as required
- Respite Centres
- Children's own home
- Residential centres
- Play schemes and nurseries

7. Individual Service User Placement

N/A

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 12th July 2016

Agenda item 15

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

Legend

	Level 2 RAPS breached escalation to executives and/or contracting
	Level 2 RAPs in place
	Level 1 close monitoring
	Level 1 business as usual

Key Issue	Level	Comments	Detail on page
Board Assurance Framework and Risk Register	1	NHSE published new CCG Assurance Framework in March 2016. CCG documentation is being brought in line with the new reporting requirements and all templates will be changed over from 1st August 2016.	
Escalated issues	2	Action: SBAR to Chief Nurse and Medical Director 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 avoidable grade 3 & 4s - close observation Monthly assurance sought at monthly CQR Meetings	6/7 7 8&9
Health Acquired Infections- CDiff	2	Increasing incidence of Cdiff, trust failed its 2015/16 target- close scrutiny	10-11
Performance	2	Meetings with RWT held	

Improvement notices impacting on Quality		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.	14
Sustaining Maternity Services at Walsall impact	2	Full Risk Assessmnet completed, go live 21st March. Needs close scrutiny of impact on Wolverhampton commissioned residents.	9/22 -23
LAC	2	Wolverhampton remains an outlier for number of LAC. There is a city wide strategy in place with improvements seen.	18
BCP Provider Performance:- Safeguarding/PREVENT 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 quarter intervals. Progress is being made and remains under scrutiny.	16&17
CQC Inspection Report	2	Rating 'requires improvement' for RWT. Action Plan completed March 2016; however the Trust is still awaiting the final report.	12

CQC General Practice	1	Practice has had a re inspection, have achieved good overall. 2 practices are being supported for 'requires improvement'	12
Mortality	1	Within expected limits, some data cleansing and audits being conducted.	13&14
Falls	1	Improvements seen in number of falls causing serious harm. CCG will maintain focus	7

1. **BACKGROUND AND CURRENT SITUATION**

The CCG's Quality and Safety Committee meets on a monthly basis.

This report is a material summation of the Committee's meeting on 14th June 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 Clinical Quality and Patient Safety, in accordance with the CCG's 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.

3.0 CURRENT SITUATION

3.1 Weekly Exception Reports

Weekly Exception Reports continue to be issued 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:

- Increasing trend of avoidable pressure ulcers was agreed to be escalated to the Governing Body at the Q&SC meeting held in June 2016.
- RWT Final CQC Report is still awaited (is now much later than expected, CQC acknowledge that there is a delay in their process).
- Vocare incident reported death of patient which occurred whilst in their care. Awaiting cause of death from post mortem and findings of full investigation. A planned quality visit is being planned to Urgent Care Centre. This incident, root cause and actions will be factored into the meeting.
- Several incidents of norovirus were reported at RWT in May and June, this is now under control. The persistence occurrence on one ward was identified as not enough time being allowed for cleaning (due to bed pressures). Appropriate action taken and at the time of writing this report, the affected ward is clear.
- BCPFT reported an IG breach incident, this is currently being investigated as the stakeholders include legacy Wolverhampton PCT, BCPFT and Wolverhampton Local Authority.
- A confidential safeguarding issue was raised to the CQC by a member of staff at the provider trust. This is being investigated by CQC and the CCG and LA will form part of the panel to hear evidence after investigation and action plan details from the provider trust in mid-July. The Governing Body will be kept appraised of outcome

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

The current CCGs internal assurance framework sets out the business critical factors for the CCG to deliver its essential functions, and in turn allows the CCG to identify any risks that may impact on its ability to deliver the national requirements. It is based upon the national Assurance Framework and associated key lines of enquiry, combined with local priorities the for the CCG relating to quality and transformation.

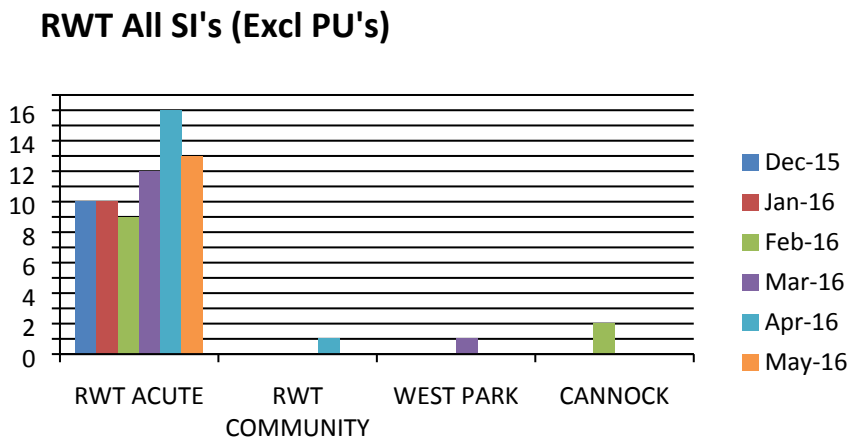
The national Assurance Framework changes each year and for the 16/17 a new 'CCG Improvement and Assessment' regime has been published.

It was agreed at a previous Governing Body meeting that quarterly updates on the BAF and Red Risk Register would be incorporated into the Quality and Safety Executive Summary.

4.0 THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

13 new Serious Incidents were reported by RWT in May 2016, this includes 1 Never Event



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

- Sub optimal care of patient transferred to another hospital
- Delays in diagnoses
- delay in commencing treatment
- Patient identifiable data loss

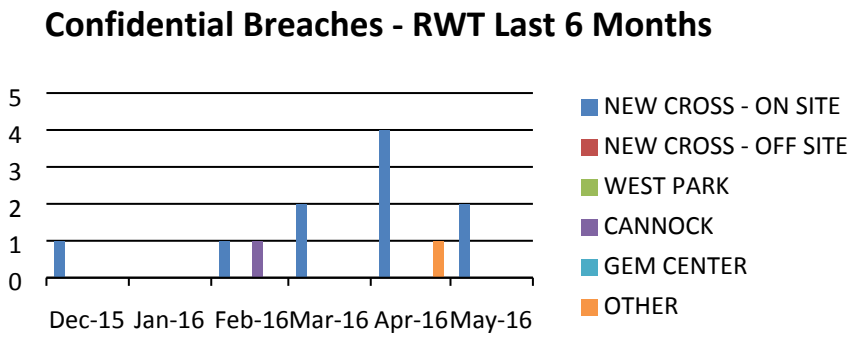
Assurance sought-these issues have been discussed at several CQRMs without satisfactory assurance. In June the Trust informed the CCG that they are commissioning an external review of all incidents related to emergency care pathways. The timescale for the completion of the review is September 2016. The

terms of reference for the review will be shared with the CCG at the July CQRM and will include the following:

- Determine which pathway most incidents occur in
- How has the outcomes of the Human Factors workshops affected performance and attitudes in these areas
- Determine if there is one member/team/professional group who is/are causing this effect – this has been excluded as determined as not a factor
- Does the excess use of locum staff in A&E compound the issue?
- 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.

4.2 Confidential Breaches

In response to the actions that were taken following a series of information governance breaches in November 2015, the Trust launched an awareness raising campaign in February 2016. This saw a surge of incidents in March and April. Whilst May saw some improvement, close scrutiny is being applied to observe the direction of travel in June and July.



4.3 Never Events

1 Never Event was reported by RWT in May 2016:

This was an incident related to a retained gauge swab following a normal delivery. No harm was reported, however, in line with national reporting requirements the Trust are undertaking a full RCA which will examine the use of the WHO Safer Surgical Check List on this occasion.

Total NEs for 15/16 was 3 and YTD 16/17 is 1.

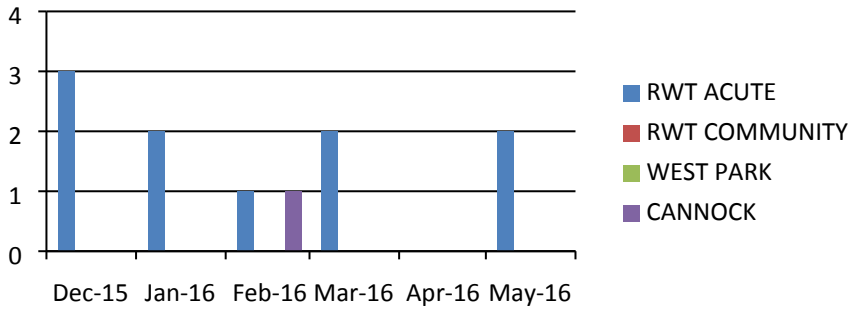
4.4 Slips Trips and Falls

There were 2 slip/trip/falls incidents meeting the SI criteria reported by RWT in May 2016, both occurred at New Cross Hospital. This is a sustained improvement over the last six months and is being monitored closely. There have been zero reported falls at West Park or Community in the last 6 months and 1 at Cannock Hospital in the same time frame.

The launch of the renewed Falls Steering Group is making good progress and key changes have been implemented across all sites;

- Standardisation of policy and process
- Standardisation of assessment technique and paperwork
- Renewed enhanced care training for patients being nursed on 1:1

Slip/Trip/Falls - RWT - Last 6 Months



4.5 Pressure Ulcers Grade 3

Previously, the Governing Body was appraised of the launch of a Health Economy Pressure Ulcer Prevention Steering Group launched by the CCG in February. Since the initial meeting, all stakeholders have undertaken a gap analysis.

Actions highlighted from the May Health Economy Pressure Ulcer Prevention Group include:

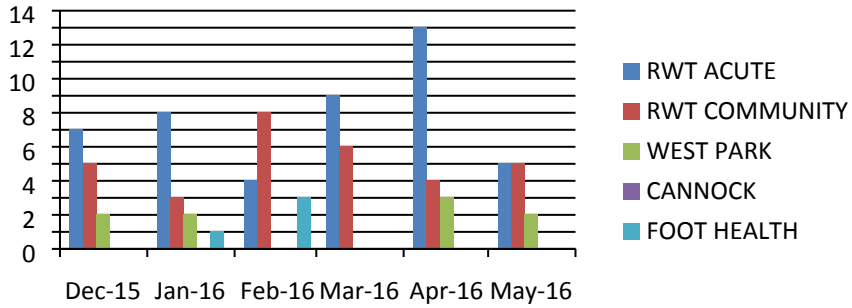
- Training - all health care staff should receive consistent training in prevention, decision making/judgements & include opportunities to develop competency.
- Who/how to refer onto other health care providers/sectors to address gaps that currently exists.
- Information – should clearly define who does what and who to escalate to.
- Communication - eDischarge to be improved to include wound care needs/implications.
- Peer support/advice for Practice Nurses.
- Wound Care Pathway to be reviewed

- Formulary - Compression Therapy Review, changes to products and skills will have implications for health economy, change process should include implementation & training cascade to all stakeholders.

In May 2016, 12 Grade 3 Pressure Ulcers were reported by RW; 5 at RWT site, 5 in the Community and 2 at Cannock Chase Hospital.

This is a reduction in the number (20) reported in April 2016.
All are progressing through the RCA process.

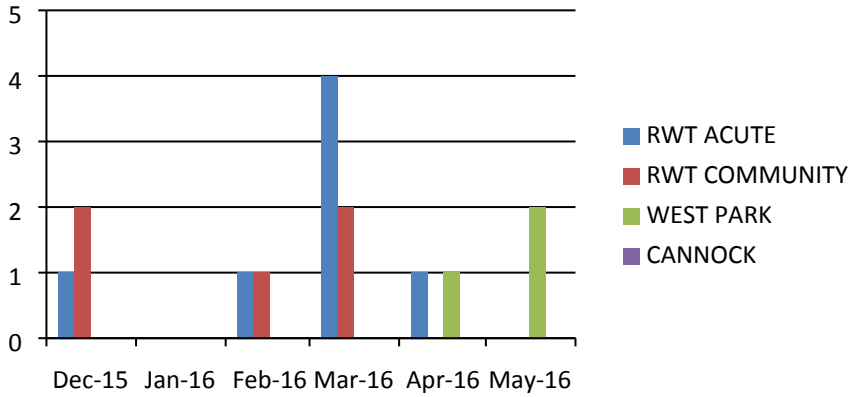
G3 Pressure Ulcers - RWT Last 6 Months



4.6 Grade 4 Pressure Ulcers

Two Grade 4 Pressure Ulcers were reported by RWT in May 2016, and they both occurred at West Park. This is encouraging and means that pressure ulcer deterioration initiatives are in place and early data is showing to have a positive impact.

G4 Pressure Ulcers - RWT Last 6 Months



4.7 Health Care Acquired Infections

Clostridium Difficile- escalated to Level II

The Trust has breached the number of CDiff cases for 2015/16 with an overall performance of 74 versus target of 35. The 2016/17 target has been set at 71.

- There have been no MRSA Bacteraemia cases reported within the quarter.
- C Difficile objectives are challenging for Wolverhampton and the Trust has breached its year-end target with 74 actual V target of 35.
- Whilst some improvements have been observed there were 11 cases reported in May
- The Trust's Cdiff action plan continues to be progressed, ensuring environmental audits, deep clean and staff training is achieved. Work also continues to monitor the number of patient moves between wards and cross infection.
- Fidaxomicin continues to be used for first line recurrences and Human Probiotic Infusion (Faecal Transplant) is also available. Three cases have been successfully undertaken since pilot in 2014 i.e. in these 3 cases there has been no further reported reocurrence
- The year-end position for cases deemed avoidable will be confirmed at July Contract Review Meeting and will reflected in the corresponding reports to each forum.
- There have been isolated cases of noro virus since the last quarterly report; all have been managed as per incident protocol, historically there has been a correlation with Noro Virus followed by outbreaks in CDiff
- Increasingly more toxin positive cases are not the same ribotyping; this excludes cross infection.
- An external review of antimicrobial prescribing guidelines was also due to take place in April 2016, this has been delayed. The Trust is however undertaking an anti-microbial prescribing study across the health economy. The CCG and Public Health are in discussions with the Trust to know more about this. In the meantime the current action plan activities are being sustained and monitored via IPCG and CQRM.
- In September, the Trust is working with PHE to undertake a point prevalence survey. The PPS audit will be carried out at acute Trusts in the UK and Europe. The information collated will inform and improve the understanding of local, national and European wide

    - Occurrence of HCAIs
    - Quality of antimicrobial prescribing
    - Quality of antimicrobial stewardship

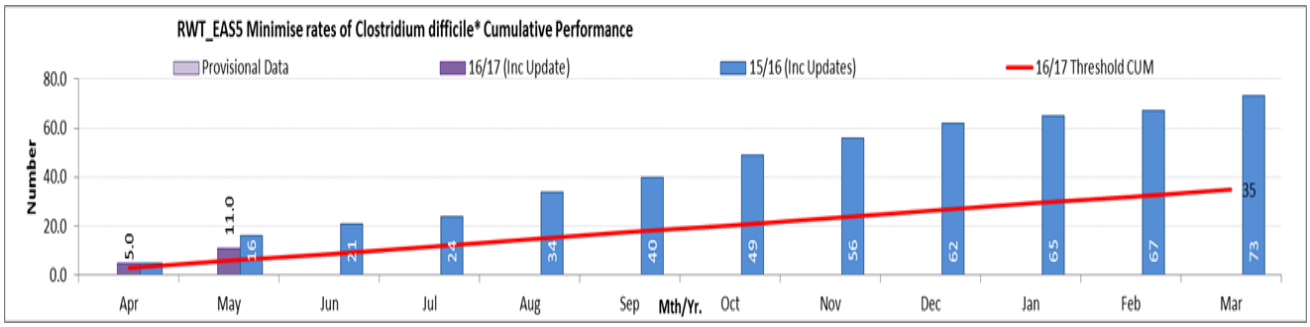
Assurance

- 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 i.e. correlation with poor audits and cdiff incidents
- The CDI rate remains high and exceeds the control limit on SPCC funnel plot against the region which is being looked at as there are some discrepancies on how RWT test stool specimens compared to others in the region. Some improvement was seen in January & February 2016, March (5) April (5) and May (11). Of these 11 there were no same ribotypes which suggests there was no likely cross contamination by staff but environments continue to be a cause for concern.
- Key action from ward audits is the Trust training and education compliance for IP level 1, 2 and hand hygiene. A rapid improvement plan starts on June 27th for 6 weeks.

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.

Cdiff 2016/17 cumulative performance (ytd)



4.8 West Midlands Quality Review Service

There are currently no active action plans from reviews. All are complete and closed. There is an ongoing programme of reviews planned for 16/17 and there is a robust system in place for the CCG to be involved from planning to closure.

4.9 Quality

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

4.10 NHS Safety Thermometer

a) Harm free care % of harm free care for RWT for 12 month period, April 2015 to April 2016. RWT's harm free care rate for April was 92.63%. Specific areas of harm are related to pressure ulcer and catheter acquired urinary tract infections.

Assurance: data from several sources has been triangulated. The Trust is reviewing the ward dashboards to identify key themes. This remains amber for close scrutiny at present until a step change is seen and sustained.

4.12 Regulator concerns

The Governing Body has previously been appraised about the 2015 CQC inspection at RWT. The Trust appealed its position of 'requires improvement' and a response from CQC is still awaited. In the meantime, a full and very comprehensive action plan is in place and is monitored at CQRM.

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

BCPFT CQC Risk Summit was held in May. A substantial action plan is in place and this is being monitored at CQRM and Contract Meetings. The Governing Body will be kept appraised of any exceptions.

4.13 Primary Care Joint Commissioning Committee (PCJCC)

The Primary Care Liaison Group has now morphed into The Primary Care Operational Management Group. Discussions from this meeting are shared with the PCJCC.

As part of the improving quality in primary care initiatives, the CCG has considered what other support can be given to practices and how this would be delivered and monitored. A Primary Care Quality Assurance Coordinator role has been created and recruited into. The incumbent will work closely with the new Head of Primary Care in assuring systems and processes to improve quality of care in primary care to successfully deliver the CCG Primary Care Strategy and is expected to commence employment in September.

Assurance – monthly overview reports from the PCOMG to the Primary Care Joint Commissioning Committee (PCJCC) to monitor areas of escalated concern have commenced.

4.14 Mortality

NHSE continue their collaborative work with CCGs and they introduced enhanced monitoring and review of mortality data associated with avoidable deaths in primary care. 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 that met on 22 March 2016. A Memorandum of Understanding for sharing information across the health sector is being developed. The CCG are working with the Trusts to have a shared approach on sharing coroner concerns at CQRMs.

The mortality alert associated with Chronic Kidney Disease alert is now closed, the re-run of date provided by the CQC showed a decrease in Standard Mortality Rate and the Trust have received formal notification from the CQC that this alert is now closed.

There are no other formal alerts for mortality, as standard practice now, the Trust is constantly reviewing their internal alerts and summaries are presented at MORAG meetings.

The Trust Mortality Assurance Review Group was cancelled in June and the next one is rescheduled for July. In previous meeting the following areas were noted:-

- Mortality alerts & audits have been undertaken for Pneumonia, acute renal failure and acute kidney injury and found no avoidable deaths in each cohort
- Coding reviews have identified areas where improvement could be realised is primary diagnosis was incorrect
- Reviews are planned for the following groups; intestinal infection, other liver diseases, acute myocardial infarction, phlebitis (thrombophlebitis and thromboembolism)
- The trust has also completed a self-assessment requested by NHS England which estimated the avoidable mortality with a trust based on trusts data and results from research conducted across England and further guidance is expected shortly.

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 next MORAG meeting is on 5th July; at the time of writing this report latest data was not available.

4.15 Workforce

Further to an extra ordinary meeting regarding safer staffing held in January 2016, attended by TDA and the CCG the trust continue to progress a series of work streams and developments in responses to the challenges they face associated with recruitment and retention of their staff, these include:-

- 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. The Trust has closed 6 beds on Ward 3 at West Park Hospital as a direct result of staffing issues impacting on quality of patient care. Ward 3 is currently staffed by an intensive support team of 6 senior nurses from RWT, this is not sustainable. It is envisaged that the Trust will scale down on bed usage in the coming weeks and months and then close the ward.

The CCG Primary Care Workforce Analysis has commenced in March and is due to conclude in July 2016. A full report will be shared with the Governing Body once this is available post completion of the work.

5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST Level of Concern as of 31st May 2016

Black Country Partnership	
Month	**Concern Level and Actions**
May 2016	**Level 2 – Recent CQC inspection rated the Trust as Requiring Improvement. BCPFT has an action plan in place and has now shared this with WCCG. Concern level to be reviewed following re-inspection by CQC.**

a) PREVENT Training

Remedial action plan agreed June 24th June. This will be monitored via CQRM and Contract Review Meetings.

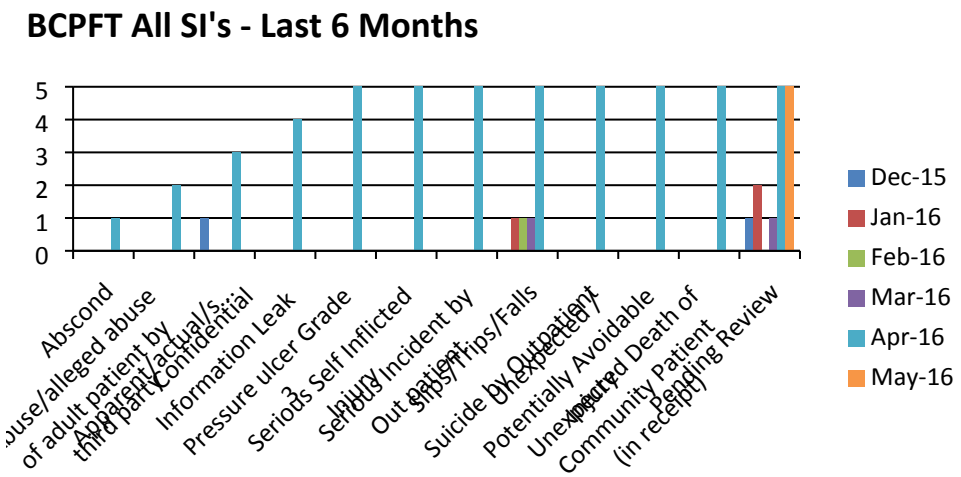
b) Early Intervention Service

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.

Please also refer to remedial action plans in place for Royal Wolverhampton Trust pertaining to A&C Recovery, Cancer Recovery & E-discharge.

5.1 Serious Incidents

There were 5 incidents reported in May 2016.



5.2 Never Events – zero reported

5.3 Falls – zero falls were reported.

5.4 Numbers of Overdue SI's – zero

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

5.6 NHS Safety Thermometer

BCPFT's harm free care rate for May 2016 was 99.32%. This is in line with previous performance.

5.7 Items to Note from Clinical Quality Review Meeting

The theme of the quality review meeting which took place in May 2016 was CAMHS theme. Key areas to note were:

- No incidents of serious harm were reported
- Staff sickness for the group is 6%
- Vacancy rate for the group is 16.7%, this is an increase from the previous month
- Improved picture for friends and family test
- Joint action plan for no improvement seen on staff survey
- One formal issue addressed via contracting team re post discharge care of patients on certain medication.

6.0 OTHER SECTORS

6.1 Compton Hospice – CQRM held, no issues of concern noted. A CQC inspection also took place in May, this report is not yet available.

6.2 Vocare - took over the Out of Hours Service at 8.00 am on 1st April 2016. Informal CQRMs are taking place on a monthly basis to review the service. One SI has been reported by Vocare, this is currently being investigated. A scheduled quality visit is being planned for the near future.

7.0 CHILDREN'S SAFEGUARDING

7.1 **Serious Case Reviews**

On 21 March 2016 Wolverhampton Safeguarding Children Board published the findings of a serious case review following the death of a child in January 2014 as a result of severe malnourishment, bronchopneumonia and rickets. Her parents admitted manslaughter and were jailed. The report makes a number of recommendations including ensuring professionals have a better understanding of how religious beliefs may impact upon a child's health and development; improving the way agencies work with families who are reluctant to engage with services; the for better information sharing and recording and the importance of reassessing an individual's circumstances when new events or information come to light. All recommendations have subsequently been implemented.

7.2 Section 11 Audits are currently being undertaken across the health economy. Primary Care are also required to be engaged in these, we are hoping for good levels of responses and the Safeguarding teams are available for additional support.

7.3 Looked After Children

The number of LAC continues to show a positive decrease, Wolverhampton CCG remain active partners within multi agency arrangements and core corporate duties and responsibilities. The following table demonstrates the number of LAC for the month of May 2016

	Number	%age
Wolverhampton City Council	**270**	**41.4**
Dudley Metropolitan Borough Council	46	7.1
Sandwell Metropolitan Borough Council	30	4.6
Walsall Metropolitan Borough Council	45	6.9
South Staffordshire Council	36	5.5
All in Adjoining LAs	**157**	**24.1**
Anywhere Else - not in W'ton or in Adjoining LAs	**225**	**34.5**
TOTAL LAC	**652**	**100**

8.0 ADULT SAFEGUARDING

8.1 The Quality and Safety Committee received a detailed assurance report on adult safeguarding, comprising the following key points:-

- Wolverhampton Safeguarding Adults Board
- Mental Capacity Act /Deprivation of Liberty Safeguards (MCA/DOLs)
- Adult MASH
- Domestic Homicide Review Standing Panel
- Safeguarding Adult Review Committee
- NHS England Safeguarding Projects

The report also detailed assurances regarding quality indicators in provider contracts and how improvements had been made in 2016/17 contracts and the introduction of an Assurance Framework for Services commissioned by the CCG to provide consistency in reporting, eliminate duplication and identifies timings for the provision of information. The report was fully accepted by the committee.

The CCG has recruited to the post of substantive, fulltime Designated Adult Safe Guarding Lead, the successful incumbent will be commencing the new role about September.

9.0 CARE HOMES

The CCG's Quality Nurse Team continue to work closely with the Adult Safeguarding Team at the Local Authority and to oversee 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
Wrottesley Park	PL
Parkfields	F

Assurance – there is a robust system in place whereby safety concerns such as safeguarding, care home acquired pressure ulcers, falls and frequent attenders to A&E are monitored. The Quality Nurse Advisors have a schedule of 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 sustained improvements are made and can be evidenced. In future homes in suspension will be recorded on the CCGs risk register in addition to the tracking that takes place via the SBAR process.

Under an Any Qualified Provider (AQP) process Arden & GEM (CSU) Commissioning Support Unit managed the procurement process on behalf of Wolverhampton CCG for care home commissioned care. This opportunity advertised in Contracts Finder opened 1stFebruary 2016 and closed on the 4th March 2016. Nine contracts have been awarded and will run for an initial 3 year period from 1st July 2016 to end of June 2019.

10.0 ADDITIONAL ASSURANCE INFORMATION TO NOTE

10.1 Supporting Walsall Maternity Services

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

Increased activity commenced on 21 March, mothers from 6 practices identified on the Wolverhampton and Walsall border have been booked for their maternity care to

be met at Royal Wolverhampton Trust. Both CCGs are working closely with the trust to ensure patient safety standards are maintained.

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.

Further plan:

June: Walsall maternity capping monitoring meeting now completed.

July: Commence Black Country data collection exercise for maternity services and commissioning semi structured interviews re: maternity services.

End of July: Commissioning stakeholder event for maternity services. Share commissioning response, in consideration of agreeing scope for Business Case going forward

11.0 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.

12.0 QUALITY AND SAFETY COMMITTEE

At the Quality & Safety Committee Meeting held in June, information from Quality Review Meetings held during the month of May 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.

13.0 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.

14.0 Risks and Implications

14.1 Key Risks

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

14.2 Quality and Safety Implications

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

14.3 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.

14.4 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.

14.5 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 and Quality**
Date: **27th June 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	**Dr Rajcholan**	**28.6.16**
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**	**June 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**	**28.06.16**

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WOLVERHAMPTON CCG

GOVERNING BODY
12th July 2016

Agenda item 16a

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 31st May 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 noted that opening budgets for 2016/17 are now loaded to the ledger and all budgets are signed off by budget managers. The CCG is awaiting formal notification that it will be allowed to utilise £800k of the non-recurrent drawdown as per the submitted financial plan.

2. QIPP

The Committee noted the QIPP target for 2016/17 is £11.2m of which 80% (£9.0m) has been identified.

3. 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. The Committee noted the new requirement to submit a monthly return to NHS England relating to procurements that have either commenced or are due to commence.

4. PERFORMANCE

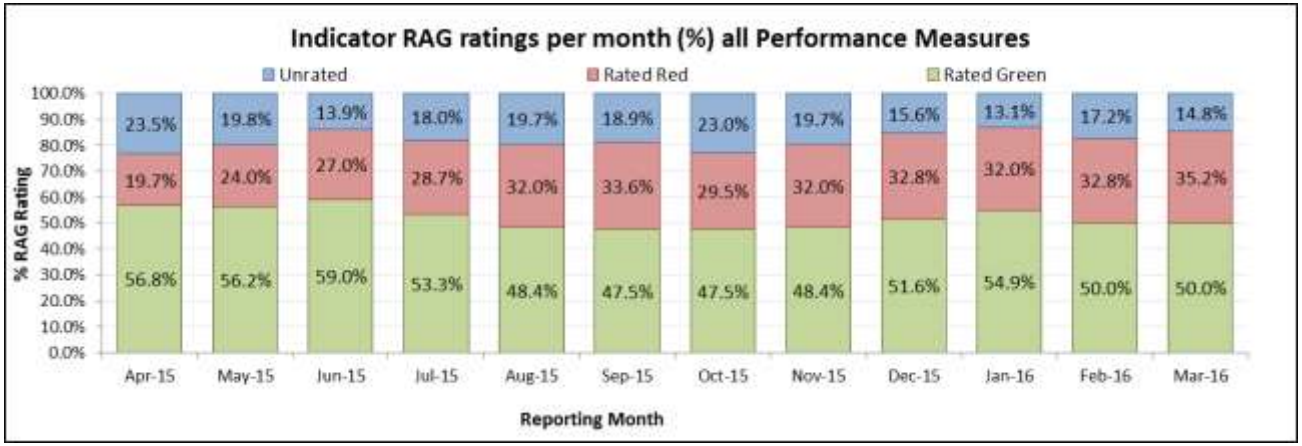
The following tables are a summary of the Month 12 2015/16 performance information presented to the Committee;

Executive Summary - Overview

Mar-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	16	16	11	10	1	2	**28**
Outcomes Framework	16	18	11	13	10	6	**37**
Mental Health	29	27	18	20	10	10	**57**
Totals	**61**	**61**	**40**	**43**	**21**	**18**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	57%	57%	39%	36%	4%	7%
Outcomes Framework	43%	49%	30%	35%	27%	16%
Mental Health	51%	47%	32%	35%	18%	18%
Totals	**50%**	**50%**	**33%**	**35%**	**17%**	**15%**



Exceptions were highlighted as follows;

Executive Summary - Commentary

Key:
See individual exception report

Mar-16

NHS Constitution

16 of the 28 Indicated areas are rated green. There were 2 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 9th consecutive month 79.00% - SQPR report and unconfirmed) against the 90% target. This is a 0.61% 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 March at (92.00%). The CCG will continue to monitor Admitted and Non Admitted levels locally.
Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 8th consecutive month 93.95% - SQPR report and unconfirmed) against the 95% target. This is a 0.59% 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 March at (92.00%). The CCG will continue to monitor Admitted and Non Admitted levels locally.
Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	This indicator remains under the 95% target and has breached both in month (90.32%) and Year End (91.89%). Attendances have continued to increase with an additional 1,742 (14.6% increase) attendances in March compared to 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 (RAP) trajectory for 16/17 has been aligned to the STF (Sustainability and Transformation Fund) improvement trajectories with the 95% target proposed to be met by July 2016. By end of May16 the RAP indicates that the recruitment of an additional 37 Senior Sister posts for 24/7 cover should be completed. Other Actions include: Embedding PWC work programme across acute, local authority and CCG, to impact positively on Delay Transfers of Care and improve flow. Co-located Urgent Care Centre is live from 1st April 2016 including streaming of ED patients to appropriate Primary Care clinicians. Discussions are taking place to share information between the ED and UCC to ensure safe transfer of patients and reporting activity against the 95% target. The Trust failed to achieve both Type I and the All Types target for the month and the predicted fine for this is £95,280.

Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator has breached the 94% target in month for March (90.63%) and Year End (92.54%) due to previous performance in month breaches (May, August, September, October and March). This indicator is affected by small number variance's with breaches impacting against a small cohort of patients. Validated figures for March have confirmed that there were 3 patient breaches (out of 33) and the Trust have confirmed that all breaches for this indicator in March 16 were due to delays in Urology. Figures have been confirmed and validated as 90.91% for March and remains below target. The CCG position for March for this indicator is 100% (22 patients all seen within standard).

Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	The Trust have responded to the CCGs GC9 initiation discussions and have proposed that taking the full 2% of monthly contract value would be disproportionate and would seek some resolution on the proportion of the permanent retention. The Trust has responded "Given that of the 9 indicators for cancer, three were not met, we would request this is taken into account for any permanent retention and would propose a cap of 0.67%. This would minimise the impact for the Trust which is currently working hard to achieve 62 day targets in very challenging circumstances. You will be aware that nationally, Urology remains a significant challenge and the service is currently putting significant additional activity, where possible, to maximise performance and avoid patient breaches". Majority of actions from the remedial action plan have been completed, however, they are not having the impact expected. A recovery trajectory has been put in place (to hit by June16) although the Trust has advised the current trajectory will be difficult to achieve in the current climate. Further Actions: Additional clinics have been scheduled and changes to pathways e.g. diagnostic tests taken place earlier. Capacity issues continue to be primary concern with Urology still the main concern (national issue) given the lack of consultants and inability to recruit to vacancies. The Trust has continued to offer robotic procedures even though there is a capacity and waiting list issue (patients opting to wait longer, even though they could breach waiting list targets). The intensive support team have visited and a draft report with recommendations is with the Trust. The CCG will be provided with a copy of the report as soon as possible. Initial review suggests there isn't one answer to fix all the issues. The Trust have also received noticed of revised national guidance with regards the 62 day pathways, which primarily relates to a revision of the apportionment of fines - e.g. fair warning on forwarding referrals – current local guidelines stated tertiary referrals had to be passed on within 42 days of the initial referral, however new guidance has been reduced to within 38 days. Guidance states that if a patient breaches the 38 day limit and then subsequently the 62 day target, then the referring organisation will get the full fine, if the patient referral meets the 28 days target, but breaches the 62 day target then the receiving organisation will receive the full fine. It was noted as part of the CQRM meeting that there could be issues with this methodology when dealing with complex care patients. 16/17 is to be performance managed as a shadow year (to embed) and will be monitored and reviewed for 17/18.

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 met the 90% target for March (91.30%) however has failed to met the Year End (87.49%) due to previous poor performance levels over the year (only achieving 4 out of the 12 months). A Remedial Action Plan has been agreed with the Trust and is aligned with STF Plan Trajectory and constitutional planning submissions for 16/17. Plans remain to deliver against standard by June 2016. This indicator is affected by small number variances with breaches impacting against a small cohort of patients. Performance had previously seen significant improvement (with December reporting 100%), however performance continues to fluctuate and performance for March has increased 19.3% since February. The Trusts validated figures for March have been confirmed as 92.3% and above target, however the CCG position has been confirmed as 88.9% and below target. The CCG breach relates to 1 patient (out of 9).
Rates of Clostridium difficile	The C-Diff performance in Month 12 brings the Year to Date number of breaches to 73 and has breached the full year threshold set for RWT by NHSE of 35. There were 9 positive cases by toxin test, 6 of these were attributable to RWT using the external definition of attribution. Fidaxomicin continues to be in use for recurrences and is encouraged by the Consultant Microbiology Team, there have also been 3 faecal transplants successfully undertaken. All CDI's are monitored locally at the monthly Clinical Quality and Safety Review Meetings and via the Incident Scrutiny Group. 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). The Trust has included a C-Diff positive cases major interventions and impact graph as part of the monthly CQRM to highlight the effects of actions. The RWT C-Diff total for March comprises of 4 x Wolverhampton CCG patients, 1 x South East Staffordshire and Seisdon Peninsula CCG and 1 x Stafford and Surrounds CCG. The Wolverhampton CCG view (Acute and Non Acute) for March is 7 (6 x Royal Wolverhampton, 1 x Royal Orthopaedic Hospital). The full year C-Diff position for Wolverhampton CCG is 86 (45 Acute, 41 Non Acute).

All handovers between ambulance and A & E must take place within 30 minutes	Month 12 breached the zero target with 49 breaches (within 30-60 minutes) and this is an improvement in performance from the previous months performance (of 79). March has also seen an improvement in the >60minute with only 2 breaches down from 13 in February. The cumulative position for 15/16 is still ahead of last year's position (76 fewer breaches overall this year). There were no patients who breached the 12 hour target during March. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department - Embedding PWC work programme across acute, local authority and CCG, to impact positively on Delay Transfers of Care and improve flow. - Further work with the voluntary sector to aid: 1) Increased capacity and slightly amended service spec for the supportive discharge service, 2) Intervention specifically targeted to the Refugee and Migrant population to promote better use of GP services as an alternative to A&E. SRG agreed to fund for a further 12 months. - Co-located Urgent Care Centre live from 1st April 2016 including streaming of ED patients to appropriate Primary Care clinicians. On-going plans to share information between ED and UCC to ensure safe transfer of patients and reporting activity against the 95% target. The total fine for ambulance handover during March is predicted at £11,800. This fine is calculated on 49 patients between 30-60 minutes @£200 per patient (£9,800) and 2 patients >60 minutes @£1,000 per patient (£2,000).
All handovers between ambulance and A & E must take place within 60 minutes	Month 12 breached the zero target with 2 breaches (>60 minutes), however this is an improvement in performance from the previous months performance (13 in February). March has also seen an improvement in the 30-60minute with 49 breaches down from 79 in February. The cumulative position for 15/16 is still ahead of last years position (23 fewer breaches overall this year). There were no patients who breached the 12 hour target during March. The total fine for ambulance handover during March is predicted at £11,800. This fine is calculated on 49 patients between 30-60 minutes @£200 per patient (£9,800) and 2 patients >60 minutes @£1,000 per patient (£2,000).

Trolley waits in A&E	There were no 12 hour trolley breaches for March, 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. The CCG Quality and Risk Team have confirmed that this breach is no longer on STEIS.

Outcomes Framework

18 of the 37 Indicated areas are rated green. There were 6 unrated indicator(s) - eg. data not received. The 13 red rated areas are :

Description	Commentary
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). March data indicates a 0.52% increase in performance to 95.10% for all wards (excluding assessment units) and has met the 95% target in month, however has breached the Year End (94.21%). It should be noted that the assessment units (see LQR2b) saw a 1.66% decrease from the previous month (82.5%) and is below target in month. The performance for both indicators remains below target on the YTD performance. The RWT clinical director has arranged a meeting on the 8th April to discuss issues, training and identify areas of concern. Stringent performance management is in place to identify issues. There is no fine for all wards (excluding Assessment Units) and a predicted £5,000 combined total fine (including Assessment Units)

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). March data indicates a 1.66% decrease in performance to 82.5% (excluding assessment units) and has failed to meet the 95% target in month, and has also breached Year End (80.81%). It should be noted that the assessment units (see LQR2a) saw a 0.52% increase from the previous month (95.1%) and met target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the April CQRM meeting at RWT: A meeting has taken place in Emergency Services, specifically with PAU regarding discharge of patients in evenings to resolve issues. The RWT clinical director arranged a meeting for the 8th April to discuss issues, training and identify areas of concern. Stringent performance management is taking place to identify issues. It has been confirmed that a meeting has taken place to discuss the remedial action plan and there are currently two main areas of concern which are being reviewed : 1) Assessment areas do not have admin support during the evening 2) Gynaecology discharge to GPs and not midwives. There is no fine for all wards (excluding Assessment Units) and a predicted £5,000 combined total fine (including Assessment Units)
Serious incidence reporting - Report incidences within 48 hours	This indicator has breached in month (1) and Year End with a total of 5 breaches. 2015/20802 - June15, Slip/Trip/Fall, 2015/22544 - Jul15, Sub-optimal Care, 2015/30119 - Sept15, Pressure Ulcer Grade 3 (overturned), 2015/34262 - Oct15, Slip/Trip/Fall, 2016/1830 - Jan16, Slip/Trip/Fall, 2016/7868 - Mar16, Pressure Ulcer Grade 4 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 did not breach in March, however has breached Year End with a total of 11 breaches. 2015/13684 Pressure Ulcer (Grade 3), 2015/18918 Sub-optimal care of the deteriorating patient, 2015/20082 Pressure Ulcer (Grade 3), 2015/20700 Pressure Ulcer (Grade 3), 2015/22136 Pressure Ulcer (Grade 3), 2015/25934 Sub-optimal care of the deteriorating patient, 2015/29091 Pressure Ulcer (Grade 3), 2015/34203 related to a Treatment Delay report, 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) Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings.
Serious incidence reporting - Share investigation report grade 2 within 60 days	This indicator has breached both in month (2) and Year End (12) against the zero target for 15/16. The March breach related to : 2016/22368 - Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria 2016/255 - Suboptimal Care of the deteriorating patient Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. The fine for this breach is estimated to be £750.
% of patients requiring assistance to eat at mealtimes receive the necessary assistance	This indicator has failed to meet the 90% target for the first time this year (86.00%). The Trust have confirmed that the March 16 reported performance was affected by a corrupted data file, the Trust have confirmed that the data is non recoverable and although the Trust believe the true performance to be within target are unable to confirm this via the data. The issue will be raised at the CQRM meeting as the CCG require assurance that future performance is accurately reflecting the true performance situation.

% 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 to March performance have seen significant improvements and have all achieved 100%, however the Year End performance is below the 98% target (95.24%). 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 clinical staff working in health care settings to have up to date level 3 Safeguarding Children training - all clinical staff who have any contact with children, young people and/or parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns	This indicator failed to achieve the 85% target in month (77.99%) however, has achieved the Year End (85.50%). As per the March CQRM minutes, RWT have confirmed that training will be reviewed and how it is delivered. The predicted fine for this March breach is £5,000.
% 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 (97.22%). 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 86.23% for March (a 6.76% increase from previous month). Attendances have continued to increase with an additional 1742 (a 14.6% increase) 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 (RAP) trajectory for 16/17 has been aligned to the STF (Sustainability and Transformation Fund) with the 95% target proposed to be met by July 2016. The March daily performance indicates the highest performance for the month was 95.5% (Sunday 27th March) and the lowest as 62.6% (Sunday 6th March). The Trust failed to achieve both Type I and the All Types target for the month and the predicted fine for this is £95,280.
% of women booked by 12 weeks and 6 days	This indicator has failed to meet the 90% target both in month (87.80%) and Year End (89.23%). It was noted at the April CQRM meeting that maternity figures now include Walsall bookings. The Trust have recurited 8 new midwives and the CCG will montor performance for improvements.
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 March, however, this indicator has already breached the annual target of zero this year due to the 4 previously reported Never Events. These included : 2015/24026 - Retained Swab 2015/30332 - Drain inserted into wrong side 2015/31339 - Lucentis injection in wrong eye 2016/3315 - Wrong Site Surgery (Wrong Tooth Extracted) - note this has since been reviewed and removed from STEIS
Category A calls resulting in an emergency response arriving within 8minutes – Red 2	This indicator failed to meet the 75% target for the first time in February and although has seen an improvement is still failing in March (74.40%). However, performance has met the Year End target reporting at 77.72%.

Mental Health

27 of the 57 Indicated areas are rated green. There were 10 unrated indicator(s) - eg. data not received. The 20 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 achieved the 95% target in month for March reporting 95.00% of CPA follow ups within 7 days, it has however, breached Year End (93.48%). There were 2 breaches (out of 40) that were not followed up within the 7 days. Staff within the inpatient wards have been reminded of the process that should be followed when patients are discharged from, specifically around ensuring that the relevant contact information is obtained from the patient and entered on to CareNotes. Continuous daily monitoring continues to take place throughout the teams.
MH Evidence of using HONOS: Proportion of patients with a HONOS score	This indicator has breached the 95% target in month (94.73%), however has achieved the Year End at 95.27%. The Trust have highlighted that the key issues in underperformance are due to clinic cancellations (due to the Junior Doctors Strikes), Staff Sickness and the an increase in demand. Reminders have been communicated to all medics and CPNs regarding the importance of recording the HONOS at all stages (including the reviewing of assessments to ensure HONOS is undertaken at the earliest opportunity). The Trust continue to manage staffing levels to ensure clinics/assessments are maintained.

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 each month since April 15 with March achieving 0% (numerator = 0, denominator = 4). 24 assessments appointments were offered in March and there were 9 DNAs during the month. DNA reasons included : Arrived too late, DNA (no reason offered), DNA (moved out of area), DNA (no fixed abode), DNA (letter arrived on day of appointment. The Team continue to text message and call 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 appointment date. The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target, however due to mandated Family Intervention training undertaken by the team in March one of the assessment clinics was cancelled to facilitate team attendance thus impacting on availability to be able to offer this. The service is delivering an assessment clinic and 3 initial assessment slots in outpatient clinics this supports the requirement for clients to be seen within 5 days and thus being able to establish a care plan within 2 weeks. The DNA rate is impacting upon the timeframe in which to support compliance regarding the care-plan being in place. There is a designated team member for ensuring prompt allocations of clients following assessment. 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. An agency nurse has now been recruited with suitable clinical skills and experience and is providing clinical resource to cover the Band 6 vacancy and will continue until the recruited staff member commences in post, this will improve availability and capacity for assessments and allocation of care co-ordinator. The job descriptions for new posts created as part of the business plan are progressing through the job matching process and will be advertised once this process is completed.

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 and has been reported at month 12 as a breach with 43 new cases (noted that average is 3.6 cases per month at M12). Performance over the year has been affected by high DNA rates and capacity within the Early Intervention Team (long term sickness, failure to recruit to Deputy Team Leader role, and 3 changes of agency staff). An agency nurse has now been recruited to cover the vacant post as an interim measure until the permanent recruited staff member commences in post. Following unsuccessful attempts to recruit to the Deputy Team Lead role, this post has been reviewed and revised and a decision made to recruit to a clinical band 6 post without the managerial elements, these elements will be supported within the wider team. Funding has been agreed for additional staffing who will increase capacity for assessment and care co-ordination and will be able to promote the service within the City linking in with GPs, schools, colleges and statutory and voluntary agencies. In order to offer increased diversity and skill mix within the team and to reflect practice population, a BME CPN role and Youth Worker role will also be recruited to.

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed to meet the 50% target both in month (6.67%) and Year End (29.5%). There were 24 assessments offered during March with 9 DNAs. DNA reasons included: Arrived too late, DNA (no reason offered), DNA (moved out of area), DNA (no fixed abode), DNA (letter arrived on day of appointment). The Team continue to send text messages and call new clients to remind them about their appointments (as well as sending out appointment letters). They inform referrers so that they have details of the initial assessments so that they can pass the information to the clients, if they are seeing them again before the appointment date. The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target, however due to mandated Family Intervention training undertaken by the team in March one of the assessment clinics was cancelled to facilitate team attendance thus impacting on availability to be able to offer this. The service is delivering an assessment clinic and 3 initial assessment slots in outpatient clinics this supports the requirement for clients to be seen within 5 days and thus being able to establish a care plan within 2 weeks. The DNA rate is impacting upon the timeframe in which to support compliance regarding the care-plan being in place. There is a designated team member for ensuring prompt allocations of clients following assessment. 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. An agency nurse has now been recruited with suitable clinical skills and experience and is providing clinical resource to cover the Band 6 vacancy, the agency nurse and will continue until the permanent recruited staff member commences in post and this will improve availability and capacity for assessments and allocation of care co-ordinator. The job descriptions for new posts created as part of the business plan are progressing through the job matching process and will be advertised once this process is completed.

Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for March (9.85%) and Year End with an average performance per month of 13.67%. Performance 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 currently cannot be split by individual commissioner. The Trust have confirmed delays are due to a lack of any alternative provision and includes 3 older adult patients who have already been escalated to local authorities but have still been delayed for a considerable time. The full Trust delay figure for March is at 4.7%.
Proportion of patients with a Care Plan when discharged from Older Adults Ward	The Trust has confirmed that an incorrect figure has been reported via the March SQPR, performance was originally reported as 20%, however has since been revised to the correct figure of 80% which remains under target. Performance for this indicator has failed to meet the 95% target in month and Year End (88.81%). 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 (num - 4, denom - 5 = 80%). The March breach relates to a patient who went to the Community Mental Health Team (CMHT) directly from the ward and there was confusion regarding if referred to the Home Treatment Team which then resulted in them not being seen within 7 days. Following this issue a crib sheet has been distributed for staff to follow and the deputy team manager will monitor on a daily basis until the team are confident with the process. Discharge plans will be discussed during the ward review meetings, and plans for HTT or Community follow-up need to be clear to avoid such reoccurrences in future.
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 6th consecutive month this year (57.24%) 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 (48.93%). 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 6 months and performance will continue to be monitored closely. Target has been met for the last 6 months and performance will continue to be monitored closely. Any decline in performance will be discussed via the Contract Review meeting. This local quality requirement was discussed at the April CQRM.

IAPT People who have entered treatment as a proportion of people with anxiety or depression (local prevalence)	This indicator has met the 15% target at M12 (15.40%). The CCG have noted that NHS England may still query the performance of this indicator as it has failed to hit the 3% increase per quarter.
SUIs Provide commissioners with Grade 1 RCA reports within 45 working days where possible, exception report provided where not met	This indicator achieved the 100% target every month with the exception of August. This indicator has therefore breached the Year End target (97.22%).
SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for March 2016, however the YTD has breached the 100% target (97.22%) 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 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 met the 95% in month (95.14%), however, has breached Year End (90.90%). The Trust previously confirmed via the CQRM meeting that the IPC training is meeting target, however, the data on the SQPR included other mandatory training.
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 subsequent months have achieved 100%, due to the null submissions in previous months the Year End performance is calculating at 60.00%. 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. March performance has been reported at 100% (numerator=1, denominator=1). 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 100% March submission relates to one member of staff that was due (and received) supervision.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and March has achieved the 85% target for the sixth consecutive month (92.21%). The Year End performance is below target at 83.77% 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 (86.98%) however the Year End performance is below target at 73.54% 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 sixth consecutive month, however the Year End is still below target 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 70.16% for March however, is still below the 85% target. The Year End performance is also below target at 50.38% and the performance is now in line with the Remedial Action Plan trajectory. The RAP trajectory for Year End is 40%.

SAFEGUARDING ADULTS % compliance with MCA/DoLS training	This indicator has seen a steady improvement since June15 and has achieved 86.78% for March16 and is above the 85% target. Although this indicator has met target for the fourth consecutive month, the Year End is still below target (55.44%). Remedial Action Plan is still in place as this covers other Safeguarding indicators. The Trust has advised that this indicator is linked to the Adult Safeguarding level 2 training.
PSYCH LIAISON & CHTTs Emergency up to 6 hours. % of assessments relating to referral within period	M12 SQPR submitted 80% in error, has since been revised to 100% and GREEN in month and Year End (99.05%)

5. CONSTITUTIONAL TARGET REQUIREMENTS FOR 16/17

The Committee was informed that all the submissions required by NHS England have been submitted in line with the required deadlines. A detailed report of the submissions was shared with the Committee and assurance was taken from the demonstration of the robust processes in place.

6. ASSURANCE RE DATA QUALITY

Following a query raised by the Governing Body at the last meeting relating to how it gains assurance that information received is correct. An internal audit report from 2015/16 was shared with the Committee for consideration. The report gave an overview of CCG system and process to ensure quality of data. The Committee took assurance from the substantial opinion and from the systems and processes in place to provide checks and balances.

7. KEY RISKS AND IMPLICATIONS

Financial Risk

The CCG has limited flexibility in its 16/17 budget and, indeed, is reporting potential unmitigated risk of £2m in-year. Strong financial management and programme management of QIPP will be continued in order to mitigate against the risk of spend in excess of plan.

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.

Further, 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 other forums such as Clinical Quality Review Meetings, Contract Review Meetings and Quality and Safety Committee.

8. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **1st June 2016**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 July 2016

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Finance and Performance Committee- 28th June 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):	

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

1. FINANCE POSITION

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

Financial Target	Target	FOT	Variance o(u)	RAG
Statutory Duties				
Expenditure not to exceed income	£6.172m surplus	£6.172m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£349.985m	£349.985m	Nil	G
Revenue Administration Resource not exceeded	£5.555m	£5.555m	Nil	G

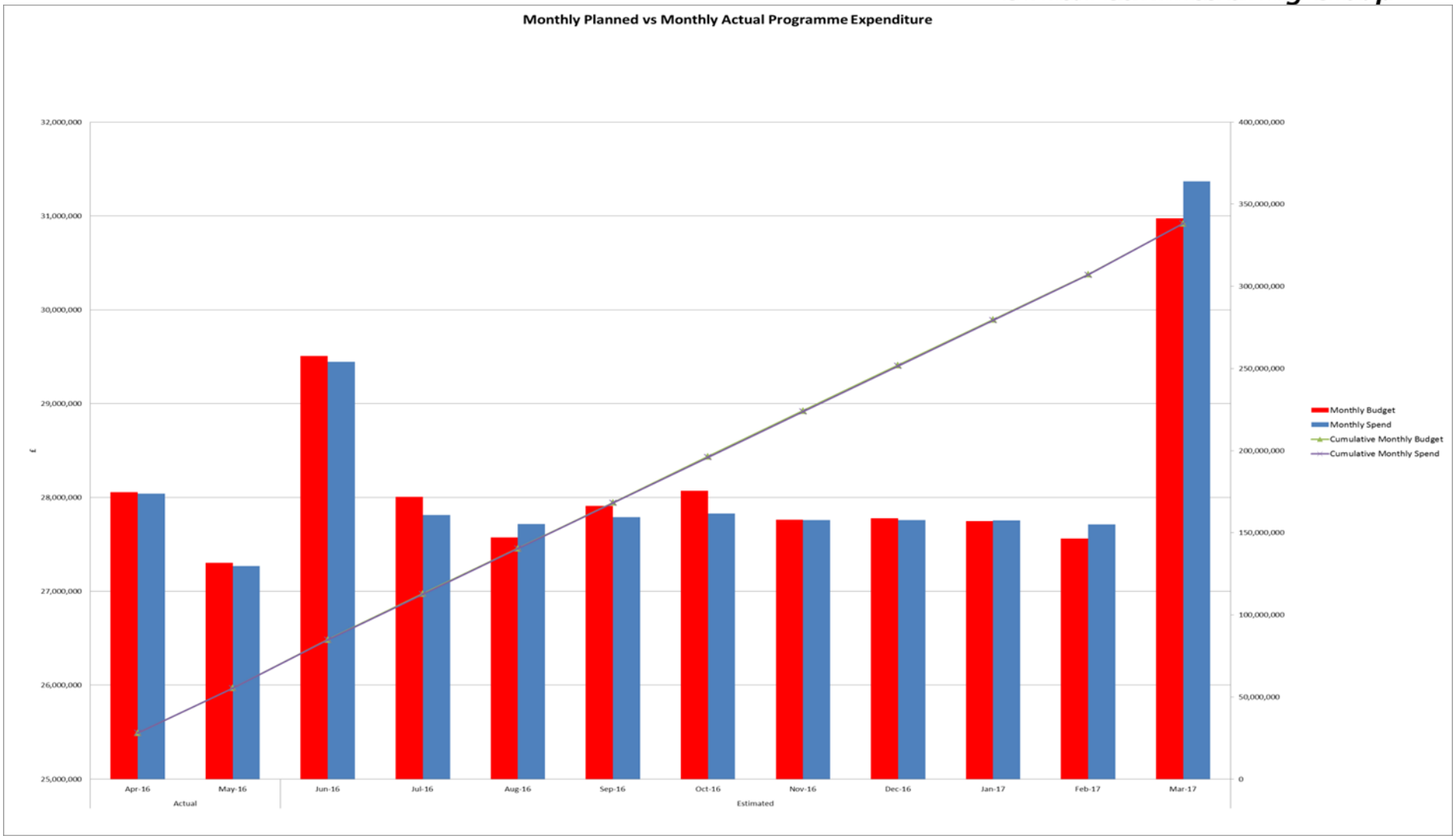
Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance £'000	281	834	553	A
Maximum closing cash balance %	1.25%	3.84%	2.59%	A
BPPC NHS by No. Invoices (cum)	95%	99%	-4%	G
BPPC non NHS by No. Invoices (cum)	95%	98%	-3%	G
QIPP	£1.26m	£1.23m	£0.03m	A
Programme Cost £'000*	55,066	55,310	244	G
Reserves £'000*	297	0	(297)	G
Running Cost £'000*	926	828	(97)	G

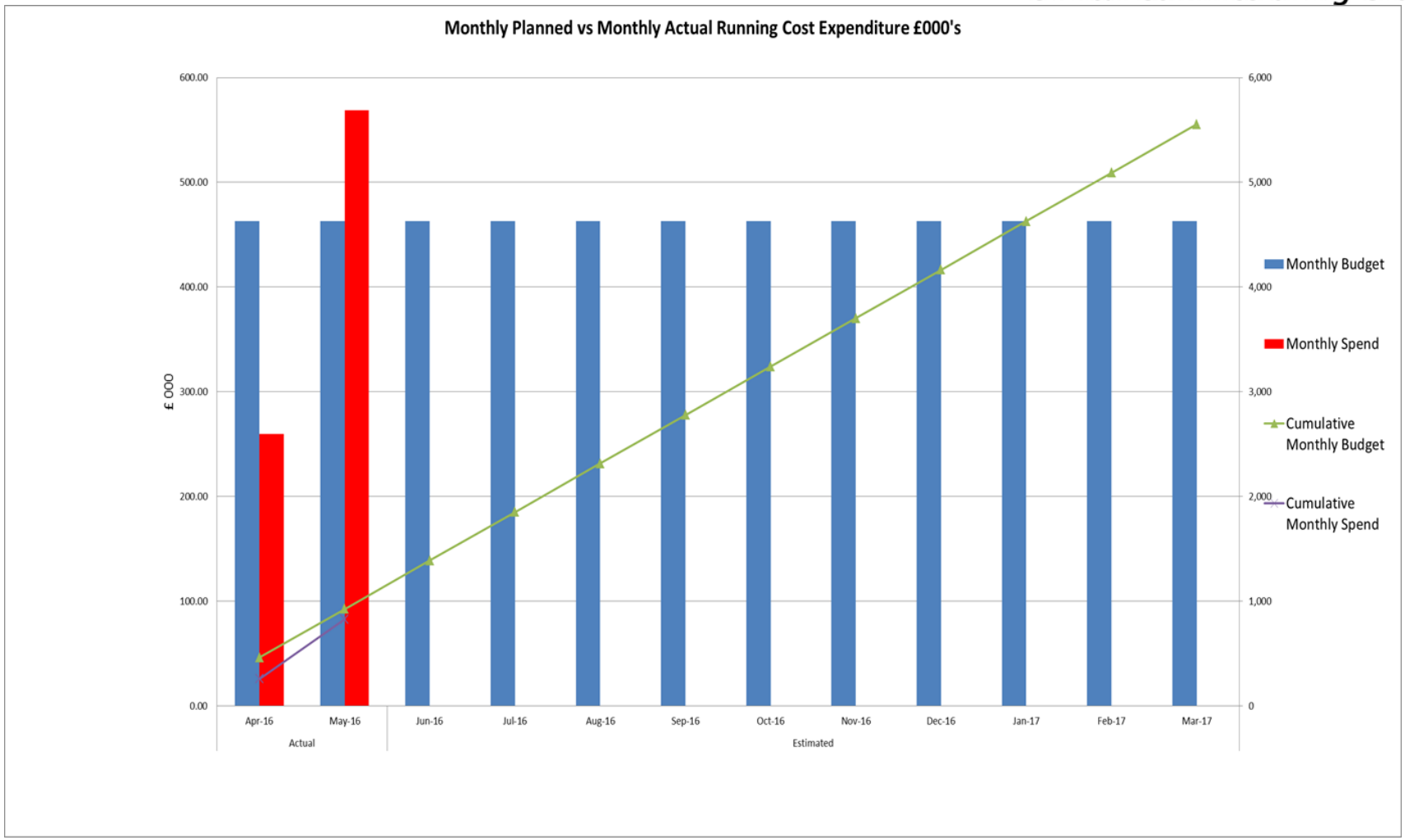
The table below highlights year to date performance as reported to and discussed by the Committee;

	Annual Plan £'000	YTD Performance M02			
		Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	179,711	29,983	29,952	(31)	(0.10%)
Mental Health Services	34,386	5,731	5,802	71	1.24%
Community Services	37,448	6,210	6,129	(81)	(1.30%)
Continuing Care/FNC	12,259	2,043	1,917	(127)	(6.20%)
Prescribing & Quality	51,918	8,476	8,310	(166)	(1.95%)
Other Programme	17,383	2,623	3,200	577	22.01%
Total Programme	**333,104**	**55,066**	**55,310**	**244**	**0.44%**
Running Costs	5,555	926	828	(97)	(10.51%)
Reserves	5,154	297	0	(297)	(100.00%)
Total Mandate	**343,813**	**56,288**	**56,138**	**(150)**	(0.27%)
Target Surplus	6,172	1,428	0	(1,428)	(100.00%)
Total	**349,985**	**57,716**	**56,138**	**(1,578)**	(2.73%)

The table below details the forecast out turn by service line at Month 2

	Annual Plan £'000	Forecast Outurn at M02		
		Actual £'000	Variance £'000	Var %
Acute Services	179,711	180,062	351	0.20%
Mental Health Services	34,386	34,393	7	0.02%
Community Services	37,448	37,275	(172)	(0.46%)
Continuing Care/FNC	12,259	11,767	(491)	(4.01%)
Prescribing & Quality	51,918	51,712	(207)	(0.40%)
Other programme	17,383	19,675	2,292	13.19%
Total Programme	**333,104**	334,883	**1,780**	**0.53%**
Running Costs	5,555	5,555	0	0.00%
Reserves	5,154	3,375	(1,780)	(34.53%)
Target Surplus	6,172	6,172	0	0.00%
Total Mandate Spend	**349,985**	**349,985**	**(0)**	(0.00%)


Monthly Planned vs Monthly Actual Programme Expenditure
£
32,000,000
31,000,000
30,000,000
29,000,000
28,000,000
27,000,000
26,000,000
25,000,000
400,000,000
350,000,000
300,000,000
250,000,000
200,000,000
150,000,000
100,000,000
50,000,000
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Actual
Estimated
Monthly Budget
Monthly Spend
Cumulative Monthly Budget
Cumulative Monthly Spend


Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
600.00
500.00
400.00
300.00
200.00
100.00
0.00
£ 000
6,000
5,000
4,000
3,000
2,000
1,000
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Actual
Estimated
Monthly Budget
Monthly Spend
Cumulative Monthly Budget
Cumulative Monthly Spend

2. QIPP

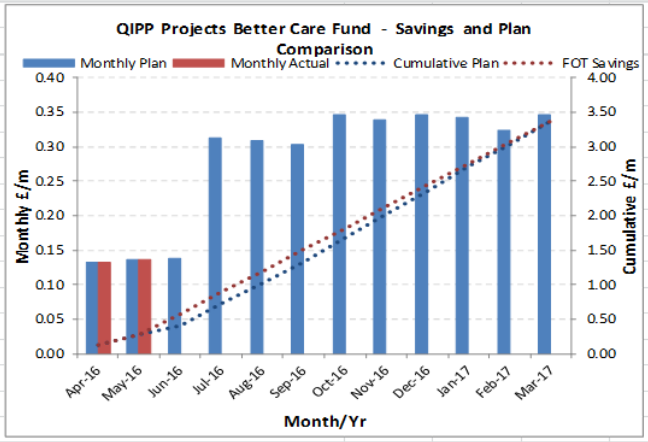
The Committee noted the current position of QIPP Programme performance as at Month 2.

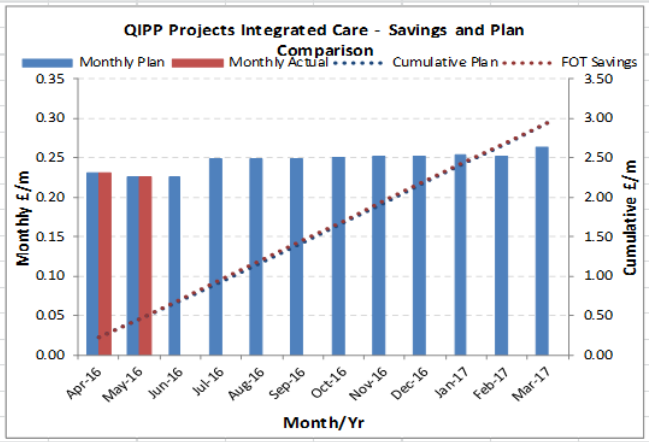
	YTD Plan £'m	YTD Actual £'m	YTD Var o(u) £m	An. Plan £'m	FOT £'m	Var o(u) £m
Transactional	0.36	0.35	-0.01	2.21	2.21	0
Transformational	0.9	0.88	-0.02	6.93	6.93	0
Unallocated				2.12	2.12	0
Total	**1.26**	**1.23**	**-0.03**	**11.26**	**11.26**	**0**

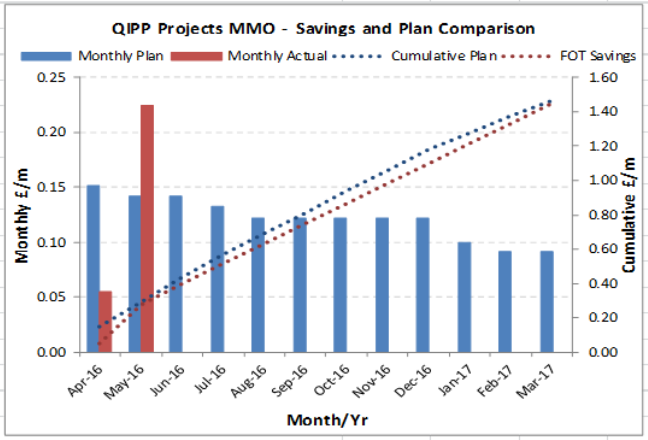
QIPP Programme Delivery Board — **Reporting Period : May-16**

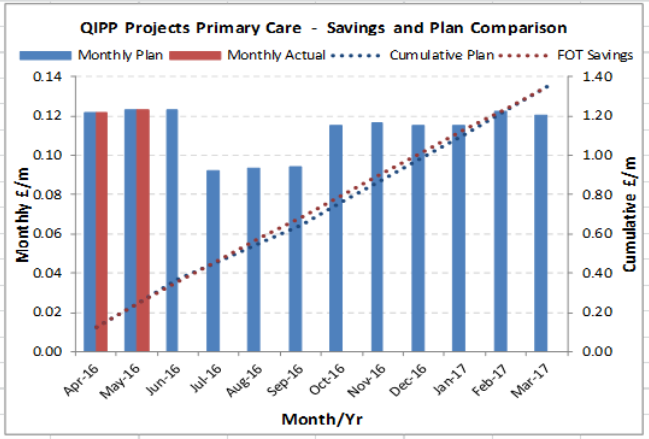
Financial Savings Projects within QIPP Programme Delivery Board and Annual Plan

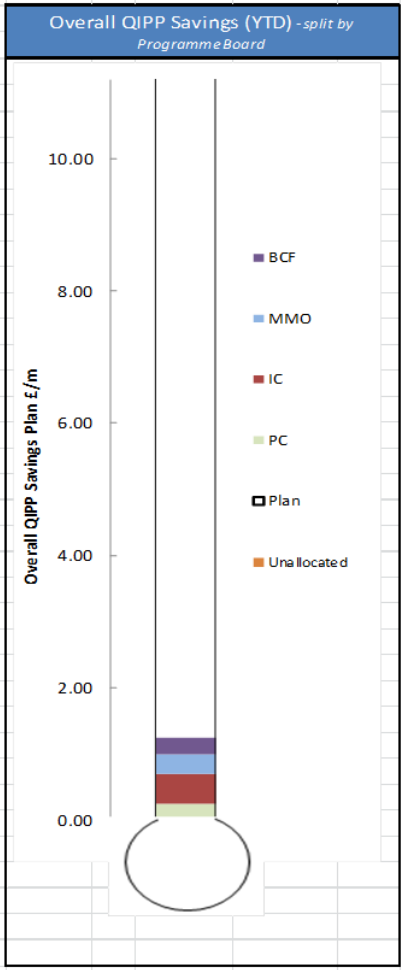
Source : Non ISFE Plan Submission by Wolverhampton CCG 16/17











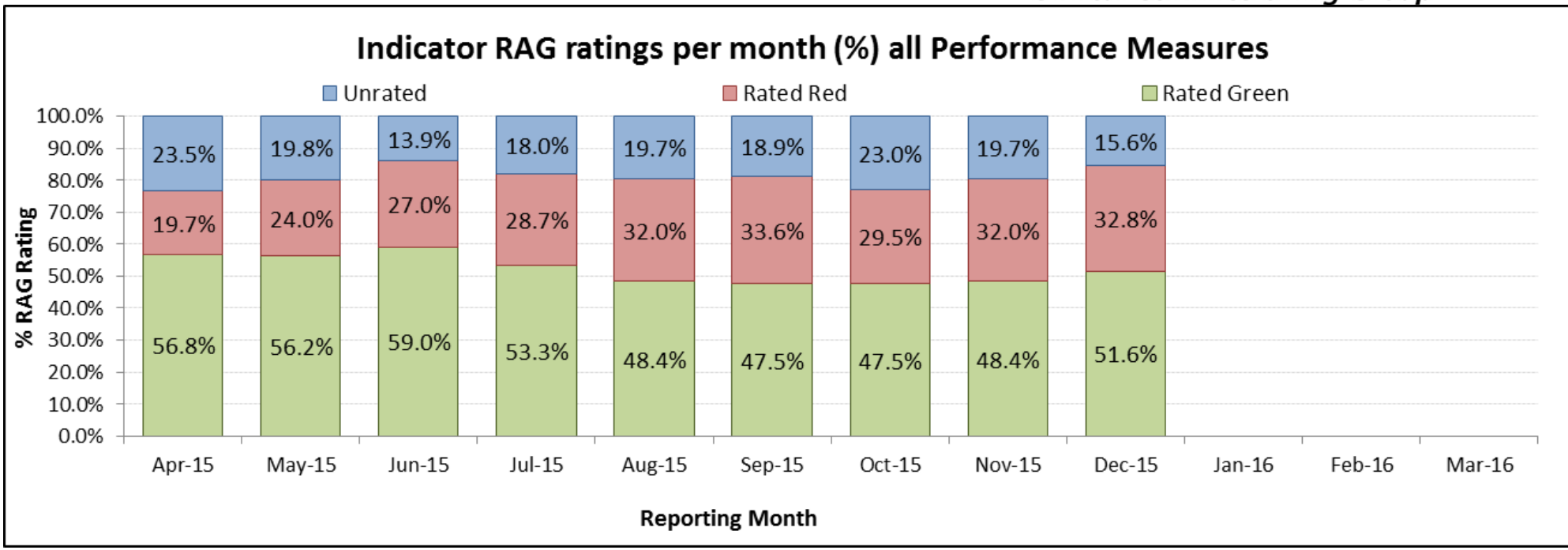
Note : Cumulative figures are based on a secondary axis

3. PERFORMANCE

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

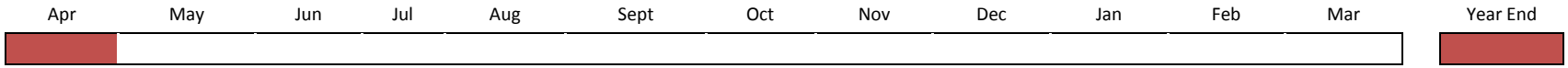
Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Awaiting Target	Total
NHS Constitution	N/A	16	N/A	7	N/A	1	0	**24**
Outcomes Framework	N/A	9	N/A	2	N/A	25	1	**37**
Mental Health	N/A	12	N/A	5	N/A	16	0	**33**
Totals	**0**	**37**	**0**	**14**	**0**	**42**	**1**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)	Awaiting Target
NHS Constitution	-	67%	-	29%	-	4%	0%
Outcomes Framework	-	24%	-	5%	-	68%	3%
Mental Health	-	36%	-	15%	-	48%	0%
Totals	**0%**	**39%**	**0%**	**15%**	**0%**	**45%**	**1%**


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

Exception highlights were as follows;

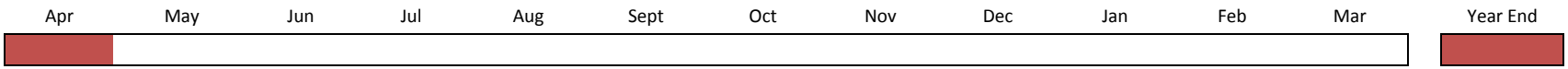
18 Weeks Referral To Treatment (RTT) Incompletes :



Performance at headline level for RTT Incompletes failed to achieve the 92.00% target for the first time in several years with Month 1 performance at 91.50%. The Trust advised that the decline in RTT performance was primarily affected by the 4 days of Junior Doctors Industrial Strike Action in April, which when combined with the Easter Bank Holiday period and reduced staffing capacity, resulted in a reduced level of activity during the month. A Remedial Action Plan (RAP) is in place for the specific specialty General Surgery (dated May 16). The RAP indicates the following areas of concern: Insufficient capacity to meet demand (Surgeon & Theatre), Alternative Providers (Identification of Private Sector Capacity), Pre-Operative Assessments, Case Mix on Waiting Lists, Waiting List Validations and Pathway Validations. The recovery trajectory is planned for February 2017.
The CCG continue to liaise with the Trust and the headline RTT and individual failing specialty performance was discussed at the May CQRM and CRM meetings.
The Trust are continuing weekly validation of the waiting list and of all the patients on the pathway to assist with pre-op planning (including forecasting priority patients and identifying 'bottle necks' in the waiting list). Patients are reviewed to assess if fit for surgery or require clock pauses.
The CCG has also requested the Trust to provide detailed individual RAP's with recovery trajectories for all current failing RTT specialties including General Surgery, T&O, Urology, Plastic Surgery and Gynaecology. The Trust have advised the RAP's will be made available to the CCG in late June 2016.
Initial data for May indicates the Trust have failed to achieve target. Detailed plans, by specialty, are being developed by the Trust to recover performance at headline level by June/July 2016.
No sanctions for headline level underperformance are currently in place as CCG taken pragmatic view that headline was not achieved primarily due to strike action. The predicted fines at specialty level for April are estimated to be £251,400.

RWT_EB3

A&E 4 hr Waits :



The A&E 4 Hour Wait performance has failed to meet the 95.00% national target since August 2015. The Month 1 (April) performance of 85.08% is the lowest reported average monthly percentage performance for several years. The Trust failed to achieve both Type 1 and the All Types target for the month. Issues affecting performance include: high numbers of attendances, patient flow and first assessment delays and increasing ambulance conveyances. The Trust have also identified that in the past few months, bed capacity issues have impacted on the numbers of beds available

The new Urgent Care Centre was fully operational from April 2016 offering primary care led facilities which enable patients with minor conditions to be seen outside of the A&E department. Currently performance data is being locally collated and monitored but is not being combined with the Type 1 A&E service. The CCG is discussing A&E performance regularly with the Trust at weekly Exec-to-Exec teleconferences and monthly CQRM and CRM meetings.

A RAP is in place with the Trust with a recovery trajectory in line with the Sustainability and Transformational Fund Improvement Trajectories. Recovery of performance is expected in July 2016.

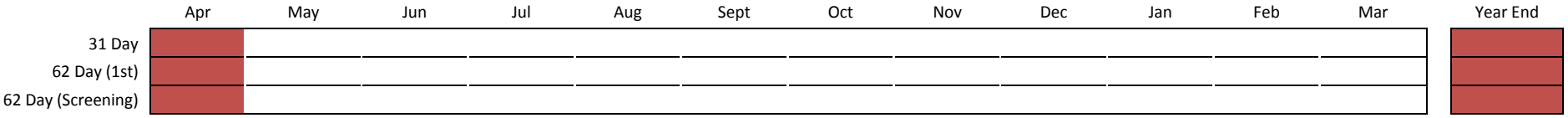
In line with contractual performance management, the CCG has enacted GC09 withhold against this line due to continual underperformance against national threshold and RAP trajectory. Initial data indicates that performance in May will not achieve RAP trajectory or national target.

The Trust and Vocare are currently in discussions around combining A&E performance data to present a health wide economy view of performance. Issues surrounding Data Sharing Agreements are to be resolved, but NHSE and SRG have given approval for this to go ahead.

The Trust are yet to confirm if they are proceeding with the STF. If so, GC09 contractual sanctions for 16/17 cannot be imposed. The predicted fine for this month's Type 1 and All Types breaches are estimated to be £102,240.

RWT_EB5

Cancer Waits



RWT_EB8, RWT_EB12 & RWT_EB13

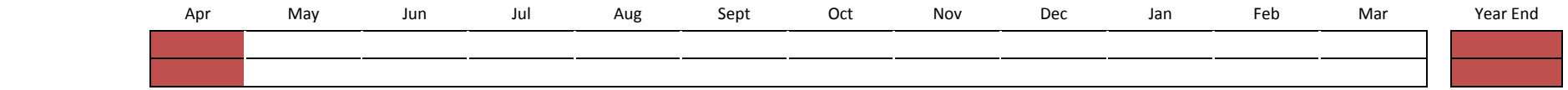
In month breaches for Cancer Waits for April 2016 are :

31 Day (1st Definitive Treatment) - 93.30% against 96% target. Validated figures now confirm April performance as 94.09% and still below target.

62 Day (1st Definitive Treatment) - 79.88% against 85% target. Validated figures now confirm April performance as 80.95% and still below target.

62 Day (Screening) - 80.77% against 90% target. Validated figures now confirm April performance remains at 80.77% and below target.

E-Discharge



RWT_LQR1 & RWT_LQR2

The Trust have advised that the primary issues with performance sit with PAU/GAU. The issues affecting performance are around delays with patients being input onto the PAS systems within these assessment units.

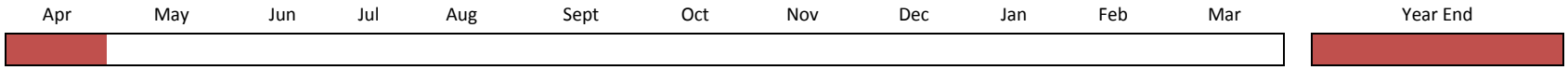
Performance for E-Discharges is split into 2 indicators:

92.84% against a target of 95% - Completion within 24 hours for all wards excluding assessment units

84.59% against a target of 95% - Completion within 24hours for all assessment units

The Trust have informed the CCG that PAU/GAU solutions are being put in place following discussions and performance improvements are expected in May and June.

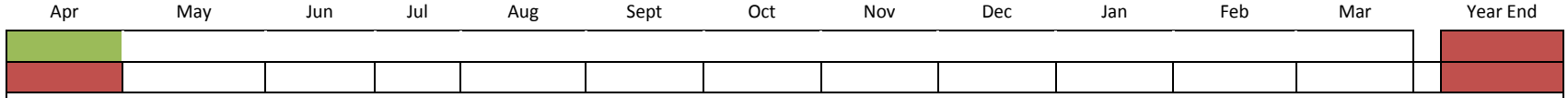
>50% of people experiencing a 1st episode of psychosis will be treated with a NICE approved care package within two weeks of referral



BCPFT_LQGE04

This indicator has failed to achieve the 50% target each month since April 15 with current performance achieving 33%. The Team have reviewed the assessment process and are developing a triage system and risk assessment to determine as to whether home visits can be instigated dependant on the risk level identified. A member of the team has been identified to take on managerial responsibility for allocations and ensure prompt allocation is made following assessment. A job description for new posts has been created as part of the Trust business plan and following confirmation of the business case finance will lead to recruitment of new posts. 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. This is a local indicator carried over for monitoring purposes from 15/16, there is a National indicator (see reference BCP_EH4) which the Area Team monitor performance directly from the Trusts Unify2 submissions.

Delayed Transfers of Care (DTOC)



RWT_LQR3 & BCPFT_LQGE11

RWT have met the in month stretch target of 3.50% for April. RWT have indicated the following top 3 delay reasons for April:
44.9% - Delay awaiting assessment (previously 39.5%)
17.6% - Delay awaiting domiciliary package (previously 13.4%)
16.9% - Delay awaiting further NHS Care (previously 22.7%).

The Black Country Partnership Foundation Trust have failed to meet the 7.50% target for April and have confirmed that delays are due to the following key issues: Lack of agreement on the funding of aftercare packages and the lack of suitable step down /aftercare provision.

4. CONTRACT AND PROCUREMENT REPORT

The Committee received the latest overview of the contract and procurement position. There were no significant points to be made at this stage of the year. The procurement plan is progressing as expected.

5. NEW LAY MEMBER – FINANCE AND COMMITTEE REPRESENTATIVE

The Committee took assurance from the process followed to recruit a new lay member to support the on-going development of its assurance and scrutiny role.

The proposed appointment is in line with the issuing of revised guidance for managing conflicts of interest and, as a consequence, the appointment of an additional lay member to the Governing Body.

6. NEW ASSURANCE REGIME

The Committee noted for information the changes made to the NHS England requirements for CCG Assurance for 2016/17.

7. ALLOCATIONS, RISK AND MITIGATION

Wolverhampton Clinical Commissioning Group, WCCG, is currently operating to a Resource limit of £349.985 million as detailed below

Allocation	Month	Recurring £'000	Non -recurring £'000	Total £'000
Opening Programme	M1	337,458	-	337,458
Opening Management	M1	5,555	-	5,555
b/f surplus	M1	-	6,972	6,972
		343,013	6,972	349,985

Finance Risk and Mitigations

The CCG submitted an annual plan which presented a net unmitigated risk of £1.99m. Following the review of the Month 2 position the CCG has been able to reduce the unmitigated risk slightly to 1.88m, the details below:

- The table below details the current assessment of risk for the CCG; a gross risk of £5.54m but risk assessed to £3.7m.

Risks	Potential Risk Value Mth01	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %
CCGs					
Acute SLAs	0.00	2.50	75.00%	1.88	50.73%
Community SLAs	0.00			0.00	0.00%
Mental Health SLAs	0.00			0.00	0.00%
Continuing Care SLAs	0.00			0.00	0.00%
QIPP Under-Delivery	0.00	2.04	50.00%	1.02	27.62%
Performance Issues	0.00			0.00	0.00%
Primary Care	0.00			0.00	0.00%
Prescribing	0.00			0.00	0.00%
Running Costs	0.00			0.00	0.00%
Other Risks	0.00	1.00	80.00%	0.80	21.65%
TOTAL RISKS	**0.00**	**5.54**		**3.70**	**100.00%**

Source: M2 Non ISFE

- Risk associated with Acute over performance and BCF is the CCG's biggest risk being £2.5m gross but mitigated to £1.88m.
- The CCG is anticipating delivering its QIPP programme. However it is prudent to identify some risk relating to the delivery of the unallocated QIPP.

- The table below details the current assessment of mitigations, £1.82m.

Mitigations	Expected Mitigation Value Mth01	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	0.00%
Contract Reserves	0.00			0.00	0.00%
Investments Uncommitted	0.00			0.00	0.00%
Uncommitted Funds Sub-Total	**0.00**	**0.00**		**0.00**	**0.00%**
Actions to Implement					
Further QIPP Extensions	0.00			0.00	0.00%
Non-Recurrent Measures	0.00	1.42	100.00%	1.42	78.02%
Delay/ Reduce Investment Plans	0.00	0.40	100.00%	0.40	21.98%
Other Mitigations	0.00			0.00	0.00%
Mitigations relying on potential funding	0.00	0.00		0.00	0.00%
Actions to Implement Sub-Total	**0.00**	**1.82**		**1.82**	**100.00%**
TOTAL MITIGATION	0.00	**1.82**		**1.82**	**100.00%**

Source: M2 Non ISFE

- Non Recurrent measures relate to the diversion of the Drawdown funding to support the financial position and the use of SOFP flexibilities.
- Delay/ reduce investment plans would require the CCG to review the use of funds to support the Primary Care Strategy.
- In delivering the financial surplus in M2 the CCG has already committed its Contingency reserve of £1.78m therefore this cannot be considered as mitigation.

In summary the CCG is reporting the following:

	Surplus £m	
Most Likely	6.172	No risks or mitigations, **achieves** control total
Best Case	7.992	Control total and mitigations achieved, risks do not materialise **achieves** control total,
Risk adjusted case	4.292	Adjusted risks and mitigations occur. CCG **misses** control total
Worst case	2.472	Adjusted risks and no mitigations occur. CCG **misses** revised control total

Other Risk

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

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

8. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **29th June 2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
12th July 2016

Agenda item 17

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC)- 24th May 2016**
Report of:	Jim Oatridge – Chair, Audit and Governance Committee
Contact:	Claire Skidmore – Chief Finance and Operating Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The AGC delivers its remit in the context of the CCG's priorities in order to provide assurance to the Governing Body of the robustness of system and process.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The AGC is accountable to the group's governing body and its remit is to provide the governing body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them. The AGC shall critically review the group's financial reporting and internal control principles and ensure that an appropriate relationship with both internal

	and external auditors is maintained.

1. BACKGROUND AND CURRENT SITUATION

1.1 Chief Internal Auditors Opinion

The Committee noted that all planned internal audit work had been completed. The report had been presented to the Committee in April and the Chief Internal Auditor was able to given an overall **Significant Assurance opinion.**

1.2 2015/16 Report to those charged with Governance (ISA260)

The Committee received an update from Ernst and Young, the CCG's External Auditors and it was expected that they would

- Issue an unqualified opinion on the financial statements
- Issue an unqualified opinion on the regularity of income and expenditure; and
- Confirm that the figures reported in the final audited statutory financial statements agreed to the figures reported in the summarisation schedules/accounts template
- In respect of Value for Money it is anticipated that there will be no matters to report about the CCG's arrangements to secure economy, efficiency and effectiveness in the use of resources.

During the audit a misstatement had been identified which was discussed with the Chief Finance and Operating Officer (CFOO) as part of the process. The CFOO's opinion was that the suggested amendment should not be made as doing so would increase the risk of error in the accounts and the amount identified was not material. The External Auditors brought this to the Committee to seek its approval for this approach. After discussion the Committee supported the management response.

1.3 CCG Annual Report, Accounts and Governance Statement

The Committee considered the CCG's Annual Report, Accounts and Governance Statement. This is a statutory document which had to be produced as one document.

The Committee recommend to the Governing Body that the documentation should be signed off.

1.4 Management Representation Letter

The Committee noted the content of the Management Representation Letter and the statements by the CFOO and Chief Officer that they would be happy to sign this off.

2. KEY RISKS AND IMPLICATIONS

2.1 Not applicable to this paper.

3. RECOMMENDATIONS

The Governing Body of Wolverhampton CCG is asked to:

- **Receive** this report and **note** the actions taken by the Audit and Governance Committee
- **Note** the successful submission of the CCG's key documents and their publication on the CCG's website further to the Governing Body signing off the accounts on 24th May 2016.

Name: **Claire Skidmore**
Job Title: **Chief Finance and Operating Officer**
Date: **25th May 2016**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12 JULY 2016

Agenda item 18

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 3 May 2016 & 7 June 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 meetings of the Primary Care Joint Commissioning Committee on 3 May 2016 and 5 July 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 3 May 2016 and 7 June. This report provides a summary of the issues discussed and the decisions made at those meetings.

3 MAY 2016 COMMITTEE MEETING

2. WOLVERHAMPTON CCG 2016/17 GP SERVICES BUDGET

2.1. The committee was given an overview of the GP services budget for 2016/17. The overall budget for GP services for the year is £34.1 million and, in line with national planning metrics, this would need to include a 0.5% contingency reserve and a 1% transformation fund surplus.

2.2. The committee discussed the fact that this allocation was based on the 2015/16 outturn and that, as the CCG was a joint commissioner of Primary Care responsibility for generating the surplus lay with NHS England.

3. GENERAL MEDICAL SERVICES (GMS) CONTRACT CHANGES

3.1. Details were given of the following changes to GMS contracts:-

- **Grove Medical Centre –** addition of Dr Mohindroo and removal of Dr Surinder Julka
- **Prestbury Medical Practice –** removal of Dr Morgan

4. PRIMARY CARE UPDATES

4.1. The Committee received the following update reports:-

- **Primary Care Operations Management Group** – It was reported that the group had received the draft of the Care Quality Commission (CQC) inspection report of Dr Christopher's practice and discussed next steps. The group were also given an update on options appraisals being undertaken on potential estates development projects in Bilston, Bradley, Heath Town and Showell Park
- **NHS England** – An update was given on the publication of the General Practice Forward view and the outcome of national negotiations on the GMS contract. The committee also discussed the arrangements for Primary Care Support services and the contribution of NHS England to the Sustainability and Transformation Plan for the Black Country. In response to a query from the Local Medical Committee, the Committee asked the Primary Care Operations Management Group to consider the most effective communication channels with GPs across the CCG and NHS England.
- **Wolverhampton CCG** – The Committee were updated on the Better Care Fund and work to support integration of health and social care through investment in additional community based services, which should improve how services linked

with GP services. It was also reported that, following specialist advice, the interpretation service would be subject to a procurement exercise.

5. OTHER ISSUES CONSIDERED

5.1. The committee met in private session to discuss specific details of the proposal by three practices to sub-contract delivery of their GMS services to Royal Wolverhampton Trust. The committee were given details of work to provide assurance that the arrangements were appropriate and gave delegated authority to the committee chair to give final approval once all of the requested documentation was received. This authority was exercised and the pilot began on 1 June 2016.

7 JUNE 2016 COMMITTEE MEETING

6. GENERAL MEDICAL SERVICES (GMS) CONTRACT CHANGES

6.1. Details were given of the following change to a GMS contract:-

- **Tettenhall Medical Practice –** addition of Dr Sanjit Sandhu

7. PRIMARY CARE UPDATES

7.1. The Committee received the following update reports:-

- **Primary Care Operations Management Group** – It was reported that the group had discussed lines of communication with GP practices and noted that NHS England would remain the prime point of contact up to the point when full responsibility for commissioning was delegated to the CCG. There was a brief discussion about effective mechanisms for obtaining patient feedback and the possibility of establishing a working group of appropriate stakeholders to take this forward.
- **NHS England** – An update was given on work to support the delivery of the GP Forward view, including the development of the GP workforce. Opportunities for the CCG to be involved in this work were discussed. Other issues discussed included a pilot project involving clinical pharmacists in General Practice and work to procure clinical waste contracts locally.
- **Wolverhampton CCG** – The Committee were updated on the CCG's organisational response to the GP Forward view and were advised that an update will be brought to the committee's August meeting. The Primary Care programme board had discussed the planned re-procurement of community equipment services and work to establish whether this could be done jointly with the local authority. Details were also given of the work of the newly established clinical reference group and the outcome of the second round of the grant funding bids and linkage into primary care.

8. OTHER ISSUES CONSIDERED

8.1. The Committee briefly reviewed its terms of reference noting that, in line with national guidance, the CCG would be recruiting an additional lay member of the Governing Body who would become a member of the committee. A more in depth review of the terms of reference will be completed in September

8.2. The committee met in private session to receive an update on the approval of the vertical integration pilot project and to approve plans for the investment of Primary Care reserve investment funds for 2016/17. A report was also presented giving details of potential submissions for the Estates and Technology Transformation Fund and an approach to prioritising them. In view of the timescales involved, it was agreed to delegate responsibility for the prioritisation of the bids to the CCG's Executive team, noting that Dr. Hibbs would not participate as she had a conflict of interest due to her practice submitting a bid.

8.3. The committee also agreed a proposal for collaborative working across Primary Care that recognised the value of joint working between Public Health, NHS England and the CCG. This proposal had been developed through the Operational Management Group and covers ways in which duplication can be avoided in key areas such as contract management and identifies ways of working to ensure issues are appropriately escalated when necessary.

9. CLINICAL VIEW

9.1. Not applicable.

10. PATIENT AND PUBLIC VIEW

10.1. Not applicable.

11. RISKS AND IMPLICATIONS

11.1. None arising from this update.

12. RECOMMENDATIONS

That the Governing Body Note the Report

Name Pat Roberts
Job Title Lay Member for Public and Patient Involvement, Committee Chair
Date: July 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**	**01/07/2016**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – 12 July 2016

Agenda item 19

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 May and June 2016. The key points to note from the report are: 2.1.1 **Annual Report** 2.3.1 **Grant Policy applications** 2.3.2 **Commissioning Intentions** 2.3.3 **Pond Lane pre-engagement and consultation**
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 May and June, 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 **Annual Report**
The final version of the WCCG Annual Report was signed off by the Auditors and the CCG Governing Body in late May. This is now available on the website https://wolverhamptonccg.nhs.uk/publications/1487-annual-report-201516/file
We will be working on the summary annual report in time for the Annual General Meeting in July.

2.1.2 **Sustainability Transformation Plans (STP)**
Work has begun across the Black Country area to formulate a STP. Alongside this, we are working with our communication and engagement partners in the Black Country from Acute Trusts, Local Authorities and other CCGs to develop a long term Communications and Engagement strategy to aid delivery of the local STP.

2.1.3 **Seven Day Hospital Services**
Working jointly with our colleagues at Royal Wolverhampton Trust (RWT) and NHS England we are developing communications and engagement around the seven day hospital services, with which RWT is an early implementer site.

Communication and Participation framework

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

2.2.2 **Practice Nurse Bulletin**
The fifth edition of the Practice Nurse bulletin went out in June. Topics include: a blog about revalidation alongside access to training on Final Revalidation and Appraisal Toolkit; information on the Community and Primary Care Nursing National Forum, various newsletters and News from NHS England.

2.2.3 **Practice Managers Forum**
The last two months meetings discussed varied topics including::

- Formulary updates/meds management updates
- Healthy Child programme - commissioning plans for health visiting and school nursing
- Primary Care Support England training, updates, debate and Q&A on registrations, records movement and practice ordering issues as nationally raised
- Diane Webb – Learning disabilities team – NHSE accessible Information Standard – background and training
- Admission Avoidance lead Nurses – meet the teams. Community matrons/Rapid Intervention teams/Hospital at Home/CICT. Presentation of how the services are going, feedback from patients and practices.
- PEARS scheme update and leaflets
- Updates and training on Patient Online Services
- Updates and training on Wolverhampton Children's Safeguarding board. Resource distribution and explanation for the Safeguarding toolkit for practitioners.
- TWIRL (The Wolverhampton Integrated Respiratory Lifestyle) project – presented by Claire Morrissey

- Update and resource distribution from Healthwatch (good update info coming in from Tracy)

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**
Two rounds of grant policy applications have now been completed. There are ten successful applications. Information about the projects can be found on the WCCG website.

2.3.2 **Commissioning Intentions**
We advertised the public meetings held in May and those to be held June to engage with the public around the CCG future commissioning intentions for years 2017/18. A report will be written following the final event and submitted to the programme boards in August.

2.3.3 **Pond Lane pre-engagement and consultation**
We held two events for pre engagement, open to service users and their carers who have accessed the inpatient beds for Learning Disability Services in the last 18 months. We have also engaged with staff and stakeholders to gather their views about the proposal to possibly move the beds to Walsall, Dudley and Sandwell. We are currently drafting up the consultation document with the pre-engagement results taken into account. We will also produce a version of the consultation document with pictures for use during the consultation for current LD service users. We will be having a public drop in event on Thursday 7 July for during the consultation period which is 4 July – 15 August. Further details can be found on the website.

Lay member's report of key meetings

2.4.1 The Lay Member is meeting with the Chief Officer of the new Healthwatch Wolverhampton on a regular monthly basis and has informed that The Staffordshire Partnership have also been successful in willing the Healthwatch Walsall contract, Healthwatch Wolverhampton has been interviewing for Board members and a new chair of the organisation.

Regular meeting have been established with RWT Patient Lead and one meeting has been held with BCFPT who are in the process of appointing a new patient lead.

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: 28th June 2016

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		
Public / Patient View	**Pat Roberts**	**May / June 2016**
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Medicines Management Implications discussed with Medicines Management team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Signed off by Report Owner (must be completed)	Pat Roberts	26 April 2016

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Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
QUALITY & SAFETY COMMITTEE

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

Present:

Dr Rajcholan	(RR)	Board Member, WCCG (Chair)
Annette Lawrence	(AW)	Quality and Safety Manager
Pat Roberts	(PR)	Lay Member Patient & Public Involvement
Kerry Walters	(KW)	Governance Lead Nurse, Public Health
Marlene Lambeth	(ML)	Patient Representative
Mr Tony Fox	(TF)	Surgeon/Secondary Care Consultant, WCCG
Sarah Southall	(SS)	Head of Quality and Risk, WCCG
Jim Oatridge	(JO)	Lay Member, WCCG
Laura Russell	(LR)	Administrative Officer, WCCG
Peter McKenzie	(PM0	Corporate Operations Manager, WCCG

Part Attendance:

Sharon Sidhu	(SSidhu)	Head of Strategy & Transformation

Apologies:

Geoff Ward	(GW)	Patient Representative
Gary Mincher	(GM)	Internal Auditor , WCCG
Manjeet Garcha	(MG)	Executive Lead Nurse, WCCG

Declarations of Interest

QSC481 There were no declaration of interest raised.

RESOLVED: That the above is noted.

Minutes, Actions from Previous Meetings

QSC482 The minutes of the Quality and Safety Committee held on 8th March 2016 were accepted as a true and accurate record.

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

RESOLVED: That the above is noted.

Matters Arising

QSC483 There were no matters arising.

RESOLVED: That the above is noted.

Feedback from Associated Forums

QSC484 **a) Draft Governing Body Minutes**

PR had highlighted the Executive Summary from the Quality and Safety Committee needed to include Care Homes as an item within the risk register. SS stated this would be included within the risk register and agreed to review the Governing Body's Executive Summary to ensure this is incorporated within future reports.

RESOLUTION: SS agreed to review the Governing Body's Executive Summary to ensure Care Homes is included in the risk register.

b) Health and Wellbeing Board Minutes

The next meeting of the Health and Wellbeing Board is due to take place on the 27th April 2016.

RESOLVED: That the above is noted.

c) Quality Surveillance Group Minutes

There were no minutes available from the previous meeting.

RESOLVED: That the above is noted.

d) Draft Primary Care Operational Management Group

The minutes from the meeting held on the 22nd March were provided for information. PR asked in relation to Information Governance in Primary Care are the CCG aware of the training provided for GP practices. PM informed the Committee the GP practice are required under the IG Toolkit submission to supply evidence that training has been provided. PM stated Primary Care is Co-Commissioned by NHS England and they should be seeking assurance, however agreed the CCG should also seek this assurance. PM agreed to review and report back to the Committee.

RESOLUTION: PM agreed to seek assurance regarding IG Training within Primary Care.

e) Draft Clinical Commissioning Group Minutes

There were no minutes available from the previous meeting.

RESOLVED: That the above is noted.

f) Commissioning Mortality Oversight Group

The next meeting of the Commissioning Mortality Oversight Group is due to take place on the 24th May 2016.

RESOLVED: That the above is noted.

Assurance Reports

QSC485 **a) Monthly Quality Report**

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

Royal Wolverhampton NHS Trust

For March 2016 RWT remained at a level 2 concern, the following reasons and mitigating actions are as follows;

- ***Infection Control (CDIFF)* –** the position has improved and numbers have reduced, which provides assurance the actions put in place are now taking effect.
- ***Pressure Ulcer Prevalence* –** The first Pressure Ulcer Steering Group took place on 25th February with key stakeholders and a Gap analysis has now been completed. Discussions took place regarding the involvement of a patient representative sitting on the Pressure Ulcer Steering Group or having patient stories if a patient representative cannot be identified.
- ***Recurring Serious Incidents (treatment delays)* -** an announced quality visit to the Urgent Care Centre by CCG Executives has been undertaken and a further follow up visit is planned with the TDA in May.
- ***Never Event(s)* –** action plans are to be revisited in July and will be linked to SISG requirements, which will provide greater assurance. The CCG were expecting response in January 2016 to the SBAR for treatment delays, this has been acknowledged by the Trust and agreement made that a response will be received in May.
- ***Quality Indicators (A&E/Cancer)* -** all the remedial action plans are at an agreed status.
- ***Workforce/Safer Staffing* -** Workforce continues to be a red risk for the Trust and reflected on the CCG Risk Register. The Trust is undertaking local, regional and international recruitment. Safer staffing data continues to be closely monitored. JO asked if the Trust sustained their stance on agency staffing, SS confirmed they have and this decision has been challenged by the TDA and CCG whether this should be reviewed.

RESOLVED: That the above is noted.

Black Country Partnership Foundation Trust

- For March 2016 BCPFT remains on a concern level 1.
- 2 new serious incidents have been reported, these were in relation to Slip/Trip/Falls and the second is pending due to be reviewed.
- The types of incidents reported were shared and it was highlighted in relation to medication incidents the number has reduced for the second month in a row. There has been a hike in the number of medication errors reported during October to December which reflects the training that has been provided.
- The workforce has been challenging for the Trust with the sickness absence reporting an increase at 0.9% in January and figures totalling 6.4% (3.0% short term and 3.4% long term).

RESOLVED: **That the above is noted.**

Private Sector/Other Providers

- NSL (NEPTS) – reporting at level 2 concern.
- Poplars Medical Practice - reporting at level 1 concern.
- Whitmore Reans – reporting at level 2 following a CQC inspection it requires improvement.
- Heath Town Medical Practice – Awaiting CQC report to be published.
- Primecare – Reporting at level 1 concern.
- Heantun Care – The Clinical Quality Review Meeting took place in March where concerns have been raised in terms of staffing and patient mix at Probert Court. There are currently 68 patients in step down.

RESOLVED: **That the above is noted.**

Care Quality Commission (CQC)/Notification or Advice from Monitor

- Black Country Partnership Foundation Trust are still awaiting their formal CQC report.
- Royal Wolverhampton NHS Trust - CQC have formally acknowledged they have received the Trusts appeal, and would not receive a response within 30 days.

RESOLVED: That the above is noted.

Adults Safeguarding

- 7 Grade 3 pressure ulcers RCA'S were undertaken during March 2016. Initial findings indicate that 5 out of the 7 pressure ulcers were as avoidable.
- WCCG has attended a Multiagency meeting chaired by West Midlands Police to discuss Orchard House Nursing Home and an action plan is being prepared.

RESOLVED: **That the above is noted.**

Formal Complaints

- There was 1 new complaint received during March 2016 regarding CAMHs.
- There are 2 complaints that remain on-going in relation to consultation for Recovery House and Mental Health Commissioning.

RESOLVED: **That the above is noted.**

Primary Care

- The GP Practices who have received CQC visits during 2015/2016 were shared with the Committee, the majority have been allocated a initial rating as good. 1 practice receiving an initial rating as inadequate and 1 practice is still awaiting confirmation on their rating from CQC.
- GP Friends and Family Test has been escalated to NHS England as some practices are not completing this, which will be picked up under their contract meetings.

RESOLVED: **That the above is noted.**

Risk Register

The Risk Register entries as of 30th March 2016 were as follows:

- 111 open risks
- 8 red risks
- 62 amber risks
- 40 green risks
- 14 overdue risks

RESOLVED: **That the above is noted.**

QSC485 **b) Safeguarding Adults Quarterly Report**

AL provided the Committee with assurance of the quarterly performance for Adult Safeguarding and the following key points were raised;

- Wolverhampton Safeguarding Adult Board had met on the 17th March 2016 and main points to highlight from meeting included;
    - Care Home Contract update provided by the Service Director Older People, Wolverhampton City Council– an exit strategy has been included in the Care Home Contract
    - Designated Adult Safeguarding Manager role has been removed from the Care Act Statutory Guidance.
    - Board Priority updates were provided by the work stream leads
    - WSAB Assurance report was presented.

- Multi Agency Safeguarding Hub Update – the Children's MASH is now' live', the Adult MASH is planned to 'go live' in August 2016
- WSAB's Risk Register has been reformatted, however more detail is needed in relation to actions and timescales.

- The MCA/DoLs project team met in February 2016, from the meeting it was reported that an MCA Champion event is taking place on 13th April at the Village Hotel, Dudley. Also a MCA awareness event is being held at Compton Hospice and there are plans to hold further events targeting Primary Care.
- Assurance documentation has been developed by the WCCG's Children's and Adults Safeguarding Teams to strengthen compliance and assurance from providers, the documentation includes;
    - A revised Quality Indicator Dashboard for the 2016/17 contract.
    - An Assurance Framework for Services commissioned by the CCG for Safeguarding Children and Adults with Care and Support Needs has been developed.

RESOLVED: **That the above is noted.**

QSC485 **c) Information Governance**

PM informed the Committee that following the re-procurement the service will now be provided by Arden and Gem CSU. PM will be working with the new provider to discuss the new services. The aim is to have the same level of support from the new team through having an embedded member of staff 1 day a week.

PM presented the Information Governance Report to the Committee and stated the IG Toolkit was submitted by 31 March deadline. The submitted toolkit reached the target score of 91%, an improvement from last year's score of 86%. A part of the submission was the Annual Report (shared for information) from the CSU IG Team, which outlined their work against the CCG's IG improvement plan.

Discussions took place around the Fair Processing Notice and JO asked do staff know how their personal information is processed. PM agreed to seek clarification.

RESOLUTION: **PM to seek classification around the extend of the fair processing notice and whether staff are aware how their personal information is processed.**

QSC485 **c) FOI Report**

PM highlighted following the re-procurement of Commissioning Support Services, the CCG has decided to bring FOI responses back in house. By doing this the CCG should see an improvement with compliance levels and all requests will be monitored and kept under review to reduce the number of requests becoming overdue.

Discussions following regarding the details of requests that have been received during the final quarter of 2015/2016 and whether in future this information could be used to correlate with complaint records.

RESOLVED: **That the above is noted.**

QSC485 **d) Board Assurance Framework Report**

This item has been deferred to May 2016.

RESOLVED: **That the above is noted.**

QSC485 **e) Business Continuity Review Update**

This item has been deferred to May 2016. The Committee raised their concerns of this item being deferred since January 2016, it was highlighted this has been escalated as a serious concern.

RESOLVED: **That the above is noted.**

Items for Consideration

QSC486 **a) National Reports and Enquires**

SS presented the National Reports and Enquires report to the Committee and provided the following updates;

Winterbourne View

- There are currently 21 patients placed in NHS England commissioned placements who have received at least an initial Care and Treatment Review who originate from Wolverhampton.
- NHS England are in the process of commencing an exercise for placement currently commissioned by specialist services, to align them to the local CCG with interest in those placements. The Transforming Care Program Board will continue to oversee the care and treatment review processes.
- Due to the subsequent actions and progress that has been made since this review was published it is recommended that this learning record is closed based on the control measures that are in place and working well locally in Wolverhampton.

Culture Change in the NHS & Freedom to Speak Up

- CQC has recruited at national level to their Freedom to Speak Up post, NHS Trusts have also commenced recruitment and identified resource to fulfil this role.

- At local level long term decisions regarding where the role of Freedom to Speak Up Guardian sits is currently been finalised.

Cavendish Review

- Assurance from commissioned providers in Wolverhampton has confirmed that both RWT and BCPFT have commissioned Care Certificate Training for their health care support workers providing evidence of this to the respective Clinical Quality Review Meetings.
- In the care homes sector, non-registered personnel have been encouraged to training provided by Health Education England.
- Practice Nurse development is a key area of interest for the future, a new role will be recruited within the Quality & Risk Team that will encourage non registered Practice Nurse support/assistants to undergo the Care Certificate in order to develop their skills and competence and in turn strengthen the practice nurse workforce in primary care.

Mazars Report

The background, key finds and recommendations were highlighted to the Committee the actions required by the CCG include the following;

- Ensure there are robust mortality review arrangements in the city that include representation from Public Health, CCG and any other stakeholders in relation to unexpected deaths involving mental health and learning disability patients.
- Review the terms of reference/agenda format for Commissioner Mortality Oversight Group Meetings to ensure sufficient attention is given to deaths involving such patients
- Seek assurance from the commissioned service provider to ensure they have undertaken their own internal review of unexpected deaths; BCPFT have provided an assurance report that was prepared to assure their Board, this confirms that they have undertaken an internal review and have robust arrangements in place to review unexpected deaths.
- In addition, the CCG is also due to adopt the Mortality Review Model for Primary Care currently being developed by NHS England Medical Directorate.

RESOLUTION: Report to be shared at the July Meeting.

QSC486 **b) DoLs Report Update**

This item has been deferred to the May Meeting.

RESOLVED: That the above is noted.

QSC486 **c) Quality and Safety Annual Report**

PM shared the Quality and Safety Committee's Annual Report, which outlines how the Committee has met their responsibilities in accordance with the Committees Terms of Reference. All the CCGs Committee's Annual Reports are in a similar format and will be presented to the Governing Body in May 2016. The conclusion has been left Blank for the Committee to discuss, it was agreed the Committee would like to see evidence on the achievements and good work they have achieved over the last year. PM agreed to finalise the conclusion and e-mail to the Committee for their information prior to submission to the Governing Body.

RESOLUTION: **PM to complete the Committees Annual Report and e-mail to the Committee members prior to submission to the Governing Body.**

QSC 486 **d) POLVC Report**

SSidhu informed the group the POLCV policy was implemented within the contract as of the 1st April 2015. The CCG have used various methods to ensure the primary care clinicians are aware of the policy. To ensure the policy is embedded it works in conjunction with use of Blueteq, providing a prior approval system requiring the provider to complete an electronic pro-forma confirming the patient meets all of the eligibility criteria.

Since the policy has been implemented the CCG has received two formal patient complaints; one relating to laparoscopic surgery for inguinal hernia repair and the other relating to the removal of a cyst. On review of the complaints the CCG deemed that the patients did not meet the eligibility criteria for treatment and the decisions have been upheld.

Data from the IFR team confirm that they have received 78 cases relating to the policy since its implementation from the 1st April 2015. The data covering the period of the 1st April 2015 – 31st March 2016 is as follows;

- The total number of requests received by IFR Team was 78 of which 65 cases were processed and there are 7 pending cases.
- The number of requests considered by IFR Panel was 14 of which 7 have been approved and 7 were declined.
- The number of requests considered by IFR team which did not go to panel was 51, of which 6 were approved and 13 closed due to containing in sufficient information or referrer being advised to refer to policy and 38 have been declined.

Since the policy has been implemented there has been a reduction of 890 procedures 1st April 2015 to 29th February 2016 equating to a financial saving of £618,622 compared to the same period last year.

The Committee welcomed the report and the excellent work undertaken. TF raised concerns that the POLVC documentation may not be completed fully by all staff and the difficulty to determine whether procedures are being coded differently to avoid the need for IFR. TF suggested it would be interesting to review those cases listed within 9/12 months' time to sse what happened to the patient if they had a different route into the services and ended up having the procedure.

RESOLUTION: **SSidhu agreed to review the IFR data in 9/12 months' time and feedback if the patients end up having the procedure, if they are the service needs to be reviewed.**

QSC 486 **e) Internal Audit Reports**

The following two reports were shared for the Committees information;

- Incidents, Feedback and Claims
- Performance and Clinical Quality

The reports are to be shared with the Audit and Governance Meetings and a summary of the findings presented to the Governing Body. The Committee accepted the report.

RESOLVED: **That the above is noted.**

Policies for Consideration

QSC487 **a) Risk Management Strategy**

AL informed the group the Risk Management Strategy has been widely circulated as part of the consultation process. The final version has been shared with the Committee along with implementation slides to outline the plan of how this will now be rolled out across the CCG. The Committee formally agreed and signed off the Risk Management Strategy.

RESOLVED: **That the above is noted.**

b) NICE Policy

AL shared with the Committee the revised NICE Policy which has been reviewed in response to the contracting negotiations and this will now form part of contracts in 2016/2017, highlighting more detail around TAGS and timescales. The Committee reviewed the NICE Policy and formally approved the Policy.

RESOLVED: **That the above is noted**

QSC489 **Items for Escalation/Feedback to CCG Governing Body**

The only item for escalation is the need to share the RWT response in terms of Urology and Cancer Waiting Times.

RESOLVED: **That the above is noted**

QSC490 **Any Other Business**

There were no further items for discussion.

Date and Time of Next Meeting

Tuesday 10th May 2016 at 10.30am – 12.30pm, CCG Main Meeting Room

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
QUALITY & SAFETY COMMITTEE

Minutes of the Quality and Safety Committee Meeting held on 10th May 2016
Commencing at 10.30am in the Main CCG Meeting Room, Wolverhampton Science Park

Present:

Sarah Southall	(SS)	Head of Quality and Risk, WCCG (Chair)
Manjeet Garcha	(MG)	Executive Lead Nurse, WCCG
Annette Lawrence	(AW)	Quality and Safety Manager
Pat Roberts	(PR)	Lay Member Patient & Public Involvement
Geoff Ward	(GW)	Patient Representative
Marlene Lambeth	(ML)	Patient Representative
Ajit Malhi	(AM)	Public Health (representative on behalf of Kerry Walters
Laura Russell	(LR)	Administrative Officer, WCCG
Philip Strickland	(PS)	Administrative Support Officer, WCCG

Part Attendance:

David Birch	(DB)	Head of Medicines Optimisation, WCCG
Andy Smith	(AS)	EPRR Manager, WCCG
Juliet Herbert	(JH)	Equality and Inclusion Business Partner, CSU
Lorraine Millard	(LM)	Designated Nurse Safeguarding Children
Fiona Brennan	(FB)	Designated Nurse Looked After Children
Sandra Aston-Jones	(SAJ)	Safeguarding Manager Adults, Local Authority

Apologies:

Dr Rajcholan	(RR)	Board Member, WCCG (Chair)
Jim Oatridge	(JO)	Lay Member, WCCG
Kerry Walters	(KW)	Governance Lead Nurse, Public Health
Mr Tony Fox	(TF)	Surgeon/Secondary Care Consultant, WCCG

Declarations of Interest

QSC491 There were no declaration of interest raised.

RESOLVED: That the above is noted.

Minutes, Actions from Previous Meetings

QSC492 The minutes of the Quality and Safety Committee held on 12th April 2016 were accepted as a true and accurate record.

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

RESOLVED: **That the above is noted.**

Matters Arising

QSC493 There were no matters arising.

RESOLVED: **That the above is noted.**

Feedback from Associated Forums

QSC494 **a) Draft Governing Body Minutes**
There were no items to raise from the draft Governing Body minutes.

RESOLVED: **That the above is noted.**

b) Health and Wellbeing Board Minutes
There were no minutes available from the previous meeting.

RESOLVED: **That the above is noted.**

c) Quality Surveillance Group Minutes
There were no minutes available from the previous meeting.

RESOLVED: **That the above is noted.**

d) Draft Primary Care Operational Management Group
There were no issues raised from the Committee.

e) Draft Clinical Commissioning Group Minutes
There were no issues raised from the Committee.

RESOLVED: **That the above is noted.**

f) Commissioner Mortality Oversight Group
The next meeting of the Commissioner Mortality Oversight Group is due to take place on the 24th May 2016.

RESOLVED: **That the above is noted.**

g) Area Prescribing Committee Minutes
DB presented the Area Prescribing Committee minutes from the meeting held on the 17th November 2015 and highlighted the developments for establishing a Regional Medicines Management Committee. SS queried the membership of the Area Prescribing Committee and asked if the membership was open to the wider health economy colleagues. DB highlighted it was open to all, however BCPFT

were the only ones who did not attend and sent apologies. SS agreed to pick this up via the BCPFT CQRM.

RESOLUTION: SS to raise none attendance of BCPFT colleagues at the Area Prescribing Committee via the BCPFT CQR Meeting.

Assurance Reports

QSC495 **a) Monthly Quality Report**

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

Royal Wolverhampton NHS Trust

For April 2016 RWT remained at a level 2 concern for the following reasons;

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

- There have been 5 confidential breaches reported in the month by the Trust which is an increase from the previous months.
- There were no slip/trip/falls reported in month.
- There were no New Never Events reported.
- There were in fact 3 CDiff cases reported in April and not 2 has mentioned in the report.
- The Trust reported 20 new grade 3 pressure ulcers in April. Annette Lawrence attends the Trusts weekly Pressure Ulcer Scrutiny Group. It was queried how the Trust benchmark against other local hospitals. It was confirmed that NHS England have classed the Trust as an outliner, however the Trust report on all pressure ulcers whether they are avoidable or unavoidable, where as other hospitals only report on avoidable. If the unavoidable including the community are not included the Trust are on par with other neighbouring hospitals. It was reported the Trust are working on a Health Wide Pressure Ulcer Strategy.
- The A&E performance was shared and GW asked if this took into account the Urgent Care Centre. It was confirmed that the it does however the models of A&E and the Urgent Care Centre are different and there have been issues with capturing information, the CCG are working with the Trust to reviewing the reporting and capturing of data.

Black Country Partnership Foundation Trust

- For April 2016 BCPFT remains on concern level 1.
- There have been no serious incidents reported in April by the Trust, however in May this has increased with a few incidents being reported. PR asked why are the numbers so low, it was reported that the majority are unexpected deaths.
- The CQC report has been shared and SS agreed to send a summary to the Committee.
- The theme of the Quality Review Meeting which took place in April was Mental Health, an overview of the incidents reported by site and type were shared.
- The sickness absence has seen a 0.9% increase with January, this has been a challenge for the Trust and practices are under review to improve support for staff returning back to work.
- The Trust are expected to achieve all CQUIN milestones in quarter 4 with the exception of Quetiapine. The Head of Contracting will be formally writing to the Trust regarding non-achievement of the Quetiapine CQUIN during quarter 2 and quarter 3, so that formal action can be taken.

Care Quality Commission (CQC)/Notification or Advice from Monitor

- Compton Hospice has been inspected by the CQC and are awaiting the first draft report to comment on.

User and Carer Experience

- There were no new complaints received during April 2016.

RESOLUTION: SS agreed to share with the Committee a summary of BCPFT CQC Report.

QSC495 **b) Safeguarding Children and Looked After Children's Report**

This item has been deferred to the June 2016.

RESOLUTION: Agenda item for June 2016.

QSC495 **c) Looked After Children Placements Assurance Report**

FB informed the Committee the number of Looked After Children (LAC) and their placements can vary from month to month and there are currently 60% of Wolverhampton LAC placed out of area. External placements are necessary when their holistic needs of a child or young person who requires specialist support and provision which is not available within Wolverhampton or CAMHS Tier 4 provision.

Wolverhampton City Council do not have the number of foster carers it needs to place all LAC within the town hence some placements are outside of Wolverhamtpton. There are plans in place by the Council to improve this situation across the City.

FB highlighted to the Committee children that are placed in the City from other areas that the Local Authority are not always informed when Children have been place in the City from out of area. The Head of Safeguarding for the Local Authority has met with care providers in the City and have agreed to develop a Children Home Provider forum in Wolverhampton to help strengthen these processes, which the CCG are involved with.

MG asked how confident they were that the CCG have robust processes in place. FB confirmed that the WCCG do have robust processes in place when they place children/young people out of area. They inform the relevant CCG and Local Authority and have 6 monthly health checks and visit the services to ensure the services meet quality assurance framework standards. There is also a national forum every three months which FB attends regularly.

FB presented to the group the LAC section of Children and Young Persons Annual Report and asked if the Committee had any questions to raise with SS and she would forward the comments onto FB for a response.

QSC495 **d) Medicines Optimisation Quarterly Report**

DB provided an update to the Committee of the Medicines Optimisation work programme and the following key points were raised;

- A lot of good progress has been made in relation to work regarding checking dose/frequency of those patients prescribed Novel Oral Anticoagulant and proves to be good area of safe working practice.
- Post-discharge reviews - this is in relation to a medication review for high-risk patients who have been identified by hospital pharmacy team. The work continues and they are making progress in integrating the two pharmacy systems.
- IMPACT Antibiotic training has been delivered and following the training the team have discussed antibiotic prescribing with GP Practices. The Practice Pharmacists have helped clinicians to produce action plans to reduce antibiotic prescribing in 21 practices.
- The CCG are ahead with electronic prescribing.
- The team have completed an antibiotic audit using the Scottish Antimicrobial Prescribing Group GP primary care audit tool. The data has been evaluated and indicated positive results, which was shared for information. The audit was carried out between September and December 2015 and carried out in eight GP practices and looked at high and low prescribers. GW asked if the audit was voluntary or mandatory, DB stated only a sample of GP Practices took part in the audit, which was based on the where the drug was used most/least. PR asked if the results are going to be

shared with the GPs, it was confirmed the results would be shared through the Practice outreach meetings.

RESOLVED: **That the above is noted.**

QSC495 **e) Quality Assurance in Care Homes Quarterly Report and PROSPER Programme BID**

MHD gave an update on the quarterly quality assurance on the progress made against the Care Home Improvement Plan and highlighted the following key points;

- The Quality Nurse Advisors have supported care home managers with conducting the 13 RCA investigations for grade 3 & 4 pressure ulcers during the quarter.
- The Quality Nurse Advisors have received 15 referrals for safeguarding quality concerns during the quarter, this is down on the last quarter of 30, a reduction of 50%.
- The lessons learnt from RCA and STEIS investigations continue to be shared with Care Home Managers and RWT.
- Participation in the Quality Indicator Survey Monkey questionnaire throughout the quarter was slightly down compared to the previous quarter. The Quality Nurse Team are reviewing different tools to capture this information to see if improvements can be made.
- Three nursing homes are currently suspended due to on-going safeguarding and quality concerns, this is slightly down on last quarter when 4 homes were suspended.
- No further progress has been made on developing the best practice guideline for end of life care (EOLC) which is being considered by the EOLC Strategy Group. A meeting has been arranged at the end of the month to progress this work.

MHD shared with the Committee the Project Initiation Document (PID) for PROSPER (Promoting Safer Provision of Care for Elderly Residents) Programme which provides the objectives, scope and desired outcomes. The Committee reviewed the PID and accepted the programme of work. MHD agreed an update on progress and the implementation plan will be shared and included within future quarterly Care Home Reports.

QSC495 **f) Quality and Risk Action Plan**

SS shared with the Quality and Risk action Plan to the Committee, as one of the reports had been omitted from the meeting papers it was agreed LR would send all the relevant reports relating to this agenda item to the Committee following the meeting for review or comments.

RESOLUTION: LR agreed to send all reports relating to the Quality Risk Action Plan for review and comments.

QSC495 **g) Board Assurance Framework Report**

SS presented to the Committee the quarter 4 position of the Board Assurance Framework and Risk Register and highlighted the following changes in risk status;

- **Domain 1** (Well Led Organisation) - the position remains the same in quarter 4.
- **Domain 2** (Performance) - has remained static reporting a score 12 throughout the year.
- **Domain 2** (Quality) - remains at a source of 12 which is significant as providers at a level 2 concern.
- **Domain 3** (Financial Management) - the score has reduced to 8 in quarter 4 as the CCG is financially stable and this position has been agreed by NHS England.
- **Domain 4** (Planning) – has remained at a score of 8 throughout the year.
- **Domain 5** (Delegated Functions) – The score has increased during the year to a score of 6 this is due to the CCG establishing Primary Care services.
- The following highlights the number of risk entries and their status;
    - Number of Open Risks – 110
    - Number of Reds – 8
    - Number of Ambers – 62
    - Number of Green – 40
    - Number of Overdue Risks - 14

RESOLVED: **That the above is noted.**

QSC495 **h) Business Continuity Report Update**

AS provided the committee with an overview of the Emergency Preparedness, Resilience and Response (EPRR) workstream. And highlighted the following key points;

- There has been a revised framework and work programme for 2016/2017 which has been drafted in consultation with the CCGs Accountable Emergency Officer.
- The 2016 EPRR Core Standards submission will require Governing Body approval prior to submission which will require a further report to the Governing Body in July 2016.
- The Pandemic Influenza Plan has been shared with the Committee and reported this will be taken to the Local Health Protection Forum.
- Work has been undertaken in relation to PREVENT on how to educate staff and will consider the implications of Primary Care going forward.

- The WCCG will need to review the 'out of hours on call' across the Black Country to see if it meets requirements in line with the new framework.
- In terms of the business continuity process the staffing element will be brought back to this meeting.
- At present the WCCG is deemed substantially complaint against 2015 core standard requirements.
- The Royal Wolverhampton Trust and Black Country Partnership Foundation Trust also have EPRR requirements and the EPRR Manager work with the providers to ensure their organisational compliance and inter-agency cooperation. Work is also being undertaken to support Vocare and the integration with existing RWT Major Incident response Policy.
- WCCG Crisis Communication Plan has been shared with the Committee, which was tested in November 2015.

The committee reviewed the report and formally agreed to the recommendations outlined.

RESOLVED: That the above is noted.

QSC495 i) Equality and Inclusion Update

JH presented to the group the draft Annual Equality and Inclusion Report and Draft Accessible information briefing note and implementation plan to the Committee for their comments and official sign off. The Committee thanked JH for all the work undertaken to support the Teams and embedding Equality and Inclusion into the responsibility of the Senior Management Team within the CCG. The Committee formally agreed and signed off the draft Annual Equality and Inclusion Report and Draft Accessible information briefing note and implementation plan.

RESOLVED: That the above has been agreed.

Items for Consideration

QSC496 a) Annual Quality Report

SS shared with the Committee the Annual Quality Report which provides a position statement based on safety, experience and effectiveness for the period 1st April 2015 to 31st March 2016. The report includes an overview on the work that has been undertaken by the Quality and Risk team during this period. SS highlighted in relation to Quality Matters and Annual Report will be presented at the June Meeting. The Committee agreed to sign off the Annual Quality Report.

RESOLUTION: Quality Matters Annual Report will be provided at the June Meeting.

QSC496 b) Annual Public Health Report

This has been deferred to the September Meeting.

RESOLUTION: **Agenda Item for June 2016.**

QSC496 **c) Annual Safeguarding Children's Report**

LM presented the Annual Safeguarding Children's Report to the Committee for assurance of the WCCG compliance against their statutory duties regarding Safeguarding and Looked After Children. LM highlighted the following points from the report;

- Themes and lessons learnt from the NHS investigations into matters relating to Jimmy Savile have resulted in a number of recommendations including: all NHS Hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff volunteers every three years. Work is on-going to ensure compliance against these recommendations and remains on an amber status.
- A joint Adult and Children's Safeguarding Audit was carried out by the Internal Audit Team in March 2016 and work is being undertaken to take forward the audits recommendations.
- Designated Professionals are required to undertake supervision for named professionals across the health community. The WCCG are fully engaged with this process, however improvement needs to be made in terms of how the Designated Professionals access supervision.
- The WCCG have improved on reporting requirements with providers and they are working with PREVENT, LAC and Adult Safeguarding to make sure there is consistency with assurances and reporting across the Providers.
- The WCCG are looking a developing a work plan, which will be implemented and monitored as part of the Quality and Risk action plan.

LM asked the Committee if there were any questions they would like to raise, the Committee were happy with the content of the report and agreed to formally sign of the report.

RESOLVED: **That the above has been agreed.**

QSC496 **d) Annual Safeguarding Adults Report**

AL provided the Committee with the Safeguarding Adults Annual Report and fed back the following key points;

- The Wolverhampton Safeguarding Adults Board have reported that regional guidance has been developed in the areas of Self Neglect, Safeguarding Adult Reviews and Position of Trust.

- A regional multi-agency Safeguarding Information Sharing Protocol (ISP) has been developed and agreed by the Wolverhampton Safeguarding Adults Board.
- It was reported by the Wolverhampton Safeguarding Adults Board that neglect continues to be the highest category of abuse and the number of adult safeguarding alerts received for the year was 1600.
- The WCCG have provided funding towards a project led by Walsall CCG for awareness raising and training in MCA/DOLs.
- The Wolverhampton Safeguarding Website is now live as of April 2016 and provides a wealth of information relating to both Adults and Children's Safeguarding.
- PREVENT training has now be made available for all CCG Staff to undertake.
- The Adult Multi Agency Safeguarding Hub (MASH) will go live in August 2016.
- A management action plan following an internal audit on safeguarding arrangements was shared for the Committee's information.
- A Quality Indicator Dashboard and Assurance Reporting Framework have been developed to strengthen compliance and assurance from Providers.
- The WCCG has secured funding from NHS England to undertaken various training for Adults and Children's safeguarding. SS asked when the Committee would be receiving the evaluation from the training, AL confirmed as when the training takes place the evaluation would be included as part of the Quality Adult Safeguarding Assurance Reports.

RESOLVED: **That the above has been agreed.**

QSC496 **e) DoLs Report Update**

SAJ provided an update on the Mental Capacity Act/Deprivation of Liberty Safeguards activity and indicated the following points;

- Following the last report presented in December 2015 the Supervisory Body had received 411 referrals, as of March 2016 931 referrals were received.
- There were 222 referrals in breach of timescales and awaiting assessment.
- The DoLs Team now have appointed to x4 dedicated assessors and they envisage the backlog will be reduced by November.
- Community DoLS - A deprivation of liberty can be authorised in one of two ways, depending on the setting in which the deprivation is occurring. If the deprivation is occurring in a care home or hospital, that facility has to obtain an authorisation from the Local Authority as the supervisory body under the statutory

DoLS scheme. If the deprivation of liberty is happening in a setting other than a care home or hospital the body seeking the authorisation (which will be the body responsible for funding the care arrangements) has to obtain authorisation from the Court of Protection.

Where the CCG fund packages of care for people who lack capacity to consent to the care and treatment and the acid test is met it is the responsibility of the CCG to apply to the Court of Protection for a community DoLS authorisation.

Advice to the CCG would be to conduct a scoping exercise of all cases which are funded by the CCG in the community where it is established those people who lack capacity to consent to their care and treatment. It was confirmed by MG that this has been undertaken and the CCG had identified 3 patients and the CCG are seeking legal advice.

RESOLVED: That the above has been agreed.

QSC496 f) Internal Audit Reports

The following audit reports were shared with the Committee for information;

- Assurance on Performance and Clinical Quality
- Assurance Framework for Wolverhampton CCG
- Assurance on Safeguarding Arrangements at Wolverhampton CCG
- Incidents, complaints and claims at Wolverhampton CCG

The results were either outstanding or substantive, the Committee raised no concerns.

RESOLUTION: Report to be shared at the July Meeting.

Policies for Consideration

QSC497 a) There were no polices for consideration.

RESOLVED: That the above is noted

Items for Escalation/Feedback to CCG Governing Body

QSC498 a) There were no items for escalation.

RESOLVED: That the above is noted

QSC499 Any Other Business

There were no further items for discussion.

Date and Time of Next Meeting

Tuesday 14th June 2016 at 10.30am – 12.30pm, CCG Main Meeting Room

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

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

MEMBERS ~

Clinical ~		**Present**
Dr J Morgans (JM)	Chair	Yes

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	No
Viv Griffin (VG)	Assistant Director, Health Wellbeing & Disability	No
Juliet Grainger (JG)	Public Health Commissioning Manager	No

In Attendance ~

Vic Middlemiss (VM)	Head of Contracting & Procurement	Yes
Ranjit Khular (RK)	WCC Public Health	Yes
Claire Morrissey (CM)	WCCG Solutions & Development Manager	Yes (Part)
Dr J Burrell	The Royal Wolverhampton Trust	Yes (Part)
Liz Hull	CCG Admin Officer	Yes

Apologies for absence

Apologies were submitted on behalf of Manjeet Garcha, Viv Griffin, Sarah Southall and Cyril Randles.

Declarations of Interest

CCM477 None.

RESOLVED: That the above is noted.

Minutes

CCM478 Minutes of Commissioning Committee held on Thursday 24th March 2016 were accepted as a true record with the following amendment:

CCM 471 Community Neighbourhood Team Specification

RESOLVED: It was agreed to report back to the Committee in May with an indication of the overarching service specification. It was acknowledged that demand profiles will form part of the on-going program of work.

RESOLVED: That the above is noted.

Matters Arising

CCM479 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

CCM480 (CCM471) Community Neighbourhood Team Specification – An update to be provided to the Committee in May with an indication of the overarching service specification.

(CCM472) Dementia Services & Older Adults Mental Health – Included as an agenda item for the private session of Commissioning Committee.

(CCM473) Learning Disability Community Service - Included as an agenda item for the private session of Commissioning Committee.

(CCM474) Commissioning Committee Draft Annual Report - Progress to be reviewed following an action outstanding from the Committee held in March, whereby it was agreed to update the annual report, to include a future plan and details to demonstrate how the Committee has made a difference. SM to follow up with Peter McKenzie.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM481 The Committee was provided with an update report relating to Month 11 (February) activity and finance performance and includes commentary and key actions from the Clinical Quality Review and Contract Review meetings conducted in March 2016.

Contracting 2016-17

- The Contract with Black Country Partnership Foundation Trust has been signed.

- The Royal Wolverhampton NHS Trust contract has been signed and arbitration avoided. The following has been agreed:
  - A compromise was agreed on growth
  - Urgent Care Centre – agreed a phased introduction and recognised 2016/17 as a transitional year

  The following was not agreed:

  - End of Life reduction – A compromise to be agreed and a holistic specification developed
  - BCF reduction in non-elective activity - £1.5m diverted into community nursing
  - Troponins – A service development improvement plan to be included in the contract
  - Money for critical care

  - West Midlands Ambulance Service – offer received and agreed as £9.6m. A contract has now been formalised.

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 decreased since January from 89.31% to 85.39%, and the RAP trajectory of 95% was not achieved. Commissioners have been asked to withhold 2% of the A&E budget for February and to retain 2% for the month of January, in line with General Conditions of the contract.

Cancer Targets

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

The percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers breached in February achieving 95.65% against a target of 96%.

The percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer has increased as expected, following a dip over the Christmas period, from 71.34% in January to 77.85% with an overall Q3 breach of 80.48%. This is directly linked to patients choosing not to have appointments during the holiday period.

The RAP target of 78.0% was not achieved 70.37%.

The percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers dipped from 83.78% in January to 72.00% in February against a 90% target. This was due to bed capacity issues.

Referral to Treatment within 18 weeks (January – Unify))

Overall, throughout the year the Trust has been achieving against this target. However, at speciality level the Trust is failing to achieve in the following areas, for which an updated action plan is in place:

- General Surgery – recovery plan in place
- Gynaecology
- Oral surgery
- Trauma and Orthopaedics
- Urology

E- Discharge - RWT

Wards - The Trust breached this target and achieved 94.59% against 95%.

Assessment Areas –The Trust achieved 84.17% against a target of 95%.

The Trust has acknowledged that they are unable to achieve the target for this year and a bid has been agreed to enable them to progress, which the CCG are reviewing.

Performance/Sanctions

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

The CCG has received thirteen bid applications from RWT; which were agreed at the Clinical Quality Review Meeting in March.

Activity & Finance - Acute

Overall Position by Commissioner

- Over performance for the total contract equates to £9.6m
  - Cannock continues to be the top over performer at £9.9m
  - South Staffs & Seisdon
  - Walsall
- Under performance
  - Stafford & Surrounds
  - Wolverhampton

Speciality Performance

- The Top 10 Specialties equate to £10m of over performance
- General Surgery - £3.3m above plan
- Accident & Emergency - £1.5m above plan

Community Services by commissioner

- RWT - £203k under plan.
- Dudley CCG - £14k above plan
- Shropshire - £78k below plan
- Wolverhampton CCG - £71k below plan
- Walsall - £27k below plan

Community – Specialties

- Community Matrons – £187k above plan (top over performer)
- District Nursing - £167k above plan
- CICT Rehab - £88k
- 14 specialties are under plan equating to £818k of under-performance. The top underperforming specialty is care of the elderly (£329k below plan)

Black Country Partnership Foundation Trust

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.

Performance issues

There are two open Contract Performance Notices and these were discussed in detail at the February Clinical Quality Review meeting and action plans are being monitored.

Other Contracts

Vocare (Urgent Care Centre Provider) – The service commenced on 1st April 2016 and a draft contract has been issued.

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

RESOLVED: That the above is noted.

Business Case Proposal: Provision of a Direct Access Diagnostic Spirometry Service (Wolverhampton and South Staffordshire GP Surgeries)

CCM482 The Committee was presented with a report requesting approval of the Direct Access Diagnostic Spirometry Service Business Case received from RWT.

- Spirometry is an essential investigation for diagnosis and severity assessment for people living with respiratory conditions such as COPD and Asthma. Nationally, most COPD cases are undetected and it is estimated that there are approximately 2.2 million people living with COPD that do not have a confirmed diagnosis.
- Locally, there are circa 5,000 patients currently on a primary care COPD register, and it is estimated on average that there are approximately 40 new cases diagnosed each month.
- Analysis from the Right Care Commissioning for Value kit (January 2016) demonstrates that Wolverhampton CCG underperforms against the mean of its peer group by 20%.
- National and local evidence indicates that there is a vast increase in admissions related to respiratory conditions. Locally, the CCG has an admission rate for COPD of 2.48/1000 which is above the regional and national means.
- Data provided by the CSU indicates that for Wolverhampton CCG respiratory spend was £8,642,664 against the RWT contract for 2014/15.
- The CCG has a local quality premium target for 2016/17 to improve recorded prevalence by 10% against estimated prevalence, this equates to circa 500 patients being added to primary care registers.

- The CCG is currently working with clinical leaders and Graphnet business intelligence analyst embedded within the CCG to develop a case finding algorithm utilising prognostic indicators to provide practices with a list of patients who may benefit from an enhanced review and further diagnostic testing.

RESOLVED: The Committee agreed to approve the Business Case in principle with the view that a clearer financial position is reported on next month.

Aiming High Agenda Business Case

CCM483 Deferred until the Committee meeting in May.

RESOLVED: That the above is noted.

Any Other Business

CCM484 None to discuss.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

CCM485 Thursday 26th May 2016 at 1pm in the CCG Main Meeting Room.

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 26th May 2016
Commencing at 1 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~		**Present**
Dr J Morgans (JM)	Chair	Yes

Patient Representatives ~

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

Management ~

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

In Attendance ~

Vic Middlemiss (VM)	Head of Contracting & Procurement	Yes
Ranjit Khular (RK)	WCC Public Health	Yes
Claire Morrissey (CM)	WCCG Solutions & Development Manager	Yes (Part)
Margaret Courts (MC)	WCCG Children's Commissioning Manager	Yes (Part)
Sarah Fellows (SF)	WCCG Mental Health Commissioning Manager	Yes (Part)
Fred Gravestock (FG)	WCCG Whole System Transformation Director	Yes (Part)
Maxine Danks (MD)	WCCG Head of Individual Care Team	Yes (Part)
Hemant Patel (HP)	Deputy Head of Medicines Optimisation	Yes (Part)
Liz Hull	CCG Admin Officer	Yes

Apologies for absence

Apologies were submitted on behalf of Viv Griffin, Sarah Southall, Wendy Ewins and Karen Evans.

Declarations of Interest

CCM486 Dr Morgans declared an interest in the following agenda items:

- Item 8 - Business Case Proposal: Provision of a Direct Access Diagnostic Spirometery Service (Wolverhampton and South Staffordshire GP Surgeries) – Finance Update
- Item 11 – GP Prescribing Incentive Scheme 2016/17
- Item 12 – Step Up Bed Specification

RESOLVED: That the above is noted and Steven Marshall would act as Chair for the listed declarations of interest.

Minutes

CCM487 Minutes of Commissioning Committee held on Thursday 28th April 2016 were accepted as a true record with the following amendment:

CCM 482 Business Case Proposal: Provision of a Direct Access Diagnostic Spirometery Service (Wolverhampton and South Staffordshire GP Surgeries)

RESOLVED: The Committee agreed to approve the case in principle with the view that a clearer financial position is reported on next month.

RESOLVED: That the above is noted.

Matters Arising

CCM488 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

CCM489 (CCM471) Community Neighbourhood Team Specification – Report back to the Committee in May with an indication of the overarching service specification. To be carried forward to the Committee in June 2016.

(CCM474) Commissioning Committee Draft Annual Report – Dealt with as a Chair's Action and the final version has been shared with Governing Body.

(CCM482) Business Case Proposal: Provision of a Direct Access Diagnostic Spirometry Service (Wolverhampton and South Staffordshire GP Surgeries) – Included as an Agenda Item.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM490 The Committee was provided with an update report, by Vic Middlemiss, relating to Month 12 (March) activity and finance performance and includes commentary and key actions from the Clinical Quality Review and Contract Review meetings conducted in April 2016.

Contracting 2016-17

- The Royal Wolverhampton Trust (RWT) contract was signed in early April and 10 out of 18 of the associate commissioners to this contract have also signed.
- Black Country Partnership (BCPFT) and West Midlands Ambulance Service (WMAS) contracts are finalised and signed.
- Offers have been agreed for all other acute and Mental Health contracts to which the CCG is an associate commissioner.

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 increased since February from 85.39%, to 90.32% and the RAP trajectory of 95% was not achieved. Commissioners have been asked to withhold 2% of the A&E budget for March and to retain the 2% for the month of February, in line with General Conditions of the contract.

In addition to the Contract Review Group, continuity of performance is being monitored through the Quality Review Group and the System Resilience Group (SRG) on a monthly basis.

There is an increased national focus on A&E performance with the Sustainability and Transformation Plan also including trajectories for A&E waits for both the 4 and 12 hour targets.

Cancer Targets

- Three cancer wait targets did not achieve their targets in March.

- The percentage of Service Users waiting no more than 31 days for subsequent treatment, where that treatment is surgery, was 90.63% against target of 94%.
- The percentage of Service Users waiting no more than 62 days from urgent GP referral to first definitive treatment for cancer has decreased from 77.85% in February to 75.58% in March.
- The validated UNIFY February cancer wait data is now available and the RAP target of 80.0% was not achieved.
- The percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers in March achieved the 90% target.

Referral to Treatment (RTT) within 18 weeks (February – Unify))

Overall the Trust has been achieving against this target throughout the year. However, at speciality level the trust is failing to achieve the following areas:

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

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

E- Discharge – RWT

The Trust continues to struggle to meet this target for assessment achieving 82.5% against a target of 95% in March. The Trust has been asked to produce a revised remedial action plan.

Performance Sanctions

The 2015-16 total sanctions levied to RWT to date equate to £2,081,097.00 across the whole contract. Two targets remain unconfirmed – RTT and Cancer; these will be included in data provided for April.

Recent Issues

Orthodontic Waiting List Issue

On 7th April 2016, the Trust alerted the CCG of a problem that would impact on referral to treatment for Orthodontics. The Trust identified a consultant within the service who had been keeping a paper diary instead

of logging patient activity on the orthodontics system. As a consequence there are a number of patients that have not been picked up against waiting list data, some of which are potential 52 week breaches. The CCG has written to the Trust requesting a number of specific points to be addressed as part of their internal investigation and to provide assurance that this practice is not being undertaken in any other specialty. Orthodontics is a specialised service, commissioned by NHSE so the CCG's interest in following up this issue is primarily from a quality perspective.

Junior Doctor Strike

The Trust wrote to the CCG in April 2016 regarding the two day strike, and advised of the number of elective procedures which had to be cancelled as a result of transferring consultants to cover emergency areas of the hospital. The letter requested leniency being applied to performance monitoring of affected targets. A response letter has been sent back confirming that a fair approach will be undertaken, so long as recovery can be demonstrated within a reasonable period of time.

Black Country Partnership Foundation Trust

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

- Early Intervention Services
- CPA
- Safeguarding training. A remedial plan is now in place.

Performance issues

There are two open Contract Performance Notices which were discussed in detail at the February Clinical Quality Review meeting. Remedial action plans are being monitored.

Recent Issues

Non-Achievement of CQUIN Target

One of the CQUIN targets within the 2015/16 BCP contract concerned the prescribing and monitoring of patients on Quetiapine, which is a drug used for patients with psychosis. A letter has been sent to the Trust informing them of non-achievement of the CQUIN for Quarter 2 and 4. A meeting has been requested to discuss safeguarding concerns associated with this drug and to agree an appropriate local quality target for 2016/17.

Other Contracts

Nuffield – This contract has now been finalised at a value of just under £3m and the contract signed.

Vocare (Urgent Care Centre provider) – A draft contract was issued in March but remains unsigned. This presents a degree of risk to the CCG, given the service has been delivered since 1st April 2016. The situation has been flagged to the provider and a resolution is urgently being sought.

Other contracts – other contracts are being developed for completion by end of May and there are no significant risk issues to highlight.

RESOLVED: That the above is noted.

Short Breaks Provision for Vulnerable Pupils

CCM491 Margaret Courts presented a business case to the Committee to request funding for additional nursing support at Penn Hall School and Green Park School for a period of 3 years, to allow pupils, with complex medical needs, access to a short breaks provision and after school activities.

Both schools have previously provided support for children with complex medical needs by accessing the Aiming High for Disabled Children Programme. It ensured there was nursing support available to enable this cohort of children to participate in out of school activities such as extracurricular activities, day trips and residential trips. The current service provides nursing support to allow pupils who are disabled, with complex and/or palliative care needs, to accompany their peers. The service provides the following nursing care whilst children are off school site and engaged in activities:

- Administers tube feeds and medications
- Monitors children's conditions and act to ensure their good health
- Provides suction and oxygen if appropriate
- Treats conditions such as epilepsy giving emergency first aid and rescue medication
- Provides emergency care as necessary/appropriate
- Undertakes dressings or other planned treatments.

Funding for this support is due to end at the end of summer and as a result concerns are that this cohort of children will be disadvantaged and will not be able to fully participate in school life.

An options appraisal has been undertaken as below, with the preferred option being 4:

Option 1 Do nothing

Option 2 Continue the programme but opt to purchase sessional nursing support from recommended agencies.

Option 3 Train school based staff to attend the short breaks without the support of a Nurse.

Option 4 Commission a service:

Recruit a Band 5 Nurse to share between the schools that are willing to offer short breaks support with a team of school staff who have enhanced medical training.

To be provided by the Community Children's Nursing Team via an SLA which would provide assurance that the post holder would receive suitable clinical supervision as well provide sick leave cover.

£30k of funding requested – available within the SEND budget.

This option allows the schools to comply with legislation and offer a risk reduction strategy for pupils and professionals.

The Nurse would have extensive background knowledge of pupils' health needs and their preventative care procedures.

Enables care plans to be kept up to date and reflective of effective practice.

Enables more effective training of school staff.

RESOLVED: The Committee welcomed the report and agreed to support the preferred option being developed into a Service Specification with input from Manjeet Garcha, to be presented to the Committee in June, which considers and addresses:

- Safety issues
- Clarity on the level of specialised training required as part of the role banding
- Confirmation that the money is not being double counted
- Feedback of performance

Business Case Proposal: Provision of a Direct Access Diagnostic Spirometery Service (Wolverhampton and South Staffordshire GP Surgeries) – Finance Position

CCM492 Chaired by Steven Marshall.

An update on the finance position was provided by Claire Morrissey.

The Trust anticipates that there will be approximately 300 referrals for first diagnosis. As the CCG has a quality performance indicator to add 500 patients onto COPD registers, it is recommended that 600 referrals are commissioned.

- DZ35Z – Spirometry with post bronchodilator testing = £73.44
- DZ44Z – Simple Airflow studies = £37.24

The worst case scenario is £131,000 (QP indicator) – £44,064 (100% activity at higher rate) = £86,936 net saving. However, it was noted that negotiations are still taking place with regards to a local reduced tariff.

The Committee approved the Business Case proposal and the recommendation to commission 600 referrals working on the assumption that this is a quality premium for 2016/17 and that a review should take place in 12 months.

RESOLVED: That the above is noted.

Service Specification for Designated Medical Officers Role – SEND Agenda

CCM493 Margaret Courts presented a Service Specification for the Designated Medical Officer role to seek approval as part of the Community Paediatrics contract held with the Royal Wolverhampton NHS Trust.

Children and young people with a Special Education Need and/or Disability (SEND), make up a significant proportion of the national childhood population, with up to 20% of school age children and young people having Special Educational Needs (SEN).
Wolverhampton's Joint Strategy for Children and Young People with Special educational Needs and Disability (SEND) 2015-2020 identifies that the city has a child population of 56,000 which includes a higher than average number of children with moderate and severe learning difficulties. Wolverhampton has 1,500 children and young people, with statements of SEN, which are currently being reviewed for transfer over to the new (September 2014) system of a single Education Health and Care plan.

The Service Specification details the requirements of the CCG to establish a Designated Medical Officer role under the Children and Families Act 2014 regarding children and young people with SEND.

The Designated Medical Officer will support the CCG in meeting its statutory responsibilities for children and young people with SEND and will be the key point of contact between the local NHS and the Local Authority and Families. Furthermore, the role will support the delivery of Supporting Pupils with Medical Conditions in Schools.

Risks if the role is not established include:

- Statutory functions not being exercised as appropriate clinical expertise will not exist within the CCG to support this function.
- Delay in delivery of assessments, planning and health support for some of the more vulnerable children, resulting in poor outcomes.

Funding for this post is available and has been agreed within the current SEND budget.

The Committee approved the Service Specification.

RESOLVED: That the above is noted.

Learning Disabilities Intensive Support Service Specification

CCM494 Sarah Fellows presented an assurance report to the Committee along with the Service Specification for a learning disability intensive support service, to be provided by Black Country Partnership Foundation Trust as part of the delivery plan under Transforming Care.

The vision put forward by NHSE was for system-wide change to enable more people to live in the community, with the right support, and close to home. Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Association of Children's Social Services (ADCS) the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH), the Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

The national plan, Building the Right Support, that has been developed jointly by NHS England, the LGA and ADASS, was the next key milestone in the cross-system Transforming Care programme, and included the development 48 Transforming Care Partnerships across England to re-shape local services, to meet individual's needs. This is supported by a new Service Model for commissioners across health and care that defines what good services should look like. It is anticipated that Wolverhampton CCG will reduce their inpatient usage by 65% over the next three years.

In 2015/6 and following a previous report to Commissioning Committee, the CCG disinvested from two inpatient beds based at Pond Lane. This was in response not only to the national agenda to reduce inpatient care levels, but also because there was considerable underperformance on the contract. Negotiations have been undertaken with BCPFT regarding the reinvestment of the money attached to this level of inpatient care into a community-based alternative – an Intensive Support Service. This specification has now been agreed by the provider (BCPFT), and an implementation plan is being developed in order to implement the new service in July 2016. The Intensive Support Service is being funded through the resources disinvested from inpatient beds (£436,000).

RESOLVED: The report was received, discussed and noted by the Committee.

GP Prescribing Incentive Scheme 2016/17

CCM495 Chaired by Steven Marshall.

Hemant Patel presented a report to the Committee, with a request from the MMO Programme Board, to approve the amendments to the Prescribing Incentive Scheme 2016/17.

RESOLVED: The Committee supported the recommendation made for the scheme to progress.

Step Up Bed Specification

CCM496 Chaired by Steven Marshall.

Maxine Danks presented a report to the Committee with a request to approve a 12 week step up bed pilot at Probert Court Care Home.

The provision of step up care aligns with the local Intermediate Care Strategy and the delivery of care closer to home as detailed within the NHSE 5 year forward view.

Patients will have their condition stabilised in the community and access to beds will be strictly monitored to ensure appropriate clinical usage. The maximum length of stay will be 72 hours and a discharge plan will be developed on admission.

The current situation is that, anecdotally, a number of admissions could have been avoided if step up provision had been available. This provision will provide evidence to support this.

There are no additional costs of funding the pilot as costs will be contained within the block contract held with Probert Court Care Home.

An evaluation of the pilot will take place and will include a review of bed utilisation and the number of admissions avoided.

RESOLVED: The pilot was approved by Commissioning Committee.

Black Country Transforming Care Partnership

CCM497 Fred Gravestock presented the Committee with an assurance report and the draft Black Country Transforming Care Partnership (TCP) Plan.

The plan builds on other transforming care work to strengthen individuals' rights, to roll out care and treatment reviews across England, to reduce unnecessary hospital admissions and lengthy hospital stays, and test a new competency framework for staff to ensure we have the right skills in the right place.

The Transforming Care programme is focusing on addressing long-standing issues to ensure sustainable change that will see:

- More choice for people and their families, and more say in their care
- Providing more care in the community, with personalised support provided by multi-disciplinary health and care teams
- More innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs
- Providing early more intensive support for those who need it, so that people can stay in the community, close to home
- But for those that do need in-patient care, ensuring it is only for as long as they need it.

Since the beginning of the implementation of the Transforming Care Programme, Wolverhampton has typically had 10 patients in CCG funded care. These hospital placements range in provision and include short-term assessment and treatment, locked rehabilitation, and forensic rehabilitation. They are usually provided under the Mental Health Act, with

a number of offenders subject to Hospital Orders or Ministry of Justice restrictions (with hospital being used as a more appropriate environment than prison). By 2019, the programme will require Wolverhampton CCG to have reduced its reliance on inpatient care from 10 beds to 3. Currently Wolverhampton CCG is funding 6 adults with learning disabilities in inpatient care.

RESOLVED: The report was well received by the Committee and a quarterly progress update requested.

Any Other Business

CCM498 None.

Date, Time & Venue of Next Committee Meeting

CCM498 Thursday 30th June 2016 at 1pm in the CCG Main Meeting Room.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 26th April 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
Mrs H Pidoux	Administrative Officer

1. Apologies

There were no apologies submitted for the meeting.

2. Declarations of Interest

FP.16.39 There were no declarations of interest.

3. Minutes of the last meeting held on 29th March 2016

FP.16.40 The minutes of the last meeting were agreed as a correct record.

One amendment to be made to item FP.16.31 QIPP Report, forecast delivery at Month 11 reported at £10.5m should read as reported at £10.3m.

4. Resolution Log

FP.16.41 There were no open actions at this time.

5. Matters Arising from the minutes of the meeting held on 29th March 2016

FP.16.42 There were no matters arising from the minutes of this meeting.

6. Finance Report

FP.16.43 Mrs Sawrey introduced the report which contained the draft year end financial position of the CCG as at 31st March 2016 as contained in the draft annual accounts. It was noted that the financial position will not be final until the annual external audit is completed. The External Auditors will be on site at the CCG from week commencing 2nd May.

Mrs Sawrey reported that the accounts were submitted with the annual report in advance of the NHS England deadline. She explained that the CCG planned to achieve a surplus of £5.9m. Following discussions with NHS England (NHSE) agreement was reached to extend this to £6.9m. The CCG actually achieved a further £67k about this.

Plans are in place to draw down over the next 3 years any surplus more than the required 1% (as requested by national guidance); however, further guidance is awaited as to whether the CCG will be able to do this in16/17.

Dr Bush queried if there were plans in place to spend the non-recurring money if agreement is given that this can be drawn down. Mr Marshall reported that there are plans that have been developed and are on hold until it is confirmed that the money is available. The aim of the plans is to reduce non-elective activity with a move of services to the Community.

Resolved: The Committee;

- noted the contents of the report and the update given.

6. QIPP Report

FP. 16.44 Mrs Sawrey reported that the QIPP delivery year to date at month 12 was £10.3m against the target of £11.8m. This means that delivery is at 87% of the QIPP target. This is the best performance since becoming a CCG.

The undelivered QIPP of 13% or £1.5m has been covered in the reported financial position of the CCG.

Resolved: The Committee;

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

7. Monthly Contract/Performance Report

FP.16.45 **Contract and Procurement**

Mr Middlemiss gave an update on the current contract negotiations position since the report was submitted to the meeting;

- Royal Wolverhampton NHS Trust (RWT) – contract signed off with the caveat that 2 key CQUINS are still to be agreed. These have been discussed throughout negotiations and both parties have agreed to resolve these outstanding issues by the end of May.

- Black Country Partnership Foundation Trust (BCPFT) – this contract has been signed. There is an increase in value from 15/16 and there are reviews planned in 2016/17 relating to service specifications and CQUIN work.

- West Midlands Ambulance Service (WMAS) – the host commissioner has confirmed that this contract has been signed. WCCG has increased its amount of investment from 2015/16 along with other local CCGs. It was noted that the amount is within the value contained in the Long Term Financial Model.

  Mrs Skidmore reported that the level of growth across commissioners has been modelled and this has indicated that Wolverhampton is an outlier compared with other local CCGs with a higher level of growth. This will be monitored over the next 12 months to identify what is happening in the system to cause the growth and how to address this.

It was noted that the offers relating to the outstanding contracts to be agreed and signed are not materially different from the CCG's plan.

The Procurement Schedule was considered and updates given since the report was issued as follows;

- Step Down/CHC Framework – valuation stage is complete. 8 providers have met the criteria and this will be taken forward to the next stage.

- MSK – no bids were submitted at ITT stage. A meeting is planned to reconsider procurement options.

- Translation – The Governing Body agreed at a private session that an OJEU procurement process should be undertaken.

- AQP Audiology – this process is live and the closing date is in 2 weeks' time.

- Non-Emergency Patient Transport (NEPTs) – bids have been received and scored and this procurement is moving to bidder interview stage.

- Independent Living Equipment Service – discussions have taken place with the Local Authority regarding a joint procurement. Consideration is being given to the viability of this approach including timescales and the level of risk for the CCG.

Mr Oatridge raised a query with regards to contracts which are nearing the time when a reprocurement process is required. He reported that it had been raised as a concern as both Commissioning Committee and Governing Body are often asked to agree 3 month extensions to contracts to allow the process

to be completed. It was agreed to attach the Contract Register as an appendix to this report for this Committee's information going forward.

Resolved: The Committee

- Noted the content of the report and the updates given
- Requested that the Contract Register in date order is appended to this report in the future.

FP.16.46 **Performance**

Mr Bahia reported that at Month 11, of the indicators, 61 are green and 40 are red. There are in total 122 indicators, 21 of which are for information only. The following key points from the report were highlighted;

- RTT (Referral to Treatment 18 weeks) – performance continues to meet headline target and this is expected to continue to year end. Work continues to improve the failing specialities General Surgery, T&O, Oral Surgery and gynaecology. The recovery plans for Urology are dependent on recruitment.

- A&E 4 hour waits – performance issues continue, the Remedial Action Plan trajectory of 90% has been missed. The Vocare Urgent Care Centre opened with a skeleton service in March and was fully opened on 1st April. As yet no significant improvement in activity has been seen, it is expect that this could take time to improve as the service becomes embedded. It was noted that there has been discussion around how the activity is counted and a meeting is planned to discuss how it should be reported.

- Cancer Waits (62 days) - targets continue to breach. The actions set out in the agreed Remedial Action Plan have mostly been met; however, currently trajectory indicates that the revised target agreed in the Plan is unlikely to be met. Guidance has been issued in relation to tertiary referrals and the issue of fines. This continues to be a concern and is being reviewed. It was noted that this target is being missed across the board locally and therefor it is not possible to refer elsewhere. Concerns are on-going regarding the recruitment of Urology Consultants which is a national problem.

- DTOC (Delayed Transfer of Care) – trend over the year has shown a significant improvement in performance. A stretch target has been agreed with RWT for 2016/17.

- IAPT (Percentage of people who are moving to recovery of those who have completed treatment in the reporting period) – work last year increased the number of patients; work was also carried out to the model of care and how to count activity. A marked change was noted in September last year and is expected to hit target in March this year. It is planned to respectively look back at counting figures for the first 6 months and it is expected that an improvement may be seen.

Resolved: The Committee;

- Noted the contents of the report.

8. Constitutional target requirements for 16/17

FP.16.47 Mr Bahia reported that a significant number of submissions have been made to NHSE over the last 6 months relating to planning and modelling for 2016/17. The final submissions had been made the week prior to this meeting. The final submission relating to the Quality Premium is due to be submitted by Friday 29th April and 3 local priority indicators have been identified.

A report will be brought to the May Committee meeting giving greater detail and the finalised documents,

Resolved – The Committee;

- Noted the update
- Will received a detailed report at the next meeting.

9. Any other business

FP.16.48 Mr Oatridge raised a query following discussion at a Governing Body Development Session as to how assurance is gained that information received is correct.

Mr Hastings reported that audits had been completed in 2015/16 relating to this area, (an overview of data quality to provide assurance on performance and clinical quality).

It was suggested that the outcome of the audit reports were shared with the Committee for broader discussion at the next meeting.

It was noted that some data sets do change as the initial data received is a snapshot at that time. The data is then validated and reported at a later stage.

Resolved – The Committee

- Noted the concerns of the Governing Body and the need for assurance.

- Outcomes of data quality audits to be shared and discussed at the next Committee meeting.

10. Date and time of next meeting

FP.16.49 Tuesday 31st May 2016 at 2.00pm, CCG Main Meeting Room

Signed:

Dated:

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 31st May 2016
Science Park, Wolverhampton

Present:

Dr D Bush	Governing Body Finance and Performance Lead (Chair)
Mrs C Skidmore	Chief Finance and Operating Officer

In regular attendance:

Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement
Mrs H Pidoux	Administrative Officer

1. Apologies

Apologies were submitted for the meeting by Mr Oatridge, Mr Marshall, Mr Hastings and Mrs Sawrey.

It was noted that the meeting was not quorate, however, no decisions were required to be taken.

2. Declarations of Interest

FP.16.50 There were no declarations of interest.

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

FP.16.51 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.16.52 Item 84(FP.16.45) – Contract Register in date order is appended to the contract/procurement report – register appended to report on agenda – action closed.

Item 85 (FP.16.47) – Constitutional target requirements for 16/17 – detailed report on agenda – action closed.

Item 86 (FP.16.48) – Assurance re data received – outcomes of data quality audits to be shared and discussed at the next meeting – on agenda – action closed.

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

FP.16.53 Item FP.16.45 – MSK Procurement – Mr Middlemiss provided the Committee with an update from the Commissioning Committee discussions. It was noted that external advice has been sought and a project group set up to review the options which will be taken back to the Commissioning Committee.

6. Finance Report

FP.16.54 Mrs Skidmore reported that the budgets have been loaded for 2016/17 and appended to the report. Mrs Skidmore highlighted that the QIPP target for 2016/17 is £11.2m

It was noted that discussions have taken place internally and Finance and Performance Committee reporting will change from Month 2 onwards. The aim is to better present finance and non finance information to aid discussion at the meeting. Changes will also be made to the performance and contracting reports to ensure the documents align and do not duplicate reporting.

Resolved: The Committee;

- noted the contents of the report and the update given.

7. Monthly Contract and Procurement Report

FP. 16.55 Mr Middlemiss introduced the report and reminded the Committee that the Contract Register was appended to the report as requested at the last meeting. It was caveated that this is a working document, showing the point in time when the report was written.

Mr Middlemiss reported that going forward colour coding will be used in the Register to indicate the contracts coming up for renewal. The Register will be brought to the Committee on a quarterly basis.

Where the information relating to Remedial Action Plan (RAP) should be reported was discussed and it was agreed that this should remain in the Contracting Report. However, going forward the Performance report should be before the Contract and Procurement report on the agenda in order to assist with the 'flow' of discussion..

A procurement update was given including the requirement to submit a monthly return to NHS England relating to procurements that have either commenced or are due to commence. There is a substantial amount of information required to be submitted for each procurement. The details of the submissions will be included in the report to this Committee going forward.

Resolved: The Committee;

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

8. Performance Report

FP.16.56 Mr Bahia highlighted that the position deteriorated slightly at month 12. It was confirmed that RWT have signed up to delivering 2016/17 Remedial Action Plan trajectories and are held to account by the CCG and nationally by NHS Improvement.

The following key points from the report were highlighted;

- A&E 4 hour waits – performance issues continue. Currently the figures do not include Urgent Care Centre figures. The Centre commenced operating in shadow format in March 2016 and went live from 1st April 2016. Discussions are on-going to include the figures going forward and a meeting has been arranged to resolve data sharing issues. The aim is to incorporate all figures from 1st July 2016. A number of issues continue to affect performance and a revised version of the RAP has been received by the CCG from RWT and is currently under review.

- Cancer Waits – A RAP has been received from RWT including a recovery date of June 2016. RWT have indicated that it will be a challenge to meet this date. The issues reported previously for Urology and Tertiary Referrals continue to impact on performance. A final report is awaited including the final recommendations to be put in place.

- E-Discharge – This target is being breached by the Assessments Units. A meeting has been held which included the RWT Clinical Director to discuss issues, training and identify areas of concern. Stringent performance management is in place. The CCG supports the business case to improve E-Discharge. A RAP is in place and if performance from the wards does not recover RWT will be asked to include this in the action plan alongside the assessment units.

Fine reinvestment was raised and it was confirmed that a business case has to be put together for each request. Mr Middlemiss agreed to raise at the next Clinical Quality Review Meeting the requirement for evaluation to be made mid-year relating to the areas where reinvestment has occurred.

It was reported that for the first time in 20 years there have been no reported MRSA breached across RWT and the CCG in year.

Significant work relating to IAPT has been carried out over the last 2 years and movement to recovery continues to be seen.

Early intervention Services (EIS) were discussed as patients failing to attend for appointments is a challenge and is impacting on the ability to hit target. It was noted that there is not a RAP in place, however, there is potential for a Contract Intervention Notice to be issued. This issue is on the agenda for the next Contract Review Meeting with BCPFT and the outcome will be reporting back to this Committee if necessary.

Resolved: The Committee

- Noted the content of the report and the updates given

9. Constitutional target requirements for 16/17

FP.16.57 Mr Bahia reminded the Committee that at the last meeting it had been discussed that a significant number of submissions had been made to NHSE with the last submission due at the end of April. The submission was made prior to the deadline and included in the Operational Plan.

Sustainability and Transformation Plans are to be submitted at the end of June 2016. Meetings, including finance, are onging and sign off will be from the NHSE Area Team.

The Committee took assurance from the demonstration of the robust process in place and noted an appreciation of the scale and breath of the information submitted.

Resolved – The Committee;

- Noted the update and took assurance from the content of the submission.

10. Internal Audit Report – Overview of Data Quality (Assurance on Performance and Clinical Quality

FP.16.58 Mrs Skidmore informed the Committee that this report was shared following a request from the Governing Body, at the previous Committee meeting, for clarification as to how assurance is gained that information received by the CCG is correct.

The Audit Report gave a substantial rating and included recommendations where things could be done better. Assurance had been taken from the report that systems and processes are in place providing checks and balances.

Mr Bahia clarified that reconciliation of data is included in the CCG's process and full audit trails are kept.

Resolved – The Committee

- Noted the outcome of the audit and took assurance from the audit opinion and content of the report.

11. Any Other Business

FP.16.59 Prescribed Specialised Services – jointly implementing the new identification rules for 2017-18 Publications.

Mrs Skidmore highlighted that a mapping exercise is underway which will provide the details to enable a re-alignment of funding between commissioning allocations in line with a consistent set of identification rules.

RWT will be required to submit data at a national level which will go towards aligning where the budget will sit. However, as the activity mapped for 14/15 included activity in North Staffordshire, this is not felt to be a representative view and it has been requested that a different time period is used for the review. Further guidance is awaited.

Resolved – The Committee;

- Noted that a mapping exercise is underway and the issues with the timeline for activity.

12. Date and time of next meeting

FP.16.60 Tuesday 28th June 2016 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

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NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 19th April 2016 commencing at 11.20am
In Main Meeting Room, Science Park, Wolverhampton

Attendees:

Members:

Mr J Oatridge	Chairman
Mr P Price	Independent Lay Member
Mr L Trigg	Independent Lay Member

In Regular Attendance:

Ms A Breadon	Head of Internal Audit, PwC
Mr J Kelly	Local Counter Fraud Specialist, WMAS (part meeting)
Ms D Kortus	Manager, Counter Fraud Specialist, PwC (part meeting)
Mr C Larby	Deputy Head of Audit and Assurance, WMAS (part meeting)
Mr P McKenzie	Corporate Operations Manager, WCCG
Mr G Mincher	Internal Audit, WMAS (part meeting)
Mr H Rohimun	Executive Director, E&Y LLP
Mrs C Skidmore	Chief Finance and Operating Officer, WCCG
Mr M Surridge	Senior Manager, E&Y LLP
Mrs H Pidoux	Administrative Officer, CCG (minute taker)

In Attendance

Dr H Hibbs	Chief Officer, WCCG
Mrs S Southall	Head of Quality and Risk, WCCG (part meeting)
Miss M Patel	Administrative Support Officer, WCCG (observer)

Apologies for attendance:
AGC/16/27 No apologies for absence were submitted.

Declarations of Interest
AGC/16/28 There were no declarations of interest.

Minutes of the last meeting held on 23rd February 2016
AGC/16/29 The minutes of the last meeting were agreed as a correct record.

Mrs Southall joined the meeting

Matters arising (not on resolution log)

AGC/16/30 The following was raised;

- AGC/16/16 – the benchmarking of risk management against that of other CCGs. This action is to be added to the Committee's action log and brought back to July meeting.

Resolution Log

AGC/16/31 The resolution log was discussed as follows;

- Item 65 (AGC/16/07) – Discuss with PwC the timetable for presentations of reports to AGC to ensure a more even spread of reports throughout the year – discussions have taken place – action closed.
- Item 66 (AGC/16/09) – Final Head of Internal Audit Opinion to April meeting – on agenda – action closed.
- Item 67 (AGC/16/10) – Updated internal audit plan 2016/17 to April meeting – on agenda – action closed.
- Item 68 (AGC/16/14) – Updated Counter Fraud Plan 2016/17 to April meeting – on agenda – action closed.
- Item 69 (AGC/16/15) – EY to share with Committee how much reliance is placed on 3rd party/service auditor reporting and include in report – no reports issued yet for year end, these are expected late April/early May. Reports will be shared when received.
- Item 70 (AGC/16/16) – Committee to consider a Deep Dive from the Risk Register on a quarterly basis – first deep dive taken place at Senior Management Team (SMT). Feedback to be brought to July meeting. Deep dives to be embedded into structure.
- Item 71(AGC/16/17) – Annual Governance Statement – updated draft to be brought to April meeting – on agenda – action closed
- Item 72 (AGC/16/18) – CCG's Chief Officer and Chair to be invited to attend Committee's April and May meetings – offer extended – action closed.
- Item 73 (AGC/16/19) – Recommend to Governing Body that revised Conflict of Interest Policy to be adopted – Governing Body accepted recommendation – action closed.
- Item 74 (AGC/16/20) –
  - Auditor Panel – Terms of Reference to go to Governing Body in March for final approval – approved by Governing Body – action closed.
  - First Auditor Panel meeting to be held on 19th April 2016 – meeting held and decision taken to use established framework route. Going forward action plan to be drawn up. It is expected that deadlines will be met – action closed.

Mr Mincher left the meeting

Risk Register Reporting/Board Assurance Framework

AGC/16/32 Mrs Southall presented the Committee with a summary of red risks and risk scores as at the end of Quarter 4. She gave an overview of the 8 current live red risks. It was noted that 2 risks have increased from amber to red in the last quarter and 2 risks have been downgraded from red to amber.

Mr Mincher re-joined and Mr Kelly joined the meeting

It was noted that due to the timing of reporting and committee meetings, this report will be shared with the Quality and Safety Committee in May and an executive summary will be taken to Governing Body in June.

Mrs Southall reported that the revised Risk Management Strategy was ratified by the Quality and Safety Committee at its April meeting. One outcome from this is that a scorecard approach will be used for scoring of risk going forward to 2016/17.

Mr Price raised a query regarding the continual rating of Tier 4 CAMHS (risk ID 267) as red as this has not reduced since the risk was identified. It was clarified that this risk has been discussed by SMT on numerous occasions and the recent deep dive had included scrutiny of this risk. Actions have been taking place to reduce the risk and mitigating controls put in place. However, this risk also sits with Specialised Services at NHS England (NHSE). It was reiterated that this risk is well managed locally but remains a national issue and has now been included on the NHSE risk register.

Dr Hibbs gave assurance that there is an increase in ownership and accountability relating to risk and that there is a good oversight at a number of forums.

RESOLUTION: The Committee;

- noted the contents of the report and the actions being undertaken.
- Took assurance from the increase in ownership and accountability.

Mrs Southall and Mrs Kortus left the meeting.

Management Action Plan Update

AGC/16/33 Mr Mincher informed the Committee of the current position in respect of implementation of audit recommendations. As at 31st March 2016 there are 1 red and 8 amber rated overdue recommendations relating to 5 audit reports.

These had been reviewed at SMT on 5th April and the outstanding actions and implementation dates agreed.

Ms Kortus re-joined the meeting.

It was confirmed that the outstanding actions will be handed over and will be monitored by the new Internal Auditors.

RESOLUTION: The Committee:

- Noted the contents of the report and current position.

Internal Audit Annual Report

AGC/16/34 Mr Mincher introduced this report and stated that to date there is nothing to prevent a Significant overall opinion with regard to the CCG's internal control system.

Mr Mincher explained that included in the report was an overview of the domains audited against compared to the outcomes last year. Every domain now has a Substantial opinion. It was highlighted that 90% of recommendations agreed in 2015/16 have either been implemented or are not yet due. SMT has agreed revised implementation dates for Red rated actions. Outstanding recommendations will be handed over to the incoming Internal Auditors for them to monitor.

RESOLUTION: The Committee:

- Noted the contents of the report and accepted the key headlines.

Head of Internal Audit Opinion on Internal Control

AGC/16/35 Mr Larby gave the Head of Internal Audit's draft annual opinion. The overall opinion is that Significant assurance can be given. Mr Larby explained that this is given in accordance with NHS Internal Audit Standards and is based upon and limited to the relevant Internal Audit work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

It was highlighted that whilst the overall opinion is the same as last year, and improvement is still required in some areas, there has been improved performance in a number of areas following the implementation of audit recommendations.

RESOLUTION: The Committee

- Noted the content of the report and the overall annual opinion.
- Noted the improvements relating to the control environment.
- Thanked the out-going WMAS Internal Auditor's for their work with the CCG since its inception.

Local Counter Fraud Specialist Progress Report including Self Review Tool (SRT)

AGC/16/36 Mr Kelly informed the Committee of activity undertaken as part of the Counter Fraud annual work plan as follows;

- The Staff survey has been completed. A final report is being compiled and a number of recommendations discussed with the Chief Finance and Operating Officer (CFOO). The final report will be shared with Committee members.
- A proactive exercise has been completed to examine the pre-employment checks undertaken on clinical staff employed by the CCG. A final report has been shared with the CCG and recommendations relating to appropriate checks have been agreed going for all new employees to the CCG.
- An investigation into a pharmacy in Wolverhampton, previously discussed at this Committee, is on-going. A meeting has been held with the new Counter Fraud providers to handover the documentation for them to continue the investigation.
- An update was given regarding the Self Review Tool; work will be completed by the outgoing LCFS up to the end of March 2016. Going forward this will be completed by the new LCFS provider (to be submitted by 31st May 2016).

RESOLUTION: The Committee

- Noted the update contained in the report.
- Staff survey report to be shared with Committee members when finalised.

Local Counter Fraud Annual Report

AGC/16/37 Mr Kelly introduced the final Counter Fraud Annual Report which provided a summary of the activity during 2015/16. It was reported that no investigations had been finalised for frauds identified in 2015/16.

RESOLUTION: The Committee

- Noted the contents of the report
- Thanked the WMAS Counter Fraud Team for their work with the CCG since its inception

Internal Audit Plan 2016/17

AGC/16/38 Ms Breadon explained that the plan has been developed in line with discussions with the CCG's Chief Officer and CFOO including the frequency of the required audits. It is anticipated that the plan will develop over the next 12 months.

Mrs Skidmore stated that a meeting had taken place between the CCG's Directors and PwC internal auditors to discuss the areas to be audited.

Mr Oatridge raised a concern regarding the Better Care Fund (BCF) audit being planned for year 3 and safeguarding audit scheduled for year 2. Assurance was given that a Safeguarding audit was completed in

2015/16 and recommendations from this were being taken into 2016/17 and there is a need for these and new services to become embedded before further audits are completed. It was reported that BCF is audited through strands of other audits and that is part of the External Audit including the financial reporting aspects. As this is a significant risk to the CCG the outcomes of this will be closely considered.

Discussion took place regarding the frequency requirements for information governance audits. Mr McKenzie was asked to clarify this with PWC. It was noted that good feedback was received this year.

Mr McKenzie reported that there is a requirement to audit Conflicts of Interest yearly as part of the annual plan. This will be completed later in the year as part of corporate governance due to the recent publication of guidelines relating to this area. The CO and CFOO confirmed that they had agreed this approach.

RESOLUTION: The Committee

- Noted the contents of the report.
- Asked Mr McKenzie to clarify the frequency requirements for information governance audits.

Counter Fraud Plan 2016/17

AGC/16/39 Ms Kortus informed the Committee that Neil Mohan is the Senior Manager for NHS Counter Fraud work at PwC and that she and Gina Lekh, supported by a nation team, would be the Local Counter Fraud Specialist (LCFS) for the CCG going forward.

Ms Kortus explained that the Plan was built on the four key principles set out in the Standards for Commissioners. A fraud risk group is to be established at the CCG, facilitated by PwC.

The Plan was considered and Mr Oatridge raised a query regarding the time commitment. Mrs Skidmore commented that this was not comparable against previous plans as the working model is very different to that of the previous provider. The CCG has deliberately opted for a different model.

RESOLUTION: The Committee

- Noted the contents of the report.

External Audit Progress Report

AGC/16/40 Mr Surridge reported that the interim audit at the CCG was completed in February/March 2016 and the Team would be in the offices for the final audit at the beginning of May.

One observation has been made in relation to the treatment of journals. It was reiterated that this was an observation and not a recommendation and that it was not unusual for a small CCG finance team to operate in this way. It is not a materiality threshold and there are no concerns, the observation made was around practice. Mrs Skidmore commented that this is a balance of risk in a small team and an entry will be made on the risk register as a low mitigated risk. The External Audit team will focus testing on this type of journal.

Mr Oatridge raised a query regarding the joint arrangements relating to BCF. It was clarified that the principles have been discussed and the External Auditors do not disagree with the CCG's management view.

RESOLUTION: The Committee:

- Noted the contents of the report.
- Mrs Skidmore to add entry to risk register to reflect the mitigated risk.

Draft Committee Annual Report

AGC/16/41 Mr McKenzie reminded the Committee that this report was presented to the Committee at its last meeting. The outcome of the self-assessment has shown that the Committee is operating effectively and in accordance with its Terms of Reference.

The report was considered and it was requested that paragraph 2.18 be amended to give further details in relation to SMT's role in 'deep-dives'.

RESOLUTION: The Committee noted

- The content of the report.
- Took assurance that it is operating effectively and in accordance with its Terms of Reference.
- Paragraph 2.18 to be revised in line with discussions.

Conflict of Interest

AGC/16/42 Mr McKenzie explained revised guidance for managing Conflicts of Interest for CCGs has been issued for consultation by NHS England and he highlighted the key points summarised in the report;

- Increasing the number of Lay Members on the Governing Body – needs to be addressed and how to do this is being discussed.
- Conflict of Interest Guardian – this has been discussed with Mr Oatridge as the Chair of Audit and Governance Committee and he will be taking on this role.
- Gifts and Hospitality – sponsorships of events will need to be revisited following the guidance.

Concerns were raised relating to how to manage the register of conflicts of interests in member practices.

It was agreed that following discussion with Mrs Skidmore and Mr Oatridge, Mr McKenzie will respond the NHSE with the CCG's comments.

RESOLUTION: The Committee

- Noted the contents of the report and guidance
- Asked Mr McKenzie to submit a response to NHSE on its behalf.

Losses and Compensation Payments – Quarter 4 2015/16

AGC/16/43 The CCG has not recorded any losses during quarter 4 of 2015/16 and has not made any special payments during the same time period.

RESOLUTION: The Committee noted the contents of the report.

Suspension, Waiver and Breaches of SO/PFPs

AGC/16/44 There have been no suspensions of SO/PFPs. The ten waivers raised have been dealt with appropriately.

RESOLUTION: The Committee noted the contents of the report.

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

AGC/16/45 The Committee noted that as at 31st March 2016 there were;

- 0 sales ledger invoice greater than £10k and over 6 months old
- 4 purchase ledger invoices greater than £10 and over 6 months old- these relate to NHS Property Service, resolution to issues being a national issue.

RESOLUTION: The Committee noted the contents of the report and updates given.

Better Care Fund Accounting Treatment

AGC/16/46 Mrs Skidmore explained that this report, showing technical consideration and accounting treatment, had previously been shared and discussed at the March meeting of the Finance and Performance Committee.

Mr Surridge confirmed that the External Auditors have reviewed the details and were comfortable with the approach taken. They will be testing its application within the CCG accounts are part of their audit.

RESOLUTION: The Committee;

- Noted the content of the report.
- Supported the accounting treatment described.

Draft Annual Report
AGC/16/47

Draft Annual Governance Statement

Mr McKenzie presented the draft statement, prepared in line with national guidelines and which draws on a range of sources of evidence to describe the CCG's systems of internal control. The statement also reflects feedback from delegation chains, such as with Clinical Commissioning Groups.

Dr Hibbs confirmed that she had reviewed the statement and that no significant internal control issues have been identified for the CCG in 2015/16.

Mr Surridge commented that they would be taking a more detailed look at the report during their final audit.

RESOLVED: The Committee;

- Noted the contents of the Statement.
- Noted the Chief Officer's assurance on internal controls.
- Noted that the Statement will be submitted with the final accounts on 22nd April 2016.

Draft Final Accounts

A working draft of accounts had been shared with the Committee. Mrs Skidmore confirmed that the final submitted accounts would be shared one they had been submitted. She asked the Committee to note that the bottom line figure would not change prior to submission. More information i.e. additional references, policies and pooled budgets had been added since the draft was shared with the Committee and further work was required around narrative and presentation. The deadline for submission is 9.00am on Friday 22nd April. It was not anticipated that there would be any problems meeting the deadline.

Mrs Skidmore reported that the CCG had met and exceeded the surplus target set by NHSE and also the Better Payment targets.

It was noted that the QIPP target for the 15/16 was £11.8m and just under £10.5m was delivered. Whilst this did not meet the target, Mrs Skidmore highlighted that these were the highest savings ever achieved; previously the savings were between £7m-£8m per year.

RESOLVED: The Committee;

- Noted the contents of the draft final accounts and the actions being undertaken prior to submission.
- Noted the achievements in meeting targets.

Any other business

AGC/16/48 There were no items raised under any other business.

Date and time of next meeting

Tuesday 24th May 2016 at 11.00am in the CCG Main Meeting Room, Science Park

Signed:

Dated:

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY TUESDAY 12 July 2016

Agenda item 24

Title of Report:	**Joint Negotiating Consultative Committee (JNCC)**
Report of:	Mike Hastings,
Contact:	Lisa Murray, Staff Side and UNISON representative
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To advise the Governing Body on discussions held at the last JNCC on 25th February, 2016
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	The CCG remains committed to maintaining a motivated and high performing workforce.
Relevance to Board Assurance Framework (BAF):	Outline which Domain(s) the report is relevant to and why – See Notes for further information
• **Domain 1:** A Well Led Organisation	A strong and motivated workforce will help the CCG to deliver against all of the BAF domains.

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

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body and provide assurance of the continued commitment of WCCG to work with staff side and staff to ensure their views are listened to and taken into consideration.

2. MAIN BODY OF REPORT

2.1. The Staff Survey launched in June 2015 has now been reviewed at the Staff Forum. The majority of the issues raised have been dealt with. A Staff Survey for 2016 is due to be launched shortly.

2.2. A Staff Away Day was being organised for June 2016. Current plans are to re-define the values of the CCG now that it has been in situ for three years. The CCG will be working with HR and Communications colleagues from the CSU to arrange the event.

2.3. The CCG continues to work with UNISON on providing all staff health and well-being awareness sessions in July / August 2016. The courses will be provided by the Open University, who delivers accredited courses on behalf of UNISON.

2.4. JNCC and WCCG are working together to ensure staff all have up to date Contracts. This is now almost complete.

2.5. Staff Side, HR and Mike Hastings, Associate Director of Operations are currently undertaking a self-assessment standards tool developed as part of Public Health England's Workplace Wellbeing Charter. This Charter is an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. The Charter will provide WCCG with an easy and clear guide on how to ensure WCCG is a supportive and productive environment in which employees can flourish.

2.6. Lisa Murray, the current Staff Side Representative, will be stepping down from her Staff Side role this year but is committed to continuing her involvement in the work around staff health and well-being awareness courses and WCCG obtaining Workplace Wellbeing Charter 'Good Employer Accreditation'.

3. CLINICAL VIEW

3.1. Not applicable for this update.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable for this update.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. WCCG wishes to continue developing and maintaining a strong workforce who delivers the best results for Wolverhampton. This is not possible if staff members feel demotivated and do not feel engaged with the organisation. This can manifest itself in low morale, high sickness levels and a high staff turnover. The JNCC ensures that WCCG continues to engage with and support staff.

Financial and Resource Implications

5.2. Not applicable for this update.

Quality and Safety Implications

5.3. Not applicable for this update.

Equality Implications

5.4. Not applicable for this update.

Medicines Management Implications

5.5. Not applicable for this update.

Legal and Policy Implications

5.6. Not applicable for this update.

6. RECOMMENDATIONS

6.1. To note the continued commitment of WCCG to consult with its staff and staff side representatives on any issues that impact on staff.

Name	**Lisa Murray**
Job Title	**Staff Side/UNISON Representative**
Date:	**27 July 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	**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)	**Claire Skidmore**	**21.12.15**

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting
Held on Tuesday 5 April 2016
Commencing at 2.00 pm in PC108, Creative Industries Centre, Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Manjeet Garcha	Executive Lead Nurse	Yes

NHS England ~

Alastair McIntyre	Locality Director	Yes
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	No
Ranz Baran	Finance Manager	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Cllr Sandra Samuels	Chair – Health and Wellbeing Board (WCC)	Yes
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	Yes
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	No
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Helen Hibbs	Chief Officer (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes

Welcome and Introductions

PCC70 Ms Roberts welcomed the Independent Patient Representatives to the Primary Care Joint Commissioning Committee and introductions took place.

Apologies for absence

PCC71 Apologies were submitted on behalf of Mike Hastings, Charmaine Hawker and Anna Nicholls.

Declarations of Interest

PCC72 Dr Bush, Dr Hibbs and Dr Kainth declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten and Ms Spencer declared that, in their role as employees of the University of Wolverhampton, they worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting Held on 1 March 2016

PCC73 RESOLVED:

That the minutes of the previous meeting held on 1 March 2016 be approved as an accurate record.

Matters arising from the minutes

PCC74 RESOLVED:

That there were no matters arising to be discussed.

Committee Action Points

PCC75 **Minute Number PCC19 Upcoming Issues for Provisional Work Programme**
It was noted that the reporting template will be brought to the May Committee meeting following the next planning deadline.

Minute Number PCC21 WCCG Estates Strategy
It was noted that this item is on the private Committee agenda for discussion.

Minute Number PCC38 West Midlands MOU for the Primary Care Hub
It was noted that an amendment to the commissioning status of the CCG was to be made to the MOU following discussion at the March 2016 WCCG Governing Body meeting. Ms Shelley to confirm with NHS England colleagues and bring the final MOU to the May Committee meeting.

Minute Number PCC53 Minutes of the Meeting held on 2 February 2016
It was noted that the requested amendments had been made.

Minute Number PCC54 Primary Care Models
It was noted that this item is on the Committee agenda for discussion.

Minute Number PCC61 Primary Care Commissioning Operations Management Group (PCOMG)
It was noted that this item is on the Committee agenda for discussion.

Minute Number PCC61 Pharmaceutical Involvement in Primary Care
It was noted that that Mr Blankley now attends the PCOMG meetings.

RESOLVED: That the above is noted.

New Models of Care

PCC76 Mr McKenzie presented this report in Mr Hastings absence and confirmed that the purpose of the report was to update the Committee on the emerging new models of care within the CCG membership.

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. 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 grouping and The Royal Wolverhampton NHS Trust (RWT) Vertical Integration (VI) arrangement.

Primary Care Home (PCH) Model
The PCH model is a collective of eight practices dispersed across the City and is currently in the very early stages, with a key focus on identifying areas where joint working would be beneficial. This includes working with the CCG to share data analysis work so that models of integrated working can be most effectively targeted. It was noted that patients are unlikely to see significant changes to the way services are delivered in the short term, the intention is that the learning from these pieces of work will then be used to support service development in future years.

RWT Vertical Integration Model

The VI model involves three practices across the City and is proposed to improve working between the Trust and GP practices with the intention of practices sub-contracting the delivery of services to RWT. It was noted this model was still in the very early stages and that ongoing discussion was taking place between NHS England, RWT and the CCG regarding governance arrangements and the management of conflicts of interest.

The Committee felt that there was a lack of clarity around the detail of the models of care and in particular, concerns around quality, finance, governance and conflict of interest. A request was made that the Committee are kept updated on any developments within the proposed models.

Mr McIntosh queried at which point within the development would patients be engaged with. It was noted that in terms of the VI, engagement has taken place with the Patient Participation Groups at the practices concerned at this stage.

Discussion took place around the roll out date for the VI model and it was noted that it is currently deferred until 1 June 2016 pending a further joint meeting taking place at the end of April 2016.

RESOLVED: That the above is noted.

NHS England Update

PCC77 It was noted that there were no issues to be discussed currently.

RESOLVED: That a short report will be provided by NHSE outlining any activity throughout the month which impacts on Wolverhampton primary care.

NHS England Finance Update

PCC78 Mr Baran provided a verbal update and noted that Primary Care services for Wolverhampton CCG were on target to deliver a break even position. Reserves were previously reported to be under utilised with around £7000 of invoices against the £632,000 funds available. This amount is now at around £560,000 and accruals of a further £66,000 are expected by year end. Work is being undertaken on 2016/17 budget planning in accordance with changes to the GP contract and planning assumptions.

RESOLVED: That a report will be produced for the May 2016 Committee Meeting to outline the full schedule for the 2016/17 budget.

Wolverhampton CCG Update

PCC79 Dr Hibbs provided a verbal update and informed the Committee that Wolverhampton CCG are currently implementing the Primary Care Strategy and as part of this, are moving towards GP Locality meetings, members meetings and contract monitoring and continuous improvement meetings taking place on a quarterly basis.

Cllr Samuels joined the meeting.

It was noted that a GP lead for the South East Locality has been secured and Dr Dan De Rosa is currently interim Lead for the South West Locality.

A forthcoming review and evaluation of the Practice Support Visit programme is being undertaken along with a review of referral data. This is in view of a move to improved triangulation, monitoring and support to include involvement of NHS England and the Care Quality Commission.

Local Incentive Schemes for asthma and Chronic obstructive pulmonary disease (COPD) are being rolled out to provide improved enhanced review of those conditions in primary care.

The NHS 5 Year Forward View Project is underway which includes VI and PCH, there are potentially additional practices who are interested in exploring the PCH model and may be bidding in the next round.

A query was raised regarding the attendance of stakeholders at the GP Locality Meetings and it was confirmed that they are currently for GP members only. It was noted that there are plans for working groups with a broader membership to be formed to assist with the delivery of the Primary Care Strategy.

The Committee was informed that Wolverhampton CCG have now appointed to the post of Head of Primary Care and are recruiting a Primary Care Transformation Lead.

RESOLVED: That the above is noted.

Update on Primary Care Programme Board Activity March 2016

PCC80 Ms Garcha presented an update report to the Committee following the Primary Care Programme Board which took place on 11 March 2016.

It was noted that specialist advice is being sought regarding the interpreting procurement in view of a decision being made at the Primary Care Programme

Board. A query was raised regarding whether the library of languages would be revised and it was confirmed that the change of provider would mean an increased number of languages being available. It was noted that patient engagement was undertaken in the early stages of this procurement.

Cllr Samuels queried the links between the CCG and RWT with regards to diabetes. It was noted that the Wolverhampton Interface Care Knowledge Empowered Diabetes (WICKED) Programme is provided by RWT and work closely with Wolverhampton GPs. There is also a strong link between the CCG and RWT Diabetes services including an integrated data information centre.

Ms Roberts requested an update on the Urgent Care Centre. It was confirmed that the Centre went live in March 2016 and is currently in the bedding down period.

RESOLVED: That the above is noted.

Primary Care Commissioning Operations Management Group (PCOMG) Update

PCC81 Mr McKenzie presented an update report to the Committee following the PCOMG Meeting which took place on 22 March 2016.

It was noted that with regards to primary care quality, the use of wifi in GP practice waiting rooms was hoped to assist with patient participation in the Friends and Family Test.

The PCOMG approved the Medicines Management Policy templates for GP practices to use, which were supported by the LMC. Consideration is also being taken as to whether the templates can also be uploaded to DXS.

It was noted that a Health Visiting Service and Child Health Information Service lessons learnt meeting would be taking place following an issue raised through Quality Matters.

RESOLVED: That the above is noted.

Any Other Business

PCC82 Cllr Samuels queried when the outcome of the Primary Care Transformation Fund expressions of interests would be communicated. It was noted that the national guidance is not currently available so no bids can be submitted at this point.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC83 Tuesday 3 May 2016 at 2.00 pm, in the Stephenson Room, Technology Centre, Wolverhampton Science Park

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting
Held on Tuesday 3 May 2016
Commencing at 2.00 pm in the Stephenson Room, Technology Centre,
Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	Yes
Steven Marshall	Director of Strategy & Transformation	No
Manjeet Garcha	Executive Lead Nurse	Yes

NHS England ~

Alastair McIntyre	Locality Director	No
Gill Shelley	Senior Contract Manager (Primary Care)	Yes
Anna Nicholls	Contract Manager (Primary Care)	Yes
Karen Payton	Senior Finance Manager (Primary Care)	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes

Non-Voting Observers ~

Cllr Sandra Samuels	Chair – Health and Wellbeing Board (WCC)	No
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	Yes
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes

Welcome and Introductions

PCC93 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC94 Apologies were submitted on behalf of Steven Marshall, Alastair McIntyre and Cllr Sandra Samuels.

Declarations of Interest

PCC95 Dr Bush, Dr Hibbs and Dr Kainth declared that, as GPs they had a standing interest in all items related to primary care.

Ms Gaytten and Ms Spencer declared that, in their role as employees of the University of Wolverhampton, they worked closely with practices to arrange placements for student nurses and therefore had a standing interest in items related to primary care.

Mr McIntosh declared an interest in the item regarding the Primary Care Delivery Board as it mentioned the Sickle Cell and thalassaemia project that he is a trustee of.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

Minutes of the Meeting Held on 5 April 2016

PCC96 RESOLVED:

That the minutes of the previous meeting held on 5 April 2016 be approved as an accurate record.

Matters arising from the minutes

PCC97 RESOLVED:

That there were no matters arising to be discussed.

Committee Action Points

PCC98 **Minute Number PCC19 Upcoming Issues for Provisional Work Programme**
It was noted that Ms Shelley would raise the reporting template query with NHS England and report back to the Committee.

Minute Number PCC38 West Midlands MOU for the Primary Care Hub
Mr Hastings informed the Committee that the MOU has now been signed off by Wolverhampton CCG Governing Body and is currently being reviewed internally prior to being submitted to NHS England by 6 May 2016.

Minute Number PCC77 NHS England Update
It was noted that the NHS England Update was included on this meeting's agenda.

Minute Number PCC78 NHS England Finance Update
It was noted that the NHS England Finance Update was included on this meeting's agenda.

RESOLVED: That the above is noted.

General Medical Services (GMS) Contract Changes

PCC99 Ms Shelley presented a report which provided notification of the following GMS contract changes at Wolverhampton practices.

Date Received	Practice Code	Practice Name	Contract	Task	Detail	Status	Completion Date
22/03/2016	M92612	Grove Medical Centre	GMS	Addition	Addition of Dr Mohindroo	Completed	29/03/2016
22/03/2016	M92009	Prestbury Medical Practice	GMS	Removal	Remove Dr Morgan	Awaiting Application	
06/04/2016	M92612	Grove Medical Centre	GMS	Removal	Removal of Dr Surinder Julka	Awaiting Practice Signature	

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC100 In Mr McIntyre's absence, Ms Nicholls presented a report to update the Committee on the latest developments in primary medical care nationally and locally. The report included updates on the General Practice Forward View, GMS contract negotiations / changes and Primary Care Support England. It was noted that the process for close down on claims for Directed Enhanced Services and Quality and Outcomes Framework (QOF) is now well underway.

A query was raised regarding the Sustainability Transformation Plan (STP) and the deadlines involved. It was noted that the STP was a jointly developed Black Country document which was to be published by the end of July 2016.

Discussion took place around the impact of the standard NHS acute contract compliance on GPs and the clauses on the general conditions in the contract which are the interface between the provider and the commissioner. The CCG is working with our providers to understand the contract requirements and welcomed Wolverhampton LMC / GP input to this work.

Discussion took place regarding methods of communication to GP practices and whether the clear channel of communication should come via the CCG or NHS England.

RESOLVED: That the above is noted.

That GP communication methods should be discussed at the next Primary Care Operational Management Group meeting.

NHS England Finance Update – Wolverhampton CCG2016/17 GP Services Budget

PCC101 Ms Payton presented a report in Ms Hawkers absence which outlined the 2016/17 Joint Commissioning GP Services budget for Wolverhampton CCG. It was noted that the allocation to fund GP services relating to Wolverhampton CCG for 2016/17 is £34.1 million. Allocations were calculated on the 2015/16 month 12 forecast outturn.

The planning metrics for 2016/17 were confirmed as follows:

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation fund of 1%

It was noted that the CCG are not required to deliver a surplus of 1% on their GP services allocations, this remains with NHS England West Midlands.

RESOLVED: That the CCG Strategy and Transformation Team will provide a report to the June 2016 Committee Meeting outlining the PMS Premium schemes.

Primary Care Programme Board Update

PCC102 Ms Garcha referred to the previously circulated report and provided an update on the delivery of the Primary Care Delivery Board and the work programme for 2016/17.

It was noted that the interpreting procurement has now been approved with a recommendation to undertake an OJEU procurement. It is anticipated that the new service provider will be in place by August 2016.

RESOLVED: That the above is noted.

Primary Care Commissioning Operations Management Group (PCOMG) Update

PCC103 Mr Hastings provided an update following the PCOMG meeting which took place on 18 April 2016. It was noted that a draft report has been issued by the Care Quality Commission (CQC) to a Wolverhampton GP practice. Once comments are received, there is potential for the practice to be taken into special measures.

The Committee were updated on developments within Wolverhampton estates and informed that options appraisals were being undertaken in Bilston Urban Village, Bradley, Heath Town and Showell Park amongst others.

Mr McIntosh joined the meeting.

LMC raised a query around protected learning time for GPs, particularly relating to support to enable GP attendance at Team W.

RESOLVED: That the above is noted.

That the CCG will explore protected learning time options for GPs and update the Committee.

Wolverhampton CCG Update

PCC104 Mr Hastings provided an update on the CCG and the Better Care Fund (BCF). The Committee were informed that the BCF programme is in the process of finalising its national submission outlining its vision and focus for 2016/17 and detailing the outline plan to develop Integrated Health and Social Care here in Wolverhampton by 2019/20.

The focus for 2016 is to build on the successes of our work during 2015/16 on Mental Health and across Adult Community Care through the development of Community Neighbourhood Teams and the mobilisation of a Rapid Response Service provided by Community Matrons in a patients home.

Across Mental Health last year the focus was around urgent care which had great success in reducing emergency admissions.

In addition to this, worktreams around developing end to end Dementia Pathways and a Frail Elderly pathway will commence, we are in the process of improving the sharing of data across health and social care to improve patient care and quality, and work is continuing to rationalise our Estate across health and social care to build opportunity to house our emerging Community Neighbourhood Teams across the 3 localities in Wolverhampton.

RESOLVED: That the above is noted.

Any Other Business

PCC105 There were no other items raised for discussion.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC106 Tuesday 7 June 2016 at 2.00 pm, in the Stephenson Room, Technology Centre, Wolverhampton Science Park

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 27 April 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Sandra Samuels OBE	Chair, Cabinet Member for Health and Wellbeing
Councillor Val Gibson	Cabinet Member for Children and Young People
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Paul Singh	Shadow Cabinet Member for Health and Wellbeing
Councillor Roger Lawrence	Leader of the Council
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Professor Linda Lang	Wolverhampton University

Employees

Carl Craney	Democratic Support Officer
Glenda Augustine	Consultant in Public Health, Community Directorate
Viv Griffin	Service Director - Disability and Mental Health
Emma Bennett	Service Director - Children and Young People
Helen Child	Chief Officer, Wolverhampton CAB
Donald McIntosh	Chief Officer
Tony Marvell	Transformation Programme Manager
Neeraj Malhotra	Consultant in Public Health
Kevin Pace	HeadStart Programme Manager
Steven Marshall	Director of Strategy & Transformation
David Martin	Wolverhampton Samaritan's
Sara Goodwin	Interim Democratic Services Manager

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence had been received from Cllr Elias Mattu (City of Wolverhampton Council), and Jeremy Vanes (Royal Wolverhampton NHS Trust) together with David Laughton CBE (Royal Wolverhampton NHS Trust).

2 **Notification of substitute members (if any)**
Mike Sharon attended as a substitute member for Jeremy Vanes (Royal Wolverhampton NHS Trust).

3 **Declarations of interest (if any)**
No declarations of interest were made relative to items under consideration at the meeting.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 10 February 2016 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

With reference to Minute No. 5 (Matters arising), the Chair, Cllr Sandra Samuels OBE enquired whether a copy of the hyperlink with a supply of fliers on the "Beat the Streets" initiative had been forwarded to Ian Darch for onward transmission to voluntary sector organisations. Ros Jervis, Service Director – Public Health and Wellbeing confirmed that the hyperlink and a supply of fliers had been forwarded on.

With reference to Minute No. 5 (Matters arising) and following a question from the Chair, the Service Director – Public Health and Wellbeing confirmed that the attention of the JSNA Working Group had been drawn to the possible inclusion of the issue of TB within the emerging JSNA.

With reference to Minute No.10 (Joint Strategy for Urgent Care – Equality Analysis – Implementation of recommendations), Steven Marshall, Wolverhampton City Clinical Commissioning Group undertook to ensure that the relevant data in relation to training on equality and diversity undertaken by employees of WCCCG and RWT was provided to the Independent Chair of the Children's and Adults Safeguarding Boards.

With reference to Minute No. 13 (Francis Inquiry – progress on implementing recommendations), Helen Hibbs, Wolverhampton City Clinical Commissioning Group reported that work was on-going on the development of a quality and safety framework and that the outcome would be reported to a future meeting with a view to quarterly reports being submitted to the Board.

With reference to Minute No. 15 (NHS Planning and Strategic Transformation Plan 2016/17), Linda Sanders, Strategic Director – People reported that the next meeting in connection with this matter was scheduled to be held on Friday 29 April 2016.

6 **Chair's Update**

i) Matters considered by the Health and Wellbeing Board during the 2015/16 Municipal Year

The Chair circulated a document which outlined the matters considered by the Health and Wellbeing Board during the current Municipal Year.

ii) Workplace Wellbeing Award

The Chair reported that the City of Wolverhampton Council had entered the Workplace Wellbeing Award in connection with the work undertaken to address obesity in the City. The Service Director – Public Health and Wellbeing advised that the City of Wolverhampton Council, the University of Wolverhampton and the Royal Wolverhampton NHS Trust were working together on this initiative and that the former two organisations had been awarded Chartermark status with the latter organisation undergoing its assessment currently.

iii) "Sugar Tax"

The Chair referred to the Chancellor of the Exchequer's recent announcement in connection with the imposition of a sugar tax which would lead to a levy of between 18p and 20p being introduced on sugary drinks during 2017.

iv) "Beat the Streets"

The Chair reminded the Board that the "Beat the Streets" initiative had been launched on 27 February 2016 for a period of seven weeks. 190 Beat Boxes had been erected around the city with some 60,000 cards being made available. 78 schools and 21 community organisations had registered to participate with a total of 27,000 players registered. A sum of 196,395 miles had been walked / run collectively. She reported that awards had been made to Dovecotes Primary School (414,580 points), St Lukes Church of England School (316,800 points) and D'Eyncourt Primary School (231,000 points). Prizes had also been awarded to teams with the highest points per player with the City Economy Division of the City of Wolverhampton Council finishing in first place with 2145 points per player, Walking for Health group finishing second and TLC College and Nursery finishing in third place. It was hoped to repeat the initiative again next year subject to funding being available.

v) Lord Bilston Challenge

The Chair reported that the son of the late Lord Bilston was organising a 5 kilometre walk around Hickman Park, Bilston to raise funds for Compton Hospice. Anyone wishing to take part should meet outside the office of Pat McFadden MP on Saturday 30 April 2016. Further details were available from her following the meeting.

vi) Partnership and Sport

The Chair reported that an event was being held on 10 June 2016 at Aldersley Stadium on "partnership and Sport" when elen different activities would be available. It was hoped that over 800 primary aged children would participate.

7 **Summary of outstanding matters**

Viv Griffin, Service Director – Disability and Mental Health presented a report on the current position with a variety of matters considered at previous meetings of the Board. Dr Helen Hibbs advised that responsibility for the NHS Capital Programme was now with the Wolverhampton City Clinical Commissioning Group and that the report should be amended accordingly.

Resolved:

That the summary of outstanding matters be noted subject to responsibility for future reports on the NHS Capital Programme – GP practices in Wolverhampton being marked as the responsibility of Mike Hastings at the Wolverhampton City Clinical Commissioning Group.

8 **Health and Wellbeing Board Forward Plan 2015/16**

The Service Director – Disability and Metal Health presented a report on the Forward Plan for the Board. She reported that the report would be refreshed for the forthcoming Municipal Year to include regular reports on matters such as: i) Better Care Fund and ii) NHS Planning Guidelines – Strategic Plan 2016/17 and 2020 Integration Plan. Steven Marshall, Wolverhampton City Clinical Commissioning Group suggested that the latter item be retitled as "Sustainable Transformation Plan"

Resolved:

That the report be received and noted.

9 **Health and Wellbeing Board - Mission Statement**

The Service Director – Disability and Mental Health presented a Mission Statement for the Board's consideration. She reported that the Joint Strategic Needs Assessment (JSNA) was to be considered later in the meeting with the revised Health and Wellbeing Strategy due for consideration at the next meeting. The Mission Statement, once adopted, would sit at the front of the Strategy. She explained that the Mission Statement was intended to reflect the life cycle and through strategic working would include prevention and integration issues. The Service Director – Public Health and Wellbeing circulated a further copy of the Mission Statement which set out the aspirations and intentions more clearly.

Mike Sharon suggested that the issue of "childhood Obesity" was given overdue prominence in the Mission Statement. The Strategic Director – People opined that this issue should, in any event, be re-badged as "Prevention of Childhood Obesity". Steven Marshall commented that a more holistic approach was required in terms of "Child and Adolescent Mental Health" as this currently did not appear to address the aspect of "wellbeing". Similarly, he suggested that "Dementia Care" should include reference to promoting independence. The Service Director – Public Health and Wellbeing reminded the Board that the main issues to be included within the Mission Statement had been identified at the Workshop Session held on 7 October 2015. Professor Linda Lang suggested that a link needed to be included with the "adult population" and the topic of "Dementia Care." The Service Director – Disability and Mental Health advised that the term "Mission" should be replaced with "Priorities". The Chair commented that the Mission Statement was in relation to health and social care generally and not solely the work of the Board.

Resolved:

That the Mission Statement be amended in accordance with the comments now made, re-circulated via email to Board Members and that a further report on the matter be submitted to the next meeting of the Board.

10 **Joint Strategic Needs Assessment (JSNA) - Update**

The Strategic Director – People reported that Strategic Joint Needs Assessments (JSNA's) had now been in existence for eight / nine years and that the aim with the refreshed JSNA for Wolverhampton was for it to be used pro-actively by Commissioners in the health and social care economy as an easily accessible point of reference available as an e.document. She suggested that there was a need for the document to include information regarding cultural and ethnicity issues together with details of sensory impairments both in terms of current and future trends. She thanked all those individuals and organisations who had been involved in the production of the refreshed document.

The Service Director – Public Health and Wellbeing presented a report which provided the Board with an update on the progress of the development of the JSNA. She commented that revising a comprehensive document such as the JSNA was a major piece of work and that every effort had been made to highlight gaps in the current document. She referred to Appendix 2 to the report and the following seven chapters. She explained that there was a need for the issue of "safeguarding" to be embedded in the refreshed JSNA and also for the topics in the various chapters to be covered fully. Inequalities needed to be readily acknowledged to enable them to be addressed and for commissioning processes to reflect the information within the JSNA.

Glenda Augustine, Advanced Health Improvement Specialist: Needs Assessment gave a PowerPoint presentation on the contents of Chapter 2 of the JSNA – Life Expectancy and invited comments on the visual contents of the document. She advised that the intention was for the JSNA to be the “go to” document i.e. the first point of reference for all health and social care professionals.

The Chair apologised for the small font in the document. The Strategic Director – People also suggested that blocks of text should be avoided and that there was a need for careful reflection on the content and order.

Donald McIntosh advised that he was happy with the process which had been used to update the document and suggested that it could benefit from the use of case studies or patient stories as examples of the patients journey, which could include examples of referral patterns. The Service Director – Public Health and Wellbeing commented that the term “Patient Voice” be amended to “Resident Voice”.

Alan Coe referred to Section 5.1 of the document and on the need for the same terminology to be used in Section 6 for the sake of consistency. With reference to Section 6.7 he commented that the term “Patient voice” be amended to “Citizen’s voice”.

Helen Child referred to Chapter 1 insofar as it referred to “Indebtedness in the City” and commented that reference needed to be made to the use of food banks and soup kitchens. With regard to Chapter 6.2.3 “Social isolation – Adult social care users and carers” she opined that as written the text referred only to service users and needed to be expanded in the broadest sense.

The Strategic Director – People was of the opinion that greater reference needed to be made to the University of Wolverhampton within the document given that many local authorities did not have such a resource to draw upon. She cited the assistance provided by the University on topics such as dementia, children and young people and connections with schools, inequalities, social wellbeing and obesity. She also opined that the section addressing “migration / immigration” should be expanded.

The Chair invited the Board to consider whether the membership of the JSNA Steering Group was adequate. It was generally felt that the University of Wolverhampton and the Third Sector Partnership should be invited to participate in the work of the Steering Group. Alan Coe advised that Stephen Dodd, as the Wolverhampton Voluntary Sector Council would also represent the Safeguarding Boards but suggested that a representative from the Regulatory Services of the Council should be included. The Strategic Director – People counselled caution on expanding the membership too widely especially as a lot of contributions were made to members of the Group from non-members. Donald McIntosh invited the Board to consider including a representative from the Inter Faith Group to join the Steering Group. The Advanced Health Improvement Specialist: Needs Assessment reminded the Board that a number of Task and Finish Groups would also be appointed to work on specific areas of the document.

Resolved:

That subject to the above points the progress and initial outputs of the Joint Strategic Needs Assessment (JSNA) be approved.

11 **Infant Mortality Scrutiny Review - Update**

The Service Director – Public Health and Wellbeing presented a report which updated the Board on the implementation of the recommendations of the Infant Mortality Scrutiny review which had been undertaken from July 2014 to March 2015 to gather evidence in relation to the high rate of infant mortality in Wolverhampton. She explained that this was an on-going process and that proxy measures had been put in place for issues such as smoking during pregnancy and encouraging pregnant ladies to stay in a smoke free environment.

A shared event with the Lullaby Trust was to be staged which would include participation from across all services and that a general willingness to take part had been evident. Work with the Royal Wolverhampton NHS Trust was continuing with a view to making the New Cross Hospital site smoke free and examples of best practice from other NHS Trusts were being sought. She advised that an annual report on Infant Mortality would be submitted to the Council's Scrutiny Board. The Chair referred to the whole system approach which had been adopted on this issue and thanked all those who had been involved in the work. Sher advised the Board that Infant Mortality rates had fallen from 7:1,000 between 2010 and 2012 to 6.4:1,000 in 2014 albeit that this was still ahead of the national average.

Mike Sharon acknowledged the comments made by the Service Director – Public Health and Wellbeing and confirmed that the staff of the Royal Wolverhampton NHS Trust were committed to the Strategy. He reported that a number of "Reducing Risks" programmes were being held with 1:1 sessions available. He confirmed that the experience of other NHS Trusts in introducing "smoke free" sites were being investigated. Dr Helen Hibbs commented that this was a positive piece of work but suggested that more work was required to be undertaken with General Practitioners and Health Visitors who were often the first point of contact in Primary Care. Donald McIntosh supported this suggestion and opined that similar work with Pharmacists would be equally beneficial. He referred to recommendation 8 and suggested that this be replicated and include examples of good practice.

Resolved:

1. That the progress in implementing the recommendations from the Infant Mortality Scrutiny Review that concluded in March 2015 be noted;
2. That the suggestions referred to above be included within the Strategy.

12 **Update on Suicide Prevention**

Neeraj Malhotra, Public Health Consultant (Transformation) presented a report and gave a PowerPoint presentation which informed the Board on the progress made in relation to the requirements outlined in the national suicide prevention strategy "Preventing Suicide in England: A Cross Government outcomes Strategy to Save Lives". In particular, the report detailed progress in relation to Mental Health and Suicide Prevention Needs Assessment" which had been completed jointly with Wolverhampton Samaritans, the establishment of a multi-agency Wolverhampton Suicide Prevention Stakeholder Forum and the development of a Suicide Prevention Action Plan for Wolverhampton. She confirmed that West Midlands Police and the Voluntary Sector had been involved actively in the production of the Action Plan.

She explained that there was an increasing need to reach out to white males and to some ethnic minority groups who were highly susceptible to suicide attempts. She advised that attempted suicide was often associated with social deprivation but was

not so closely linked to this as some other health issues. She reported that the majority of cases had not been known previously to “Specialist Services”.

Dr Helen Hibbs enquired as to whether any data was available as to if potential cases had made contact with Primary Health Care in order to seek support. The Public Health Consultant (Transformation) undertook to analyse the available data.

David Martin confirmed that the Wolverhampton Branch of The Samaritans confirmed that this organisation was committed fully to the Action Plan and explained the organisations involvement in its formulation. This included the adoption of Public Health England guidelines on suicide prevention. He reported that the cost to the local economy of cases of suicide exceeded £1 million. He reported further that there were six steps to reducing incidences of suicide and that the first three had now been addressed. The remaining three steps were being tackled robustly including working with Pharmacies, Network Rail and British Transport Police. Work was also on-going with the media with a view to positive messages being issued.

Cllr Roger Lawrence commended the work that had been undertaken on this issue and advised that it was a topic which was raised often with him during Councillor Surgeries and whilst conducting his role as Leader of the Council. Professor Linda Lang confirmed that the University of Wolverhampton worked closely with the Wolverhampton Branch of The Samaritans and other Charities in order to signpost individuals and groups to relevant services.

David Martin advised that his organisation also worked closely with other charitable organisations but commented that the “Mental Health Resource Directory” was not an easy tool to use, especially for those in desperate circumstances. He suggested that this was an issue which needed to be addressed.

The Public Health Consultant (Transformation) reported that 53 individuals had received training in respect of signposting to appropriate services. Donald McIntosh advised that Healthwatch Wolverhampton was also undertaking work on public wellbeing.

Resolved:

1. That the overall partnership approach taken to suicide prevention be endorsed;
2. That the establishment of a Suicide Prevention Stake holder Forum be approved and that the Forum be charged with improving the Mental Health Resource Directory;
3. That the Suicide Prevention Action Plan be approved;
4. That the inclusion of suicide prevention work as an additional workstream within the Crisis Concordat programme be approved;
5. That the Suicide Needs Assessment be noted;
6. That compliance with national requirements for a suicide audit / needs assessment stakeholder forum and action plan be noted;
7. That the early progress made to date on the action plan tasks be noted.

13 **Headstart Stage 3 Bid**

The Service Director – Metal Health and Disability explained the digital version of the bid for future funding for Headstart Stage 3. Kevin Pace, Headstart Programme Manager gave a PowerPoint presentation on the contents of the bid. He outlined a number of issues including:

- Currently the Children and Adolescent Mental Health Service (CAMHS) was overburdened with requests for assistance which placed many young people in a position of believing that their case was not urgent enough to receive assistance;
- The need to identify those young people most at risk;
- The four geographical areas in the city would each have a Hub including a Police Community Support Officer (re-named as Community Support Worker) attached to it;
- The intention to build community and family capacity to respond to mental health issues;
- Undertaking work with schools on a whole system change approach in order to identify warning signs of potential problems.

The Service Director – Mental Health and Disability reported that a presentation would be made to the Bog Lottery Board in late May with the outcome being known in June 2016 with a potential award of £8.8 million. The Strategic Director – People informed the Board that work on this issue had been shortlisted for an award by the Municipal Journal. Professor Linda Lang advised that she was delighted that the University of Wolverhampton had been involved in this particular piece of partnership work. Cllr Val Gibson, on behalf of the Board, expressed her thanks to all those involved in the Headstart Stage 3 Bid.

Resolved:

That the report be received and noted.

14 **Better Care Fund 2016/17 outline plan**

The Service Director – Disability and Mental Health presented a report which updated the Board on the progress towards the establishment of a Section 75 Agreement between the City of Wolverhampton Council ("CWC") and the Wolverhampton City Clinical; Commissioning Group (WCCCG) for the purpose of delivering the Better Care Fund in the business year 2016/17. She reported also on progress for developing the 2016/17 delivery plan. She reminded the Board that it had been agreed previously that final approval of the 2016/17 Better Care Fund delivery plan had been delegated to the Chair, Cllr Mattu with advice from the Director of Strategy and Transformation, WCCCG (Steven Marshall) and Better Care Fund Leader for "CWC" (Service Director for Disability and Mental Healthy – Viv Griffin). She confirmed that the final bid was due for submission.

The Strategic Director – People reported that the report was commended by Cllr Elias Mattu. She suggested that the final bid included details of examples of end of life care and that this issue be looked at holistically during 2017/18. Steven Marshall, Director of Strategy and Transformation, WCCCG advised that end of life care was often provided by District Nurses but that a number of other individuals and organisations were also involved. He commented that a comprehensive review of end of life care and palliative care was required.

Donald McIntosh opined that there were risks associated with the achievement of some of the objectives within the Agreement. The Strategic Director – People reminded the Board that Healthwatch Wolverhampton was a member of the Better Care Fund Board. The Director of Strategy and Transformation commented on the need to recognise the involvement of the Royal Wolverhampton NHS Trust in the delivery of many of the services within the Agreement. The Strategic Director –

People advised that she was of the opinion that the Agreement would be approved without any additional conditions being imposed by NHS England.

Resolved:

1. That subject to the above amendments, the progress towards the development of the Section 75 Agreement between the City of Wolverhampton Council (CWC) and Wolverhampton City Clinical Commissioning Group be noted;
2. That the arrangements for the final submission to NHS England of the Wolverhampton Better Care Fund 2016/17 delivery plan be noted.

15 **Children's Trust Board - Progress Report**

Cllr Val Gibson, Cabinet Member for Children and Young People presented a report which provided the Board with an update on progress with the Children, Young People and Families Plan (2015 – 25). She explained that the Plan had been aligned with the Health and Wellbeing Board Strategy and that the structure of the Children's Trust Board had been reviewed. The Plan now concentrated on early intervention. A Stakeholder Event had been held on 8 March 2016 which had been attended by over 80 delegates including representatives of young people. The Event had included a session with Wolverhampton Homes on the subject of homelessness and this matter would be considered further at a future meeting of the Children's Trust Board.

Dr Helen Hibbs enquired as to the position with recruitment of foster carers' in the city. Emma Bennett, Service Director – Children and Young People reported that some 20 additional foster carers' had been recruited during 2015/16 and a Workshop facilitated by iMPOWER was planned for week commencing 2 May 2016 on that issue. She advised that work was also on-going to align the recruitment process and terms and conditions across the Black Country. Cllr Val Gibson referred to "National Fostering Fortnight" which would include use of the promotional vehicle and also to the regular "Fostering Fridays'" events.

Resolved:

1. That the 2016/17 work programme of the Children's Trust Board be supported;
2. That the necessary reporting and governance arrangements that were in place to oversee progress of the Children, Young People and Families Plan (2015 – 25) be approved.

16 **Feedback on Shadow Combined Authority Mental Health Commission**

The Service Director – Disability and Mental Health presented a report which updated the Board on the progress to date of the Shadow Combined Authority – Mental Health Commission and which raised the profile of the work of the Commission. She advised that the Commission was looking to produce an evidence base with a view to reducing the costs to the public sector. Currently, this work was at the evidence gathering stage with a view to identifying best practice and how improvements could be made. She reported that a Steering Group had been established on which she had been invited to participate. She had been nominated to lead the Employment Sub Group which was seeking how to get people with mental health problems into work and to sustain their employment. A report on the outcomes from the Commission would be submitted to a future meeting.

The Chair referred to the role of Cllr Darren Cooper as the Shadow Combined Authority Leader Champion on the Commission and his recent untimely death.

Mike Sharon commented that the work of the Commission appeared to exclude the work of the Children and Adolescent Mental Health Service (CAMHS). The Strategic Director – People advised that this point had been raised already. The Leader of the Council undertook to follow up this matter and reported that schools and mental health was a further issue which had been identified for consideration.

Resolved:

That subject to the above comments the progress to date with regard to the Shadow Combined Authority – Mental Health Commission be noted.

17 **Consultation on Joint Autism Strategy**

The Service Director – Disability and Mental Health presented a report on the draft Joint Autism Strategy for consideration and comment as part of the consultation process. She explained that the draft Strategy would be subject to a three month consultation exercise and that the Strategy had deliberately crossed over between children and adults. Eight priorities had been identified in the Strategy and that a further report would be submitted to a future meeting.

Helen Child enquired as to whether sufferers of autism had been involved in the development of the Strategy. The Service Director – Disability and Mental Health confirmed this to be the case and, furthermore, that they would also be involved in the consultation exercise.

Resolved:

That the draft Autism Strategy be received.

18 **Minutes from Sub Groups**

Resolved:

That the minutes of the meetings of the Children's Trust Board held on 1 December 2015, the Integrated Commissioning and Partnership Board held on 10 March 2016 and the Public Health Delivery Board held on 15 March 2016 be received and noted.

19 **Chair's Remarks**

The Chair offered her thanks to all members, partners and officers for their contributions to the work of the Board during the current Municipal Year.