NHS
Wolverhampton
Clinical Commissioning Group

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

A G E N D A

		1	Apologies for absence		
		2	Declarations of Interest		
		3	Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on 11 October 2016		1 - 10
		4	Committee Action Points		11 - 12
		5	Matters arising from the minutes		
		6	Chief Officer Report	Ms T Curran	13 - 28
		7	Action plan on the CCG Board Assurance Framework following the Governing Body Development session on 27 September 2016	Ms M Garcha	29 - 32
		8	Outcome of Pond Lane Consultation	Mr S Marshall	33 - 76
		9	Equality Delivery System2 (EDS2)	Ms J Herbert	77 - 84
		10	Primary Care Full Delegation	Mr P McKenzie	85 - 96
		11	Commissioning Committee	Dr J Morgans	97 - 148
		12	Quality and Safety Committee	Dr R Rajcholan/Ms M Garcha	149 - 172
		13	Finance and Performance Committee	Ms C Skidmore	173 - 202
		14	Primary Care Joint Commissioning Committee	Ms P Roberts	203 - 206
		15	Primary Care Strategy Committee	Mr S Marshall	207 - 216
		16	Communication and Engagement update	Ms P Roberts	217 - 220

		17	Minutes of the Quality and Safety Committee		221 - 228
		18	Minutes of the Commissioning Committee		229 - 236
		19	Minutes of the Finance and Performance Committee		237 - 242
		20	Minutes of the Primary Care Joint Commissioning Committee		243 - 250
		21	Minutes of the Primary Care Strategy Committee		251 - 260
		22	Any Other Business		
		23	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 13 December 2016 – Governing Body Board Meeting		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 11 October 2016
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

VOTING MEMBERS ~

Clinical ~		**Present**
Dr D De Rosa	Board Member	No
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 ~		
Ms T Curran	Interim Chief Officer	Yes
Ms M Garcha	Executive Lead for Nursing and Quality	No
Mr S Marshall	Director of Strategy and Transformation	Yes
Ms C Skidmore	Chief Finance Officer/Chief Operating Officer	Yes
Lay Members/Consultant ~		
Mr J Oatridge	Lay Member	No
Mr P Price	Lay Member	Yes
Ms P Roberts ~ Chair	Lay Member	Yes
Ms H Ryan	Lay Member	Yes

In Attendance ~

Ms K Evans	Solutions and Development Manager
Mr S Forsyth	Head of Quality and Risk
Ms K Garbutt	Administrative Officer
Mr M Hastings	Associate Director of Operations
Mr R Jervis	Public Health Director
Ms E Learoyd	Healthwatch Wolverhampton
Mr P McKenzie	Corporate Operations Manager
Dr S Reehana	Interim South East Locality Chair

Ms P Roberts Chaired today's meeting and welcomed Ms Liz Learoyd, Chief Officer for Healthwatch to the meeting.

Apologies for absence

Apologies were received from Dr D De Rosa, Ms M Garcha and Mr J Oatridge

Declarations of Interest

WCCG.1582 Ms P Roberts reported declarations of interest for all Governing Body GPs in respect of the Primary Care agenda items. She also reported a conflict of interest regarding agenda item End of Life Strategy as she is a member of the Patient Advisory Cancer Group.

RESOLVED: That the above is noted.

Dr M Kainth arrived

Minutes

WCCG.1583 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 13 September 2016 be approved as a correct record. However the following items were noted ~

Minute 1555 – Commissioning Committee

Ms C Skidmore pointed out for clarity the second sentence should read "He highlighted concerns that the Vocare contract is not yet signed". She also pointed out that the second sentence in the last paragraph should read "Ms Skidmore confirmed that whilst the contract is managed by the CCG, the monitoring of the Sustainability Transformation Fund (STF) is a national initiative".

Minute 1557 – Finance and Performance Committee

Ms Skidmore highlighted that the first bullet point should read "National price of funded nursing care". She added that the third bullet point should read "Slippage against the Quality, Innovation, Productivity and Prevention (QIPP) target which puts pressure into the system".

Ms H Ryan arrived

Matters arising from the Minutes

WCCG.1584 There were no matters arising from the minutes.

RESOLVED: That the above is noted

Committee Action Points

WCCG.1585 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer update

WCCG.1586 Ms T Curran introduced the Chief Officer report which is submitted to the Governing Body to provide assurance of robust leadership across the Clinical Commissioning Group (CCG). She highlighted Estates and Technology Transformation Fund (ETTF). Mr M Hastings had attended a meeting and reported that bids have been submitted to match the funding available for Cohorts 1 and 2. Cohort 3 has not yet been decided. He confirmed that we should receive notification shortly and once received this will be disseminated at the Members Meetings on the 19 October 2016.

Ms Curran reported that the Junior Doctor's Industrial Action has now been formally suspended which is good news. The Governing Body will be kept appraised of any future potential industrial action and the mitigating actions in place to keep patients safe.

She referred to the Electronic Referral system, previously known as 'Choose and Book'. Several practices are using the system, however if this could be increased by circa 20% the CCG would realise about £270,000 from the quality premium, which could then be reinvested into primary care. All agreed this was worthy of effort to increase usage of the system. Ms Roberts expressed concern about informed choice and patients receiving correct information. Dr Bush pointed out that the referral system is about the route of referral and choice is offered to patients irrespective of the route the referral then goes through. Ms Curran confirmed that the CCG is meeting its constitutional rights. Mr P Price asked what would encourage practices to use the system more. Dr J Morgans confirmed that practices will receive an email and it will be discussed at the Members Meeting.

The Clinical Commissioning Group (CCG) continues to work with colleagues on new care models around primary care in line with the Primary Care Strategy ratified by member practices.

Ms Curran highlighted that the Black Country Sustainability and Transformation Plan (STP) remains a draft document and a further meeting is scheduled to take place on the 20 October 2016. A further iteration of the DRAFT STP plan is due for submission to NHSE on 21

October 2016 – at present the Governing Body has not had sight or, or had the opportunity to discuss, the draft plan. Mr S Marshall said that there was a paper on this on the agenda for the Governing Body to consider and agree on.

The 'go live' date for NHS 111 is still on track for 8 November 2016. There will be a 48 hour operation window and the full system will be in place from the 10 November 2016.

RESOLVED: That the above is noted.

End of Life Strategy

WCCG.1587 Mr S Marshall referred to the report stating that a number of discussions have taken place regarding End of Life services. Ms K Evans added that the strategy was co-produced with Public Health England and Healthwatch which places patients firmly at the centre. The Strategy is aiming to improve the cost effectiveness and efficiency of End of Life care across the whole health and care economy through development of an integrated, responsive care pathway.

Ms Roberts commended the strategy which covers nearly everything patients require.

RESOLVED: That the Governing Body approved the End of Life Care Strategy and timeline.

Constitution Variation

WCCG.1588 Mr P McKenzie presented the report for the Governing Body to agree to make an application to vary the CCG Constitution in preparation for the application for full delegation of Primary Care Co-Commissioning from April 2017 and to give effect to previously reported changes to Governing Body membership to meet new requirements for managing Conflicts of Interest. Details of the application documentation required for submission to NHS England have now been made available which have clarified the changes in respect of the Governance arrangements that the CCG will need to have in place.

RESOLVED: That the Governing Body agrees to make an application for full delegation of Primary Care Commissioning. Authorises the Interim Accountable Officer and the CCG Chair to agree the final versions of the amended constitution and associated documents in line with the agreement that will be reached with NHS England in respect of the delegated powers.

That a further report Full Delegation report is brought back to the Governing Body in November 2016.

That the document with all track changes is forwarded to all Governing Body members.

Sustainability and Transformation Plan (STP)

WCCG.1589 Mr Marshall presented the report which is to seek agreement from the Governing Body for the Black Country Sustainability and Transformation Plan (STP) to be submitted on the 21 October 2016 as a draft work in progress. Ms Curran pointed out to the Governing Body that it was being asked to acknowledge the submission and the high level briefing contained in Mr Marshall's report, however, the Board should recognise the lack of detail it was aware of to date. The report sets out the process for consulting and engaging with patients, the public and wider stakeholders following the October submission and in advance of formal sign off by any legal entity and consequent implementation of the Black Country STP.

Ms Skidmore commented on assurance regarding the financial side. A long term financial report will be submitted to the Finance and Performance Committee. Ms Curran commended Ms Skidmore and the finance team. The plan is around the people the CCG serve and the Governing Body cannot agree a plan that has not been seen. A discussion took place and it was agreed to the submission stating the Governing Body has not seen the document.

RESOLVED: That the Governing Body agrees to the submission of the Black Country STP on 21 October 2016 noting that is a draft, that the Governing Body has not seen the document and that is in effect 'work in progress', which will be subject to full consultation and engagement.

Commissioning Committee

WCCG.1590 Dr Morgans presented the report. He highlighted 2.2 Social Prescribing Business Case. A 12 month pilot for social prescribing is proposed, to be delivered by the Wolverhampton Voluntary Sector Council. The model proposed would see 3 trained "link workers" across the City working with and supporting individuals that require low level, non-clinical support but whom access Health and Social Care services regularly. Mr Marshall stated that the second bullet point regarding Finances should read "For Financial Year 2016/17 there is a part year effect equivalent to £148.316/12) x 3 = £65063.50".

The funding route is the GP development reserve we hold and the third sector organisation want to take on more activity. The Governing Body supported the action taken.

Dr Morgans referred to Atrial Fibrillation. A Business Case was submitted to the Committee which sought to introduce a project to improve diagnosis and treatment of Atrial Fibrillation in Primary Care. The Committee did not approve the pilot. The Governing Body noted this.

Currently Nuffield Health Limited (The Nuffield) is currently commissioning to provide a range of elective services including pain management, orthopedics and general surgery. At present, this does not include spinal services. The Nuffield has submitted a business case to extend the current directory of services commissioned to include spinal services. The Committee approved the Business case.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1591 Dr S Rajcholan referred to the report which provides assurance on quality and safety of care, and any exception reports that the Governing Body should be sighted on. She gave an update on the key issues of concern.

Dr Rajcholan pointed out that the Board Assurance Framework will be the subject be at the next Governing Body Development Session in November 2016. She highlighted that it is proposed that the themes for the Clinical Quality Review meetings are combined. Ms Curran is happy to have a discussion regarding this outside the meeting. She added that the Governing Body were given assurance with safeguarding embedded into this report and gave thanks to the safeguarding team for the work carried out.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1592 Ms Skidmore gave a brief outline of the Finance and Performance Committee reports. The finance performance reporting for month 5 meets all our financial targets for the year. She pointed out that the Acute portfolio outside the Royal Wolverhampton Trust (RWT) had worsened. The variance in Continuing Health Care costs is associated with increasing numbers in Terminal Phase as well as an increase in average

length of stay in Terminal Phase. There has also been a deterioration in the Quality, Innovation, Productivity and Prevention (QIPP) programme.

There has been deterioration in our Better Care Fund target. We have managed to find cover, however if this deteriorates we do not have contingency and may have to switch off something to accommodate. Ms Curran added that there has been a huge amount of work being carried out to bring our budgets back in line.

Ms Skidmore reported that within performance all of our indicators and trend information is now included within the report. RWT are have difficulty in achieving their Referral to Treatment and we are still monitoring this. A&E is further off target.

Dr M Kainth left

RESOLVED: That the above is noted.

Primary Care Joint Commissioning Committee

WCCG.1593 The report is to provide the governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee on the 6 September 2016. Ms Roberts gave a brief overview of the document.

RESOLVED: That the above is noted.

Primary Care Strategy Committee

WCCG.1594 Mr Marshall presented the report. He pointed out that an extensive program of work has been defined to underpin the successful delivery of the Primary Care Strategy and comprises a series of task and finish groups. Ms Roberts referred to the structure chart which accompanied the report and asked if this will change following full delegation. Mr McKenzie stated there is scope to look at this as the strategy develops.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1595 Ms Roberts gave a brief outline of the report. She highlighted the key updates on page 2 of the report.

RESOLVED: That the above is noted.

Commissioning Intentions

WCCG.1596 Mr Marshall apologies for the late paper and gave an overview of the report. On the 30 September 2016 witnessed the requirement for the CCG to issue its Commissioning Intensions to providers. In September 2016 this was mandated on a two year contract cycle and include decommissioning Intentions for GP Primary Care as it is assumed the CCG will be fully delegated as of 1 April 2017. He confirmed that The Nuffield will be advised of our intentions.

RESOLVED: That the above is noted

Minutes of the Quality and Safety Committee

WCCG.1597 RESOLVED: That the minutes are noted

Minutes of the Commissioning Committee

WCCG.1598 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1599 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Joint Commissioning Committee

WCCG.1600 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Strategy Committee

WCCG.1601 RESOLVED: That the minutes are noted

Joint Negotiating and Consultation Committee

WCCG.1602 RESOLVED; That the report is noted.

Any Other Business

WCCG.1603 There were no matters.

RESOLVED: That the above is noted.

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

WCCG.1604 **Question ~** Can the papers be posted to the public.

Answer ~ It would be very expensive to carry this out, however papers are available on the website and if you do not have access to a computer this could be carried out at a public library.

Date of Next Meeting

WCCG.1605 The Board noted that the next meeting was due to be held on **Tuesday 8 November 2016** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 3.15 pm

Chair……..

Date ……

This page is intentionally left blank

Wolverhampton Clinical Commissioning Group Governing Body

8 November 2016

Date of meeting	Minute Number	Action	By When	By Whom	Status
12.7.16	WCCG.1520	Grant Policy Funding Allocation A report is brought back at the end of the year relating to details of the evaluation process.	February/March 2017	Vic Middlemiss	
13.9.16	WCCG.1553	Emergency Preparedness, Resilience and Response (EPRR) – A progress report is submitted to the Governing Body before Christmas and a full report in February 2017.	December 2016 February 2017	Andy Smith/Mike Hastings	
11.10.16	WCCG.1558	Constitution Variation – A report is submitted in respect of Primary Care Full Delegation. The document containing all track changes is disseminated to the Governing Body.	November 2016 October 2016	Peter McKenzie	

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING

8 NOVEMBER 2016

Agenda item 6

Title of Report:	**Chief Officer Report**
Report of:	Trisha Curran – Interim Chief Officer
Contact:	Trisha Curran – Interim 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 by the Chief Accountable Officer.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties. By its nature, this briefing includes matters relating to all domains contained within the BAF.
• **Domain2:** Performance – delivery of commitments and improved outcomes	
• **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 Estates and Technology Transformation Fund (ETTF)

2.1.1 Colleagues were briefed at the October meeting on the ETTF. The maximum funding for ETTF improvement grant schemes will be 100% for Technology schemes, 66% for improvement grant schemes and circa 40% maximum funding for new build schemes. The West Midlands has been awarded £33m to spend by March 2019, with £8.3m identified for cohort 1 (spend before April 2017) and £24.6m identified for cohorts 2 and 3 (spend before April 2019).

2.1.2 CCG bids for Cohorts 1 and 2 have been agreed in principle at a national level and final Project Initiation Documents have been submitted with final capital and revenue costs. We are expecting this final stage to be a formality and have begun the process of working with NHS Property Services for the estates bids and IM&T are engaging suppliers for the IT bids. Cohorts 1 and 2 are for projects to be completed by 31 March 2017 and 31 March 2019 respectively. The IT bids support the implementation of Wolverhampton CCG's commitment to the Local Digital Roadmap, working with The Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust and the Local Authority to support the vision of a paperless NHS by 2020.

2.2 Commissioning Support Services (CSU)

2.2.1 The support services from Arden and GEM CSU continue to deliver against the service specification with the overall rating from CCG staff members of 3/4 (Good). There are some individual service lines which are requiring further contract management such as the SSSI team who supply strategy intelligence reports to the CCG. A meeting is arranged to discuss delivery to date and whether this fits with the CCG requirements as dictated by both the service specification and CCG strategies. The services supplied by Midlands and Lancashire CSU are mainly Business Intelligence - the CCG is working closely with the embedded and remote teams to ensure we have everything we need to support what is going to be a challenging contract negotiation, involving a shorter negotiation period and longer contract over two years.

2.3 Demand Management

2.3.1 The Performance Team are working with the local NHS England team to develop a demand management plan for referrals. There is a national focus on how CCG's are placed to manage demand, looking at alternatives to first outpatient appointments in acute settings. The expectation is that CCG's will work with primary care colleagues

in both GP Practices and community services to reduce the burden on demand for these acute services, offering patients alternatives such as structured education, self-management, alternative providers (such as pharmacists) etc. There is a collective effort from all departments within the CCG to collate all of the work that is already being done and plans for new projects to be collated into a single demand management plan to be submitted this month.

2.4 Wolverhampton CCG Members Meeting

2.4.1 The Wolverhampton CCG Members Meeting took place on 19 October 2016. At the meeting, the membership agreed, in line with the intention in the Primary Care Strategy, to submit an application to NHS England for full delegation of Primary Care Co-Commissioning and to make the necessary changes to the CCG's constitution in order to take on full delegation. This was on the basis that no objections were made at the meeting to the application for full delegation.

2.4.2 At the meeting David Birch, Head of Medicines Optimisation – Wolverhampton CCG, talked about the role of the Clinical Pharmacist as NHS England are proposing to jointly fund clinical pharmacist posts in GP practices. This is a different role to the CCG commissioned prescribing support and is focused on assisting with the clinical workload of GP practices.

2.4.3 Primary Care Commissioning representatives also facilitated discussion around how commissioning primary care differently from 2017 onwards will effect and involve GPs.

2.5 New Care Models

2.5.1 At the Members Meeting this month there was strong attendance to hear about NMC's from Capsticks and the ensuing discussions were aimed at clarifying the reasoning from a national level why these new models are being encouraged. Currently in the City there are three Primary Care Home groups, one Vertically Integrated group and a Medical Chamber group which range in size from circa 32,000 patients to over 100,000 patients.

2.5.2 The Primary Care Team is continuing its work with practices forming into mutually agreed groups to support New Care Models (NCM's). Further meetings are being held between practices and with support from the CCG Primary Care team, project managers are working to solidify the arrangements with Memorandums of Understanding and/or formal contracts between practices. The CCG will support member practices in this process and are encouraging individuals to contact the CCG Primary Care team for advice.

2.6 Delegated Primary Care Commissioning from April 2017

2.6.1 Wolverhampton CCG is currently in the process of completing an application to NHS England for **fully** delegated responsibilities for the commissioning of primary medical

services from 1 April 2017. The delegated commissioning model delivers a number of benefits for the Wolverhampton population and allows CCGs greater ability to transform local primary care services.

2.7 Diabetes

2.7.1 The 2016/17 Spending Review provided additional dedicated funding streams for a number of core priorities. Within this it was announced that:

'CCGs will have the opportunity to bid for additional national funding of approximately £40m per year to promote access to evidence based interventions - improving uptake of structured education; improving access to specialist inpatient support and to a multi-disciplinary foot team for people with diabetic foot disease; and improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs.'

2.7.2 Within the next few weeks details will be sent to CCGs outlining the opportunity to bid for this money and bids will be welcomed in one or more of these four areas:

1) To enable an increase in achievement of the 3 NICE recommended treatment targets
2) To increase attendance at structured education
3) To implement or expand a multidisciplinary foot care team (MDFT)
4) To implement a diabetes inpatient specialist nursing service

2.8 Commissioning Intentions - update

2.8.1 The Commissioning Intentions list for 2017/2018 was presented and approved at the Private Governing Body meeting on the 13th September 2016. It was acknowledged that additional intentions may be identified between approval by Governing Body and formal publication of the list on the 1st October 2016.

2.8.2 The attached document *"Wolverhampton CCG Commissioning Intentions 2016/17"* provides an updated list of the final commissioning intentions that were published and shared with all providers on the 1st October 2016. The following items were added as additional intentions:

- Con 032 Rapid Response Team - Evaluation of rapid response team with a view to consideration of future model in terms of respecifying, reprocuring or reconfiguring team.
- Con 033 Infection Prevention – Review of current services in light of increasing collaboration with public health.
- Con 038 TB Services – Review of current services in light of increasing collaboration with public health.

- Con 058 Review of Community Contract – Need to agree meaningful activity definitions and subsequent monthly reporting for all service lines with the community contract.
- Con 062 CSU Proposed Costing, coding & reporting changes (see Appendix 2)
- Con 076 Re-commission Model for older Adults Mental Health including Dementia Day Care Services with focus on connectivity with Memory Clinic and Older Adult Mental Health Services.

2.9 BCF Update

2.9.1 A meeting of the BCF Programme Board took place on 10 October 2016, the focus of the discussions were around progress on rationalising estates to co-locate health and social care staff and the various options that exist around the local health and social care economy. Within the BCF local delivery plan for 2016/17 a vision of integrated working with co-located teams is described for all work streams. Options have been explored in North East, South East, and South West to identify suitable locations for each of the multidisciplinary teams. Approval was granted by the BCF Programme Board to progress with feasibility studies and the expectation was that a paper would be resubmitted to the Board outlining the 3 options for each of the Community Neighbourhood Team bases across each of the localities with the Local Authority being the lead for this process.

2.9.2 A December 'go-live' date was confirmed for the Fibonacci system, which supports integrated working through the use of a joint health and social care (view only)

record. A presentation was made to the BCF Programme Board by Graphnet to outline the work being undertaken as part of the Local Digital Roadmap which could potentially provide a longer term solution. The vision is for a digital system that facilitates the planning and delivery of care services across a whole health community based on the collection, analysis and sharing of data, allowing care providers and patients to manage healthcare proactively.

2.10 Black Country Sustainability and Transformation Plan (status is still draft)

2.10.1 A teleconference of the Black Country STP Sponsorship Group took place on 20 October 2016 to agree the submission of the draft STP for the Black Country to NHSE – this was subsequently submitted by the deadline of the 21 October 2016 and feedback from NHSE is awaited. The proposals will be published in full during November.

2.10.2 A stakeholder engagement event took place on 3 October at the Molineux Stadium when presentations were made giving an overview of the draft plan and work streams in place. A public engagement event is being planned for 6 December and further event planning is in train.

2.10.3 Staff at the CCG were briefed on the overall plan at a staff meeting on 12 October, further briefings will be given at future staff meetings.

2.11 System Leadership and Integration – Transition Board Workshop

2.8.1 A workshop took place on 13 October focused on the differing models of care and next steps to support integrated working – key milestones and actions are being drawn up and will be ratified at the next meeting of the Transition Board on 10 November 2016.

2.12 Seven Day Services

2.12.1 A meeting took place on 26 October at the Royal Wolverhampton NHS Trust – this was a collaborative event organised by the CCG and Trust to discuss where we as a local health and care system are with seven day services and next steps. Mrs Celia Ingham Clarke MBE, Medical Director for Clinical Effectiveness also spoke at the event.

2.13 **NHS 111**

2.13.1 Mobilisation of the new provider remains on track with a 'go live' date of 8 November 2016. CCG Accountable Officers will hold a conference call on 4 November to mitigate any as yet unseen risks that may arise.

Trisha Curran
Interim Chief Officer
Date: 27 October 2016

Appendices:

1 *"Wolverhampton CCG Commissioning Intentions 2016/17"*
2 Con 062 CSU Proposed Costing, coding & reporting changes

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)	**Trisha Curran**	**27/10/16**

This page is intentionally left blank

This document is being issued as formal notice of Commissioners intentions with regard to counting and coding changes for 17/18 in accordance with Service Condition 28 of the Contract.

1) The CCG will seek assurance that all CMU and PAS prices are applied to drugs monitoring and are effective immediately after their release date

2) The Trust is required to outline any drug or device uplift over and above the unit price paid

3) The Trust is required to outline any drugs where VAT is not being paid

4) Locally agreed or non-tariff prices will be reviewed

5) Commissioners would like to carry out a review of any day-case activity with a view to working with the Trust to move this activity to outpatient settings where clinically appropriate to do so

6) The Trust must work to report in line with schedule 6 requirements with the support of commissioners. The data will be at patient level and will be submitted via the Midlands and Lancashire DSCRO. A template must be agreed for each service type before contract sign off

7) Commissioners would like to undertake a review of any activity being recorded as day-case that could be coded as a home visit

8) A review of non-consultant led outpatient tariffs

9) Commissioners expect that the correct treatment function code must be used for all acute activity

10) Providers must be able to demonstrate contract positions prior to any adjustments made to the specialised IR

11) Outpatient telephone consultations: Where clinically appropriate Providers will be expected to move to telephone consultations.

12) Outpatient Nurse Led activity – Commissioners would expect any Outpatient activity seen by a nurse to be coded and charged via a locally agreed price

13) Planned procedure not carried out – Commissioners will only pay a locally agreed tariff for activity that is for medical or patient reasons (WA14B)

14) A locally agreed price will be determined for patients attending A&E who leave before being treated

15) Multiple diagnostic tests occurring on the same day will be reviewed to ensure correct clinical coding is applied. This applies to any scans that occur in more than one area

16) Procedures of low clinical value will be adhered to and challenged. Any exclusions from the policy must be supported and evidenced by IFR approval

17) Neonatal level of care field to be populated in accordance with data dictionary national codes. For avoidance of doubt this is codes 0,1,2,3

18) Activity will be coded as regular day/night attendances with a locally agreed price. This is where a patient is admitted electively during the day or night as part of a planned series of regular admissions for an ongoing regime of broadly similar treatment and who is discharged the same day/next morning

In addition to the counting and coding changes listed above, Commissioners will also be expecting the following additional information items to be included in the contract for 17/18:

19) Additional information will be required from patient level monitoring, therefore commissioners will be requesting the following SUS data fields are completed:
    - All admissions should be time stamped including a discharge ready date
    - Outpatient appointment should be time stamped
    - All critical care admissions must include a discharge ready date
    - All critical care admissions must display the number of organs supported per day
    - Ambulance incident number (CAD ID) to be populated in A&E submission. This will allow tracking of patients between both A&E and ambulance services

20) A timetable must be agreed during the contract negotiation process for SLAM and non-SUS patient level information submissions to commissioners (No later than the 23rd of the month)

21) Maternity antenatal and postnatal pathway: patient level data will be required to be submitted to the Midlands and Lancashire DSCRO using a standard template that will be sent to providers.

22) Best practice tariffs: All activity flagged as best practice tariff where all compliance cannot be demonstrated through SUS will require additional local data feeds and information requirements to be made in order for payment to be validated and then processed

23) Any patients that have been approved via IFR will be given a unique identifier (Blueteq number if using Blueteq for approval) within an agreed field in SUS

24) Activity will be identified in both local monitoring (SLAM) and SUS where it relates to any prime contractor arrangements

25) A locally agreed price will be negotiated for all Outpatient Follow-Up activity

This page is intentionally left blank

CI Ref	Impact Area	Wolverhampton CCG Commissioning Intentions 2017-2018
Con 001	Acute	**Dementia Pathway Review** - Review of current dementia pathway and implementation of revised model/pathway
Con 002	Acute	**Elective Activity Review** - An end to end pathway review of two specialities (Gynae & Opthalmology) in the first phase seeking to identify and reduce variation
Con 003	Acute	**Review of A&E Chest Pain pathway and associated tariff** - following clinical audit undertaken recommendation is to implement 0-4 hour stay tariff for patients presenting with chest pain
Con 004	Acute	**Review of funding for breast feeding peer support -** review the current service outcomes and intelligence from public health which will inform continuation of funding
Con 005	Acute	**Review of Unplanned Paed admissions for resp and GI conditions**
Con 006	Acute	**A&E/PAU Peadiatric Pathways -** Review of Acute paediatric pathways into A&E and PAU in conjunction with Staffs and surround CCG
Con 007	Acute	**Bariatic surgery policy** - As the CCG is now responsible for Tier 4 obesity services it will be undertaking a review of its existing policy and criteria and implementing any changes through the contract
Con 008	Acute	**Implementation of updated POLCV policy** - Following the finalisation of the West Midlands harmonisation the CCG will be undertaking a review of its existing policy to ensure as far as possible that it still aligned and will incorporate any changes within the contract
Con 009	Acute	**Lower GI Cancer** (Right Care) Determine non-elective profile : reducing variation, pre-elective for undiagnosed or post-operative aftercare
Con 0010	Acute	**Heart Disease Pathway** (Right Care) Review of pathway to reduce variation & improve patient outcomes, includes ECG reporting, AF, & echocardiology
Con 0011	Acute	**Optimising Follow Up Appointments -** reduction in new to review ratios by reducing the number of face to face follow ups, implementation of alternative methods such as telephone consultation etc & review of tariff
Con 0012	Acute	**Cancer** - Implementation of the Achieving World Outcomes: Taking the Strategy Forward
Con 0013	Acute	**Maternity** - Implementation of findings/recommendations from NHS England Maternity Review
Con 0014	Acute	**Integrated MSK Procurement** - Procurement of an integrated community MSK service including orthopaedics, rheumatology, Orthotics, Pain management, OCAS and Physio
Con 0015	Acute	**Psoralen combined with ultraviolet A / B pathway** - Implementation of pathway cost based on a set number of procedures as currently charged an outpatient procedure tariff for each follow up attendance
Con 0016	Acute	**Looked After Children (LAC) Assessments -** expansion of LAC assessments undertaken by RWT to cover a wider geographical area (upto 50 miles)
Con 0017	Acute/Community	**Heart Failure Service & Specialist Nurses** - Review of current service pathways, service specification to ensure service outcomes are delivered and provide value for money
Con 0018	Acute/Community	**Development of Community Neighbourhood Teams and Ambulatory Care Pathways -** the review and redesign of ambulatory care pathways in order to provide proactve and reactive management of patients in a community setting where appropriate
Con 0019	Acute/Community	**Health Navigator Research Project -** a research project providing health coaching to a cohort ofpaptients identified as high risk of admission. Joint project with Cannock/South east staffs.
Con 0020	Acute/Community	**Co-location/Integration of Community Neighbourhood teams.** the continued development of the community neighbourhood teams as described in the BCF plan 2016/17, including co-location and revised working practice to work in an integrated way with other organisations i.e. social care and voluntary sector
Con 0021	Acute/Community	**Fibonacci - Implementation and subsequent expansion.** Continued implementation of the Fibonacci product. Review and evaluation and scoping of future need i.e. integrated health and social care record.
Con 0022	Acute/Community	**Moving clinics from Acute to community settings -** identification and relocation of clinics/services that can be provied in a community setting i.e. new community neighbourhood hubs or existing community/primary care locations.
Con 0023	Acute/Community	**End of Life & Palliative Care** - Development & Implementation of End of Life/Palliative Care Strategy including RWT EOL SDIP & Review of Palliative Care Consultants
Con 0024	Acute/Community	**Frail elderly pathwa**y - Development and Implementation of a frail elderly pathway which entails cross boundary and multi agency working which emcopasses healthy Living/Ageing Well, Proactive Care, Assess to admit, Frail Elderly ED Team, Acute admission under geriatrician, Discharge to Assess and Comprehensive Reablement
Con 0025	Acute/Community	**Review & redesign of current Wound Care Services -** Review of wound care services which will include indepth scoping of capacity of Community Clinics, capability of GPN's to undertake chronic/complex woundcare, capacity within Primary Care to deliver woundcare under the basket of services, lack of compliance to the standard formulary. This project is an element of the re design of Community Services and will inform the review of a number of services under that programme of work including district nursing & community access clinics
Con 0026	Acute/Community	**Dietician Service Review -** Review of community dietetic service also seeks to address the inequity of the current service provision and also strengthen the weight management Tier 3 services in light of the Citywide obesity challenge and the local shift of Tier 4 services returning to the CCG.
Con 0027	Acute/Community	**The trust is required to use the national demand capacity model**
Con 0028	Acute/Community	**Paediatric Pathway Review -** review of community paediatrics, paediatric OT and PT, SLT and CCNS to ensure it meets the 0 - 25 SEND agenda and that C & YP are being seen at the right time, right place by the right person.
Con 0029	Acute/Community	**Review of Diabetes Pathway/Service -** Joint review of current service provision & pathways
Con 0030	Acute/Community	**Review & Redesign of Anti-Coagulation Service -** Review and redesign of anti-coagulation services, which incompasses a number of different strands
Con 0031	Acute/Community	**Review of ENT Pathways - Opportunities to improve** Acute and Community ENT pathways for example ear wax removal
Con 0032	Acute/Community	**Rapid Response Team -** Evaluation of rapid response team with a view to consideration of future model in terms of respecifying, reprocuring or reconfiguring service.
Con 0033	Acute/Community	**Infection Prevention -** Review of Current Services in light of increasing collaboration with Public Health
Con 0034	Acute/Community	**Review feeding clinic needs in paediatrics and development of pathway**

Con 0035	Acute/Community	**Transition pathways for all paediatrics services including acute and community services**
Con 0036	Acute/Community	**Peadiatrics - Disaggregating block contracts across RWT and BCPFT**
Con 0037	Acute/Community	**Reprocurement of Community Eyecare Services -** This includes PEARs, IOP and Cataracts schemes and may be extended to also encompass additional elements such as post operative follows up etc. and childrens vision screening
Con 0038	Acute/Community	**TB Services -** Review of Current Services in light of increasing collaboration with Public Health
Con 0039	Acute/Community/Primary Care	**Development of Social Prescribing Model in Primary Care -** Implementation of Social prescribing in enabling primary care to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.
Con 0040	Acute/Mental Health	**Personal Health Budgets** - Supporting the personalisation and choice agenda through implementation of personal health budgets
Con 0041	Acute/Primary Care	**Update to Commissioning for Quality In medicines Optimisation in RWT contract**
Con 0042	Acute/Primary Care	**GP Peer Review (Right Care/Aristotle Data)**
Con 0043	Acute/Primary Care	**Primary Care Enhanced COPD Review -** scheme aims to reduce COPD admissions for patients aged 18 and above by ensuring a consistent and systematic management of COPD in the community
Con 0044	Acute/Primary Care	**Primary Care Enhanced Asthma Review -** scheme aims to reduce asthma admissions for patients aged five and above by ensuring a consistent and systematic management of asthma in the community
Con 0045	Acute/Primary Care	**Primary Care In Reach Team -** Provision of GP cover for residential homes to prevent avoidable emergency admissions
Con 0046	All Providers	**Implementation of Seven Day Working -** in line with clinical standard nine, transfer from hospital to social, community and primary care
Con 0047	Community	**TWIRL** (Wolverhampton Integrated Respiratory Lifestyle Project) - Continuation of RWT support for the TWIRL project which is a support group based in the community, utilising community based assets for patients living with COPD.
Con 0048	Community	**Review and redesign of all community services including intermediate care** - review of CICT, Hospital at Home and District nursing which help inform an options appraisal for whether services are respecified, reprocured or reconfigured)
Con 0049	Community	**Walking for Health** - Review of block contract line funding for walking for health
Con 0050	Community	**Falls Service -** Review of current falls service with a view to implementing a revised service specification in the interim whilst the CCG undertakes a reprocurement exercise
Con 0051	Community	**Continue to expand AQP framework for Care Homes**
Con 0052	Community	**Commission step up bed provision -** commissioning of appopriate step up provision will help suppirt admission avoidance and provide care closer to home
Con 0053	Community	**Review of Neuro Bed Currency -** implementation of UKROC WBD tariff for neuro rehab beds
Con 0054	Community	**Community Equipment Independent Living Service -** Joint CCG/LA procurement of community equipment service to enable the delivery of a high quality and patient centred service
Con 0055	Community	**Review of Palliative care pathways for paediatrics including respite care, hospice at home and end of life care**
Con 0056	Community	**Community Dermatology** - Review of existing community dermatology service with a view to potential extension of existing contract for a further two years or reprocurement
Con 0057	Community	**Respiratory Consultant in A&E/AMU -** Dedicated presence of respiratory consultant in A&E to help reduce emergency admissions
Con 0058	Community	**Review of Community Contract** - Need to agree meaniful activity definitions and subsequent monthly reporting for all service lines within the community contract
Con 0059	Costing & Coding	**Local prices above national reference cost**
Con 0060	Costing & Coding	**Review and adjustment of PAU rebate**
Con 0061	Costing & Coding	**Implementation of robotic surgery PBR tariff**
Con 0062	Costing & Coding	**CSU Proposed costing, coding & reporting changes** (See Appendix 1)
Con 0063	Costing/coding	**Currency model for wheelchair services**
Con 0064	Costing/coding	**Implementation of shadow arrangements** • Critical care bed day cost reduction • Lucentis – application of NICE pathway and charging • Gynae TV scans • Paeds subspecialty coding • Neuro pysio exclusions • Telephone consultations • IP neonates
Con 0065	Costing/coding	**Require split of neuro rehab and stroke activity within reporting dataset including SLAM to enable appropriate pathway reviews to be undertaken**
Con 0066	Local Authority	**Review health needs of children and young people with specialist health, education and care needs placed out of area -** Review of EPP policy, procedure and process and revision of joint funded EPP budget
Con 0067	Mental Health	**Mental Health Whole System** - commission a portfolio of services and care pathways across the mental health and social care system working with commissioning colleagues in organisations across our STP foot print to actively seek opportunities to align and consolidate care pathways and interventions to improve and transform services via co- commissioning and collaborative commissioning. Areas of focus to include: bed capacity and capability modelling, Transforming Care and urgent and planned mental health, including assertive out-reach and crisis services & psychosis pathway (as per RightCare). Align all with work of the Mental Health STP Workstream.
Con 0068	Mental Health	**CAMHS - Locally Commissioned Tier 4 Placements** - implementation of a West Midlands project to provice locally commissioned Tier 4 placements, in which BCPT will be required to collaborate with a range of partners and commissioners
Con 0069	Mental Health	**CAMHS & Adult Mental Health - Eating Disorder & Early Intervention in Psychosis** - BCPT will provide more accessible and improved specialist Eating Disorder & Early Intervention on Psychosis services in collaboration with adult mental health

Con 0070	Mental Health	**Urgent and Planned Mental Health Care Pathways** - Under Better Care Fund commission recovery focused Care Pathways for Urgent and Planned Mental Health care to better meet the needs of people with mental health difficulties across a range of providers, providing pro-active and responsive multi-agency care closer to home in line with the CRISIS CONCORDAT and delivering connectivity across the mental health 'whole system'. Include focus on Mental Health Liaison and Crisis Resolution Home Treatment (Urgent) and remodelling of Early Intervention in Psychosis into 14-65 years Model and re-alignment of Well-Being and Complex Care into Community Recovery Service. Ensure easy access into Consultant Psychiatry support and advice and guidance (for service users and carers and GPs), development of Assertive Outeach and reduction in Acute Overspill and Out of Area Placements.
Con 0071	Mental Health	**IAPT Model** - Commission a revised IAPT model which provides timely and responsive psychological interventions for people with mild to moderate mental health difficulties.
Con 0072	Mental Health	**Neurodevelopmental Conditions Strategy** - commission a series of care pathways and interventions that support the assessment, diagnosis, care and treatment and review of children, young people and adults with neurodevelopmental conditions.
Con 0073	Mental Health	**Specialist Mental Health Care Pathways** - commission a series of care pathways and interventions that support the assessment, diagnosis, care and treatment and review of people with specilaist mental health needs, including Peri-Natal Mental Health, Eating Disorders, Neurodevelopmental Conditions and Personality Disorder.
Con 0074	Mental Health	**Learning Disability Services** - Design commission and implement a learning disability service model which responds to local need and the leraning from Tansforming Care and providing assertive community support in an integrated whole system with social care.
Con 0075	Mental Health	**Dementia Care Pathway** - Under Better Care Fund commission Care Pathways and services to support early intervention and prevention, diagnosis, care and treatment of people for people with dementia across a range of providers, providing pro-active and responsive multi-agency care closer to home in line with NICE Guidance and the CRISIS CONCORDAT and delivering connectivity across the mental health and social care 'whole system'. Ensure focus on highest level of care for those with greatest level of need.
Con 0076	Mental Health	**Re-Commission Model for Older Adults Mental Health Including Dementia Day Care Services with focus on connectivity with Memory Clinic and Older Adult Mental Health Services.**
Con 0077	Mental Health/Acute	**CAMHS Transformation Programme** - To work closely with BCPT to introduce a place-based care model for delivering specialist CAHMS services in Wolverhampton. This is to commence with a trial in one or more HeadStart hubs and two or more Strengthening Family Hubs. Once learning from trials has been reviewed, roll-out to all HeadStart hubs and Strengthening Family Hubs is to occur, including the employment of CAHMS Link Workers. A new service agreement will be negotiated and implemented in year.
Con 0078	Primary Care	**Skype** - Use of skype technology for patient consultations
Con 0079	Primary Care	**Quality & Outcomes Framework (QOF) & GP incentives Schemes** - Review and redesign of QOF and GP Incentive Schemes
Con 0080	Primary Care	**GP Access** - Extended opening hours for primary care hub services
Con 0081	Primary Care	**Primary Care prescribing efficiencies**
Con 0082	Primary Care/Acute/Community	**Primary Secondary Care Interface -** Implementation of new requirements in contract, failure to satisfy requirements may result in sanctions being applied through the contract
Con 0083	Primary Care/Mental Health	**Implementation of Carers Strategy**
Con 0084	Third Sector	**Sickle Cell Service Review** - Undertake a review of current service provision, service specification and potential reprocurement of service

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – Tuesday 7th November 2016

Agenda item 7

Title of Report:	**Update on actions from Governing Body Risk Management Workshop on 27th September 2016**
Report of:	Manjeet Garcha Executive Director of Nursing and Quality
Contact:	Manjeet.garcha@nhs.net
(add board/ committee) Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To update the Governing Body of actions agreed and how this is being progressed
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.

1. BACKGROUND AND CURRENT SITUATION

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 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.

As part of the CCGs audit requirements Pricewaterhouse Coopers LLP are engaged in auditing our current systems and processes. Several planning discussions were held between July and September and, as a result a Governing Body Risk Management Workshop was delivered on 27th September 2016.

2. ACTIONS AGREED AND PLAN FOR PROGRESSION

No.	Action	Lead to action	Timeframe to be completed by
1	A PwC facilitated away time to refresh the key risks for the CCG BAF, BAF format and risk alignment to CCG sub board committees.	Execs/PwC Joanna Watson	Recommendation is Nov 22nd or 24th January (there is no session planned for December)
	The current BAF format to be reviewed and a draft presentation to Executive Group followed by Governing Body	Quality and Risk Team Executive/Nonexec Team Manjeet Garcha	January 2017
3	PwC to conduct meetings with individual GB members to review individual risk management maturity and identify key areas of further development	Joanna Watson	Final report end of November
4	PwC internal audit work on risk management to consider ownership of risks at local level, identify any learning opportunities and review of randomly selected risks and use of Datix	Abigail Vincent PwC	Completed 5th October 2016

5	PwC to undertake a series of meeting observations planned for Senior Management Team & Governing Body	Joanna Watson	1st November SMT 8th November GB
6	PwC to meet with CCG to sign off report	Joanna Watson Manjeet Garcha Claire Skidmore	9th November
7	PwC report for Audit and Governance Committee	Joanna Watson	15th November
8	PwC report and action plan to Governing Body	M Garcha	January 2017

3. SUMMARY

The action plan is being progressed and will be completed by 13th December.

4. RECOMMENDATIONS

The Governing Body are requested to

4.1 **Receive and take assurance that the Action Plan is being progressed.**
4.2 **Agree the date for the dedicated Governing Body time out session facilitated by PWC (recommend 22nd November 2016).**
4.3 **Receive an update on progress on action plan December 2013**
4.4 **Receive copy of PwC Risk Management Review Report at Governing Body meeting in January 2017**

Name: **Manjeet Garcha**
Job Title: **Director of Nursing and Quality**
Date: **27th October 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		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	MGarcha	21/10/16
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) (V2.0 final)	MGarcha	27/10/16

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body 8 November 2016

Agenda item: 8

TITLE OF REPORT: **Redesign of Learning Disability Assessment and Treatment Services**

REPORT PRESENTED BY: **Wendy Ewins**

Title of Report:	Redesign of Learning Disability Assessment and Treatment Services
Purpose of Report:	To seek Governing Body's approval to redesign Assessment and Treatment services provided by BCPFT following a period of formal consultation
Author(s):	Wendy Ewins
Owner:	Wendy Ewins
Filepath:	
Key Points:	Governing Body is asked to approve the proposal to relocate the learning disability inpatient provision based at Pond Lane (3 beds) to alternative sites across the Black Country, in Dudley, Sandwell and Walsall.
Recommendation to the Committee	To agree to the relocation of the learning disability inpatient provision based at Pond lane (3 beds) to alternative sites across the Black Country, in Dudley, Sandwell and Walsall.
(add board/ committee) Action Required:	☒ **Decision** ☐ **Assurance**
Clinical view:	Clinicians are satisfied that there is sufficient community capacity being developed in Wolverhampton to significantly reduce the number of admissions to inpatient services. Clinicians believe that a clinically safer service can be provided on the Trust's larger sites.

View of patients, carers or the public and the extent of their involvement.	People with learning disabilities and their family carers want to be treated in the same way as the general population, expecting timely access to community support as an alternative to hospital admission. Where admission is necessary people with learning disabilities want this to be as close to home as possible and for as short a duration as possible.
Resource Implications and Financial consequences:	Services to be redesigned within current resources. Activity for Inpatient Assessment and Treatment is agreed at 1095 Occupied Bed Days (3 Beds). The service is commissioned on a cost and volume basis, a 10% tolerance will be applied to inpatient assessment and treatment activity, any activity outside the tolerance will be refundable /chargeable at 100% of unit price.
Relevance to Board Assurance Framework (BAF): **Domain 1: A Well Led Organisation**	This programme of work supports the Transforming Care Partnership across the Black Country, with a partnership-wide commitment to become one commissioner for the provision of inpatient services in line with the STP.
Domain 2a: Performance – delivery of commitments and improved outcomes	This programme of work supports the delivery of a national model of service at a Black Country level. Proving inpatient services at greater scale, and on sites that are larger, facilitates the provision of clinically and environmentally safer service provision.
Domain 2b: Quality (Improved Outcomes)	Clinical safety will be improved through the provision of more robust clinical cover arrangements, particularly at night and at weekends and by nature of being on a larger site Single-sex accommodation will be able to be delivered as Black Country Plans with the Trust seek to have inpatient provision concentrated on only three sites Clinical effectiveness will be improved through delivering inpatient services over few sites, with

	more expertise focussed onto three wards Patient experience will be improved due to the delivery of a safer, more clinically effective model of care
Domain 3: Financial Management	
Domain 4: Planning (Long Term and Short Term)	The relocation of Wolverhampton inpatient bed to the other three Black Country areas supports local work to deliver the Transforming Care agenda to reduce reliance on inpatient models of care for people with learning disabilities by 2019 and to offer effective community support services.
Domain 5: Delegated Functions	
Risk / Legal implications:	Formal consultation has taken place, and the report from this is attached in Appendix 1.
Implications on Quality and Safety:	The Winterbourne Report raised a number of key safety challenges for CCGs in ensuring that people with learning disabilities are safe in services. Ensuring that people are supported at home wherever possible and where this is not possible - as close to home as possible, with assertive reviewing arrangements and access to family and advocacy - maximises the chance of good and safe outcomes. The relocation of inpatient services is expected to deliver clinically safer services due to the location of the other sites, environmental factors and greater clinical cover.
Equality Impact Assessment:	EIA demonstrates that people with learning disabilities are particularly vulnerable to mental health difficulties, and that they should have appropriate services in the community to support good mental health, in addition to effective inpatient

	services where required.
Implications on Information Governance	Information is returned to NHS digital on a weekly basis about all people with learning disabilities who have inpatient episodes of care.
Relevance to National / Local Policy:	• Winterbourne Concordat 2010 • The National Plan - Building the Right Support 2015 • Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition Service model for commissioners of health and social care services 2015 • NICE Guideline: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges • NICE Learning disabilities: challenging behaviour Quality standard • NICE Guideline: Mental health problems in people with learning disabilities: prevention, assessment and management 2016 • Equality Act 2010 • NHS England Guidance - CCG Assurance Framework • NHS Constitution

1. PURPOSE OF THE REPORT

1.1 To consider the proposal to relocate assessment and treatment inpatient provision for learning disabilities to alternative sites across the Black Country, in Sandwell, Walsall and Dudley.

2. BACKGROUND

2.1 Pond lane is a five bedded assessment and treatment unit situated in the Parkfields area of Wolverhampton. As a hospital site it is isolated from any of the other BCPFT services, including inpatient provision. The service provides specialist assessment and treatment inpatient services to male and female adults with learning disabilities and additional complex health needs, such as autistic spectrum disorders, mental health difficulties and / or behaviours that challenge services.

2.2 Working with the Wolverhampton Clinical Commissioning Group the Black Country Mental Health Partnership Trust wishes to relocate the three Pond Lane inpatient beds to services provided at Dudley, Sandwell, and Walsall. This will involve the closure of the three inpatient beds at Pond Lane. This action is required because the very low numbers of beds provided within the service are isolated from other Trust services and this raises environmental, clinical and staffing safety concerns which are impacting upon the delivery of the service to this very vulnerable group. A clinically safer and more viable service could be provided from the BCPFT Learning Disability inpatient services in Dudley, Sandwell and Walsall where other Wolverhampton patients are in receipt of inpatient services currently. All of these services are less isolated, provide a critical mass of service provision that offers clinically and environmentally safer services, and all are accessible by public transport.

2.3 In recent years Wolverhampton Clinical Commissioning Group has reduced the level of commissioned activity at Pond Lane Hospital from five beds to three in line with reduced levels of demand for Wolverhampton patients. Reduction in bed numbers is in keeping with the “Transforming Care- national response to Winterbourne View” which will require a reduction in bed based services for people with a learning disability and / or autism. The revenue from the reduced bed based capacity at Pond Lane is already being invested in an alternative community model which delivers intensive support and interventions providing increased care and support for patients and their families from Wolverhampton in their own homes. In addition to this local service development, Wolverhampton CCG is part of the Black Country Transforming Care Partnership which has submitted an implementation plan to NHS England which will deliver further service change and transformation over the next three years, resulting in more community based services including bespoke packages of care.

3. CURRENT SITUATION

3.1 Wolverhampton is currently embedding a model of Intensive Community Support within its provision of specialist healthcare for adults with learning disabilities, in keeping with the National Model. In 2016, there have been only two admissions to inpatient services for adults with learning disabilities, both have needed short interventions before being discharged back to community services. As an example, one of the two patients was discharged after 11 days and then supported by the Intensive Support Service.

3.2 Since the launch of the Transforming Care Programme all admissions now have Care and Treatment Reviews as a central and regular monitor and driver of a person's care and treatment. These Care and Treatment Reviews have supported the clinical teams to ensure that people can access high-quality assessment and treatment in a hospital setting, staying no longer than they need to, and with discharge planning starting from the point of admission or before.

3.2 Formal consultation took place between 4th July 2016 and 22nd August 2016, following a period of pre-engagement. The full consultation report is attached to this report, in Appendix 1. The recommendations arising from the consultation centre on the need to consider transport and support families to be able to make appropriate arrangements when visiting their family member.

3.3 It is recommended that Wolverhampton does not continue to offer a local inpatient service. Positive behaviour support and intensive support services are supported in the research as cost-effective and as enabling good outcomes in terms of supporting people to lead valued lives in their communities as opposed to spending long periods of time in hospital / institutional settings.

3.4 It is recommended that through Care and Treatment Reviews, transport and family contact is considered on an individual basis, and with personalised leave and family contact arrangements being developed and reviewed in line with best practice, and supported financially where necessary by the CCG. Financial support could then be reviewed after 12 months.

4. CLINICAL VIEW

4.1 It is the view of clinicians that more people could be effectively supported within their usual living environments though an Intensive Support response. Where admission is unavoidable, clinicians are supportive of services being consolidated onto three sites to improve safety and clinical cover. Clinicians are supportive of the Care and Treatment review approach, which enables the multidisciplinary team to work with health and social care commissioners, an independent expert and an expert by experience, the patient and their family / advocate to consider each admission / possible admission and to plan positively with them.

5. PATIENT AND PUBLIC VIEW

5.1 Please refer to full Consultation report, attached in Appendix 1

6. KEY RISKS AND IMPLICATIONS

Key Risks

4.1 If approved, all future admissions to Assessment and Treatment will be out of Wolverhampton. This raises travelling issues for some families, and consideration will need to be given to ensure that relationships can be maintained and supported when people are inpatients.

4.2 Pathways will need to be agreed with mainstream mental health services to ensure positive access for people with learning disabilities where appropriate (this is part of ongoing with the Trust, and within the STP mental health work stream).

Financial and Resource Implications

4.3 There are no financial and resource implications; delivery of the relocation of beds will be from existing budgets. Activity for Inpatient Assessment and Treatment is agreed at 1095 Occupied Bed Days (3 Beds). The service is commissioned on a cost and volume basis, a 10% tolerance will be applied to inpatient assessment and treatment activity, any activity outside the tolerance will be refundable /chargeable at 100% of unit price.

Quality and Safety Implications

4.4 It is anticipated that the relocation of inpatient services to the three other Black Country areas will deliver improved quality and safety outcomes overall. The Head of CCG Quality and Safety has made some comments and suggestions regarding mitigating any risks associated with increased distance, recovery planning associated with distance, and the possibility of in-reach voluntary sector services (for example ACCI) not being able to be part of inpatient support. We have also discussed that people's usual routines may be more disrupted due to the distance of the other hospitals. These issues will be addressed through individual Care and Treatment Reviews which will ensure that each episode of care is person-centred, and that a plan is developed with each person and their clinical team to ensure that their induvial needs are met.

Equality Implications

4.5 There are Equality implications arising from this proposal. This proposal affects people with learning disabilities who will have to travel further to visit their families, and their families will have to travel further to visit them.

Medicines Management Implications

4.6 There are no medicine management implications

Legal and Policy Implications

4.7 There are no legal implications

6. RECOMMENDATIONS

6.1 It is recommended that the Governing Body:-

- Receives and discuss this report
- Agrees to the relocation of three inpatient beds from Pond Lane to other sites across the Black Country, namely Orchard Hills, Penrose and Daisy Bank.

Name: **Wendy Ewins**
Job Title: **Joint Commissioner**
Date: **18.10.16**

ATTACHED:

Appendix 1: Wolverhampton CCG Public Consultation

GLOSSARY:

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 Gomez**	**Ongoing discussions**
Public/ Patient View	**Healthwatch**	**14/07/2016**
Finance Implications discussed with Finance Team	**Andrea Hadley**	**Ongoing**
Quality Implications discussed with Quality and Risk Team	**Steve Forsyth**	**24/10/2016**
Medicines Management Implications discussed with Medicines Management team	**N/A**	**N/A**
Equality Implications discussed with CSU Equality and Inclusion Service	**Juliet Herbert**	**16/08/2016**
Information Governance implications discussed with IG Support Officer	**N/.A**	**N/A**
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	**N/A**
Signed off by Report Owner (Must be completed)	**Wendy Ewins**	**24/10/2016**

This page is intentionally left blank

NHS Wolverhampton Clinical Commissioning Group (WCCG)

A public consultation on:

Moving three Assessment and Treatment Learning Disability in-patient beds at Pond Lane Hospital to existing services in Dudley, Walsall and Sandwell

Monday 4 July 2016 to Monday 22 August 2016

Executive Summary

This report highlights the evaluation of the Public Consultation on moving three Assessment and Treatment Learning Disability in-patient beds at Pond Lane Hospital to existing services in Dudley, Walsall and Sandwell. The consultation took place from Monday 4 July 2016 to Monday 22 August 2016.

The consultation process

Over 300 Stakeholders representing inclusive and varied organisations were invited to feedback their views on the consultation by completing an online questionnaire, hard copies and an easy read version were also available. Nineteen people completed the questionnaire.

Two events were held, the first was a public drop in session which took place on 7 July. Five people attended the event.

Service users who had been inpatients during the past 18 months, their, families and carers were invited to a second event which took place 18 August 2016. This event also included a sensory room and specially (for this consultation) an independent advocacy group was commissioned consisting of an expert by experience and independent professional advisor. Seven people attended.

Questionnaire analysis

Most people chose Option 1 (9 people) to permanently close the inpatient service.

The second largest group chose Option 2 (7 people) to keep the beds at Pond Lane.

Three people chose to close the in-patient service and only have a community home treatment model of care.

This means that 12 respondents would be in agreement with permanently closing the beds at Pond Lane.

The majority of responders identified themselves as either professionals, where eight people responded (42.1%) or members of the public where again eight people responded (42.1%). These groups were represented by 50% more than the next highest group who were Carers at 4 respondents (21.1%).

Q1. If this proposal to close the beds at Pond Lane goes ahead the impact on me will be:

No impact 10 people (52.6%)
Negative impact 5 people (26.3%)
Positive impact 4 people (21.1%)

Therefore 14 people are not concerned over the impact on them.

Q2. If the inpatient service is kept at Pond Lane, what impact will this have on you?

No impact 11 people (57.9%)
Positive impact 6 people (31.6%)
Negative impact 2 people (10.5%)

Q3. If the inpatient service is moved out of Wolverhampton to Dudley, Walsall and Sandwell, what impact travel wise will this have on carers and families of service users?

Most patients (10) said that if the service moved out of Pond Lane it would have a negative impact travel wise (52.6%). One person (5.3%) said it would have a positive impact travel wise. 8 people said there would be no impact on them travel wise if the service moved. Therefore 9 people did not have concerns over the impact on them travel wise if the service was closed at Pond Lane.

Q4.Question four asks people to tell us of any other comments that they would like to be considered:

The six written comments received in answer to question 4 express a concern that if the beds do not remain at Pond Lane, loss of service provision will ensue. One respondent comments that these services are for the most vulnerable people and another respondent worries that closing the beds will lead to a reduction in resources. Concerns are also raised about need to travel further to visit relatives.

Two respondents do not understand why the service cannot remain in Wolverhampton. One person feels that the decision to close the beds had already been made prior to the consultation:

Conclusion

- When considering the Options, although more people are in favour of Option 1 to close the beds (9 people) the difference between those choosing Option 2 to keep the beds (7people) is only a margin of 2 people in favour. However, when we take into consideration Option 3 to have only a community model of care the overall margin in favour of not keeping beds open in Pond Lane is 12, therefore the margin in favour is three.
- When considering the impact respondents felt the closure of the Pond Lane service would have on them, the majority of participants told us that the closure would have no impact on them 52.6% (ten people). Five people (26.3%) felt they would experience a negative impact and 21.1% of respondents felt the closure would have a positive impact on them. Therefore, in total14 people felt that the impact of closing the beds at Pond Lane would not cause them concern.
- Most respondents felt that the Pond Lane service remaining would have no impact on them, neither, positive or negative.
- Ten respondents were concerned about the impact having to travel further if the Pond Lane beds were closed would have on them. However, 9 people in total did not

express concern around the impact travel would have on them if the beds at Pond Lane were to close

- Some people expressed concern about the potential loss of a local service if the Pond Lane service was closed. The main concern is having to travel further to visit loved ones. There is also a concern that if the service moves elsewhere the loss of more local community services will follow and the need for support and advice will not be met. One person is also concerned that in an emergency the further distance will delay a rapid response.

Recommendations

1. It is recommended that the commissioners note the concerns highlighted in the report before making final decisions on the option to take forward:
    - **Travel issues:** Initial feedback from service users and their families highlighted that travel to the beds (if placed outside of the city) may be a concern, but this was raised as a possible concern for other families, as it wasn't an issue for the families involved in the pre-engagement. Stakeholders noted that relocation of the services to be closer to associated services and thereby potentially secure service improvements was acknowledged as probably of merit. 52.6% of survey respondents that if the beds were moved, there would be a negative impact on them in terms of travelling out of Wolverhampton. Written responses suggested that extra support could be offered:
    - **Options:** 12 people chose Options 1 and 3, therefore it would seem that a total of 12/19 people would be in agreement with not to keep beds at Pond Lane.
    - **Impact of closure:** 14 survey respondents indicated that the impact of the closure of Pond Lane site would not cause them concern.

2. It is also recommended that this report is published and circulated to those who took part in the consultation, with thanks to them for the time they spent responding and for their very useful input.

Introduction

Who we are

NHS Wolverhampton Clinical Commissioning Group (WCCG) is responsible for commissioning healthcare services for people with learning disabilities and/or autism.

The service currently provided at Pond Lane

The Black Country Partnership NHS Foundation Trust (BCPFT) provides three inpatient beds in Wolverhampton at Pond Lane Learning Disability Assessment and Treatment Service, for people with learning disabilities who require admission to hospital because of a mental health problem, or a behaviour that is labelled as challenging. These beds are in a five-bedded hospital.

Pond Lane site is isolated from the Trust's other services for people with learning disabilities and this raises environmental, clinical and staffing concerns which have an impact on the delivery of the service to this very vulnerable group. The CCG and the provider NHS Trust feel that a clinically safer and more viable service could be provided at BCPFT's other Learning Disability Inpatient services in Dudley, Sandwell and Walsall.

At the moment the three beds in Pond Lane are temporarily closed to new admissions.

The Case for Change

Pond lane is a five bedded assessment and treatment unit situated in the Park Field area of Wolverhampton. As a hospital site it is isolated from any of the other BCPFT services including In-patient provision. The service provides specialist assessment and treatment In-patient services to male and female adults with learning disabilities and additional complex health needs, such as autistic spectrum disorders, mental health difficulties and / or challenging behaviour.

Working with the Wolverhampton Clinical Commissioning Group the Black Country Mental Health Partnership Trust wishes to relocate the three Pond Lane In-patient beds to services provided at Dudley, Sandwell, and Wolverhampton. This will involve the closure of the three In-patient beds at Pond Lane. This action is required because the very low numbers of beds provided within the service are somewhat isolated from other Trust services and this raises environmental, clinical and staffing safety concerns which are impacting upon the delivery of the service to this very vulnerable group. A clinically safer and more viable service could be provided from the BCPFT Learning Disability In-patient services in Dudley, Sandwell and Walsall where other Wolverhampton patients are in receipt of In-patient services currently. All of these services are less isolated; provide a critical mass of service provision that offers clinically and environmentally safer services, and all are easy accessible by public transport.

In recent years Wolverhampton Clinical Commissioning Group has reduced the level of commissioned activity at Pond Lane Hospital from five beds to three in line with reduced levels of demand for Wolverhampton patients. Reduction in bed numbers is in keeping with the “Transforming Care- national response to Winterbourne View” which will require a reduction in bed based services for people with a learning disability and / or autism. The revenue from the reduced bed based capacity at Pond Lane is already being invested in an alternative community model which will deliver assertive outreach support and interventions providing increased care and support for patients and their families from Wolverhampton in their own homes. In addition to this local service development Wolverhampton CCG is part of the Black Country Transforming Care Partnership which has developed and submitted a robust implementation plan to NHS England which will deliver further service change and transformation over the next three years resulting in more community based services including bespoke packages of care.

Listening to our patients, their families, Carers and stakeholders

During May and June 2016 BCPFT engaged with patients, Carers and other stakeholders to find out their views on the possibility to move the services

permanently from Pond Lane to the other locations. All feedback was considered and a decision made by WCCG and BCPFT to continue to Public consultation. The consultation took place from **Monday 4 July 2016 to Monday 22 August 2016**.

The pre-consultation engagement process – what people said

Pre-consultation engagement was undertaken from 16 May - 6 June 2016 with patients, families, carers and service commissioners. Two events were held specifically for service users, their families and carers and views scoped from WCCG and BCPFT stakeholder lists (which total over 300 organisations such as Healthwatch and Wolverhampton Voluntary Sector Council). Both BCPFT and WCCG have membership schemes which were also targeted for their general views on the possible proposal. Views were also sought views from staff within BCPFT and City of Wolverhampton Council. Invitations were sent out from BCPFT to patients and their carers/families admitted in the last eighteen months along with a link to the consultation document and questionnaire and a briefing including information on how to get involved with the consultation was emailed to all stakeholders.

Initial feedback from service users and their families highlighted that travel to the beds (if placed outside of the city) may be a concern, but this was raised as a possible concern for other families, as it wasn't an issue for the families involved in the pre-engagement. Feedback from local stakeholders noted that it would be preferable to stay local for convenience for service users and their families, but noted that relocation of the services to be closer to associated services and thereby potentially secure service improvements was acknowledged as probably of merit.

The consultation process

The consultation took place from 04 July 2016 to Monday 22 August 2016. Below are the various communication and engagement methods:

How we let people know about the consultation

Week commencing 4 July 2016:

- Distribution of a printed and pdf consultation document, an easy read version in both printed and pdf version including survey and an online version of survey. Distributed to Mencap, Social Workers, Pond Lane outpatients waiting area, A4I, Scott House outpatients and Dudley Ridgehill Centre.
- Live webpage on both WCCG website and BCPFT website outlining consultation including links to online surveys, public event poster and pdf consultation documents.
- Link to consultation webpage on Healthwatch Wolverhampton website
- 4 July – 22 August 2016 – Tweet schedule implemented advertising consultation, online survey and public event
- 05 July 2016 email out to WCCG stakeholders informing them about the consultation and links to the webpage and online survey.
- 29 July 2016 - Healthwatch advertised our consultation to their members via email.

Engagement events

Two engagement events took place during the consultation period. The first was a drop-in public event which took place 7 July 2016 at the Brickkiln Community Centre, Cherry Street, WV3 0QW. To let as many people as possible know about the event information, including posters, was sent to all stakeholders. Examples include, Mencap, Social workers, Pond Lane outpatients waiting areas. Five people attended the event, statutory agencies present included BCPFT, City of Wolverhampton Council , WCCG and Healthwatch.

Service users who had been inpatients during the past 18 months, their, families and carers were invited to a second event which took place 18 August 2016. This event also included a sensory room and specially (for this consultation) an independent advocacy group was commissioned consisting of an expert by experience and independent professional advisor.

Key stakeholders

Over 300 Stakeholders representing inclusive and varied organisations were invited to feedback their views on the consultation. *These organisations represented the*

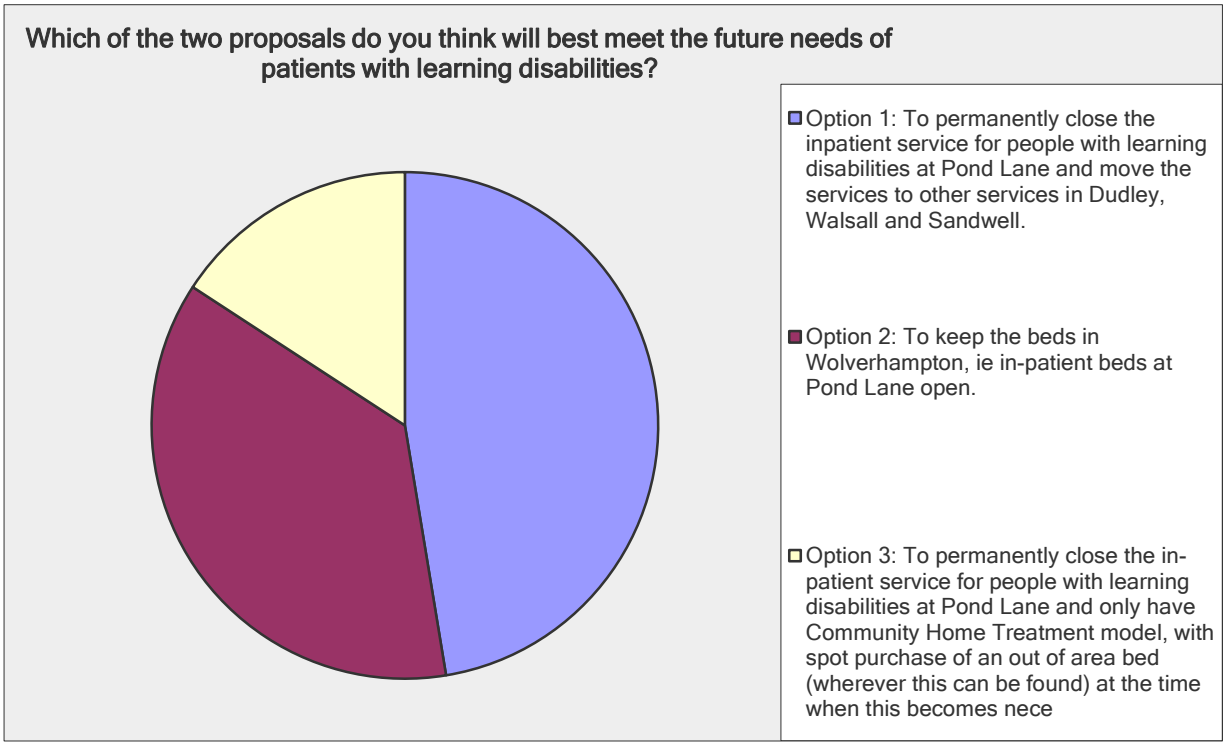
nine protected characteristics as outlined in the Equality and Diversity Act 2010 (the full stakeholder list can be seen Appendix A).

Feedback from completed questionnaires

The following section of the report analyses the feedback received from the 19 completed questionnaires received. Not all respondents answered all the questions, and this accounts for some different totals in answers to some questions.

Analysis of questionnaire responses

Which of the three proposals do you think will best meet the future needs of patients with learning disabilities?



Answer Options	Response Percent	Response Count
Option 1: To permanently close the inpatient service for people with learning disabilities at Pond Lane and move the services to other services in Dudley, Walsall and Sandwell.	47.4%	9
Option 2: To keep the beds in Wolverhampton, ie in-patient beds at Pond Lane open.	36.8%	7

Option 3: To permanently close the in-patient service for people with learning disabilities at Pond Lane and only have Community Home Treatment model, with spot purchase of an out of area bed (wherever this can be found) at the time when this becomes necessary.	15.8%	3
If you wish, please give a reason for your choice.		8
answered question		**19**
skipped question		**0**

Commentary

The table and graph show that the largest group of people answering the questionnaire, 9 people in total (47.4%), chose Option 1 to permanently close the inpatient service. The second largest group voted to keep the beds in Wolverhampton (36.8%), 7 people. It is interesting to note that the difference in opinion between Option 1 and Option 2 is only two people. However, three people chose Option 3, to close the Pond Lane in-patient service for people with Learning Disabilities and only have a community Home Treatment model of care (15.8%).

Therefore it would seem that a total of 12 people would be in agreement with not to keep beds at Pond Lane.

In answer to this question respondents were also asked to express their views by adding any additional comments. As seen in the seven comments received people were:

- Concerned about having to travel further to visit relatives and friends if they needed hospital admission (three comments), although one further respondent did mention good public transport links (one comment)

Out of area option would have an impact on families/carers ie visiting, network of people already established in Wolverhampton

Best to be in the community but if it became necessary for someone to go as an impatient then families need to be able to get to their family member as easy as possible

it's ner to their famley

The services mentioned being assessable by public transport is good.

- In two cases supportive of the community model

- In support of having beds provided more centrally (one comment)

Too many beds across Black Country. Pond Lane is least viable as smallest. Inpatient units need 'critical mass' in order to offer flexible and competent services

Option 3 maintains the learning disabled person in a familiar home environment rather then moving to an institutional setting i.e. pond lane or similar. spot purchase when required is a better solution.

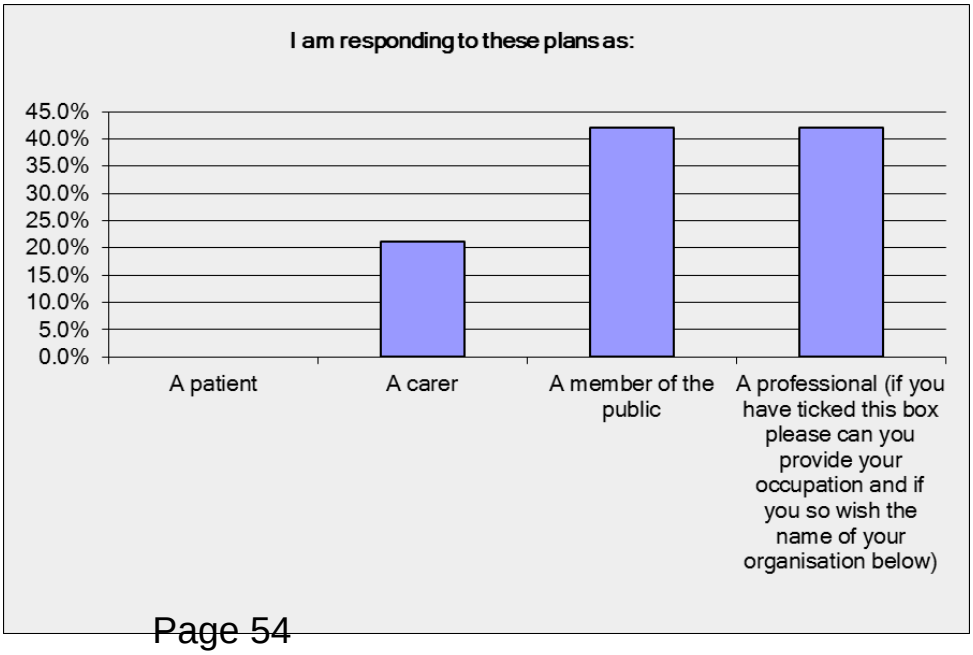
My only proviso is that the community Home Treatment model must be individually tailored to the person's requirements bearing in mind also the support and respite needs of relatives who are caring.

The comments above are recorded as verbatim.

To understand the mix of respondents the following question asked people to identify themselves as a patient, Carer, a member of the public, a professional, by representing an occupation or organisation.

I am responding to these plans as:

A patient; a Carer; a member of the public; a professional; occupation/organisation



I am responding to these plans as:		
Answer Options	**Response Percent**	**Response Count**
A patient	0.0%	0
A carer	21.1%	4
A member of the public	42.1%	8
A professional	42.1%	8
Occupation and organisation		8
answered question		**19**
skipped question		**0**

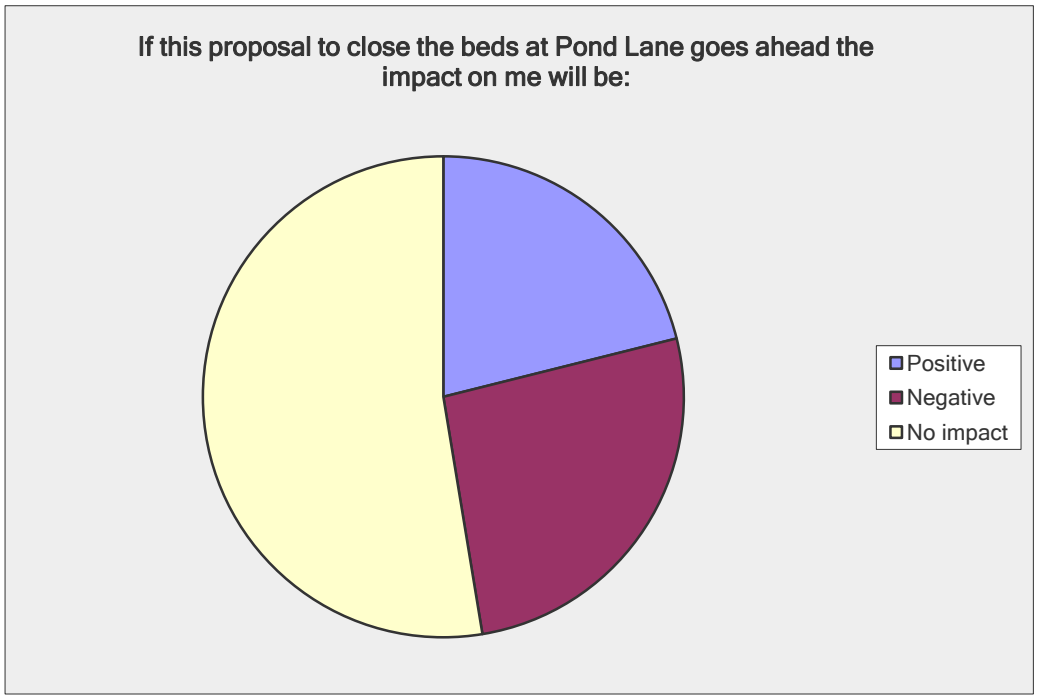
Commentary

This table shows the statistics of survey responders. The majority of responders identified themselves as either professionals, where eight people responded (42.1%) or members of the public where again eight people responded (42.1%.).

These groups were represented by 50% more than the next highest group who were Carers at 4 respondents (21.1%).

Unfortunately, no one identifying themselves as a patient responded to the questionnaire. As an easy read version of the questionnaire was available and experts in attendance to help with communication at the patient only event it may be supposed that patients were happy to let their Carers, families and professionals respond, although this cannot be ascertained as fact.

Q1. If this proposal to close the beds at Pond Lane goes ahead the impact on me will be:



Answer Options	Response Percent	Response Count
Positive	21.1%	4
Negative	26.3%	5
No impact	52.6%	10
If you wish, please explain your reasons for saying this here		7
answered question		**19**
skipped question		**0**

Commentary

The table above shows the impact respondents felt the closure of the Pond Lane service would have on them. The majority of participants told us that the closure would have no impact on them 52.6% (ten people). Five people (26.3%) felt they would experience a negative impact and 21.1% of respondents felt the closure would have a positive impact on them. *Therefore, In total, 14 people felt that the impact of closing the beds at Pond Lane would not cause them concern.*

Seven written comments on impact were received. One person felt the closure of the beds at Pond Lane would ensure more support and resources were available to people in the community and hopefully prevent admission. Most concerns were around the loss of a local service and its perceived benefits (5 comments) and one comment on increased workload if the service moves:

Not having a service that can respond immediately and give advice and guidance.

Being able to get to family member essential

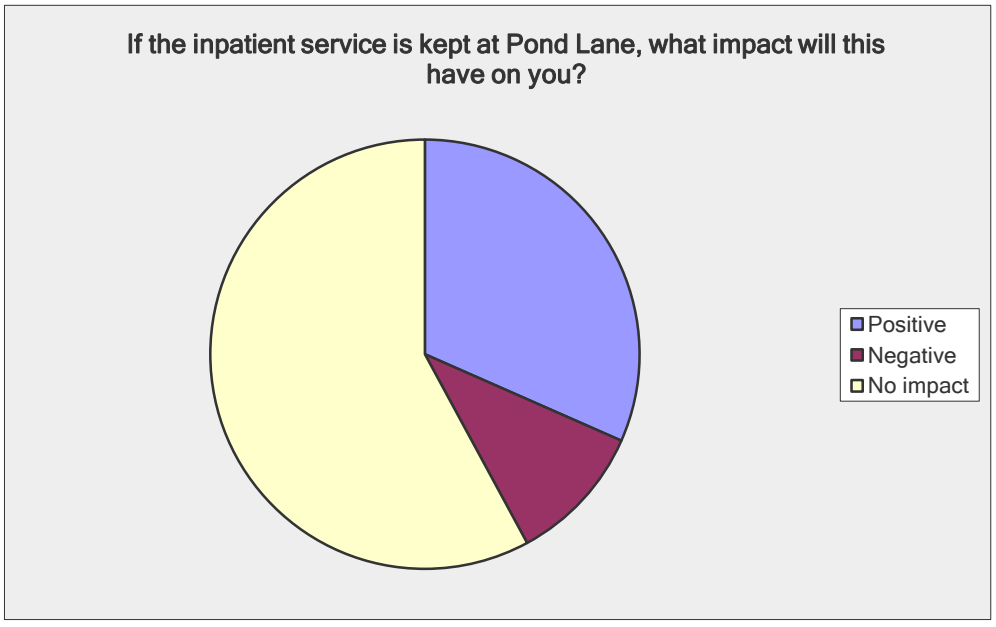
I have a fear of services being reduced for the community. This is not a personal issue.

I know someone who's relative has benefitted from Pond Lane and the fact it is a small, local facility

OT is well placed to provide services that are not offered by any other profession. Denying these services to clients by way of removing the service is not only denying them medical treatment but also the opportunity to enhance their daily living skills and general well-being.

My workload likely to increase if inpatients move to my service.

Q2. If the inpatient service is kept at Pond Lane, what impact will this have on you?



If the inpatient service is kept at Pond Lane, what impact will this have on you?		
Answer Options	**Response Percent**	**Response Count**
Positive	31.6%	6
Negative	10.5%	2
No impact	57.9%	11
If you wish, please explain your reasons for saying this here		4
answered question		**19**
skipped question		**0**

Commentary

More than half of the people (11), who answered this question felt that the Inpatient service staying at Pond Lane would have no impact on them (57.9%).

Six people out of 19 who answered the question felt the Inpatient service staying at Pond Lane would have a positive impact on them (31.6%).

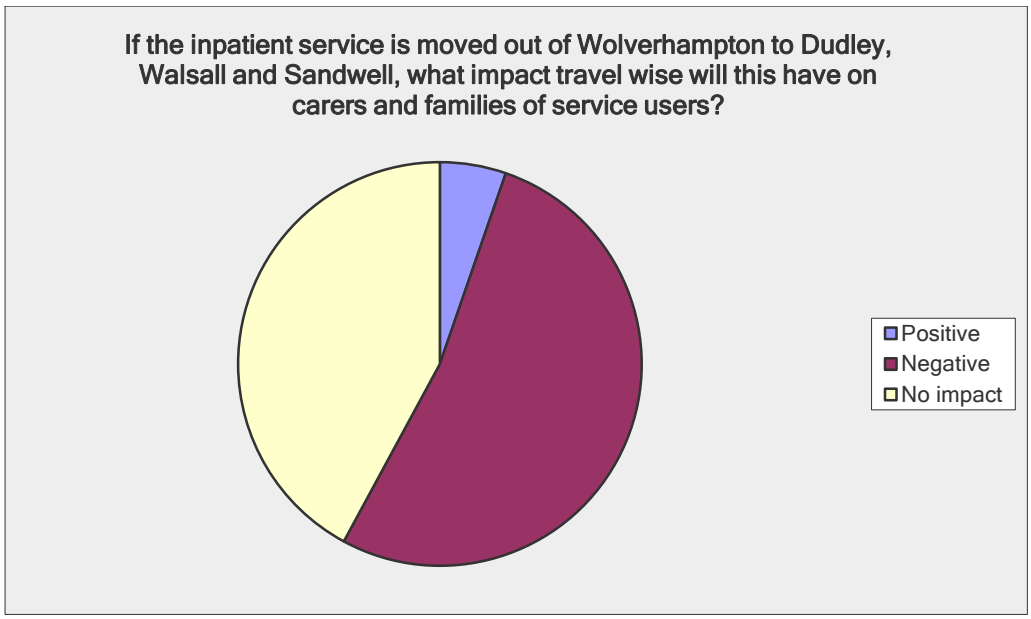
Having a service in Wolverhampton that can respond in an emergency or can give advice and guidance

A service in Wolverhampton for Wolverhampton people

Two people felt it would have a negative effect (10.5%).

Two people sent written comments in response to this question, both of which highlighted concerns around the perceived loss of services if the beds did not remain in the local area.

Q3. If the inpatient service is moved out of Wolverhampton to Dudley, Walsall and Sandwell, what impact travel wise will this have on carers and families of service users?



If the inpatient service is moved out of Wolverhampton to Dudley, Walsall and Sandwell, what impact travel wise will this have on carers and families of service users?		
Answer Options	**Response Percent**	**Response Count**
Positive	5.3%	1
Negative	52.6%	10
No impact	42.1%	8
If you wish, please explain your reasons for saying this here		8
answered question		**19**
skipped question		**0**

Commentary

As demonstrated in the table, the majority of respondents to this question, ten people (52.6%) felt that if the beds were moved there would be a negative impact on them in terms of travelling out of Wolverhampton.

However as eight people (42.1%) felt travelling further would have no impact on them and one person (1.3%) felt travelling would have a positive impact on them *we can conclude that nine people did not feel they would experience any negative impact on travelling* if the service was provided outside Wolverhampton.

The seven written responses received in answer to this question all raise concerns around having to travel further although one respondent does suggest that extra support could be offered:

Some carers may not have vehicles ie cars. Have to rely on public transport. This could have financial implications.

Families may have to travel slightly further this will appear negative but extra support could be offered

Many will have to travel further. Some carers may be elderly or rely on public transport.

Certainly negative for patients and carers from Wolverhampton.

Disastrous. It's hard enough organising visiting within the city. The closer a loved one the better.

The importance of having a regular contact with family and friends will only help the patient recover. Financial pressure of travelling around Wolverhampton. Unable to visit twice daily

Obviously

Question four asks people to tell us of any other comments that they would like to be considered:

Q4. Any other comments? Please use the space if you have any additional comments.

Vulnerable peoples services are being omitted or decreased. Vulnerable people in Wolverhampton deserve better care.

I hope that this will not lead to reduction in resources as there is a need to promote health and independence in the community

I wonder if this consultation should have been undertaken at the outset of the proposal to move these beds. Had that been so I would have had more confidence in the process. As it is I am left with a sense of a fait accompli being performed as the process is now (possibly) irreversible. Your email and this questionaire give no background into the rationale behind the proposal.

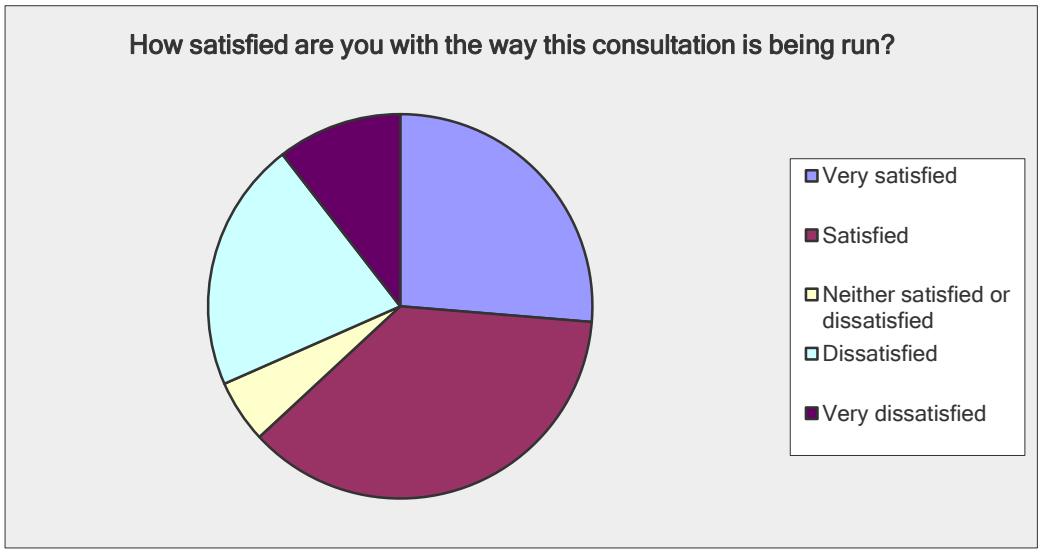
dont mind the change

Why not close the same services in Dudley, Sandwell and Walsall they can travel to Wolverhampton. What about the commitment to having care close to home and family.

I do not understand why the service is being moved in the first place. If it is viable for the above boroughs to offer this service, I do not understand the drivers preventing Wolverhampton from offering it.

The six written comments received in answer to question 4 express a concern that if the beds do not remain at Pond Lane, loss of service provision will ensue. One respondent comments that these services are for the most vulnerable people and another respondent worries that closing the beds will lead to a reduction in resources. Concerns are also raised about need to travel further to visit relatives. Two respondents do not understand why the service cannot remain in Wolverhampton. One person feels that the decision to close the beds had already been made prior to the consultation.

Q5. How satisfied are you with the way this consultation is being run?



How satisfied are you with the way this consultation is being run?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	26.3%	5
Satisfied	36.8%	7
Neither satisfied or dissatisfied	5.3%	1
Dissatisfied	21.1%	4
Very dissatisfied	10.5%	2
answered question		**19**
skipped question		**0**

Commentary

More than 50% of respondents (63.1%) were very satisfied or satisfied.

Conclusion

- When considering the Options, although more people are in favour of Option 1 to close the beds (9 people) the difference between those choosing Option 2 to keep the beds (7 people) is only a margin of 2 people in favour. However, when we take into consideration Option 3 to have only a community model of care the overall margin in favour of not keeping beds open in Pond Lane is 12, therefore the margin in favour is three.

- When considering the impact respondents felt the closure of the Pond Lane service would have on them, the majority of participants told us that the closure would have no impact on them 52.6% (ten people). Five people (26.3%) felt they would experience a negative impact and 21.1% of respondents felt the closure would have a positive impact on them. Therefore, in total, 14 people felt that the impact of closing the beds at Pond Lane would not cause them concern.

- Most respondents felt that the Pond Lane service remaining would have no impact on them, neither, positive or negative.

- Ten respondents were concerned about the impact having to travel further if the Pond Lane beds were closed would have on them. However, 9 people in total did not express concern around the impact travel would have on them if the beds at Pond Lane were to close

- Some people express concern about the potential loss of a local service if the Pond Lane service was closed. The main concern is having to travel further to visit loved ones. There is also a concern that if the service moves elsewhere the loss of more local community services will follow and the need for support and advice will not be met. One person is also concerned that in an emergency the further distance will delay a rapid response.

Recommendations

1. It is recommended that the commissioners note the concerns highlighted in the report before making final decisions on the option to take forward:
   - **Travel issues:** Initial feedback from service users and their families highlighted that travel to the beds (if placed outside of the city) may be a concern, but this was raised as a possible concern for other families, as it wasn't an issue for the families involved in the pre-engagement. Stakeholders noted that relocation of the services to be closer to associated services and thereby potentially secure service improvements was acknowledged as probably of merit. 52.6% of survey respondents that if the beds were moved, there would be a negative impact on them in terms of travelling out of Wolverhampton. Written responses suggested that extra support could be offered:
   - **Options:** 12 people chose Options 1 and 3, therefore it would seem that a total of 12/19 people would be in agreement with not to keep beds at Pond Lane.
   - **Impact of closure:** 14 survey respondents indicated that the impact of the closure of Pond Lane site would not cause them concern.

2. It is also recommended that this report is published and circulated to those who took part in the consultation, with thanks to them for the time they spent responding and for their very useful input.

Equalities monitoring

Q6. Please state the first letters and numbers of your postcode, eg, WV1

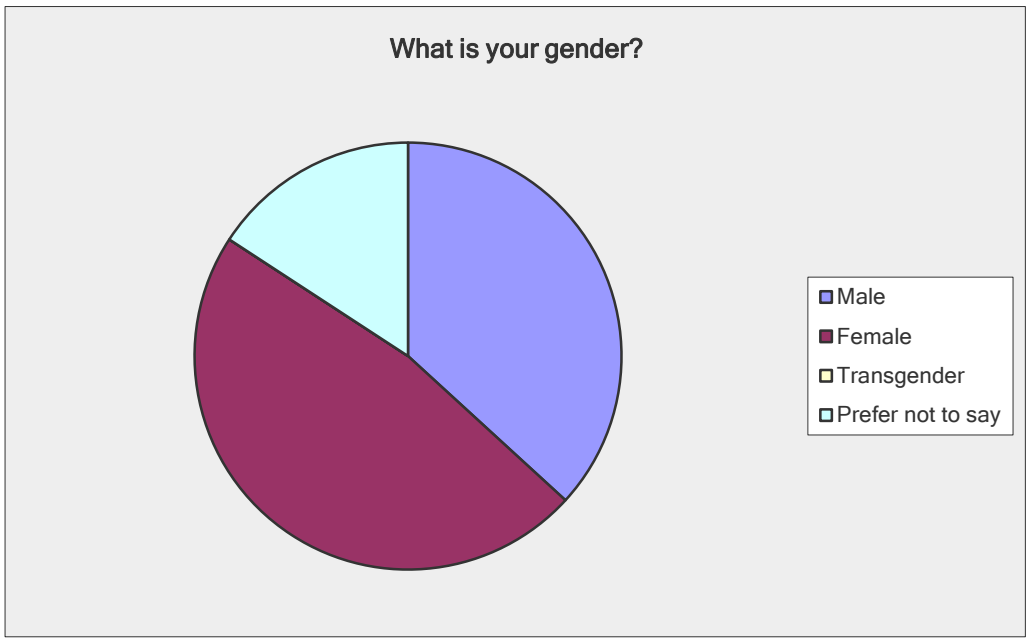
Response
WV2
WV1
Wr1
wV1
WV1
ST17
WV4
WV6
WV10
WV10
wv10
WV10
WS5
WV1
WV4
B68
WV3
WV6

Please state the first letters and numbers of your postcode, eg, WV1.	
Answer Options	**Response Count**
	18
answered question	**18**
skipped question	**1**

Commentary

The table above shows the postcode/location of the respondents. *The majority of respondents were from the WV1 and WV10 area.*

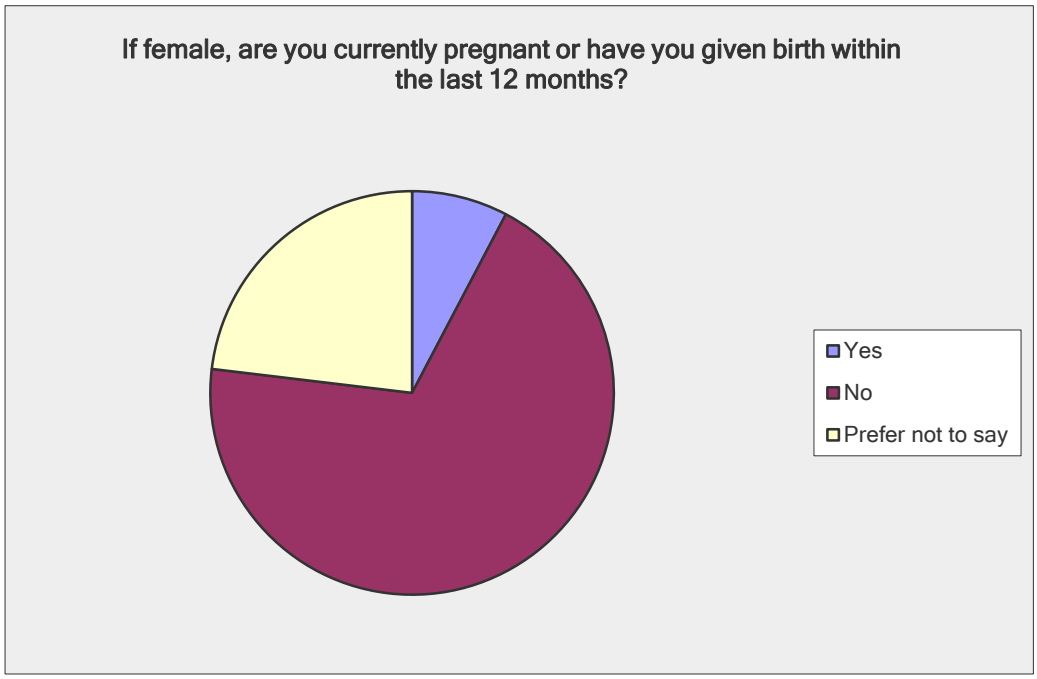
Q7. What is your gender?



What is your gender?		
Answer Options	**Response Percent**	**Response Count**
Male	36.8%	7
Female	47.4%	9
Transgender	0.0%	0
Prefer not to say	15.8%	3
answered question		**19**
skipped question		**0**

Two more women than men answered the questionnaire, three people preferred not to say.

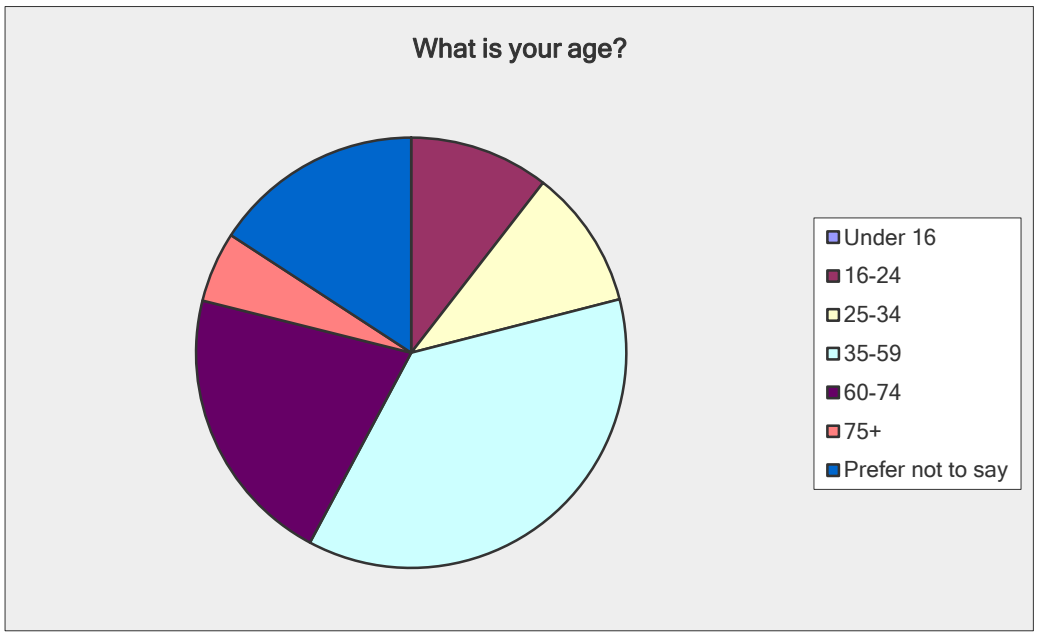
Q8. If female, are you currently pregnant or have you given birth within the last 12 months?



If female, are you currently pregnant or have you given birth within the last 12 months?		
Answer Options	**Response Percent**	**Response Count**
Yes	7.7%	1
No	69.2%	9
Prefer not to say	23.1%	3
answered question		**13**
skipped question		**6**

Only one person completing the survey was pregnant.

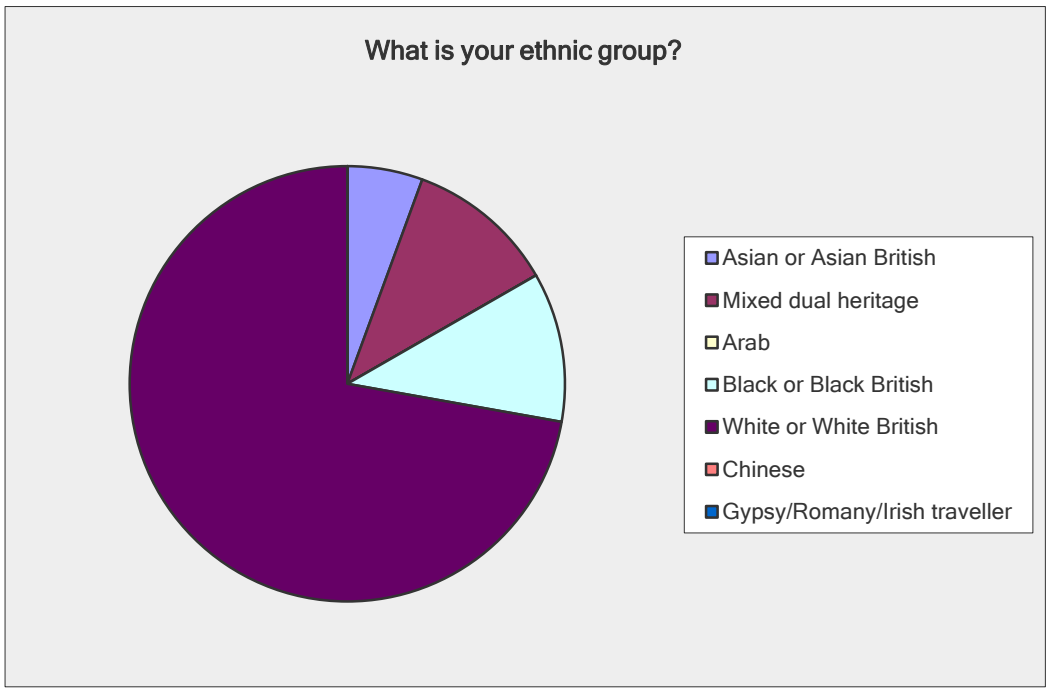
Q9. What is your age?



What is your age?		
Answer Options	**Response Percent**	**Response Count**
Under 16	0.0%	0
16-24	10.5%	2
25-34	10.5%	2
35-59	36.8%	7
60-74	21.1%	4
75+	5.3%	1
Prefer not to say	15.8%	3
answered question		**19**
skipped question		**0**

The majority of those completing the survey were aged between 35 and 79.

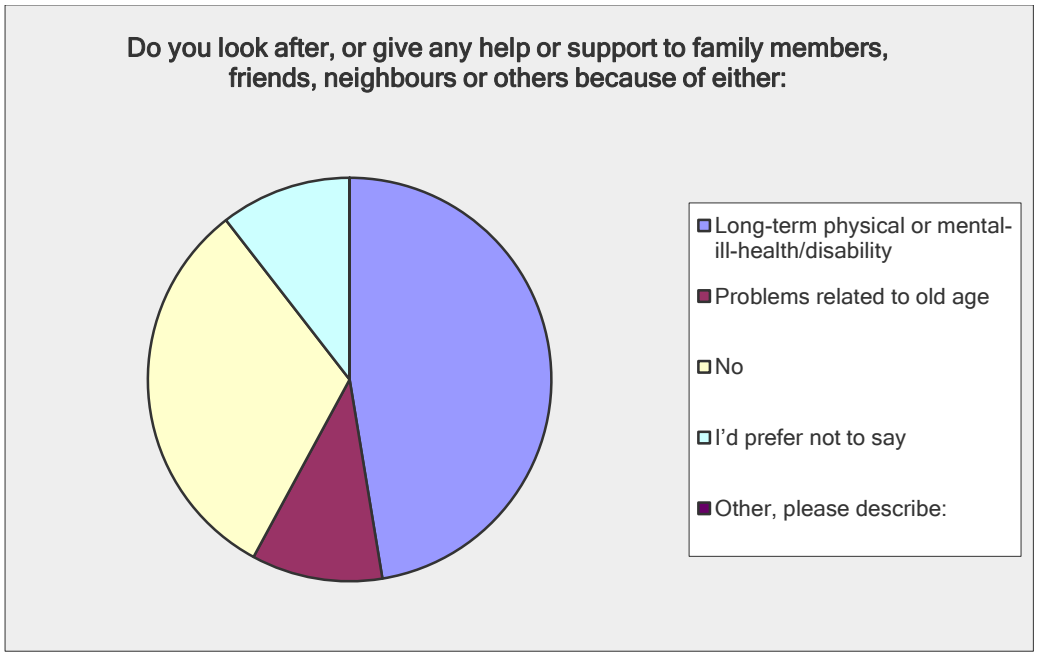
Q10. What is your ethnic group?



What is your ethnic group?		
Answer Options	**Response Percent**	**Response Count**
Asian or Asian British	5.6%	1
Mixed dual heritage	11.1%	2
Arab	0.0%	0
Black or Black British	11.1%	2
White or White British	72.2%	13
Chinese	0.0%	0
Gypsy/Romany/Irish traveller	0.0%	0
Other (please specify)		0
answered question		**18**
skipped question		**1**

13 people out of the 18 people who responded to this question were White or White British, one Asian or Asian British people responded and two people of Mixed dual heritage.

Q11. Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

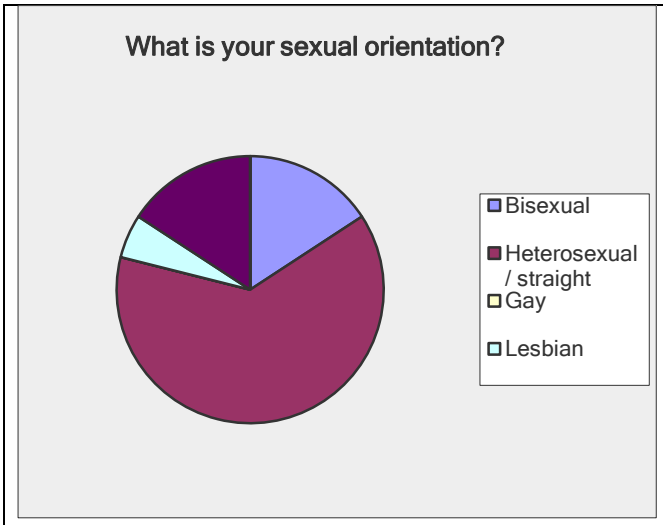


Do you look after, or give any help or support to family members, friends, neighbours or others because of either:		
Answer Options	**Response Percent**	**Response Count**
Long-term physical or mental-ill-health/disability	47.4%	9
Problems related to old age	10.5%	2
No	31.6%	6
I'd prefer not to say	10.5%	2
Other, please describe:	0.0%	0
answered question		**19**
skipped question		**0**

Q12. Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months?

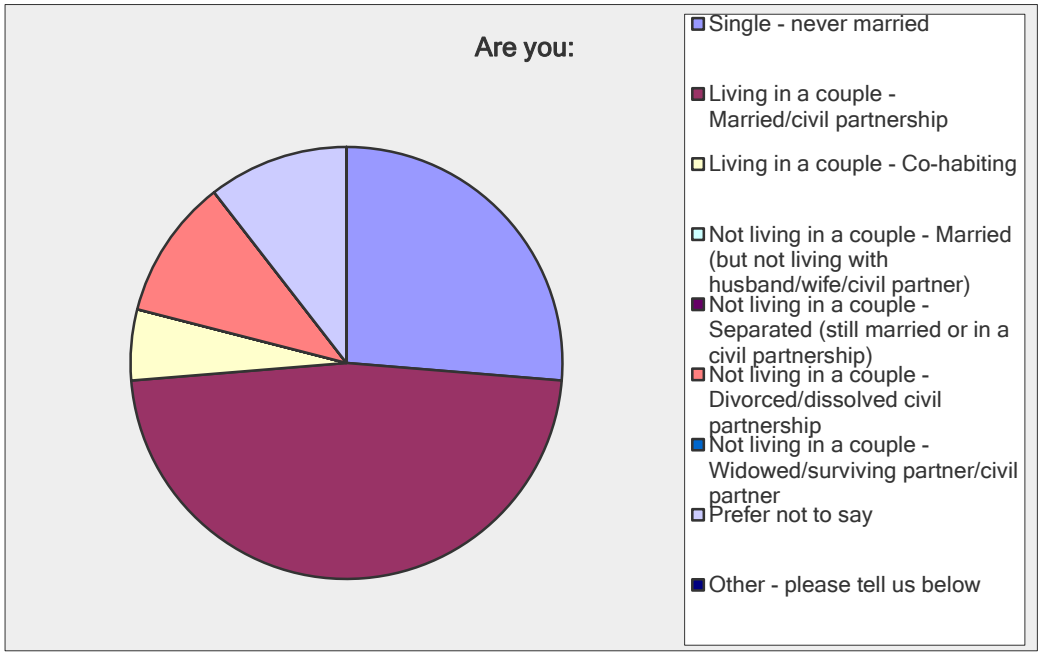
Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)		
Answer Options	**Response Percent**	**Response Count**
Vision (such as due to blindness or partial sight)	0.0%	0
Hearing (such as due to deafness or partial hearing)	15.8%	3
Mobility (such as difficulty walking short distances, climbing stairs)	0.0%	0
Dexterity (such as lifting and carrying objects, using a keyboard)	0.0%	0
Ability to concentrate, learn or understand (learning disability/difficulty)	0.0%	0
Memory	0.0%	0
Mental ill-health	10.5%	2
Stamina or breathing difficulty or fatigue	0.0%	0
Social or behavioural issues (for example, due to neuro diverse conditions such as autism, attention deficit disorder or Aspergers' syndrome)	0.0%	0
No	68.4%	13
Prefer not to say	5.3%	1
Any other condition or illness, please describe:	0.0%	0
answered question		**19**
skipped question		**0**

Q13. What is your sexual orientation?



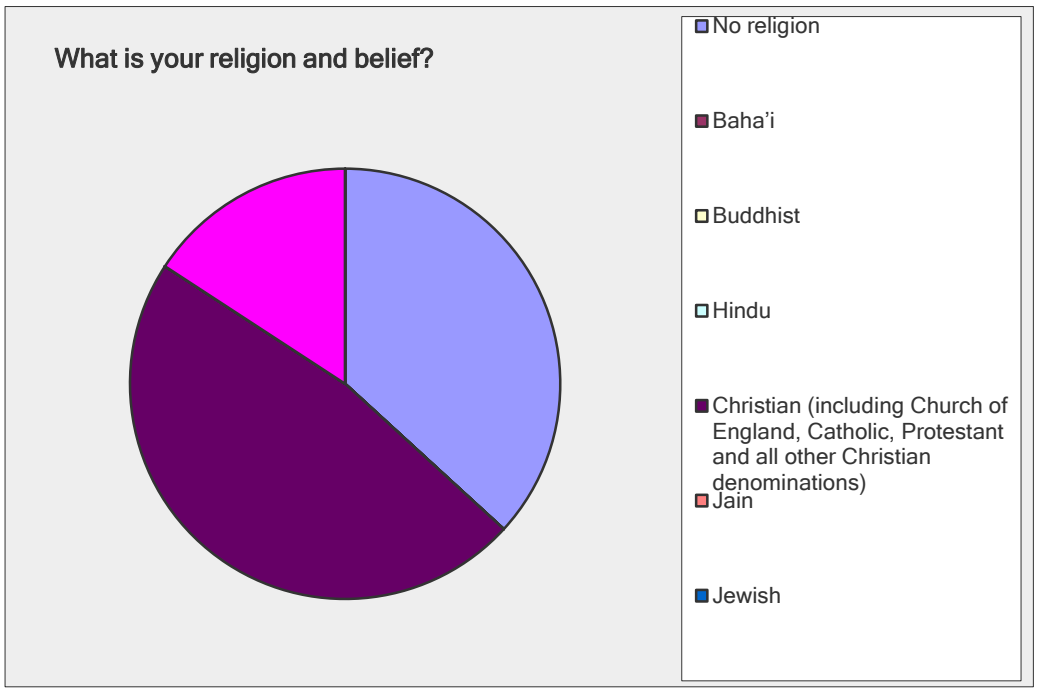
What is your sexual orientation?		
Answer Options	**Response Percent**	**Response Count**
Bisexual	15.8%	3
Heterosexual / straight	63.2%	12
Gay	0.0%	0
Lesbian	5.3%	1
Prefer not to say	15.8%	3
Other (please specify)	0.0%	0
answered question		**19**
skipped question		**0**

Q14. Are you:



Are you:		
Answer Options	**Response Percent**	**Response Count**
Single - never married	26.3%	5
Living in a couple - Married/civil partnership	47.4%	9
Living in a couple - Co-habiting	5.3%	1
Not living in a couple - Married (but not living with husband/wife/civil partner)	0.0%	0
Not living in a couple - Separated (still married or in a civil partnership)	0.0%	0
Not living in a couple - Divorced/dissolved civil partnership	10.5%	2
Not living in a couple - Widowed/surviving partner/civil partner	0.0%	0
Prefer not to say	10.5%	2
Other - please tell us below	0.0%	0
answered question		**19**
skipped question		**0**

Q15. What is your religion and belief?



What is your religion and belief?		
Answer Options	**Response Percent**	**Response Count**
No religion	36.8%	7
Baha'i	0.0%	0
Buddhist	0.0%	0
Hindu	0.0%	0
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	47.4%	9
Jain	0.0%	0
Jewish	0.0%	0
Muslim	0.0%	0
Sikh	0.0%	0
Prefer not to say	15.8%	3
Other (please specify)	0.0%	0
answered question		**19**
skipped question		**0**

APPENDIX 1

Stakeholders list

A41 - Action for Independence
Action for Diabetes
Adult Social Care Access Point
African Caribbean Community Initiative (ACCI)
African Women of Substance
Against Group Closures
Age UK
All Nations
All Saints Action Network (ASAN)
Alzheimer's Society
Anchor Trust
Animal Assisted Therapy
Aquarius (Adults)
Aquarius (Young People)
Aspiring Futures
Autism West Midlands
Awaaz - Dost
Awaaz (Asian Women's Adhikar Association)
Beacon Centre for the Blind
Believe 2 Achieve
Beth Johnson Foundation
Better Understanding of Dementia for Sandwell (BUDS)
Between You and Me (SEVA)
Bhai Lalo Gurmat Parchar Society
BID Services for Deaf People
Black Country Visual Arts
Blakenhall Action Community Forum (BACF)
BME Housing Consortium
BME United
Brain Tumur Support Group
Brickkiln Dunstall Gateway Club
Breast Cancer Action Group
Buddha Vihara
Cameroonian Community of Wolverhampton
Carer Support Team
Catch 22
Changing Our Lives
Chinese Welfare and Information Centre
Citizens Advice Bureau - Bilston
Citizens Advice Bureau - County Court
Citizens Advice Bureau - Low Hill
Citizens Advice Bureau - Wolverhampton
Compton Hospice
Creative Support Wolverhampton Women's Wellbeing Centre
Darlington Street Methodist Church
Deafblind UK
Deon Jordan Foundation
Desire of Nations
Early Years Childcare & Play Service
Eating Disorder Service
Educare
Equalities Officers
Equality and Diversity Forum
Escape Productions
Eyes to Success
First Person Plural
Friends, Families and Travellers
Gender Matters
Get Connected
Gloucester Street Community Centre
Good Shepherd Ministry
Guru Nanak Gurdwara
Guru Nanak Satsang Gurdwara
Guru Nanak Sikh Gurdwara
Guru Nanak Sikh Temple
Headway (Black Country)
Healthwatch
Healthy Gay Life
Hear our Voice
Hearing Voices
Home Start
Hope Community Project
Hope into Action: Black Country
Improving Futures
Include Me TOO

Islamic Society of Britain (ISB)
Jamia Masjid Bilal and Muslim Community Centre
Jobcentre Plus Wolverhampton
Kic FM
Let us Play
LGBT Network Wolverhampton
Life Direct
Life Spring Church
Local Neighbourhood Partners
Local Neighbourhood Partners (Whitmore Reans)
MacMillan BID Services for Deaf People
MacMillian Cancer Information and Support
Madina Masjid
MENCAP
Mental Health Plus
Midland Heart
Moreland Trust
Mosque and Shia Muslim Community and Welfare Centre
Multiple Sclerosis Therapy Centre
Muslim Educational Trust
Nanaksar Thath Isher Darbar
Navjeevan Project
Nehemiah-UCHA
Netmums (Wolverhampton and Walsall)
Neville Garratt Centre for independent living
Newhampton Arts Centre
No Panic
Omega Care for Life
One Voice-Action for Disability
Over 50's Deaf Group
Over Eaters Anonymous
P3 Charity - Direct Access Pathway Service
Patient Advisory Cancer Team (PACT)
Parkinson’s (Early Onset)
Parkinson's (Older)
Partnership

Platform 51
Positive Action 4 Mental Health (PA4MH)
Positive Participation Ltd
Quakers
Ramgarhia Board and Temple
Ramgarhia Sabha
Red Cross
Refugee and Migrant Centre Ltd
Remploy
Revive
Rethink Community Support Service
Royal Voluntary Service
Sai Bab Mandir Wolverhampton
Samaritans
Scope
Shaan
Shine (Midlands Region)
Sickle Cell and Thalassaemia Support Project
Sikh Gurdwara
Social Steam Engine
St Georges House (Hub)
St Peter and St Paul
St Peter's Collegiate Church
Support for over 50's
Support Group for Autism (Adults)
Tabernacle Baptist Church
Terrence Higgins Trust
The Golden Years Project
The Haven Wolverhampton
The Himmatt
The Kaleidescope Group
The Key Team
The Polish Community Centre
The Sahara Centre
The Way Youth Zone
The X2Y LGBT Youth Organisation
Thomas Pocklington Trust
TLC College
Voice 4 Parents
VoiceAbility Black Country
Wednesfield Diabetes Group
Welfare Reform

West Midlands Caribbean Parents and Friends Association
West Midlands Consortium Services for Travelling
West Midlands Pensions Convention
West Park User Group
Wolverhampton Black Strategic Health Group
Wolverhampton Church Association for the Deaf
Wolverhampton Connextions Centre
Wolverhampton Coronary Aftercare Support Group
Wolverhampton Ethnic Minority Council
Wolverhampton Health Advocacy Complaints Service
Wolverhampton Improving Futures
Wolverhampton Improving Futures - Warstones
Wolverhampton Improving Futures - Bilston
Wolverhampton Improving Futures - Haven
Wolverhampton Improving Futures - Heath Town
Wolverhampton Interfaith Council
Wolverhampton LD partnership board
Wolverhampton Mental Health Empowerment Team
Wolverhampton Mosque
Wolverhampton Muslim Forum
Wolverhampton Over 50's Forum
Wolverhampton Parent Partnership Service
Wolverhampton Pensioners Association
Wolverhampton People's Parliament
Wolverhampton Pioneer Ministries
Wolverhampton Rheumatology Support Group
Wolverhampton Sickle Cell Care & Social Activity Centre
Wolverhampton Sports Specialist Centre

Wolverhampton University
Wolverhampton Urdu Centre
Wolverhampton Voluntary Sector Council (WVSC)
Wolverhampton Wellbeing Service
Wolverhampton WVSC Empowerment Team
Wolverhampton WVSC Drug Service User Involvement Team
Wolverhampton Young Carers
Wolverhampton Young Minds
Wolves Disabled Supporters Association
Women of Wolverhampton (WOW)
YMCA
Your Helping Hands
Youth Offending Service
Youth Organisations of Wolverhampton (YOW)
YWCA
Zebra Access
Zebra Uno Ltd
Elder Asians
Engagement Youth Empowerment Service
Mental Health Empowered Team
Positive Action for Mental Health
Samaritans
St Georges
Wolverhampton Coronary Aftercare Support Group
Wolverhampton Ethnic Minority Council
Black Country Partnership NHS Foundation Trust Members, Wolverhampton Constituency, Gold member status (53)
BCPFT Public Governors

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
8 November 2016

Agenda item 9

Title of Report:	**Equality Delivery System2 (EDS2)**
Report of:	Manjeet Garcha
Contact:	Juliet Herbert
(add board/ committee) Action Required:	☒ **Decision** ☒ **Assurance**
Purpose of Report:	To seek approval to implement EDS2, this will require some operational changes.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Equality, Inclusion and Human Rights
Relevance to Board Assurance Framework (BAF):	This report is relevant to all domains.
• **Domain 1:** A Well Led Organisation	This will assess the extent to which a 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; This element of the framework builds on several of the domains of the original assurance framework. Given the level of organisational maturity that the CCGs have now attained, NHS England will need to re-assess this element in detail when there has been a significant organisational change, such as to the leadership arrangements, or where particular

	problems have arisen
• **Domain 2a:** Performance – delivery of commitments and improved outcomes	Delivery of commitments and improved outcomes: a key focus of assurance will be how well CCGs deliver improved services, maintain and improve quality, and ensure better outcomes for patients. This includes their progress in delivering key Mandate requirements and NHS Constitution standards, and ensuring that they are meeting standards for all aspects of quality, including safeguarding, and digital record keeping and transfers of care. This focus on quality, performance and outcomes will be continuous throughout the year, and will be underpinned by a set of delivery metrics, which will constitute the CCG scorecard, which is also intended to publication.
• **Domain 2b:** Quality (Improved Outcomes)	As above
• **Domain 3:** Financial Management	The monitoring of a CCG's financial management capability and performance will be continuous throughout the year, including an assessment of data quality and contractual enforcement. Immediate remedial action will be required when financial problems become evident. Such action could include the use of special measures and NHS England's statutory powers of direction.
• **Domain 4:** Planning (Long Term and Short Term)	The assurance of a CCG's plans will be a continuous process, 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	Specific additional assurances will be required from CCGs which have taken responsibility for delegated functions. From April 2015 it will include primary care and may, in time, include other services. An annual review of the assurance of delegated functions will be required prior to the NHS England business planning process for 2016/17. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed

	rather than delegated function.
• **Domain 6:** Equality & Inclusion (Legal compliance)	EDS2 was developed by the NHS for the NHS to help NHS organisations, in discussion with their local partners and local people, review and improve their performance in respect of people with a protected characteristic. Using the EDS2 demonstrates the CCGs approach to meeting the Public Sector Equality Duty, at statutory requirement as set out in the Equality Act 2010.

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

1. BACKGROUND AND CURRENT SITUATION

1.1. The EDS for NHS organisation was formally launched November 2011. Following an evaluation of the implementation of the EDS in 2012, the EDS was refreshed and the EDS2 2013. EDS2 is a generic tool designed for both NHS commissioner and NHS provider. For more detail please see appendix 1

Appendix 1
eds-nov131 (EDS2).p

1.2 At the heart of the EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. These outcomes relate to issues that matter to people who use, and work in, the NHS. They are grouped under four goals:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Appendix 2 provides more detail.

Appendix 2
NHSEDS2GoalsNOutc

2. MAIN BODY OF REPORT

2.1 The main purpose of the EDS2 is to help local NHS organisation, in discussion with local partners, people and stakeholders, to review and improve their performance for people with characteristics protected by the Equality Act 2010. The nine characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race (national and ethnic origin)
- Religion or belief

- Sex
- Sexual orientation

Other disadvantaged groups include people who are:

- Homeless
- Live in poverty
- Stigmatised groups i.e. prostitution
- Misuse drugs
- Geographically isolated

2.2 Human rights and principals of equality should never be a secondary consideration in the provision of NHS services or in the development of the workforce. The five principles are referred to as FREDA:

- **F**airness – at the heart of recruitment and selection processes (outcome 3)
- **R**espect – making sure complaints are dealt with respectfully (outcome 2)
- **E**quality – underpins commissioning (outcome 1)
- **D**ignity – core part of patient care and the treatment of staff (outcome 2 & 3)
- **A**utonomy – people should be involved as they wish to be in decisions about their care (outcome 2)

(Outcome 4 would be a golden thread as part of all outcomes)

These have been developed to provide general principles that NHS should aspire to.

2.3 By using the EDS2, NHS organisations can also be helped to deliver on the public sector equality duty (PSED). It ensures that NHS organisations can respond to the PSED, and demonstrate their continued activities to meet the requirements to:

- eliminate unlawful discrimination;
- advance equality of opportunity between different groups and;
- foster good relations between different groups;

2.4 Part of the process requires an internal and eventually an external grading. The EDS grading process provides the CCG's Governing Body with an assurance mechanism for compliance with the Equality Act 2010 and enables local people to co-design the CCG's equality objectives to ensure improvements in the experiences of patients, carers, employees and local people. For further information regarding grading, see appendix 3.

Appendix 3 EDS2 - Grading.docx

2.5 The EDS is a generic tool designed for both NHS commissioners and NHS providers. As different NHS organisations apply EDS2 outcomes to their performance, NHSE guidelines recommend that this should be with regard to their specific roles and responsibilities, and that adjustments can be made to the generic language of the outcomes to suit what their organisation does.

With this in mind a project plan has been developed for Wolverhampton CCG. The Plan looks at:

- governance;
- staff briefings;
- the development and implementation of a task and finish group;
- terms of reference for the task and finish;
- evidence gathering and;
- internal grading;

You can view the EDS2 action plan below, appendix 4.

Appendix 4 - EDS2 Action Plan.docx

3. CLINICAL VIEW

3.1. Not applicable

4. PATIENT AND PUBLIC VIEW

Not at this stage.

5. RISKS AND IMPLICATIONS

Key Risks

5.1. All deadlines have been outlined in the EDS2 Action plan (appendix 4). Missing these deadlines could mean the CCG may not be fully compliant by the 31 March 2017.

Financial and Resource Implications

5.2. None for this report.

Quality and Safety Implications

5.3. The implications on Quality and Safety are Intrinsic to the report.

Equality Implications

5.4. Equality Analysis implications are Intrinsic to the report.

Medicines Management Implications

5.5. Not applicable.

Legal and Policy Implications

5.6 The Public Sector Equality Duty is a statutory duty of the Equality Act 2010. Any breaches of the duty could leave the CCG decision makers vulnerable to litigation.

There are also NHS England mandatory equality activity that CCG's needs to ensure their providers are compliant with, such as the AIS, WRES and EDS2. Any breaches here would compromise the equality compliance of the CCG.

6. RECOMMENDATIONS

6.1. Recommendations for approval by the Governing Body are to:

- Approve the EDS2 action plan
- Agree to the implementation of the action plan subject to any amendments
- To receive a further report upon completion of the work prior to publication

Name: Juliet Herbert
Job Title: Equality and Inclusion Business Partner
Date: 24 October 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		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Medicines Management Implications discussed with Medicines Management team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Signed off by Report Owner (Must be completed)		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING

8 NOVEMBER 2016

Agenda item 10

Title of Report:	**Application for full delegation responsibilities for the commissioning of primary medical services**
Report of:	Sarah Southall – Head of Primary Care
Contact:	Sarah Southall – Head of Primary Care
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To ask that the Governing Body note the steps that will be required for the CCG to make an application for full delegation of Primary medical services in line with the intention set out in the Primary Care Strategy.
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
• **Domain 1:** A Well Led Organisation	The application for delegated commissioning will result in an amendment to the CCG's constitution and governance structure.
• **Domain 5:** Delegated Functions	Full delegation will result in a change to how the primary medical services are commissioned in Wolverhampton.

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG is currently at level 2 (joint commissioning) for Primary Care Co-Commissioning with NHS England. The Primary Care Strategy approved in January 2016 included an aspiration to move to fully delegated commissioning by 2017.

1.2. NHS England have provided details on the process for applying for full delegation for 2017 and this report details the next steps in the approval process.

2. APPLICATION PROCESS

2.1. At the Governing Body meeting held on 11 October 2016 the approach for the CCG to make an application for full delegation of Primary Care Commissioning was agreed. The Governing Body also agreed to make a recommendation to the membership to make the consequent variation to the membership.

2.2 The WCCG membership agreed, at the Members meeting which took place on 19 October 2016, in line with the intention in the Primary Care Strategy, to submit a application for full delegation of Primary Care Co-Commissioning and to make the necessary changes to the CCG's constitution in order to take on full delegation. This was on the basis that no objections were made at the meeting to the application for full delegation.

2.3 The deadline for making an application to NHS England for fully delegated commissioning is 5 December 2016. A Delegated Commissioning Checklist (appendix 1) and finance template for delegated budgets (appendix 2) is to be completed by CCGs and the NHS England Director of Commissioning Operations jointly.

2.4 Following the submission of the checklist, our application will be reviewed by NHS England as part of a short approvals process. NHS England will then inform CCGs of the outcomes of this process by early January 2017.

3. CLINICAL VIEW

3.1 The CCG's application for full delegation was discussed at the GP Members Meeting on 19 October 2016.

4. RISKS AND IMPLICATIONS

Key Risks

4.1. The risks associated with the process for fully delegated commissioning are being managed through the application process. Assurance that the CCG will be able to deliver fully delegated commissioning will be assessed through the application process by NHS England.

Financial and Resource Implications

4.2 The figures contained within Finance template is based on 2016/17 forecast outturn as provided by NHSE. The delegation process needs to be based on 2016/17 forecast outturn. The CCG is working closely with NHSE primary care finance department to work up 2017/18 budgets in line with the notified allocations.

4.3 Undertaking 2017/18 budgets the CCG will need to consider and make provision for the following areas which will not be finalised:

- QOF reward payments level for 2016/17 still need to be finalised and NHSE are currently working this up and is difficult to forecast as it depends on contractor performance
- Locums – again difficult to forecast
- GMS/Enhanced Services price uplifts
- Managing investments such as PMS Premium, reserve flexibilities

Quality and Safety Implications

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

Equality Implications

4.4 There are no equality implications arising from this report.

Medicines Management Implications

4.5 There are no medicines management implications from this report.

Legal and Policy Implications

4.6 The application will be submitted in line with the national prescribed process and statutory guidance for constitutional review.

5. RECOMMENDATIONS

5.1 That the Governing Body **approves** Wolverhampton CCGs application for full delegation responsibilities for the commissioning of primary medical services.

Sarah Southall
Head of Primary Care
Date: 26 October 2016

RELEVANT BACKGROUND PAPERS:
https://www.england.nhs.uk/commissioning/pc-co-comms/pb-cc-approval/

ATTACHED DOCUMENTS:
Attached items: Delegated Commissioning Checklist (Appendix 1)
Finance Template for Delegated Budgets (Appendix 2)

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)	**Sarah Southall**	**26/10/16**

This page is intentionally left blank

Delegated commissioning application process and checklist for 2017/18

Introduction

NHS England's Board has committed to support the majority of CCGs to assume delegated responsibilities for the commissioning of primary medical services from 1 April 2017. Giving CCGs more control over general practice is part of a wider strategy to support the development of place-based commissioning and a key enabler of the development of new care models.

The delegated commissioning model is delivering a number of benefits for CCGs and local populations. It is critical to local sustainability and transformation planning (STP), supporting the development of more coherent commissioning plans for healthcare systems and giving CCGs greater ability to transform primary care services. CCGs have also reported that delegated commissioning is giving them greater insight into practice performance issues, greater opportunities to develop a more sustainable primary care workforce and is helping to strengthen relationships between CCGs and practices.

In 2016/17, 114 CCGs have delegated commissioning responsibilities. NHS England has invited the remainder of CCGs operating under joint or the "great involvement" co-commissioning models to apply for full delegation between **now** and **5 December 2016.**

CCGs are encouraged to have an early conversation about their delegated commissioning application with their NHS England local team and finance leads to ensure that all the necessary documentation is updated and approved in advance.

We request that CCGs and the NHS England Director of Commissioning Operations (DCO) jointly complete the delegated commissioning checklist and finance template for delegated budgets for submission nationally. The completed templates should be signed by the CCG and the relevant NHS England DCO and emailed to england.co-commissioning@nhs.net, with a copy to regional leads for co-commissioning, details are as follows

Region	Regional lead for co-commissioning	Contact email address
North	Richard Armstrong	richard.armstrong1@nhs.net
Midlands and East	Vikki Taylor	vikkitaylor@nhs.net
London	Christina Windle	Christina.windle@nhs.net
South	Sarah Khan	sarah.khan12@nhs.net

Next steps towards primary care co-commissioning

Following submission of the checklist, your application will be reviewed by NHS England as part of a short approvals process. We will inform CCGs of the outcomes of this process by early January 2017.

Please note we will consider applications from CCGs with directions or in special measures on a case-by-case basis.

If you require any further information, please contact your regional co-commissioning lead in the first instance, followed by england.co-commissioning@nhs.net.

Delegated Commissioning Application Checklist

This checklist and finance template should be completed jointly by the CCG and the relevant NHS England DCO. **All supporting documentation should be submitted to the NHS England DCO and not the national co-commissioning team.**

Delegated Commissioning Application Checklist	
Wolverhampton CCG has set out clearly defined objectives and benefits of the delegated arrangement.	Yes
The CCG's constitution or proposed constitutional amendment has been updated in line with the guidance[1] (and this has also been approved by the NHS England regional office with confirmation sent to england.co-commissioning@nhs.net - constitutional amends can be confirmed by 1 April 2017).	Yes
The CCG has updated its governance documentation in line with the NHS England guidance (on constitutional amendments).	Yes
The CCG has reviewed its conflicts of interest policy in line with NHS England's *revised statutory guidance on managing conflicts of interest for CCGs* *https://www.england.nhs.uk/commissioning/pc-co-comms/coi/*. The CCG confirms that they will be fully compliant with the conflicts of interest guidance by 1 April 2017.	Yes
The CCG's IG Toolkit meets level 2 criteria as a minimum.	Yes
The CCG's Year End Assurance rating is outstanding	

[1] *Constitutional changes will be required if the CCG takes on delegated commissioning because the CCG will need to establish a new committee to manage the delegated functions and to exercise the delegated powers. In the CCG Model Constitution, the references to this committee will need to be added to sections referenced in 6.4.1.a. and 6.6.3.c. unless there is already a clause permitting new committees without additional direct references. These will also need to refer to the Terms of Reference for this committee.*

<table>
<tr><td>The DCO confirms that there are no performance, finance, leadership or governance issues that prevent the CCG taking on the function.</td><td>Yes</td></tr>
<tr><td>Finance template for delegated budgets completed in full (include completed table below):

Notes for completing the finance template:
1. Double click into the table to complete the excel template.
2. Please enter the notified numbers for your CCG and how the primary care allocation is split between GP Services and other primary care services for 2016/17 (below)
3. This will be reconciled back to the area team allocation for primary care and subsequent in year adjustments. Where possible M6 2016/17 figures should be used.

<table>
<tr><td></td><td>Notified delegated Budget (1)</td><td>Movement out of GP Services (2)</td><td>Movement Into GP Services (3)</td><td>Total</td></tr>
<tr><td></td><td>£'000</td><td>£'000</td><td>£'000</td><td>£'000</td></tr>
<tr><td>GP Services</td><td>+</td><td>-</td><td>+</td><td>+/-</td></tr>
<tr><td>General Practice - GMS</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>General Practice - PMS</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Other list based services (APMS)</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Premises cost reimbursements</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Other premises costs</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Enhanced services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>QOF</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Other GP services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Primary care NHS property services - GP</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Sub Total GP services</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>N/A</td><td>+</td><td>-</td><td>+/-</td></tr>
<tr><td>Acute services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Mental health services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Community health services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Primary care services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Continuing care services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Other care services</td><td></td><td></td><td></td><td>0</td></tr>
<tr><td>Sub total CCG programme costs</td><td></td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td colspan="5">Please provide a description in the change in spend detailed above</td></tr>
</table>
</td><td>Yes (see appendix)</td></tr>
<tr><td>The DCO confirms the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements.</td><td>Yes</td></tr>
<tr><td>The DCO confirms the CCG is capable of taking on delegated functions</td><td>Yes</td></tr>
<tr><td>Three scanned / electronic signatures provided at the foot of this email. Typed names unfortunately cannot be used.</td><td>Yes</td></tr>
</table>

I hereby confirm that Wolverhampton CCG membership and governing body have seen and agreed to all proposed arrangements in support of taking on delegated commissioning arrangements for primary medical services on behalf of NHS England for 2017/18.

NHS England is requested to progress the application to the regional panels for consideration.

Signed by Wolverhampton CCG Accountable Officer
Signature (scan/electronic version required):
Print Name:
Position:
Date:

Signed on behalf of Wolverhampton CCG Audit Committee Chair
Signature (scan/electronic version required):
Print Name:
Position:
Date:

Signed by NHS England Director of Commissioning Operations
Signature (scan/electronic version required):
Print Name:
Position:
Date:

PART II

Finance Template for delegated budgets

	Notified delegated Budget (1)	Movement out of GP Services (2)	Movement Into GP Services (3)	Total
	£'000	£'000	£'000	£'000
GP Services	+	-	+	+/-
General Practice - GMS	19,653			0
General Practice - PMS	1,798			0
Other list based services (APMS)	2,248			0
Premises cost reimbursements	2,771			0
Other premises costs	106			0
Enhanced services	1,556			0
QOF	3,484			0
Other GP services	1,575			0
Primary care NHS property services - GP				0
Sub Total GP services	33,192	0	0	0
	N/A	+	-	+/-
Acute services				0
Mental health services				0
Community health services				0
Primary care services				0
Continuing care services				0
Other care services				0
Sub total CCG programme costs		0	0	0
Total	0	0	0	0

Please provide a description in the change in spend detailed above

Notes for Completing the template

1) Please enter the notified numbers for your CCG in column 1.

2) In column 2 please enter any changes in planned spend from the notified numbers entered in column 1.
As this column captures the movement in spend the total in C27 should equal zero.

3) In column 3 please enter any investment in primary care spend from other areas of CCG spend.
As this column caputres the movement in spend the total in D27 should equal zero.

06A Wolverhampton CCG

	£'000	
Notified 2016/17 Allocation	34,073	As per Annexe C issued January 2016
In Year Movements;		
Transfer of WIC Budget	(694)	Recurrent RTF transfer to CCG Month 3
Transfer of Collaborative Fees	(187)	Recurrent RTF transfer to CCG Month 3
Revised Allocation	**33,192**	
	0	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body Meeting – 11th October 2016

Agenda item 11

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

1.2. The Governing Body is asked to consider the report and associated recommendations for action.

2. CONSULTATION ON THE REDESIGN OF LEARNING DISABILITY ASSESSMENT AND TREATMENT SERVICE (POND LANE)

2.1 The Committee considered the report from Wendy Ewins, which outlined the results of the public consultation on relocating assessment and treatment provision away from Pond Lane. A separate report is included on the agenda, which sets out the Committee's recommendation to agree to the relocation of the service. During the Committee's discussion points were highlighted around the difficulty of engaging with patients, potential issues with transport for patients and their carers and improvements to the service that would result from the relocation.

2.2 **Action – The Committee's recommendation is being considered as a separate report.**

3 CONTRACT AND PROCUREMENT UPDATE

3.1 The Committee was given its regular monthly update on Contracting and performance. Issues highlighted included the continuation of Recovery Action Plans for A&E, E-Discharge and Cancer 62 Waits with RWT and discussions around PREVENT and safeguarding Training with Black Country Partnership Trust. Details of contract sanctions applied during the year were also provided.

3.2 An update was given on contract negotiations, including the highly challenging nationally set deadlines and that Sandwell and West Birmingham CCG would be leading on the negotiations with Black Country Partnership. Wolverhampton CCG are

playing a full part in the process and will continue to hold a separate contract with the Trust.

3.3 A number of contractual performance issues were discussed and RWT are being asked to clarify their position in respect of service delivery models in A&E and Consultant to Consultant referral patterns. It was noted that coding issues in A&E had been resolved and that the Trust would be issuing a commensurate rebate. The CCG was also in discussion with Vocare to take the appropriate contractual steps to address underactivity in the GP led urgent care centre.

3.4 The Committee also discussed a request from a local CCG to become an associate to our contract with Nuffield. The implications of this are being discussed and will be reported back to the Committee.

3.5 **Action – To note the update.**

4 WOLVERHAMPTON CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING LOCAL TRANSFORMATION PLAN

4.1 The Committee considered and approved a refresh of the CCG's Local Transformation Plan for Children and Young People's Mental Health and Wellbeing. The plan had been prepared as part of the CCG's application for additional funding as part of the Future in Mind Programme and gave details of how the funding would be spent.

4.2 The Committee noted that the plan set out the CCG's approach to system transformation and approved the refreshed plan for publication on the CCG's website by the end of October. The Plan is appended to this report.

4.3 **Action – To note the update.**

5 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:	**31 October 2016**

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton

Children & Young People's Mental Health and Wellbeing

Local Transformation Plan

October 2016

Contents

'Early Intervention to promote social and emotional development can significantly improve mental and physical health, educational attainment and employment opportunities. Early Intervention can also help to prevent criminal behaviour (especially violent behaviour), drug and alcohol misuse and teenage pregnancy'. Early Intervention: The Next Steps: An Independent Report to Her Majesty's Government, Graham Allen MP, 2016.

Introduction

In Wolverhampton emotional health and wellbeing health needs to be everyone's business and that all agencies (public, community, and private) need to work together to ensure that all children and young people enjoy good mental health and emotional wellbeing, including those that are most vulnerable in society such as children looked after by the local authority. This emphasis on children and young people is essential as the evidence shows that over three quarters of all mental health problems have emerged by the age of twenty, making childhood determinants primary in future mental wellbeing[1]. Good mental health and emotional wellbeing will be achieved by emphasising prevention, early identification and intervention using evidence-based approaches that represent value for money. Where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need.

The Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan 2015-20 (LTP) outlines the vision to implement a *tier-less whole system* across health, education and social care. This will include significant system re-design which involves all providers of emotional health and wellbeing services. This is not a criticism of the current Child and Adolescent Mental Health Service (CAMHS) provision, but recognition that resources and services need to be aligned and joined-up in order to meet growing need and increased demands upon the whole service system. Collaborative commissioning opportunities exist across the Black Country, for example regarding CAMHS Tier 3 Plus Services (CAMHS Crisis, Home Treatment and Assertive Outreach Services) and tri-partite funded care packages for children placed out of city. Aligning all contracts with the proposed model will be essential if transformation efforts are to be successful. Consequently, co-commissioning and partnering arrangement are essential for Wolverhampton Clinical Commissioning Group (WCCG) and City of Wolverhampton Council (CWC), as is the alignment of new developments with Strengthening Families initiative, HeadStart, the local offer for children and young people, initiatives delivered within schools such as counselling services, pastoral care and universal services, and the return of budgets for Tier 4 placements to local commissioners. It also includes the service re-design that is occurring in the Black Country Partnership Foundation Trust (BCPFT) – CAMHS provider – as part of their sustainability and partnering developments with two other West Midland NHS providers. The fundamental principle that underpins all of this transformation activity is the shifting of financial and service resources from acute settings to local community and early intervention services.

The CAMHS LTP for 2017-2020 is primarily a refresh of the previously submitted LTP for 15/16 and 16/17. The work outlined in this document builds upon the analysis that was conducted for the initial plans, and extends the scope of the original plan to ensure that services are sustainable, effective, integrated, and fit to meet future challenges.

For the sake of clarity, it is important to note that while the BCPFT provides a specific CAMH service, the proposed model focuses on improving the whole system of delivering emotional health and well-being services. It is suggested therefore that we review the language used in discussing services, to differentiate between the whole service system and the organisation that delivers 'Tier 3' and specialist services. When referring to the organisation and the specific service they deliver it is appropriate to reference CAMHS.

1 Better Mental Health For All: A public health approach to mental health improvement. Faculty of Public Health; London, 2016.

However, when referring to the whole system – early help to inpatient support – this is not CAMHS, but a range of emotional health and wellbeing services delivered by various providers.

Purpose of service system transformation and LTP

The Wolverhampton Transformation Partnership Board (WTPB) is the joint forum with responsibility to implement the strategic and service level changes required of the emotional health and wellbeing services for children and young adults. Membership of the Board includes senior managers from WCCG, CWC (social care and education), BCPFT, Royal Wolverhampton Trust (RWT), NHS England, and the voluntary sector. It is a key partnership Board that reports to Wolverhampton Health and Wellbeing Board, as well as the Wolverhampton Children's Trust. This Board has responsibility for overseeing the refresh and implementation of the Children & Young People's Mental Health and Wellbeing Local Transformation Plan (LTP). The CAMHS LTP has been submitted for review and sign off by the Health and Wellbeing Board at their next meeting on Wednesday 19th October 2016. Following successful progress through this Board, the CAMHS LTP will be published on the WCCG website.

Given the current financial circumstances, and the need to obtain greater efficiencies with current services, the WTPB must oversee and direct a range of activities, including**2**:

- re-design of the whole service system delivering emotional health, well-being and mental health services to children, young people and their families across Wolverhampton
- re-design of the whole system ensuring services are meeting the needs of all vulnerable children and young people, including children in need, looked after children, and those subject to child protection orders
- align the new service system with prevention and early help initiatives (i.e. HeadStart), and universal services (i.e. Health Visitors, and Public Health Nurses)
- identify opportunities for new and integrated models of working across the whole system and with a range of partners, including re-allocating resources across community and local services
- reduce need for high cost, out of area interventions; keep young people local; bring young people back to Wolverhampton early as possible, and improve patient and carer experience
- maintain Quality as pivotal in all developments, as well as safety and management of risk
- report to the Area Team and National Programme on performance against the Future in Mind CAMHS Transformational Plan.

To achieve the transformation outlined in the LTP**3**, the WTPB established 5 Task and Finish Groups**4** to progress its work. The Early Intervention and Pathways Task and Finish Group were responsible for the production of this proposed model.

The WTPB has a very clear vision for what the CAMHS transformation**5**. There will be an integrated range of services

> *….where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need.*

The service system will be continuous, from self-help, to early help, through early intervention, to specialist help. The service system will move children and young people smoothly to more intensive interventions and then down to less intensive interventions as the child and young person's need dictates. Professionals will work in a flexible manner, with as many services delivered locally. Multi-organisation and multi-disciplinary working will be the standard way of operating, with agreed governance arrangements in place. The service

2 Vision and model: CAMHS Transformation in Wolverhampton. March 2016.
3 Wolverhampton CAMHS Local Transformation Plan 2015/16.
4 Wolverhampton Transformation Partnership Board: Task and Finish Groups. April 2016.
5 Vision and model: CAMHS Transformation in Wolverhampton. CAMHS Transformation Partnership Board, 2016.

system will be without tiers, with intervention based upon a child need rather than the services that an organisation has been commissioned to deliver. The local authority, CCG, and providers will work closely at all levels within the respective organisations, with transition to adult services part of the seamless local offer.

Working across the whole of Wolverhampton, there are a number of critical fora that are key strategic drivers in the delivery of the LTP plan. The participation and cooperation of each of these bodies is essential to whole system transformation, and include:

- Wolverhampton CCG Commissioning Committee
- HeadStart Programme Board
- Integrated Commissioning Board
- Children and Young Peoples Trust Board
- Safeguarding Board
- Mental Health Stakeholder Forum
- Mental Health Partnership Forum
- Black Country Mental Health Leads
- Specialised Commissioning Oversight Group
- Health and Well-Being Board
- Families In Focus Programme Board
- WCCG and BCPFT Contract Monitoring
- WCCG and BCPFT Clinical Quality Review
- WCCG and BCPFT Joint Efficiency Review
- Black Country Clinical Senate
- Specialised Commissioning Oversight and Scrutiny Group.

Factors relevant to local transformation plan

Before considering the LTP, it is important to have an understanding of the Wolverhampton context, and the factors contributing to the model's design. These include the identifying the numbers of children and young people with emotional health and wellbeing challenges, the economic circumstances, policy drivers, as well as findings from mental health research. These are discussed briefly below.

1. Wolverhampton population

According to the latest Office for National Statistics (ONS)**6** population estimates, there are 252,987 residents in Wolverhampton. Of these, 32% (n=81,428) are children and young people under 25 years of age. This is a higher percentage compared to England's average, where 30.4% of the population are children and young people under-25 years – see Figure 1. While the Joint Strategic Needs Assessment (JSNA) for

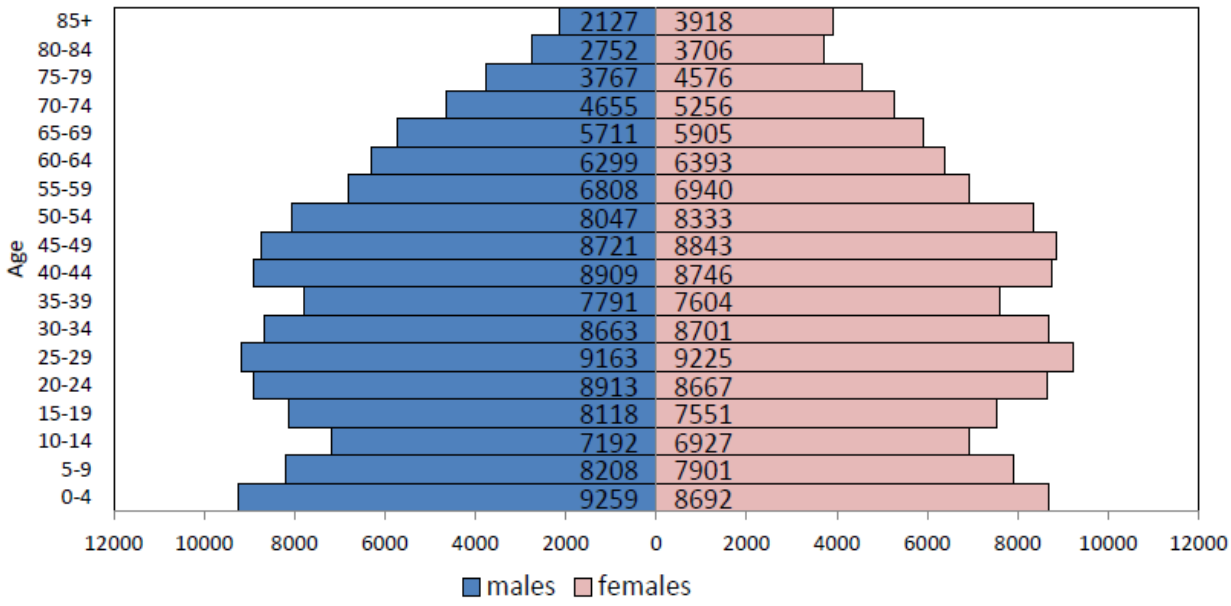


Figure 1: Mid 2014 Population estimates for Wolverhampton

6 Wolverhampton in Profile, City of Wolverhampton Council, *www.wolverhamptoninprofile.org.uk/*

Wolverhampton**7** is in the process of being refreshed, preliminary findings from this as well as the Children's Outcomes Framework spine chart (Appendix A) are used to inform the development of this strategy.
In Wolverhampton, the highest proportion of children and young people are in the age bands 0-4 years (22%) and 20-24 years (22%). This is similar to the national picture where 21% and 22% of children and young people are in the age bands 0-4 and 20-24 respectively – see Figure 2..

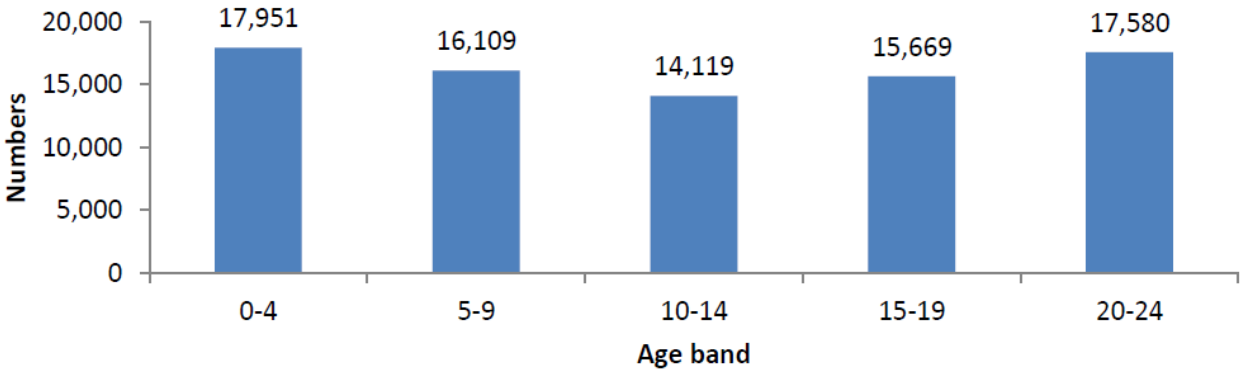


Figure 2: Population of children and young people by age bands

Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our City Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health for children and young people including:

- high numbers of Black and Minority Ethnic communities
- parents in prison or in contact with the criminal justice system
- social deprivation and high levels of unemployment
- high rates of housing and homelessness
- refugees and asylum seekers (new arrivals)
- children and young people with long term conditions/physical and/or learning disabilities
- lesbian, gay, bisexual and transgender people (LGBT)
- children and young people who are questioning their sexual orientation and/or gender (LGBTQ)
- substance misuse
- children and young people who are victims of violence, abuse and crime including domestic violence and bullying.

2. Emotional health and wellbeing challenges

Prevalence[8,9] estimates are available for a range of common mental health disorders, and show that in Wolverhampton:

- nearly 4,000 children and young people (5 to 16 years) have a diagnosable mental health disorder
- conduct disorders are the most common diagnosis equating to nearly 2,400 young people

7 Draft Joint Health and Wellbeing Strategy 2013-2018, Published by City of Wolverhampton Council in 2013. *www.wolverhampton.gov.uk/CHttpHandler.ashx?id=2944&p=0*

8 Data in this section was obtained from Wolverhampton children and young people mental wellbeing needs assessment 2015 – A needs assessment to support Wolverhampton's Big Lottery HeadStart Phase 3 bid. Summary of Key points from analysis to date (28 Nov 2015).

9 Black Country CAMHS Tier 3 / 4 Co-Commissioning Project Report, April 2016, WCCG.

- more boys than girls are affected by conduct disorders
- over 1,500 young people have an emotional disorder - more girls than boys
- 570 boys, and 85 girls are estimated to have a hyperkinetic disorder
- 4,000 young people are expected to have an eating disorder
- 4,000 children and young people are expected to have ADHD
- 40% of young people who have a learning disability may also have a mental health disorder
- 70 children (aged 9 – 10 years) are estimated to have some form of autism spectrum condition
- 351 of looked after children have a mental health disorder
- 196 young people were admitted to an acute setting with diagnosis of self-harm or mental health disorder.

Since January 2014[10], the Child and Adolescent Mental Health (CAMH) service has been running at a capacity with 1,000 contacts per month, equating to 400 children. During the period January 2014, - September 2015, data indicates that 2,383 individual children and young people were seen by the CAMH service, with 49% (1,165) female, and 51% (1,201) male. Most children were between the ages of 10 and 17 years, however a significant proportion (26%) were under 9 years of age. Service users came from a wide range of ethnic backgrounds. 95% of referrals waited less than18 weeks, with 61% waiting for eight weeks or less. Fallings Park, Bushbury South and Low Hill, and East Park were the Wards with the highest numbers of children and young people referred to CAMHS. When compared with national data[11], children and young people in Wolverhampton receive a responsive service which is apparent from the positive patient reports obtained by BCPFT.

3. Consultation with children, young people, and stakeholders

The transformation plans have been developed and shaped through extensive consultation with children and young people, as well as stakeholders. This has been an on-going process that had commenced in early 2015. Emotional health and wellbeing issues were clearly identified through the consultation process conducted by HeadStart as they commenced designing the phase 3 of The Big Lottery bid. The initial consultation with HeadStarters (groups of young people actively engaged in design of HeadStart programme) and continued with stakeholders and service users. The most recent consultations are outlined in Figure 3.

Consultation	Stakeholder group
Emotional health and wellbeing	Children, young people, and families
Emotional health and wellbeing	General public and providers
CAMH services	Children, young people, and families
CAMHS transformation	Youth Council
CAMHS transformation plan 2017-19	Paediatric staff Royal Wolverhampton Trust
CAMHS transformation plan 2017-19	Voluntary sector agencies
CAMHS transformation plan 2017-19	Clinicians at Black Country Partnership NHS FT
CAMHS transformation plan 2017-19	CWC – Children & Young People's Team
CAMHS transformation plan 2017-19	CWC – People's Leadership Team
CAMHS transformation plan 2017-19	YOT Board
CAMHS transformation plan 2017-19	Wolverhampton Children's Trust Board
CAMHS transformation plan 2017-19	Better Care Fund Partnership Board
CAMHS transformation plan 2017-19	Strengthening Family Hub managers
CAMHS transformation plan 2017-19	HeadStart Executive Board
CAMHS transformation plan 2017-19	HeadStart Board
CAMHS transformation plan 2017-19	Head teachers and senior education staff
Commissioning intentions 2017-2019	BCPFT Commissioning and Contract leads

Figure 3: Consultations on CAMHS LTP, June – September 2016

10 Black Country CAMHS Tier 3 / 4 Co-Commissioning Project Report, April 2016, WCCG.
11 See Page 12 of this paper for national data.

These particular meetings were critical in obtaining confirmation from a broad range of stakeholders on the current model for transformation. The general consensus from these meetings was that the transformation plan:

- designed to meet needs of children and young people in Wolverhampton
- used the contribution of all stakeholder in its development
- effective governance process in place with the WTPB
- effective contract management processes for ensuring continuity of services
- taken into account the developments in the local service system
- linked effectively with the STP
- incorporated plans for eventual return of specialist commissioning's Tier 4 funds
- provide better outcomes for children and young people.
- improved and enhanced crisis and home treatment services.
- improved and enhanced Early Intervention in Psychosis Services.
- improved response times across all services
- introduced a single point of access.

Areas that had been identified through consultation that need further work, but are included in the LTP include:

- care as close to home as possible with fewer out of area education, health and social care placements outside Wolverhampton
- greater connectivity across education, health and social care system with fewer barriers and gaps and far greater integration in terms of delivering help and support
- support and advice in school, including peer support, targeted support in school/s from CAMHS staff and resilience and mental health awareness building training for staff, children and parents
- support and advice at 'our finger tips', i.e. digital resources including web based and social media solutions that provide help support and guidance
- '*a place to go'* which provides social interaction, support and positive role models and parental advice.

4. Locally available data

Comprehensive data is collected locally and presented in the Service Quality Performance Report (SQPR). The data for 15/16 and 16/17, used in the monthly contract monitoring meetings with provider, are included as embedded documents in Appendix B. The contract meeting analyses the activity and performance of the provider on a number of important measures, with actions agreed for the provider to implement.

5. Economic environment, and Sustainability and Transformation Plans

The current economic environment requires that all local authorities and NHS commissioners have reducing funds available, but must drive quality improvement and economic efficiencies within established financial parameters. Indeed, the NHS has to close a £30 billion gap and has outlined in *Five Year Forward View* how this can be achieved through transformational systemic changes[12].

In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was required to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next

12 Tackling the growing crisis in the NHS. The King's Fund 2016. http://www.kingsfund.org.uk/publications/articles/nhs-agenda-for-action.

five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency[13].

i) Black Country STP

Wolverhampton's CAMHS LTP is aligned to the Black Country STP. The ambition of the BC STP is to operate as 'one NHS commissioner' across the Black Country, leading to: substantial reductions in care and service variations; standardised services; maximisation of resources and workforce through better use of skill mix; alignment with West Midlands Combined Authority regeneration and MH Commission strategy. To deliver plans that are based on the needs of local populations, local health and care systems came together in January 2016 to form a Black Country 'footprint', with health and care organisations working together to develop a Black Country STP to drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.

By agreeing common service specifications/models across CAMHS, Black Country CCGs will be able to develop standardised and potentially more cost effective solutions, minimising 'differentiated' services and 'service flavours'. By comparing service delivery approaches across the Black Country and performance, opportunities to reduce variation will be identified. With the aim of reducing role duplication, streamline service management and allow investment in front line staff development and up-skilling, there will also be further opportunities to develop this across the wider West Midlands' health economy through the work in the MERIT vanguard. Standardisation across local areas will:

- simplify access to services improving health and wellbeing for users, families, staff and communities
- common responsive and standardised all age, Early Intervention services
- reduce variation in care and service delivery across the Black Country
- ensure clear, simplified pathways for users, ensuring most effective use of resources
- achieve economies of scale for providers and reduction of duplication
- improve utilisation in front line services through better skill mix usage and reduction in temporary and locum costs.

ii) Action plan for Black Country STP – workforce planning

Following the announcement of the £8.8M funding awarded by The Big Lottery for the HeadStart programme (early intervention services for emotional health and wellbeing), WCCG commenced a review of the whole service system workforce. Workforce issues had previously been identified with the provider of specialist CAMHS (BCPFT) by an external quality audit[14], as well as apparent in challenges faced in recruiting staff following the Future in Mind funding. With workforce development being one of the important areas of strategic planning for the Black Country STP, the local work in reviewing current workforce, and planning workforce requirements have been taken over by footprint wide efforts. It is anticipated that a complete five year forward workforce review and plan will be available by March 2017.

6. Influential policies and reports

Over the past three years there have been a number of influential policies and reports published. The direction established by these has helped to shape local thinking and the creation of a Wolverhampton model for mental health and wellbeing services. From a range of authors / organisations, these documents indicate that the CAMHS is not able to meet the current demand, that many children and young people are not able to access services, that the service will not be sustainable without significant

13 NHS: Sustainability and Transformation Plan https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

14 WM QRS (2016). Towards Children and Young People's Emotional Health and Well-being: Sandwell & Wolverhampton Health & Social Care Economy. January 2016.

change - '*more of the same is simply not an option*[15]', and that whole service system transformation is required. They emphasise the benefits of early intervention, locally based multi-disciplinary teams, the impact of resilient families in reducing demands on services, and the emphasis on self-help using a strength based approach. They also identify the importance of schools in developing resilience in children and in providing a supportive environment.

The intention of this local transformation activity is best summarised by the 'triple aim' of NHS England outlined in the Five Year Forward View, which directs CCGs to (i) improve the health and wellbeing of the whole population; (ii) provide better quality for all patients, through care redesign; and (iii) have better value for taxpayers in a financially sustainable system**16**. There are also a significant number of key documents that have influenced the direction taken in the LTP and are listed in Appendix C:

7. Developments in mental health research

Psychological research over the past ten years has focused on the roles of nature and/or nurture in the determinants of mental ill health, and how this impacts on services development. Research has shown that the best predictors by far of all of mental health conditions, whether it is depression, suicidality, psychosis, are all life events, with the strongest predictor all by itself being poverty (Read, 2005). This is not because poverty by itself causes depression, but because it is a predictor of all the other things that are causal. So poverty has been described as the cause of the causes (Read, 2005).

In studying the determinants of psychosis for example, a condition thought to have a strong genetic predisposition, researchers have explored psychosocial factors as a causal agent, rather than as a mere triggers or contributing factor (Joseph, 2003: Kinderman, 2014). Indeed, poverty (Read, 2004), urban living (van Os et al., 2001), racism (Karlsen & Nazroo, 2002), other forms of discrimination (Janssen et al., 2003), child abuse (Read et al., 2003; Read et al., 2005), and having a rather battered mother (Whitfield et al., 2005) have all been shown to be highly predictive of psychosis. Some researchers have even suggested that schizophrenia is preventable via universal programmes enhancing children's safety and quality of life (Davies & Burdett, 2004). *'The simple truths appears to be that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions'* (Read, 2005). As mental health is greatly influenced by complex psycho-social-biological factors, an integrated, multi-disciplinary approach focused on meeting the needs of children, young people, and families is essential.

The proposed vision for transformation of emotional health and wellbeing service system, and the associated LTP outlined in this paper have been informed from a number of sources. These have included the outcomes from the range of consultations with service providers, children and young people, and commissioners; as well as a review of the research literature on current trends in provision of health and social care services. Following is a brief review of each of these important and influential sources.

Research and best practice informing LTP

There is a large body of research and best practice documents that have influenced the development of the Wolverhampton transformation plan. Rather than going into to much detail, a number of key findings are highlighted below.

[15] Local Transformation Plans for Children and Young People's Mental Health and Wellbeing: Guidance and support for local areas, NHS England, August 2015; p. 9.

16 CCG improvement and assessment framework 2016/17, NHS England 2016.

1. Early intervention and prevention as a priority

Psychological and social research have demonstrated clearly that early intervention in a problem cycle results in better outcomes for children and families, including improvements in academic results, behaviour, educational progression and attainment; reduction in delinquency and crime, and labour market success[17][18]. These interventions also reduce stress and trauma experienced by the family, as well as the curbing the extent of associated issues that problem escalation produces.

The economic case for building sustainable prevention and early intervention programmes is argued in a published in 2011 by London School of Economics and Political Science[19]. It reported that:

- high value for money achievable by prevention and early intervention programmes
- ability to recover costs within a relatively short period of time for programmes addressing childhood mental health problems, which in the absence of intervention have a strong tendency to persist into adult life
- ability of such programmes to become self-financing in the longer term.

The report continues by calculating the return on investment across the NHS, public sector and non-public sector for every £1 spent on prevention and early intervention[20]:

- social and emotional learning programmes to prevent conduct disorder in children and young people showed a return on investment of £48.30 in 5 years, and
- school based interventions to reduce bullying showed a return on investment of £14.35 in 5 years.

2. Service integration

Apart from the research findings indicating that an integrated and multi-disciplinary approach is essential in delivering mental health services, governments view service integration as a key initiative in delivering efficiencies as well as improving patient outcomes (KPMG, 2013). While integration is a complex process it denotes efforts to increase the coordination of operations within the health and social care services systems, aiming to improve efficiency and client outcomes. There is no universal approach, and services integration may be viewed as a continuum of organisational relationships ranging from restricted integration (loose, informal cooperation) to full integration (joined infrastructure, resources and case management). Integration removes duplication and overlap, with services sharing common vision and values, and organisations working in close partnership, sharing infrastructure and resources.

3. Primary Care as important partners

A literature review[21] conducted by Public Health (CWC) found that universal delivery of interventions in schools has the best evidence for prevention of child mental health problems. GPs and other primary care professionals have been identified as a potential avenue for early intervention but the review shows that this may not be so straightforward. The research demonstrates that self-care has the potential to improve children and young people's mental health literacy, to help them recognise problems and help themselves. However, as demonstrated from the key messages extracted from the national and international literature on good practice in the delivery of CAMHS to build capacity in primary care. The following factors must be taken into account:

- financial and human resources are critical enablers in primary care

---

17 Early Intervention: The Next Steps, 2011, HM Government.
18 Proven Benefits of Early Childhood Interventions, Rand , 2005.
19 Mental health promotion and mental illness prevention: The economic case, London School of Economics and Political Science, April 2011.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
20 Similar savings were found in research conducted in USA – see Proven Benefits of Early Childhood Interventions, Rand, 2005
21 Public Health Wolverhampton Evidence Review: CAMHS. April 2016

- capacity needs to be built to collaboratively embed mental health services in primary care
- primary care providers must be supported with direct and easy access to specialist CAMHS consultation
- capacity of primary care workers to deliver child and adolescent mental health services must be developed through training, supervision and support (Leahy, et al., 2015).

4. Involvement of parents

While research has found that the involvement of parents is indicated in effective programmes for pro-social, mental health promotion, social and educational learning and stress and coping (Weare and Nind, 2011), it does not happen as often and consistently as needed. A major consultation**22** undertaken in England with parents found that parents and carers want:

- to be more involved in their children's treatment in CAMHS
- their opinions and experiences to be listened to and their skills and expertise valued
- to participate in service development, both locally and nationally.

Despite finding that parents and carers wanted greater involvement, how this is best achieved is still to be determined (Weare and Nind, 2011). CAMHS partnerships are at a less advanced stage of parent and carer involvement than with children and young people's participation, with a limited number of dedicated participation staff available to offer the engagement support needed[20].

5. Schools based interventions

In a recent publication, schools were reminded that they must ensure that arrangements are made to safeguard and promote the welfare of pupils.**23** Another Department for Education document stated that all pupils will benefit from learning and developing in a well ordered school environment that fosters and rewards good behaviour and sanctions poor and disruptive behaviour.**24** Governing bodies of maintained schools have a duty under section 175 of the Education Act 2002 requiring them to make arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children. The proprietors of Academies have a similar duty under paragraph 7 of Schedule 1 to the Education (Independent School Standards) (England) Regulations 2010.

School based programme had significant positive effects on students' emotional and behavioural wellbeing, including reduced depression and anxiety and improved coping skills. (Barry et al, 2013). In addition school-based life skills and resilience programmes received a moderate quality rating, with findings indicating positive effects on students' self-esteem, motivation and self-efficacy (Barry et al, 2013).

With regard to the school-based interventions, the quality of evidence from the 14 studies is moderate to strong. Findings from these studies indicate that there is reasonably robust evidence that school-based programmes implemented across diverse LMICs can have significant positive effects on students' emotional and behavioural wellbeing, including reduced depression and anxiety and improved coping skills.

> *'In order to help their pupils succeed, schools have a role to play in supporting them to be resilient and mentally health.***25**

6. Children and young people

Research has repeatedly found hurdles that make it difficult for children and young people to access mental health services. These barriers are no different to those identified by children and young people

---

22 The involvement of parents and carers in Child and Adolescent Mental Health Services. Report to CYP IAPT of the consultation conducted with parents and carers. Greater Involvement Future Thinking, November 2013 – March 2014.
23 Behaviour and discipline in schools: Advice for head teachers and school staff. DfE January 2016.
24 Mental health and behaviour in schools Departmental advice for school staff, DfE, March 2016.
25 Mental health and behaviour in schools Departmental advice for school staff, DfE, March 2016.

in Wolverhampton and include: stigma and embarrassment; difficulty in identifying symptoms of mental ill health; lack of knowledge of mental health services; lack of accessibility of services about mental illness and mental ill health; concerns about confidentiality, and lack of trust for those they might seek help from; fear and stress in seeking help; and a preference for self-reliance, rather than seeking help externally. (Gulliver et al, 2013). Strategies for improving the help-seeking behaviours of children and young people ought to focus on improving mental health literacy, reducing stigma and taking account of young people's desire for self-help.

One researcher identified the key feature, principles and targets for redesign of services to better meet the needs of young children and young people as:

- participation at all levels by children and young people, essential to create youth friendly, stigma-free cultures of care;
- holistic, preventive and optimistic stance with sequential/ stepwise care governed by risk/benefit and shared decision making principles;
- early intervention, social inclusion and vocational outcomes as core targets;
- care reflecting both the epidemiology of mental ill health in young people and the new developmental culture of emerging adulthood in the early 21st century;
- elimination of discontinuities at peak periods of need for care and developmental transition;
- positive and seamless linkages with services for younger children and older adults (McCorry et al, 2013).

Many of the issues identified by children and young people across Wolverhampton about CAMH services were consistent with those outlined in a recent report from the Children's Commissioner for England. Following extensive consultation the report found that young people wanted a number of important changes in CAMHS**26**:

- shorter waiting times
- someone to be available to talk to between the referral to CAMHS and the first appointment, 'they could be like a bridge and help you at the first CAMHS meeting'
- not relying on letters to get you to the first appointment, especially when your family is not reliable. Contacts and reminders should be sent by phone and text
- reducing the stigma around being in care or having a mental health need
- provide a drop-in service for young people where they could chat about things that worried them and get to know the people running the service.

7. Self help

Recent reviews have identified that self-help services for young people with mental health needs are not as effective, responsive, accessible or child-centred as they could be, research demonstrates that these interventions were effective at 6-month and 12-month follow-ups (Pryjmachuk, Elvey, Kirk, Kendal, Bower, & Catchpole, 2014). Using systematic literature reviews, it was found that the key elements of self-care support identified in the perceptions review were the acquisition of knowledge and skills, peer support and the relationship with the self-care support agent. While there were a mixture of theoretical approaches underpinning the services provided, no single model dominating. There was a wide variety of professional and lay people facilitating the services – even within the services themselves; the self-care support agents included social workers, counsellors, nurses, psychologists, youth workers, coaches, school staff, volunteers and CYP themselves.

While mental health self-care support interventions for Children and young people are modestly effective in the short to medium term, self-care support can be conceptualised as a process which has overlap with 'recovery'. Children, young people and their families want choice and flexibility in the provision of self-help interventions as well as a continued relationship with services after the nominal

26 Lightening Review: Access to child and adolescent mental health services, Children's Commissioner, London, 2016.

therapy period. Those delivering self-care support need to have specific child-centred attributes (Pryjmachuk, Elvey, Kirk, et al, 2014).

8. CCG Improvement & Assessment Framework

The LTP assurance process has been integrated within the WCCG's mainstream planning framework This plan outlines the priorities and key actions for 2017/18 and should be regarded as an iterative document, subject to assurance and evaluation and monitoring processes and therefore subject to continued development and change. The LTP has also been influenced by developments in the key initiatives:

- learning from the pilot schemes and initiatives that have provided additional funding into CAMHS Crisis Services, the Single Point of Access and Early Intervention in Psychosis Services through use of Targeted Resilience Funds in 14/15 and Future in Mind funds 15/16
- development and implementation of the Wolverhampton Mental Health Strategy including the Urgent and Planned Better Care Fund Care Pathways to support urgent and planned mental health care across the lifespan.
- promoting equality and addressing health inequalities are at the heart of NHS Wolverhampton's values. Throughout the development of this transformation plan due regard has been given to eliminate discrimination, harassment, victimisation and stigma and to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it and to reduce inequalities in terms of access to and outcomes from healthcare services and to commission children and young people's mental health services in an integrated way to support the reduction of health inequalities.

Transformation plan: Moving to a whole system approach

Promoting resilience, prevention and early intervention to support children and young people's wellbeing are best achieved through a whole system's approach from universal service provision through to highly specialist and bespoke intervention (Future in Mind, 2015). No one service can do this important work and improve mental health and emotional wellbeing. Starting with Health visitors, Sure Start Children's Centres, schools, school health services, school nurses, colleges, primary care and youth centres, all playing a key role in preventing mental health problems, through to specialist mental health consultants working with those experiencing significant emotional and mental health conditions. The 'As Is' picture of services in Wolverhampton is presented in Appendix D.

1. Workforce training and empowerment

The success of universal services requires staff to be trained and competent to deliver preventative services. Many staff working in primary health, social care, or educational contexts lack confidence and experience of helping children who have mental health issues, and thus training is required (Walker, 2008). Front line staff, including teachers, early years staff, and primary care practitioners often lack the necessary skills to assess and intervene, and need the skills to be identify and refer appropriately (Barry et al, 2013, Weare & Nind, 2011). A culture of protecting professional and organisational identities is one of the most prominent barriers to new ways of working, especially where established skills and roles are reconfigured (Gilburt, 2016). GPs identify low satisfaction about their postgraduate training in relation to child and adolescent mental health. Similarly in relation to early intervention, this requires being able to refer or direct children and young people into available services. Accessing services that meet the needs of children and young people with mental health difficulties was identified as problematic by GPs (Leahy et al, 2015).

Several studies reviewed highlighted the importance of teacher training and the provision of on-going support during programme implementation. Harnessing the skills of teachers and providing support in the school setting offers a sustainable and low cost method of improving children's emotional and behavioural wellbeing, developing positive coping strategies and promoting school performance.

However, single focussed and brief interventions are not always effective. Reviews found that interventions of at least 9 months to a year are more effective and show small to moderate effects. However, high quality implementation characterised by fidelity of implementation gives the best results, with interventions based on loose guidelines and broad principles were found to be ineffective. To be successful an intervention needs high levels of intensity, consistency, clarity, multi-resources, and programme fidelity.

2. Development of self – help resources

Self-help and self-care can be effective in helping children and young people to address their mental health and wellbeing concerns. A meta-analysis of self- help interventions and initiatives for children and young people with mental health problems shows that it is moderately effective at 6 and 12 months follow up, (Pryjmackhuk, 2014). However, effective self-care support services are predicated on flexibility; straightforward access; non-judgmental, welcoming organisations and staff; the provision of time and attention; opportunities to learn and practice skills relevant to self-care; and systems of peer support. In addition self-care needs to be child centred (Pyjamackuk, 2014). Establishment of effective self-help materials requires a great deal of time and research in order to identify, collate and produce the resources that are effective as well as child and parent friendly.

3. Primary and secondary schools supports and interventions

Primary and secondary schools play a central and pivotal role in the lives of children and young people. They are often the first place for a child's emotional or behavioural challenges to become apparent. In order to help their pupils succeed, schools have a role to play in supporting them to be resilient, as well as emotionally and mentally healthy. There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way. Schools therefore need to be involved as a key agency in the transformation of the service system for children and young people. The importance of their position is reinforced by many of the policy and reports identified earlier in this document – see Appendix C for a summary of key findings.

School seek to be a safe and affirming place for children and young people, where they are able to develop a sense of belonging, feel able to trust, and talk openly with adults about their problems. For children and young people with an unsettled home environment, school may provide an important haven.

4. Centrality of the GP in interventions

The identification of mental health problems will often be through a child's GP. While GPs are not specifically trained in the complex needs of children and young people, they nonetheless play a pivotal role in the management of any intervention (Leahy, Schaffalitzky, Armstrong, et al., 2013; Leahy, Schaffalitzky, Saunders, et al 2015; Schaffalitzky, Leahy, Cullen, et al, 2015). Although medical practitioners cannot always share information, where possible service providers should try to be aware of any support programmes GPs are offering that may affect the child's behaviour. Due to the pivotal role played by GPs, it is vital to keep them apprised of interventions and outcomes.

5. Factors for success

Operating as a whole service system is not easily achieved, and requires a number of significant elements to be successful[27][28], including:

- strong leadership across the system, from chief executive to front line staff
- clear understanding of what success will look like
- agreement on what the issues are
- clear governance model with shared leadership across

27 Breaking the Lock: A new preventative model to improve the lives of vulnerable children and make families stronger. iMPOWER, 2015 Amanda Kelly

28 CAMHS: A time to transform, iMPOWER, London, 2015.

- clear roles and responsibilities
- sufficient capacity and capability to support and deliver change
- robust, open and honest relationships with local area
- aligned implementation of local partner's agreed vision for an 'integrated approach'
- real performance management focus and developing a culture of tackling poor performance
- focus on getting permanent staff in place and building a culture of support and trust.

The LTP acknowledges the importance of these elements and through the WTPB and five Task and Finish Groups has worked to implement these in all of its activities.

Wolverhampton context influencing LTP

To change any service system, and implement any plan, it is useful to understand the service system as it currently exists. A high level service mapping was undertaken, plotting the financial spend and activity (where possible) for emotional health and wellbeing related provision during 15/16 – see Appendix D. For the sake of simplicity, the 4 tier model of intervention has been used to classify the financial and activity data. As with any service system, the challenge is to improve early intervention to reduce the number of children accessing higher levels of intervention. An initiative of the WTPB is to explore how funds available to specialist commissioning in NHS England could be returned to the Black Country, and how with better management of intensive support, monies could be released and more effectively utilized for funding activities earlier in the intervention cycle. Both CWC and WCCG are committed to moving funds from acute provision to community based services that are more local to service users and patients.

1. Strengthening Family hubs

CWC is implementing a new early intervention and prevention strategy which sees the establishment of Strengthening Family Hubs. These provide creative and seamless support to families; ensuring children are safe and have a wide range of opportunities open to them. This movement to place based services is a trend that is occurring across a number of service sectors[29][30]

Eight Strengthening Families hubs are designed to facilitate an approach based on outreach work into the community – see Appendix E for a graphical representation of this model. Networks of universal services professionals will work within the locality to support and signpost families. Early Intervention and Prevention (EIP) staff will have a role in supporting, developing and training non-council community-level networks to fulfil their role in supporting families earlier. The aim is to build on the existing assets within the community, establishing better links with the voluntary sector, schools, health and adult education.

The principles that underpin this programme development include:

- supporting families to safely prevent family breakdown
- common and easily understood approach for early intervention and prevention
- approach that is flexible with the variation in need within localities and families
- interventions that respond as family needs change
- alignment with the MASH to be a powerful influence in good decision making across the partnership
- clear pathways allowing the service to offer the right level of support at the right time to families
- resources to be allocated based on meeting EIP objectives whilst providing value for money.

29 Place-based systems of care: A way forward for the NHS in England. Kings Fund, London, November 2015.
30 CAMHS: A time to transform, iMPOWER, London, 2015.

Practice principles that guide the operation of these hubs are:

- maintain a focus on impact, bringing more creativity and flexibility to respond to needs in order to achieve the best outcomes
- strong relationships with families, based on a clear set of values that encourage motivation, support empowerment of families and lead to the development of resilience
- staff skills and knowledge that draw upon evidence based practice but reflects local need
- great relationships across the partnerships which build confidence in EIP whilst balancing each other's' priorities, supported by clear information and experience sharing to break down siloes.

2. HeadStart hubs

Managed by CWC as lead partner, Wolverhampton has been successful in obtaining £8.8m in funding from The Big Lottery to extend the HeadStart programme following two years of pilot work. The funding is provided for the period 2016 to 2021. As well as a city-wide, mostly digital offer, a specific concentration of efforts will focus on four geographical areas within the city. The service will be to promote, protect and preserve the mental wellbeing of 10-16 year olds across our City, by inspiring them to dream big, supporting them to maintain motivation and control, and equipping them with resilience and the skills to cope with setbacks and adversity. The programme will empower the young people of Wolverhampton to improve and spread awareness of their own mental wellbeing and that of their peers[31]. Based in the local area, a range of interventions will be made available through community groups, schools and public services, including:

- city-wide mental wellbeing information and awareness raising
- an area-based, Universal Offer for 4 geographical areas, including school and community based activities
- a Universal Plus Offer for those in specified age-range, including specialised group work and peer support
- targeted Intervention for those most at risk.

3. Other key initiatives in Wolverhampton influencing system transformation

Several other important developments have influenced the development of the LTP. These include:

A. Project grant by the Children and Young People's Task Force to scope potential to re-design / improve current CAMHS commissioning models. The project focused upon CAMHS Tier 4 and TIER 3 plus model/s across the Black Country and this includes a focus on tri-partite funded placements for children and young people that are 'out of area'. This work was delivered by Wolverhampton CCG on behalf of all of the four CCGs (Dudley, Walsall, Sandwell and Wolverhampton) across the Black Country covering a population of 1,152,500 (ONS 2013 mid-year population estimates).

B. Wolverhampton Clinical Commissioning Group and Wolverhampton City Council are currently reviewing all children placed tri-partite funded placements including looked after children to inform commissioning intentions, and support plans to reduce numbers of looked after children placed in and out of city including those in high cost packages and placements. This will be addressed by delivering preventative, supportive and pro-active services locally and improving the outreach provision to and repatriation of children and young people placed out of City by ensuring far greater connectivity with CAMHS care pathways and services. Critically this will involve a special emphasis on children and young people with a Learning Disability, physical disabilities and / or autism to ensure full alignment with Transforming Care and SEND guidance and reforms.

31 HeadStart bid for The Big Lottery Funding 2016. http://www.headstartbid.com/

C. The Wolverhampton Crisis Concordat. The urgent care pathway development that has delivered a refreshed approach to the compassionate, pro-active and safe sound and supportive across the lifespan holds opportunities for further evaluation to develop greater connectivity across CAMHS and AMHS urgent care pathways, again across a Black Country wide footprint where possible and support and improve outcomes for the most vulnerable. In CAMHS this includes closing gaps concerning Section 136 MHA and Place of Safety facilities and developing new and dynamic 24/7 services, including Street Triage, Paediatric Liaison and Crisis Resolution and Home Treatment services for example.

D. Wolverhampton CCG is developing a Primary Care Strategy which will inform the Commissioning, modernisation and transformation of services and care pathways across primary, secondary care and tertiary care. Opportunities exist to increase connectivity across these tiers, to align this with the troubled families' agenda and to increase the capacity, capability and responsiveness of CAMHS at a primary care level.

4. Current pathway for accessing emotional health and wellbeing services

The current pathway for the majority of children and young people moving through the emotional health and wellbeing services is displayed in Figure 4. This includes referrals from a range of sources using inconsistent criteria. It has been known that a child could be referred to several agencies in the hope that one agency may have a shorter waiting list. It also involves children meeting a threshold of severity before a service is provided. Such an approach restricts the possibility of early intervention, and encourages silo working across a system with organisations struggling to manage demand.

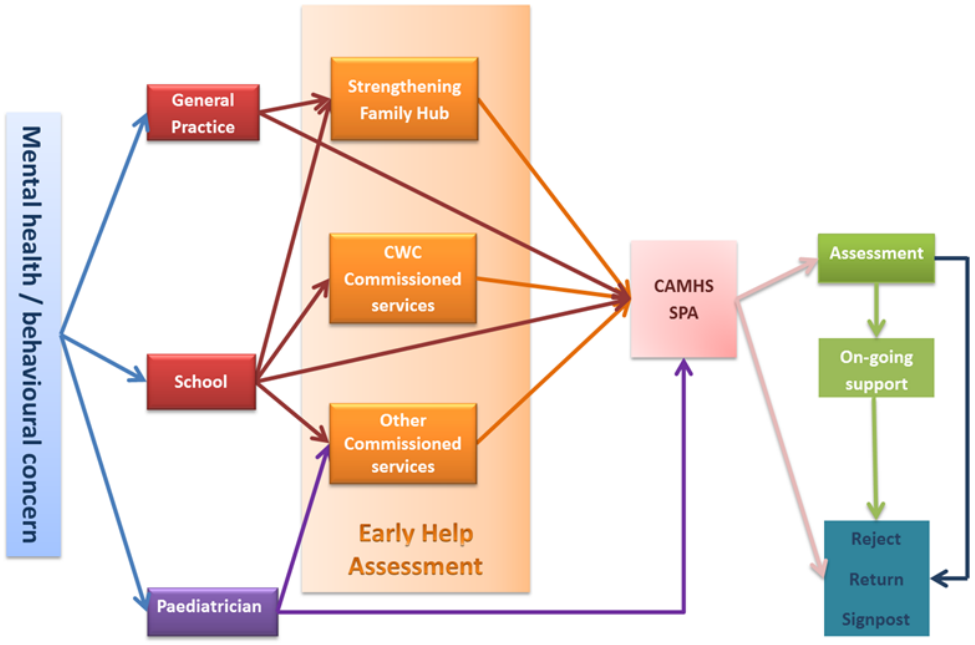


Figure 4: Current CAMHS pathway

To assist with local transformation planning it is important to understand the current flow of children and young people accessing the specialist provision of CAMHS – see Figure 5 below with 15/16 data[32]. This information relates to the flow of children and young people through the current CAMH service. While 66 per cent of children and young people assessed by a mental health practitioner were provided specific intervention by CAMHS professionals, a large minority (711 or 34%) were not. While a number

32 Figures obtained from BCPFT in email correspondence 2016.

of these children and young people were signposted to information, or other possible agencies to receive a service, many were returned to referral point (50%), or simply told that they did not meet threshold for service (36%). It is unfortunate that as providers and organisations have different information and data systems, it is currently impossible to track children and young people as they navigate through the pathway, and whether some return later with problems that have escalated such that they meet service thresholds.

The LTP links the emotional health and wellbeing services, including specialist CAMHS with the local authority's children and young people's services (Strengthening Family Hubs) and the early help available in four specific regions through HeadStart. By providing assessment and early help supports linked to both HeadStart and Strengthening Family Hubs, a number of assumptions have been made about future service demand. Based upon research, best practice and experience, it is likely that with an integrated system with a focus on early intervention, over time, there will be:

- reduction in referrals to Specialist CAMH for intervention will reduce
- reduction in wait times for Specialist CAMHS and all other services
- reduction in inappropriate referrals to agencies
- reduction in children and young people falling between agency/service gaps
- increase in services available locally
- increase in cooperation across agency and school boundaries
- reduction in children and young people admitted to external placements
- reduction in time spent by children and young people in external placements
- reduction in young people admitted to acute settings with primary mental health diagnosis
- reduction in time children with a primary mental health diagnosis spend in an acute setting
- improved understanding of how children and young people travel through services.

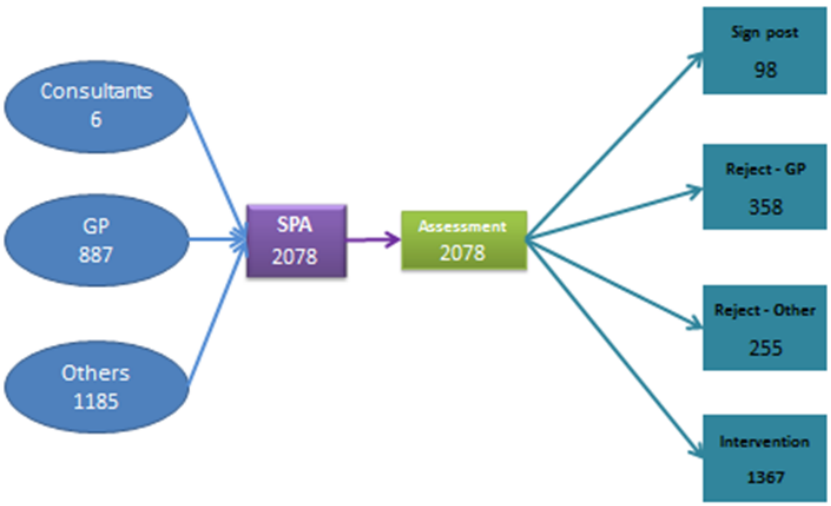


Figure 5: Flow of children and young people through CAMHS (15/16)

5. Issues with current service system

The current mental health service system is a referral based pathway. This means that agents pass the patient along to another agent whom they believe to be better placed to provide a solution to the patient. There are numerous issues with this system, including[33][34]:

33 Towards Children and Young People's Emotional Health and Well-being: Sandwell & Wolverhampton Health & Social Care Economy. WM QRS, January 2016.

34 Issues obtained through variety of consultations held with children, young people and stakeholders in 2014, 15, & 16

- referral handoff, where responsibility is transferred with a referral
- repeated patient storytelling, as each agent undertakes their own assessment
- little opportunity to refer patient to a lower level of intervention
- expert help is assumed to be able to 'fix' patient's problems
- system reliant upon interpersonal communication between professionals and agencies, without this built into the infrastructure
- no consistent form of case management or case activity recording
- inability to transfer knowledge to earlier levels of intervention
- lack of a robust programme of prevention and early intervention has an impact on service system
- limited range of targeted 'Tier 2' services has a significant detrimental impact on specialist CAMHS and on community paediatric services
- system being organisation and service focussed rather than patient centred and outcome focussed
- lack of integration across health, education, or social care, as they each have independent pathways
- children and young people not seen by CAMHS, filling appointments with other services (e.g. acute and community paediatricians), reducing capacity to see new patients
- lack of agreement on how and where neurodevelopmental conditions are best managed
- delayed discharge and lack of support on acute wards for young people with primary diagnosis of mental health
- complexity of referral processes of paediatricians to psychiatrists, as well as obtaining advice and guidance, not straight forward
- lack of easily accessed and readily available support for looked after children
- CAMHS workforce which was heavily weighted to psychology and more senior staff such as band 7 mental health practitioners
- transition of young people to adult mental health services not clearly defined
- arrangements for discharge from CAMH service not well developed.

The recent Children's Commissioner review[35] of the issues across England of the CAMH service presents a stark picture. While some of these findings may not be relevant to Wolverhampton, it is worth reviewing the local service with this data in mind. The investigators found that:

- 28% children and young people referred to CAMHS(on average) were not allocated a service
- 79% of CAMHS stated that they imposed restrictions and thresholds on children and young people accessing their services
- waiting times were extremely long – one West Midlands CAMHS the average waiting time was 200 days
- 3,000 children and young people were referred to CAMHS with a life-threatening condition (such as suicide, self-harm, psychosis and anorexia nervosa), of whom:
    - 14% were not allocated any provision
    - 51% went on a waiting list
    - Some waited over 112 days to receive services.
- 35% of all CAMHS stated that children and young people who missed appointments would face restrictions in accessing their services:
    - 28% of all CAMHS said that children and young people were stopped from accessing CAMHS if they missed appointments
    - 8% of CAMHS stated that this would happen following 2-3 missed appointments.

35 Lightening Review: Access to child and adolescent mental health services, Children's Commissioner, London, 2016.

The wide ranging mental health difficulties addressed by CAMHS LTP include conduct disorder; anxiety and depression, ADD, psychosis, Learning Difficulties, Co-morbid substance misuse, Eating Disorders, self-harm, suicidal behaviour, bullying, and challenging behaviour.

LTP for emotional health and wellbeing in Wolverhampton

The LTP summarises a number of important developments with the emotional health and wellbeing services in Wolverhampton. While some of the activities outlined in the plan serve to increase the number of children and young people accessing specialist services, the most important element is the cultural change that underpins all of the LTP. The changes that are necessary will impact on information governance, workforce, information technology, as well as governance and supervision of professional practice. A schedule for the implementation of the underpinning change is contained in Appendix F. The Gantt chart outlines the actions and timeframe during which the transformation activity of aligning services will be undertaken. This is an ambitious undertaking, but with the funding made available through The Big Lottery, and Future in Mind, coinciding with the restructuring of early intervention services in Wolverhampton, a unique opportunity was presented. Following are important elements in the cultural change required for service transformation.

1. Place based care system

The direction taken by HeadStart, and Strengthening Family Hubs is consistent with the approach suggested by a number of leading health and social care think tanks and policy makers[36]. To introduce efficiencies and to produce the best outcomes for service users, providers need to be developing integrated early help services with multi-agency, multi-disciplinary teams around localities – known as place based system of care. Fundamental changes to the role of commissioners are needed to support the emergence of placed based systems of care, with organisations needing to collaborate to manage the common resources available to them. Commissioning in future will need to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Commissioning arrangements will also need to be flexible to facilitate the development and operation of multi-agency and multi-disciplinary working.

Place based systems of care aims to provide a range of integrated services, including:

- dedicated multidisciplinary teams to provide and commission a broad range of support based upon the needs of the child, young person and family in each locality
- supports that build resilience, empowers others, and aids in developing self-help skills, and look to being solution focussed
- commissioned support and services to meet local needs with the aim of reducing demand
- focus on meeting child, young person, or family need, with less requirement to hand off or refer
- support for the individual (i.e. family member, community service provider, coach, minister, teacher, etc.) with whom the child, young person or family has the strongest relationship
- facilitate and encourage creative local commissioning arrangements to better meet local needs
- shifts focus from organisational allegiances to needs of child, young person, or family
    - holistic assessment and system for monitoring and managing the child, young person, or family's journey
    - support provided that is focussed on need, as well as reducing demand and improving outcomes.[37]

Place based care and integration also prioritises the key themes identified Future in Mind, including:

- emphasises the building resilience, promoting good mental health, prevention and early intervention

36 The Kings Trust, and iMPOWER

37 Place-based systems of care – A way forward for the NHS in England'. The Kings Fund: London, November 2015.

- simplifies structures and improve access
- deliver a clear joined up approach
- harness the power of information
- sustains a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience
- makes the right investments, with clarity about how resources are being used in each area.

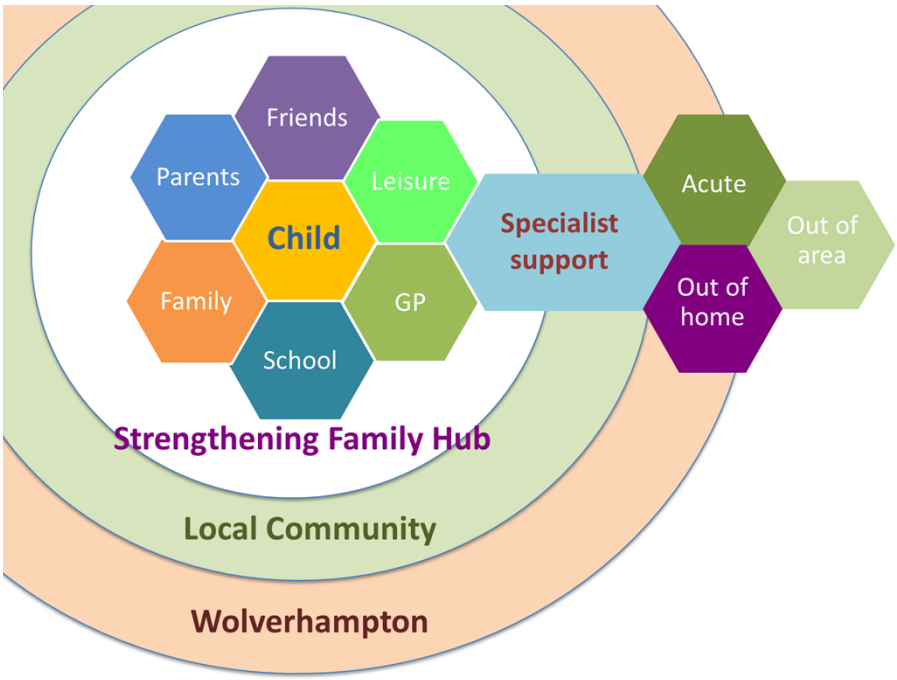


Figure 6: Place based care model resulting from system transformation

For place based care to be successful, a number of important activities need to be undertaken, including:

- CCGs and local authorities working together to review and develop services
- service providers within a locality, together with GPs and schools must work together
- service system must have a multi-agency design, of which there is little current evidence
- detailed needs analysis to create understanding of where change will make the most impact
- service mapping across all service areas to identify any gaps in services and duplication.[38]

The figure above (Figure 6) is a graphical representation of the proposed new model. As services are for the most part local to the child or young person, professionals are the ones that move to a location that is easily accessible for the family. Interventions are built around the child, even when escalation of support is required.

The place based model of care has a dramatic impact on the pathway that children and young people will need to travel to access increasing support. Figure 3 represents the current pathway, while Figure 7 depicts the pathway emerging from the proposed transformation plan. When a child, young person or family need help for emotional health and well-being challenges, they are able to assess the local Strengthening Family or HeadStart hubs. The assessment conducted by the multidisciplinary team, in consultation with Link

38 CAMHS: A time to transform, iMPOWER, London, 2015.

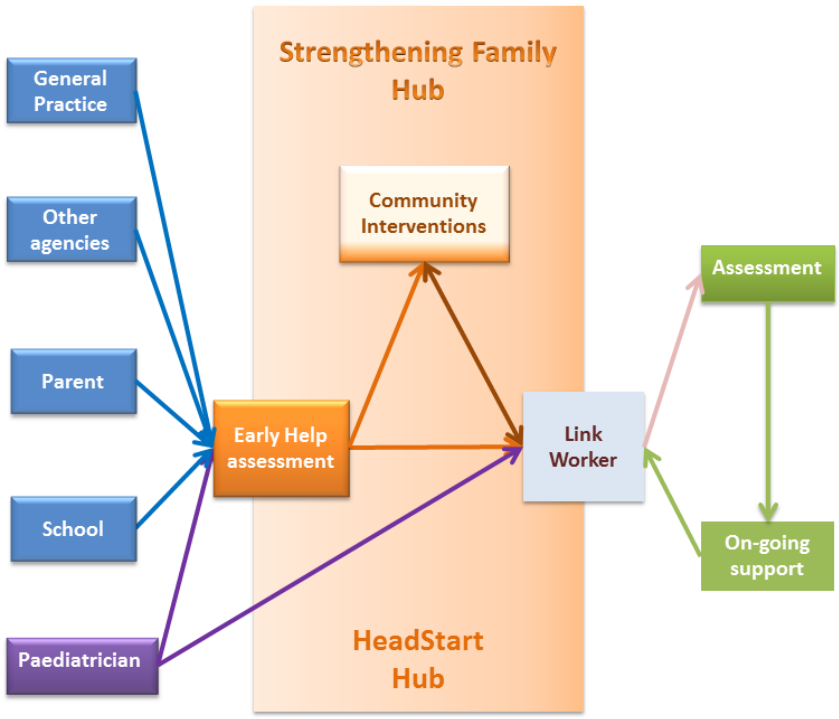


Figure 7: Proposed new CAMHS pathway

Workers will ensure that appropriate specialist support is obtained in a timely manner. The Link Worker is able to maintain the link between specialist services and local supports, so the transition to less intense interventions and support in the local community is managed effectively with minimal delay.

2. Key focus areas of LTP

The LTP has a focus on the following seven areas in order to transform emotional health and wellbeing services:

IAPT collaborative	Wolverhampton CCG has been accepted to join an IAPT collaborative. This will include interventions for very early years and linkage with the Adult IAPT programme in terms of parental IAPT programmes. This will all be aligned with the deliverables outlined in the HeadStart Wolverhampton Pilots in terms of resilience building and awareness raising in schools, use of digital technology and social media and other local anti-stigma and resilience funded initiatives including the pilots funded under HeadStart providing 'a place to go'.
Crisis and home treatment	Increased capacity and capability in crisis and home treatment services, in line with the national and local Crisis Concordat/s, bridging the gap between hospital and community services and reducing the need for high cost CAMHS Tier 4 Services and providing child suitable Section 136 MHA and Place of Safety facilities. This will include substantive funding for the Single Point of Access (SPA).
Early Intervention in Psychosis Services	Additional investment in Early Intervention in Psychosis Services for children and young people to achieve greater compliance / fidelity with the NICE guidance model, increasing numbers of patients achieving recovery and reducing the numbers of patients requiring high cost out of area placements and care packages. This includes a particular focus on improved joint working with substance misuse services for those with dual diagnosis needs and requirements. This model will be co-commissioned with Sandwell and West Birmingham CCG.

Eating Disorder Service	Investment in a local community Eating Disorder Service co-commissioned with Sandwell and West Birmingham CCG building on existing service provision which will deliver an assertive outreach community approach with better liaison with Acute, Paediatric, Primary Care and Tertiary Care services for children and young people as part of an all age model. This will also bridge the gap between hospital and community services, reducing the need for high cost Tier 4 Services and reduce the prevalence and impact of SEED (Severe and Enduring Eating Disorders).
CAMHS Link workers	Investment in CAMHS Link workers for schools, special schools and alternative provision providing targeted and specialist interventions within establishments and facilitating and supporting the HeadStart: Wolverhampton school peer support and mental health resilience training programmes and also facilitating speedy and responsive access to care pathways and services within generic and specialist CAMHS and primary care and universal services including GPs.
CAMHS Learning Disability	The re-specification of CAMHS Learning Disability services and Specialist and Generic CAMHS to support the needs of children with learning disabilities and / or physical disabilities who have the most complex requirements including children and young people with neurological conditions such as Attention Deficit Disorder and Autism. This will include a focus upon the local service developments required to deliver transforming care bed reductions at national regional level and local level and development of community based alternatives to In-patient provision, prevent and repatriate from tri-partite funded out of city placements wherever possible and ensure transition to adult services that is focussed upon and meets the needs of the individual young person. Co-commissioning options for repatriation, reviews and development of local services will be explored with neighbouring CCGs and Local Authorities. The re-specified services will include focus on compliance with most recent guidance regarding care and treatment reviews and step up and step down from TIER 4 services.
Perinatal Mental Health Service	Develop a Perinatal Mental Health Service working across CAMHS AMHS and Child and Maternity, Primary Care and Specialised Services develop a local Perinatal mental health service which will deliver local care pathways across agencies and support improved maternal mental health as outlined in Future in Mind.

Progress on the implementation of these specific areas of service transformation are reported on quarterly to NHS England visa a self-assessment process. This is used by WCCG to measure implementation against plan and introduce remedial action if necessary. The financial data is included as Appendix G.

3. Emotional health and wellbeing service system transformation

i) Local mental health practitioners

While specialist mental health staff are organised as a centralized resource, these can be accessed in a timely manner through CAMHS Link Workers. Through the Link Workers, this specialist mental health expertise is more readily available and accessible to all in the local area. Direct mental health service can be carried out alongside other family interventions in a more coordinated and effective manners. Communications will be enhanced with co-location or frequent visits to local hubs. CAMHS Link Workers will be available at each HeadStart hub to navigate children and young people

to more specialist services, while also being available to re-establish them into locally available services at the appropriate time. While specialist mental health professionals would be directly available at each locality, access to interventions from non-local resources would be expedited through the CAMHS Link Workers who will have well established communication systems and professional relationships.

Secondary consultation is available to support professionals known to the child, young person and family, continue to provide support. This will reduce the referrals for specialist CAMHS, and enables the child and family to be supported by local services, which could flex as needed. The availability of this consultation service will enable local professions to learn more about a young person's condition and treatments that are effective. The learning can be generalised to other children and young people as well as shared with colleagues. A stronger and more knowledgeable workforce would be the outcome.

ii) Specialist emotional health and wellbeing service

The current Crisis Team, Home Treatment services, Youth Offending Team worker, and Looked After team, will remain centralised resources, with specialist workers engaging with localised services. It may be that these two services are combined into a joint specialist service that works closely with family support workers from the Strengthening Family Hubs, and other Link Workers in HeadStart Hubs. This would ensure that a whole service response could be mobilised to support all members of the family affected by the crisis. The benefit of close locality working means that the child, or young person remains known to local workers who are able to continue working with the family through the crisis, and continue well after crisis has past, This will ensure that children and young people do not fall through the gaps. Young people requiring Tier 4 specialist care would be monitored by local professionals, as well as the Crisis Team. This oversight will enable a coordinated treatment plan to be delivered to the young person and their family, and enable localised planning to reduce length of stay.

iii) Special Education needs and/or a disability (SEND) service

A requirement of the Children and Families Act 2014 is that each Local Authority is to produce and publish a Local Offer. This sets out in one place information about provision available across education, health and social care for children and young people in the area who have special educational needs or are disabled[39]. Part of the local offer is the Inspire Team, which supports children and young people (from birth up to the age of 18years) who have a learning disability, as well as their families. Inspire is part of the Specialist CAMH services provided by BCPFT and provides a broad range of community and school based, emotional health and wellbeing interventions, including individual therapy, group support, family working, consultation to professionals and services, teaching and training, skills training. Educational Psychology staff have developed specific to guidance about what schools should be offering for students with social, emotional and mental health needs, and is to be used to inform decisions about whether a child needs an education health and care plan, and what level of support they need[40].

iv) Implementation of Improving Access to Psychological Therapies

An important aspect of the LTP is the establishment of Improving Access to Psychological Therapies (IAPT) for children and young people. A major NHS initiative, the aim of IAPT is to increase the provision of evidence-based treatments for common mental health conditions (i.e. anxiety and depression) by primary care organisations. While unsuccessful in an early application to join an IAPT collaborative, Wolverhampton has just been accepted into the Midlands Collaborative.

---

39 City of Wolverhampton Council have published the local offer for children and young people at: http://win.wolverhampton.gov.uk/kb5/wolverhampton/directory/localoffer.page?localofferchannel=0

40 Social, emotional and mental health. Produced by Educational Psychology service, CWC.

The IAPT development means that front line staff will receive specialist training to provide evidence based interventions, and then not need to refer to more specialist services. This will have a positive impact on the workforce, by providing front line workers with new skills in managing emotional health and wellbeing issues. If these interventions are unsuccessful, more intense interventions would be available from specialist CAMHS practitioners.

4. Barriers to service transformation

A review of all the published LTP was conducted by the Education Policy Institute and identified six barriers to transformation (Frith, 2016). The Wolverhampton LTP has taken account of these and worked with BCPFT on developing strategies to minimise their impact – see Figure 8.

Barrier [41]	*Strategy adopted in Wolverhampton*
Workforce	• Employment of temporary staff with associated skills • Training and supervision given a priority
Funding	• Future in Mind funding was dedicated to specialist CAMH service • Alignment of services so early intervention services bolstered
Commissioning	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing
Data	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing • While IT systems will not be integrated, the move is to develop more flexible information sharing arrangements. • Data will be captured through the Strengthening Family and HeadStart hubs, and providers will contribute data to the system used in these hubs
Fragmentation	• LTP involves systems transformation with a focus on aligning all services involved with emotional health and wellbeing, so gaps between services disappear
Intervening too late	• LTP focuses on whole system transformation with an emphasis on early intervention. • Pathways will be made more straightforward, to ensure children are seen by right practitioner in a timely manner

Figure 8: Barriers to transformation across England with action taken

5. Transformation implications

Working together in a multi professional and multi-agency environment requires a new set of relationships and rules to be established. These include:

- traditional organisational authority structures will need to become more flexible, as multi-agency team members learn how to work together and overcome professional and organisational differences
- professionals may need to work beyond what has been seen as outside their traditional ways of working

41 Barriers identified in the Education Policy Institute – see report by Frith (2016).

- commissioning of local activities will need to be changed so that multi-agency (and multi-commissioning arrangements) can be used to support children and their families more flexibly
- workforce will need further training on managing mental health issues and when to involve other team members, or when to refer to crisis services
- rules for sharing information will need to be examined otherwise records or notes that would be useful for one practitioner may be unavailable to others
- governance arrangements will need to be put into place to ensure that multi-agency and multi professional working is not hindered by bureaucratic processes, and that staff are appropriately supported

6. Funding and sustainability

The model proposed for CAMHS transformation is built upon the following assumptions about budgets:

- current levels of expenditure will remain constant, with possibility of adjustments due to inflation only
- no further investment will be made by either CWC or WCCG in early intervention services
- any structural or organisational changes will have to be met within current financial resources
- savings derived from reduced spending in acute and specialist services may be redistributed into early intervention and prevention services.

The sustainability of emotional health and wellbeing services in Wolverhampton services is based upon the three elements outlined below.

1. *Whole system transformation*: There is currently an over reliance on NHS acute care for children with mental health and emotional wellbeing issues. Lack of preventative measures and early interventions means that there is a continual slide into the more intense and costly secondary care services. The delivery of HeadStart activities, as early intervention and resilience building 'downstream' is likely to reduce the demand on CAMH services 'upstream'. It is expected that some of the budget savings due to reduced demand will be used to fund further early intervention and prevention services.

2. *Tier 4 commissioning returning to local area*: With NHS England committed to returning the commissioning of specialist Tier 4 provision to local commissioners, there may be an opportunity for reinvestment of savings. If per capita funding is returned to Wolverhampton, then as a low user of Tier 4 beds, funding may be able to be released for early intervention and prevention services. However, how the budget to be returned to local commissioners is calculated is yet to be announced.

3. *Schools in joint funding or traded services model*: The positive impact of emotional health and well-being services on student attainment and attendance may provide the foundation joint funding of locality based initiatives. Some schools have already started to invest in pastoral care workers who will be supported through the HeadStart and Strengthening Family hubs. As other schools recognise the benefits it is anticipated that they will move towards a joint funding or even purchase of a traded services model on a phased and incremental basis. With the Director of Education (CWC), commissioners from WCCG have established a working party to develop a plan for working closely with head teachers to explore alternative sources of funding.

Risks and mitigations associated with the transformation plan

An undertaking of this magnitude is not without its risks. A number have been identified below, with some strategies that can be used to mitigate these risks. Prior planning and anticipation are crucial in increasing the chance of successful transformation.

Risk	*Mitigation*
Failure of NHS E to return commissioning and funds for Tier 4 placements back to CCG commissioners.	NHS England are committed to returning specialised commissioning to the local area. It will be very difficult to provide the service without the associated funding (@£1.5M).
Failure of BCPFT to implement agreed changes	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
CAMHS staff unwilling to work in or with Strengthening Family hubs and in a collaborative manner	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Skill mix of CAMHs staff not appropriate to meet intervention requirements of new model	Will need to use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Insufficient resources (human and financial) to meet the demands of place based care – assumption is that over time, referrals to Specialist CAMHS will reduce.	Using population and service utilisation data, a robust model needs to be developed. Using parity of esteem and other levers, the CCG and partners may need to review the level of services that can be delivered.
Failure of organisations to work together due to structural or contracting impediments	Due to the imperative of STP, senior executives will need to be informed of any failure of organisations to cooperate with agreed plans. Also, could use contracting levers, with the possibility of considering an open tender process if they fail to deliver the necessary changes.
Increase in identification of children and young people with emotional health and wellbeing challenges	As this is likely to be a temporary increase, the numbers will be managed by front line staff having IAPT training, and secondary consultation support from Link Workers, and availability of advice and guidance from specialist CAMHS consultants.
Management of current referred cases while transition to new processes occurs	The new arrangements will be rolled out over a period of time, and Hub by Hub, so change will occur gradually, and the transition from current workload to new processes will not happen all at once.
Confusion resulting from poor planning and lack of clarity concerning roles and responsibilities	The LTP and cultural transformation is occurring with the full participation of all organisation involved in commissioning and delivering services. A comprehensive communication plan will be developed and implemented to minimise confusion due to change in processes and pathways.

Next steps

Next steps that need to be taken in the implementation of the system transformation include: as follows:

- Development and implementation of service specifications as outlined in the 16/17 and 18/18 plan
- Report to Health and Well-Being Board and development of communication, consultation and publication plan with timelines
- Continue the transformation of the service system using actions outlined in Gantt Chart in Appendix F
- Continued development of commissioning intentions and service models across our Black Country STP Footprint, following NHS England assurance continued implementation, monitoring and review of pilot schemes.

Summary

Using current resources, the LTP address the problems that have been articulated about the current service system. Using a collaborative approach which encourages organisations to work in new ways, the aligning of emotional health and wellbeing services with locally based hubs has been devised. There is no one solution that will keep all stakeholders satisfied, as the resources available are limited and need to be deployed wisely for the good of children and young people of Wolverhampton. Change is an element of the service system landscape, as supports need to be flexed to meet emerging needs. The LTP needs to be judged by whether it meets the vision established by for Wolverhampton.

> *In Wolverhampton we believe that mental health is everyone's business and that all agencies (public, community, and private) need to work together to ensure that all children and young people enjoy good mental health and emotional wellbeing, including those that are most vulnerable in society such as children looked after by the local authority. We will achieve this through an emphasis on prevention, early identification and intervention using evidence-based approaches that present good value for money. Where a mental health problem or disorder is identified children and young people will have access to timely, integrated, high quality and multidisciplinary mental health services that are accessible and responsive to individual need[42].*

42 Vision and model: CAMHS Transformation in Wolverhampton. CAMHS Transformation Partnership Board, March 2016.

References

Barry MM, Clarke AM, Jenkins R, Patel V (2013) *A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries*. BMC Public Health 13 835.

Children's Commissioner (2016). Lightening Review: Access to child and adolescent mental health services, London.

Frith. E. (2016). *Progress and challenges in the transformation of children and young people's mental health care*. Mental Health Commission, Education Policy Institute. London.

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. NHS England Publication Gateway Ref. No 02939 2015.

Gilburt, H. (2016). Supporting integration through new roles and working across boundaries. Kings Fund, London.

Gulliver, A., Griffiths, KM., & Christensen, H (2010). *Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review*. BMC Psychiatry 2010, 10:113.

iMPOWER, (2015) Breaking the Lock: A new preventative model to improve the lives of vulnerable children and make families stronger. London.

Janssen, I., Hanssen, M., Bak, M. et al. (2003). Discrimination and delusional ideation. British Journal of Psychiatry, 182, 71–76.

Joseph, J. (2003). *The gene illusion*. Ross-on-Wye: PCCS Books.

Karlsen, N. & Nazroo, J. (2002). Relation between racial discrimination, social class and health among ethnic minority groups. American Journal of Public Health, 92, 624–631.

Kinderman, P (2014) New Laws of Psychology: Why Nature and Nurture Alone Can't Explain Human Behaviour. Robinson. London.

Kings Fund (2015). Place-based systems of care – A way forward for the NHS in England'. The Kings Fund: London, November 2015.

KPMG, (2013). *The Integration Imperative: reshaping the delivery of human and social services*. www.kpmg.com/hss.

Leahy, D., Schaffalitzky, E., Armstrong, C., et al, (2013). Early intervention for youth mental health and substance use disorders: the role of the GP. University of Limerick Repository.

Leahy, D., Schaffalitzky, E., Saunders J., et. al. (2015). *Role of the general practitioner in providing early intervention for youth mental health: a mixed methods investigation*, Early Intervention in Psychiatry.

McCorry, P., Bates, T., & Birchwood, M. (2013). *Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK*. The British Journal of Psychiatry, 202.

Pryjmachuk, S., Elvey, R., Kirk, S., et al. (2014). Developing a model of mental health self-care support for children and young people through an integrated evaluation of available types of provision involving systematic review, meta-analysis and case study. Health Services and Delivery Research, 2(18). .

Rand Corporation (2005). Proven Benefits of Early Childhood Interventions.

Read, J., (2005). The bio-bio-bio model of madness. The Psychologist, Oct 2005, Vol 18.

Read, J., Agar, K., Argyle, N. & Aderhold, V. (2003). *Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder*. Psychology and Psychotherapy: Research, Theory and Practice, 76, 11–22.

Read, J. & Haslam, N. (2004). *Public opinion: Bad things happen and can drive you crazy*. In J. Read et al. (2004). Hove: Brunner-Routledge.

Read, J., Mosher, L. & Bentall, R. (2004). *Models of madness*. Hove: Brunner-Routledge.

Read, J., van Os, J., Morrison, A.P. & Ross, C.A. (2005). *Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications*. Acta Psychiatrica Scandinavica. 112 (5).

Schaffalitzky, E., Leahy, D., Cullen, W. et al. (2015). Youth mental health in deprived urban areas: a Delphi study on the role of the GP in early intervention. Irish Journal of Medical Science 184.

van Os, J., Hanssen, M., Bijl, R. & Vollebergh, W. (2001). *Prevalence of psychotic disorder and community level of psychotic symptoms.* Archives of General Psychiatry, 58, 663–668.

Walker, S. (2008). An Evaluation of an Innovative Project Designed to Enhance Child and Adolescent Mental Health Provision. The Journal of Mental Health Training, Education and Practice, Vol. 3 Iss 3 pp. 4 - 13

Weare, K., and Nind, M. (2011). P*romoting Mental Health of Children and Adolescents Through Schools and School Based Interventions. Evidence Outcomes of School Based Interventions*. Report of Workpackage Three of the DATAPREV Project. Southampton: School of Education University of Southampton.

Whitfield, C., Dube, S., Felitti, V. & Anda, R. (2005). *Adverse childhood experiences and hallucinations*. Child Abuse and Neglect, 29, 797–810.

WM QRS (2016). Towards Children and Young People's Emotional Health and Well-being: Sandwell & Wolverhampton Health & Social Care Economy. January 2016.

Reports - NHS

NHS Shared Planning Guidance: Operational Planning and Contracting Guidance 2017 – 2019 (NHS, 2016)
Specialised tertiary Mental Health Commissioning to return to local CCGs (NHS 2016)
Five Year Forward View (NHS 2014)
Five Year Forward View for Mental Health (NHS 2015)
Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing (NHS, 2015)
Transforming Care Partnerships (NHS, 2015)

Reports - Other

CAMHS: A time to transform (iMPOWER, 2015)
Young People in Mind (Youth Action, 2016)
Lightening Review: Access to CAMHS (Children's Commissioner, 2016)
Better Mental Health For All: A public health approach to mental health improvement (Faculty of Public Health, 2016)
Mental health and behaviour in schools: Departmental advice for school staff (DfE, 2016)
THRIVE: Model for CAMHS. (AFC, 2014)

Appendix A: Children's Outcomes Framework spine chart - JSNA

Appendix 5: Children's Outcomes Framework spine chart

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Spine chart explanation:

National average

Wton LA peers

Worst — Best

25th Percentile 75th

Completed by Wolverhampton Public Health Intelligence Team-September 2012

Area	Indicator	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
Be healthy	Infant mortality 2008-10	7.7	4.6	19.2		2.2
	Under 18 conception rate 2010	55.5	38.1	64.9		10.8
	Teenage mothers (under 18) 2010-11	2.8	1.5	3.5		0.3
	Hospital admissions due to alcohol misuse (under 18) 2007-2010	37.2	61.8	154.9		18.6
	Children using alcohol 2009	12.0	15.0	23.0		3.0
	Substance misuse by young people 2009	8.3	9.8	16.5		2.6
	Children and young people smoking 2009	4.0	4.0	9.0		1.0
	Breast feeding initiation Q4 2011-12	65.2	74.5	39.0		94.7
	Proportion of Reception children classified as obese 2010/11	12.6	9.4	14.6		6.0
	Proportion of Year 6 children classified as obese 2010/11	23.8	19.0	26.5		10.7
	Rate of tooth decay in children aged 5 years 2007-08 (completed every four	0.7	1.1	2.5		0.5
	Hospital admission due to substance misuse (15-24) 2008-10	36.1	63.5	163.6		19.8
	Child mortality rate (aged 1-17) 2002-10	15.6	16.5	27.6		10.5
	% low birth weight babies, under 2500g 2010	7.7	7.0	11.5		4.3
	Breastfed at 6-8 weeks Q4 2011-12	41.6	46.1	19.0		83.2
	% of women smoking at delivery Q1 2012-13	18.3	12.7	28.0		1.0
	Hospital admissions for mental health 2010-11	37.9	109.4	722.1		36.8
	Hospital admissions for self harm 2010-11	176.4	158.8	359.5		34.3
Stay safe	Children in care 2011	94.0	59.0	142.0		20.0
	% of pupils who say they have been bullied 2009	10.9	9.6	14.4		5.6
	Homeless households 2010-11	3.3	2.0	10.4		0.1
	DTaP/IPV/Hib uptake at 2 years at Jan-Mar 2012 (by PCT)	95.7	96.3	85.5		99.5
	Men C coverage at 2 years at Jan-Mar 2012 (by PCT)	93.7	95.3	82.0		99.5
	PCV coverage at 2 years at Jan-Mar 2012 (by PCT)	89.0	92.5	72.7		100.0
	Hib/Men C booster at 5 years at Jan-Mar 2012 (by PCT)	90.9	91.4	70.1		99.0
	PCV booster at 5 years at Jan-Mar 2012 (by PCT)	87.7	91.4	68.4		96.8
	MMR uptake at 2 years at Jan-Mar 2012 (by PCT)	90.0	92.0	73.1		97.7
	MMR 1 dose coverage at 5 years at Jan-Mar 2012 (by PCT)	93.0	95.8	83.0		98.8
	MMR 2nd dose uptake at 5 years at Jan-Mar 2012 (by PCT)	80.9	91.2	68.7		95.2
	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was a	17.4	18.6	0.3		100.0
	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	61.8	82.6	45.2		97.6
	Children in care immunisations 2011	93.4	79.0	20.0		142.0
	Accident admissions rate per 10,000 population for 0-17 year olds due to inj	106.0	124.3	235.1		73.2
	KSI rate for children 2008-10	24.9	23.6	64.2		2.1
	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	2733.5	1979.2	5995.0		464.0
Enjoy and achieve	% participation in at least 3 hours of sport/PE 2009-10	60.6	55.1	40.9		79.5
	Good development at age 5 2011	52.0	59.0	48.0		74.0
	% GCSE pass rate (5 A*-C, inc English and Maths) 2010-11	57.6	58.4	40.1		79.9
	% GCSE pass rate (5 A*-G) 2010-11	93.6	93.8	85.1		100.0
	% GCSE pass rate for children in care (5 A*-C) 2010-11	<5	12.8	0.0		40.0
Positive contribution	Children who have someone to talk to 2009	67.0	64.0	56.0		74.0
	% of children working securely at foundation level 2010-11	46.0	54.0	40.0		85.0
	Pupils who voted in school elections % 2007					
Economic wellbeing	School absentees, % half days lost to unauthorised absence 2010-11	1.5	1.1	2.4		0.2
	First time entrants to the justice system, young people 2011	830.8	748.8	953.6		450.5
	Children in Poverty 2009	30.8	20.9	57.0		3.9
	NEET's at 16-19 years as at 2010-11	7.6	6.7	8.9		4.9

Source: http://www.wolverhampton.gov.uk/article/3647/Joint-Strategic-Needs-Assessment-JSNA

Appendix B: Data available in planning

Service Quality Performance Report 15/16 and 16/17

Wolverhampton_SQPR_2015-16_M12_v2 (

Wolverhampton_BCPFT_1617_SQPR_V05_

Using data from the SQPR, the following Key trends for 2015/16 were noted:

Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks	• remained on target throughout the year • has not breached.
Percentage of caseload aged 17 years or younger - have carers care plan. (CAMHS and EIS)	• 100% for 11 months
Percentage of DNAs for follow-up contact	• on target for the full year.
SAFEGUARDING CHILDREN% compliance with staff safeguarding training strategy at level 2	• under target from April to November • substantial improvement in Qtr 4 • remained on target for the rest of the year.
SAFEGUARDING CHILDREN% compliance with staff safeguarding training strategy at level 3	• under target from April to November • substantial improvement in Qtr 4 • remained on target for the rest of the year.

Using data from the SQPR, the following Key trends for 2016/17 were noted:

Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	• 100% every month YTD
Every young person presenting with self-harm or crisis seen within 4 hours regardless of setting.-	• 100% every month YTD
Percentage of caseload aged 17 years or younger – have care plan (CAMHs and EIS	• 100% for Q1 • Q2 data not available yet.

Appendix C: Influential policy and reports

	Major implications or findings
NHS Shared Planning Guidance: Operational Planning and Contracting Guidance 2017 – 2019 *(NHS, 2016)*	NHS England and NHS Improvement have published this year's operational and contracting planning guidance three months earlier than normal to help local organisations plan more strategically. For the first time, the planning guidance covers two financial years, to provide greater stability and support transformation. This is underpinned by a two-year tariff and two-year NHS Standard Contract. It provides local NHS organisations with an update on the national priorities for 2017/18 and 2018/19, as well as updating on longer term financial challenges for local systems. Key features include: • planning process has been built around STP so that the commitments and changes coming out of these plans translate fully into operational plans and contracts • timetable has been brought forward to enable earlier agreement locally about contracts • adjustments have been made to national levers such as tariff and CQUIN to support local systems in implementing service transformation • in line with NHS England's expectation of greater collaboration between organisations locally, there will be a single NHS England and NHS Improvement oversight process providing a unified interface with local organisations to ensure effective alignment of CCG and provider plans.
Five Year Forward View *(NHS 2014)*	This policy sets out a new shared vision for the future of the NHS based around the new models of care: • radical upgrade in prevention and public health activities • patients gaining far greater control of their own care • breaking down the barriers in how care is provided • new models of care, i.e. multi-specialty community providers • care provided closer to patient's home • seven day services • CCGs to develop Sustainability and Transformation Plans
Five Year Forward View for Mental Health *(NHS 2015)*	The independent Mental Health Taskforce published this report, setting out the beginning of a ten-year journey for the transformation of NHS mental health services in England. Commissioning Managers will need to work in new ways, including: • work in partnership with local stakeholders and voluntary organizations • co-produce with clinicians, experts-by-experience and carers • consider mental and physical health needs • plan for effective transitions between services • enable integration • draw on the best evidence, quality standards and NICE guidelines • make use of financial incentives to improve quality • emphasise early intervention, choice and personalisation and recovery • ensure services are provided with humanity, dignity and respect.
Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing *(NHS, 2015)*	This policy recommends '*Promoting resilience, prevention and early intervention*' and '*Improving access to effective support – a system without tiers'*. It considers ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. It brings together core principles and requirements considered to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people developed around key themes: promoting resilience, prevention and early intervention improving access to effective support – a system without tiers accountability and transparency developing the workforce. '*One-stop-shop services based in the community should be a key part of any universal offer*.' Future in Mind.

Transforming Care Partnerships *(NHS, 2015)*	The Transforming Care programme is now changing how we deliver and commission services, so that more people with learning disabilities and/ or autism, with behaviour that challenges – including those with a mental health condition – can live in the community, closer to home. This will reduce the reliance on in-patient beds and close some facilities.
CAMHS: A time to transform *(iMPOWER, 2015)*	iMPOWER produced the A Time to Transform in 2015, detailing a model based on a shared understanding that mental ill health problems are far more commonplace issues than we think for our children and young people. It is essential that the system cut through the complexity. Demand management, new service models, and multiagency work and support offer unique opportunities to change the way CAMH services are commissioned and delivered. Delivery of this change will require: • earlier intervention when a child's difficulties first arise • focus on the lower tiers in the system, in the hope that escalation to the higher ones will not be needed • breaking down the barriers between services as a deliberate, focused, planned action for all concerned • good information sharing and a mind-set that expects to share, not to withhold • triage as a way of assessing children's needs at each stage, not creating barriers but means of ensuring the child "lands" with the next stage of help and support • multi-agency working as a foregone conclusion, including during the transition to adults' services, or out of intensive help and support and back into communities and lower level interventions after a period of specialist treatment • developing the workforce to have at least a basis of knowledge, understanding and expertise in mental and emotional health, wellbeing and development.
Young People in Mind (*Youth Action, 2016*)	This report forms part of the Young People in Mind project, funded by the Department of Education. The project was delivered via a consortium of nine Youth Information, Advice and Counselling Services (YIACS) working across England led by Youth Access, with two key strands of activity: 1. increase young people's access to counselling and other psychological therapies 2. build the local YIACS' capacity to engage with local statutory bodies. The report focuses on the first area of Young People in Mind's areas of activity by providing an insight into the young people who accessed the counselling and other psychological therapies offered during the year in which the project ran. It provides policymakers, commissioners and providers with a practical insight into the range of young people's needs. The reports also show how investment in YIACS can bring an improved and integrated response to the delivery of local mental health and wellbeing support to young people; showing their particular value to young people as they move through late adolescence and into young adulthood.
Specialised tertiary Mental Health Commissioning to return to local CCGs *(NHS 2016)*	NHS England is committed to returning a range of specialised commissioning responsibilities back to the local CCG commissioners. In particular, commissioning of specialist placements for children and young people with serious mental health conditions (known as Tier 4 placements) will be returned to the local areas. This will provide local commissioning partnerships to seek more creative solutions for local children and young people rather than the current situation where the regional managers from NHS England take over commissioning responsibilities. NHS E has recently called for applications for the funding of new care model for tertiary mental health services. Partners across the Black Country have requested funding of £10.5M.
Lightening Review: Access to CAMHS *(Children's Commissioner, 2016)*	This Review, published by the Children's Commissioner in May 2016, was designed to cast light on potential issues that existed in the mental health services vulnerable young people need. The Commission found that: • large numbers of children and young people are turned away from CAMHS upon referral and/or are having to wait long periods of time for treatment • many children are waiting a long time to be seen by mental health services • many children are falling out of the system because they miss appointments and then have to be re-referred.

Better Mental Health For All: A public health approach to mental health improvement *(Faculty of Public Health, 2016)*	Public mental health is fundamental to public health in general because mental health is a determinant and consequence of physical health as well as a resource for living. A public mental health approach is concerned with promoting mental wellbeing, preventing future mental health problems and with recovery from mental health problems. It advocates that public health practitioners become advocates for public mental health providing strong leadership and prioritising mental health within current public health practices. Here is a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems. • consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate • move from deficit to strengths-based approaches and ensure you promote good mental wellbeing, • adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups • ensure that you are working towards your own mental wellbeing and your colleagues • move towards ensuring mental health receives the same priority as physical health • adopt a life course approach. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities. • reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population, and • contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact.
Mental health and behaviour in schools: Departmental advice for school staff *(DfE, 2016)*	This non-statutory advice clarifies the responsibility of the school, outlines what they can do and how to support a child or young person whose behaviour - whether it is disruptive, withdrawn, anxious, depressed or otherwise - may be related to an unmet mental health need. The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. School should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems. The culture and structures within a school can promote their pupils' mental health through: • committed senior management team that sets a culture within the school that values all pupils • ethos of setting high expectations of attainment for all pupils with consistently applied support • effective strategic role for the qualified teacher who acts as the special educational needs co-ordinator (SENCO) • working with parents and carers as well as with the pupils themselves, ensuring their opinions and wishes are taken into account • continuous professional development for staff that makes it clear that promoting good mental health is the responsibility of all members of school staff and community • clear systems and processes to help staff who identify children with possible mental health problems; providing routes to escalate issues with clear referral and accountability systems • working with others to provide interventions for pupils with mental health problems • healthy school approach to promoting the health and wellbeing of all pupils in the school, with priorities identified and a clear process of 'planning, doing and reviewing'. Schools with these characteristics mitigate the risk of mental health problems in their pupils by supporting them to become more resilient and preventing problems before they arise. In addition, schools should also have in place arrangements which reflect the importance of safeguarding and protecting the welfare of their pupils as set out in the latest safeguarding guidance. Schools should work closely with other professionals to have a range of support services that can be put in place depending on the identified needs (both within and beyond the school). These should be set out clearly in the school's published SEND policy.

- National service framework: children, young people and maternity services (2004).
- Joint Commissioning Panel for Mental Health Guidance for commissioners of child and adolescent mental health services (2013).
- Mental Health Policy Implementation Guide -Dual Diagnosis Good Practice Guide (HM Government 2002).
- The National Service Framework for Mental Health (HM Government, 1999, 2004).
- Preventing suicide in England: One year on (HM Government 2014).
- 'Closing the Gap' (HM Government 2014).
- Achieving Better Access to Mental Health Services by 2020 (HM Government 2014).
- Wolverhampton crisis concordat action plan (2016).
- Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16
- Access and Waiting Time Standard for Children and Young People with an Eating Disorder
- Commissioning Guide (2015)
- House of Commons Education Committee
- Mental health and well-being of looked-after children Fourth Report of Session 2015–16
- Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report (2014)
- Promoting the health and well-being of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England (HM Government March 2015)
- Looked-after children and young people NICE guidance PH28 (NICE and SCIE MAY 2015).
- The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review.
- National Framework for Children and Young People's Continuing Care (HM Government 2010).
- Winterbourne view – Time for change Transforming the commissioning vof services for people with learning disabilities and/or autism (HM GOVERNMENT 2014)
- Transforming Care for People with Learning Disabilities Next Steps (2015)

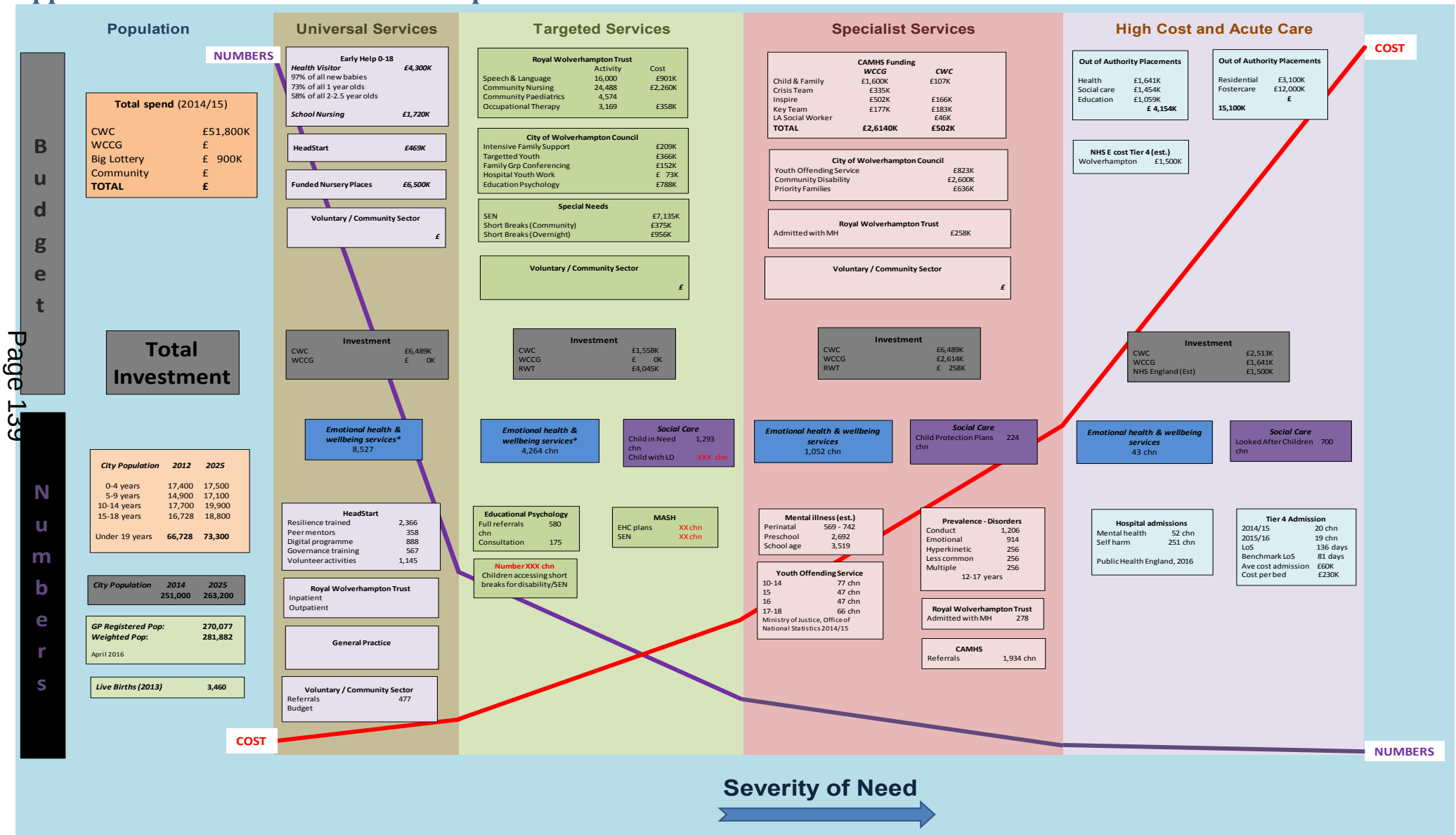
Nice Guidance Including but not exclusively includes:

- Depression in children and young people: Identification and management in primary, community and secondary care
- Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
- Self-harm: longer-term management
- Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum.
- Autism NICE quality standard [QS51]
- Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults.
- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

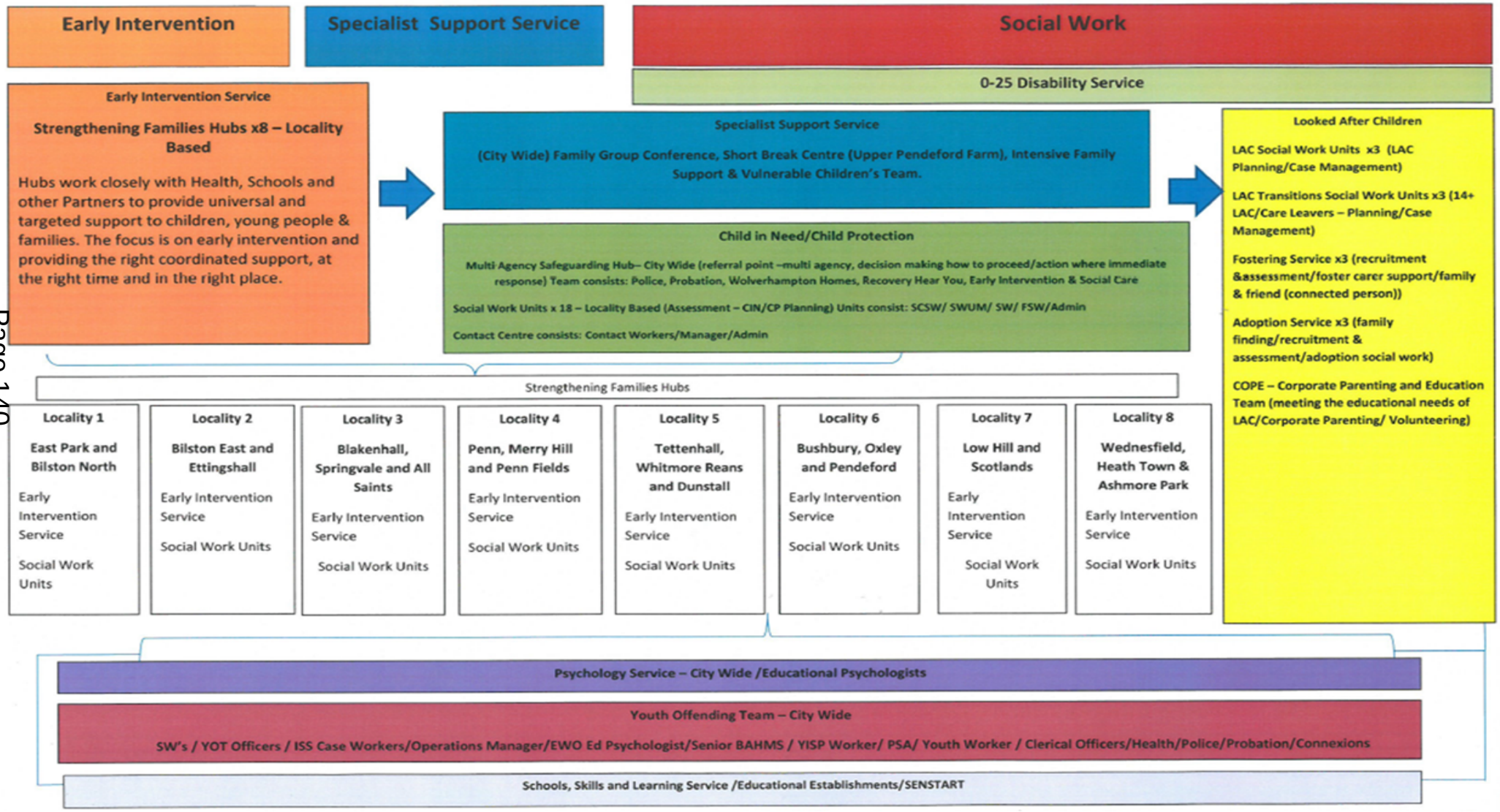
Appendix D: The 'As Is' in Wolverhampton



CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Appendix E: Service model for Children and Young People's Services



CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Appendix F: Gantt Chart outlining transformation plan to align services

Activity	*Action*	*RAG*	*Jan 16*	*Feb 16*	*Mar 16*	*Apr 16*	*May 16*	*Jun 16*	*Jul 16*	*Aug 16*	*Sep 16*	*Oct 16*	*Nov 16*	*Dec 16*	*Jan 16*	*Feb 16*	*Mar 16*	*Apr 17*
Establishing transformation process	Establish CAMHS Transformation Partnership Board (CTPB)																	
	Agree Terms of Reference of CTPB																	
	Develop mode of working of CTPB - aims, objectives, and outcomes																	
	Participate I Head Start funding application																	
	Establish Task & Finish Groups - leads, members, and meetings																	
	Establish reporting mechanism on activity and finances associated with each Transformation activity																	
	Establish links with community & voluntary agencies																	
	Develop robust reporting process for NHS E																	
Diagnostic and design	Obtain research & examples of best practice resources for early intervention																	
	Develop and agree work plans for each Task & Finish Group																	
	Undertake mapping of current service provision for emotional health and well being in Wolverhampton																	
	Complete Black Country CAMHS Tier 3 / 4 Co-Commissioning Project																	
	Co produce pathways for Early Intervention & Prevention																	
	Approval of co-produced pathways by CTPB																	

	Agree plans and service specification for increased operational capacity of Eating Disorder service																	
	Agree plans and service specification for increased operational capacity of Early Intervention for Psychosis service																	
	Meet NHS E Director and establish agreement about progressing Tier 4 commissioning locally in Black Country																	
Building	Develop plan with options for implementation for commissioning Tier 4 locally																	
	Review governance and operational structure to ensure suitable for implementing co designed pathway																	
	Identify and develop strategic plans that build on enabling factors and minimise project risks																	
	Operational Processes, Human Competencies; Information Technologies																	
	Develop performance and outcome measures																	
	Engagement with staff affected by transformation plans																	
	Consider draft Service Specification																	
	Produce Project Initiation Document for Better Care Fund Partnership Board																	
Implementation	Interim service arrangements																	
	Develop transition plan																	
	Roll out of implementation plan																	
	Implement quality measures and outcomes																	

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Appendix G: Transformation funding

1. COMMISSIONING CAPACITY COSTS					
COMMISSIONING CAPACITY COSTS			15/16	16/17	Additional 16/17 (£148,000)
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	
TRANSFORMATION DIRECTOR	8D	0.50	13,697	30,819	
CAMHS TIER 3 PLUS / TIER 4 BLACK COUNTYRY WIDE PROJECT SUPPORT	8B	1.00	23,614		
DEDICATED PROJECT COSTS, COMMS, BUSINESS INTELLIGENCE SUPPORT, STAKEHOLDER ENGAGEMENT			20,000		
TOTAL PAY COSTS			57,311	30,819	
NON PAY COSTS (5%)			2,866	2,866	
PLUS OVERHEADS (5%)			2,866	2,866	
TOTAL COSTS			£63,042	£36,550	£0

2. CAMHS IAPT COSTS					
CAMHS IAPT COSTS					
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	Additional 16/17 (£148,000
CAMHS IAPT SCOPING CLINICAL LEAD	7	1.00	16,782	0	
TOTAL PAY COSTS			16,782	0	
NON PAY COSTS (5%)			839		
PLUS OVERHEADS (5%)			839		
TOTAL COSTS			£18,460	£0	£0

3. CAMHS CRISIS RESOLUTION HOME TREATMENT COSTS					
CHRT COSTS TO INCLUDE SPA					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL NURSE SPECIALIST	7	1.00	16,737	37,845	
BAND 6 NURSE PRACTITIONERS	6	2.00	21,047	63,142	
ENHANCEMENTS EXISTING STAFF		3.00	8,491	25,473	
TOTAL PAY COSTS			46,275	126,460	
NON PAY COSTS (5%)			2,314		
PLUS OVERHEADS (5%)			2,314		
TOTAL COSTS			£50,903	£126,460	

4. EARLY INTERVENTION IN PSYCHOSIS COSTS					
EARLY INTERVENTION IN PSYCHOSIS SERVICE COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
PHARMACIST	7	0.50	8,391	21,397	
NURSE	6	1.00	14,116	35,996	
TOTAL PAY COSTS			22,507	57,393	
NON PAY COSTS (5%)			375	1,125	
PLUS OVERHEADS (5%)			375	1,125	
TOTAL COSTS			£23,257	£59,644	£0

5. EATING DISORDER SERVICE COSTS					
EATING DISORDER SERVICE COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
MEDICAL COVER	CONSULTANT	1.00	70,496	44,941	
PSYCHOLOGY	8A	1.00	19,553	0	
CLINICAL SPECIALIST	8A	0.40	5,869	14,966	
DIETICIAN	6	0.20	2,016	5,141	
BAND 6 NURSE PRACTITIONERS	6	3.00	31,571	80,506	
TOTAL PAY COSTS			129,505	145,554	
NON PAY COSTS (5%)			6,475		
PLUS OVERHEADS (5%)			6,475		
TOTAL COSTS			£142,456	£145,554	£0

6. CAMHS LINK WORKERS FOR SCHOOLS					
CAMHS LINK WORKERS FOR SCHOOLS COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL NURSE SPECIALIST	7	1.00	16,782	37,845	
BAND 6 NURSE PRACTITIONERS	6	3.00	52,928	47,357	
ADMIN	2	1.00	7,323	9,223	
TOTAL PAY COSTS			77,033	94,424	
NON PAY COSTS (5%)			3,852		
PLUS OVERHEADS (5%)			3,852		
TOTAL COSTS			£84,736	£94,424	£0

7. SPECIALIST, COMPLEX AND LEARNING DISABILITY CAMHS COSTS					
SPECIALIST AND LEARNING DISABILITY CAMHS COSTS					
Role Description	Band	Total WTE	Total 15/16 COST	Funds required for 16/17	Additional 16/17 (£148,000
CLINICAL LEAD EPP	7	1.00	16,782	0	
CLINICAL LEAD YOUTH OFFENDING TEAM	8	1.00	22,486	0	
TOTAL PAY COSTS			39,268	0	
NON PAY COSTS (5%)			1,963		
PLUS OVERHEADS (5%)			1,963		
TOTAL COSTS			£43,195	£0	£0

8. PERI-NATAL MENTALHEALTH COSTS					
PERI-NATAL MENTAL HEALTH COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000)
MEDICAL COVER	CONSULTANT	0.40	20,886	0	
CLINICAL NURSE SPECIALIST	7	1.00	16,782	37,845	
BAND 6 NURSE PRACTITIONERS	6	1.00	14,316	31,571	
ADMIN	2	0.50	3,662	0	
TOTAL PAY COSTS			55,646	69,416	
NON PAY COSTS (5%)			2,782		
PLUS OVERHEADS (5%)			2,782		
TOTAL COSTS			£61,211	£69,416	

9. COMMUNITY MENTALHEALTH COSTS					
COMMUNITY MENTAL HEALTH COSTS					
Role Description	Band	Total WTE	Total 4 Month Cost	Funds required for 16/17	Additional 16/17 (£148,000)
SUPPORT FOR CRISIS HELP LINE LGBT					£10,000
SEXUALLY HARMFUL BEHAVIOUR TRAINING					£10,000
TOTAL COSTS					£20,000

	Total 15/16	16/17 ALLOCATION	ACTUAL 16/17 ALLOCATION	Additional 16/17 (£148,000)	
	COSTS				
1. COMMISSIONING CAPACITY COSTS	63,042	36,550			
2. CAMHS IAPT	18,460	0			
3. CAMHS CRHT	50,903	126,460			
4. EARLY INTERVENTION IN PSYCHOSIS	23,257	59,644			
5. EATING DISORDERS	142,456	145,554			
6. CAMHS LINK WORKERS IN SCHOOLS	£84,736	£94,424			
7. SPECILAIST AND LEARNING DISABILITY CAMHS	43,195	0			
8. PERI-NATAL MENTAL HEALTH	61,211	69,416			
9. COMMUNITY MENTAL HEALTH					
TOTAL COSTS	487,261	532,047	587,000	£20,000	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body - Tuesday 8th November 2016

Agenda item 12

Title of Report:	**Executive Summary from the Quality & Safety Committee**
Report of:	Dr Rajshree Rajcholan – GP Lead Quality
Contact:	Manjeet Garcha Director of Nursing & Quality
(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/RAG
SBAR issues escalated	2	• Delayed diagnoses • Delayed treatment • NEs • Sub-optimal care (transfer of patient)	4/5
Confidential Leaks	1	Close monitoring	4
Pressure Injury Grade 3	1	Close monitoring	7/8
Health Acquired Infections- CDiff	2	Potential risk of increased incidence and potential harm Increased likelihood that RWT will breach its annual target	9
Performance Improvement notices impacting on Quality	2	Meetings with RWT held regularly and action plans agreed. More detail will be covered by the Finance and Performance paper.	
Workforce- RWT Risk Register	2	RWT Nursing and consultant recruitment issues are impacting on Quality and Patient Safety and A&E performance.	14
Sustaining Maternity Services at Walsall impact	2	Full Risk Assessment completed, go live 21st March. Close scrutiny of impact on Wolverhampton commissioned residents. Joint Quality Review Visit planned for 31st October 2016.	20
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.	15/17
CQC Inspection Reports (BCPFT & RWT)	2	Rating 'requires improvement' for RWT & BCPFT Action Plans in place.	10/16
CQC General Practice	1	2 practices are being supported for	11

		'requires improvement'	
Mortality	1	Within expected limits, some data cleansing and audits being conducted.	13
Falls	1	Improvements seen in number of falls causing serious harm. CCG will maintain focus	6

1.0 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 11th October 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.

2.0 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 four weeks the key concerns raised were:

3.1.1 A Never Event has been reported by RWT, this involves the injection of Lucentis into the wrong eye. This is the 4th Lucentis related NE in the last 3 years. The CCG has written to the Medical Director at RWT, a quality visit scheduled for January 2017 has been brought forward to 14th November. A full RCA will be undertaken and received at CQRM with an action plan.

3.1.2 An incident involving a male urology patient. Whilst being prepared for a trial without catheter at home, the nursing team found that the balloon of the catheter could not be deflated. After attending OPD the patient had to have emergency surgery the following day to remove the catheter. This incident has been reported to the product manufacturer as initial review suggests that this is a manufacturing fault.

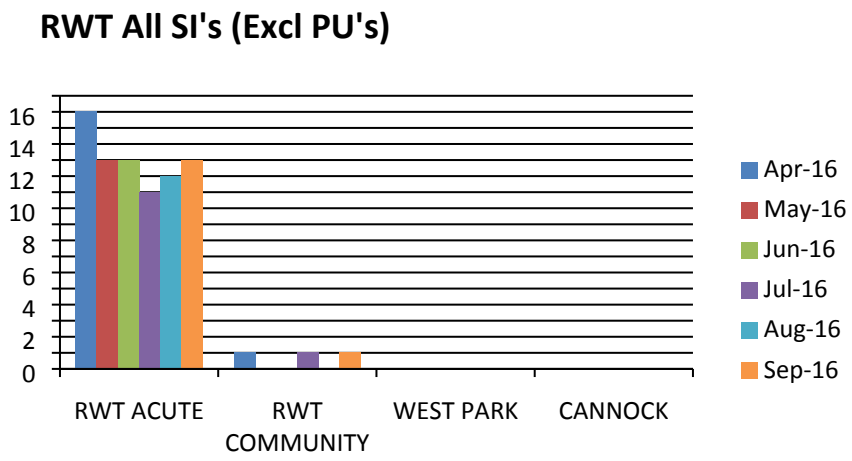
3.1.3 Unexpected death of a BCPFT service user. This is being investigated currently and cause of death is not yet known.

3.1.4 A delay in assessment and transfer from midwifery led unit to delivery suite. The baby was delivered with use of forceps and required immediate specialist NNU care. The baby recovered quickly and is well with no long term effect. An investigation has commenced and the Chief Nurses are in liaison to assure safety of care in MLU. A visit to the maternity unit is planned for Monday 31st October 2016 and an update will be provided at the Governing Body meeting.

4.0 THE ROYAL WOLVERHAMPTON NHS TRUST

4.1 Serious Incidents (SIs)

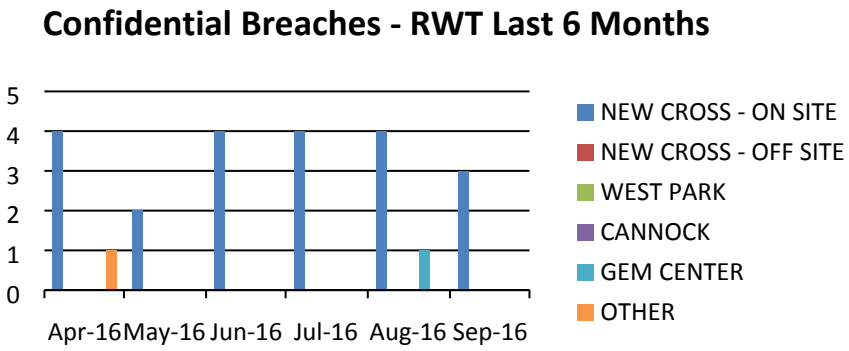
14 new Serious Incidents were reported by RWT in September 2016.



The Trust has completed an external review of SIs reported from key areas as A&E and emergency admissions areas. The report is being written and the findings will be shared at the January 2017 CQR meeting. The National Reporting and Learning System monitors all NHS Trusts for reporting timescales and numbers reported. RWT is not considered as an outlier.

4.2 Confidential Breaches

This remains on the CCG radar; in February 2016 a new Trust wide policy was launched with an awareness raising week of road shows across all sites. As expected we saw a surge of incidents reported in April then a dip in May, June to July did not demonstrate the expected sustained improvement but there was some improvement in August. September has unfortunately seen a small deterioration again and 3 incidents have been reported. The Trust was requested to review this at the September CQRM and an update is schedule for the November meeting.



4.3 Never Events

RWT reported its 4th NE for the current year on October 21st 2016. As mentioned earlier under exception reporting page 4, this is being investigated by the Trust and in addition the CCG are carrying out a planned quality visit on 14th November. This review will take into consideration actions taken by the Trust following the previous incidents and what learning can be demonstrated including immediate actions taken following the most recent incident to ensure safety of patients. In addition a formal SBAR has been raised, Dr De Rosa has written to Dr J Odum (Medical Director) at RWT and we are awaiting the response for further consideration. This has been communicated to the Contracts Teams for appropriate application of sanctions.

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

4.4 Slips Trips and Falls

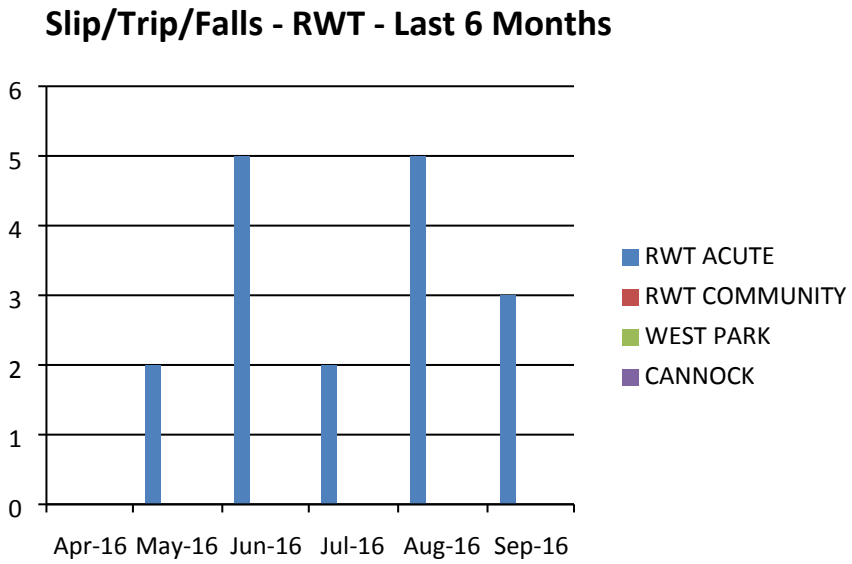
Three slip/trip/falls were reported by RWT in September 2016 (C24 – Renal, C41 – Gastroenterology and Anti Coagulation Clinic). C24 is on our radar for further deeper dive and all intelligence on this ward has been triangulated to identify themes which will be discussed with the Trust for assurance on leadership, staffing, infection and prevention audits, education and training on this ward.
There have been zero reported falls at West Park, community or Cannock Chase Hospital. This information has been verified since the last report in October.

The RWT Falls Group continues to meet on a monthly basis. The RWT Falls Policy has been reviewed (Prevention and Management of Falls). This is as a result of feedback from the National Inpatient Falls Audit. It was ratified by the Trust Board in October 2016.

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



4.5 Pressure Injury Grade 3

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

The main findings of the gap analysis led to the distinct variation in practice across the health economy. Key areas have been identified:

- 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, a single protocol to be designed.
- Information – should clearly define who does what and who/how to escalate.
- Communication - eDischarge to be improved to include wound care needs/implications.
- Peer support/advice for Practice Nurses to be improved
- Wound Care Pathway to be reviewed and pathways agreed
- Formulary –several areas to be addressed but e.g. Compression Therapy Review, changes to products and skills will have implications for health economy; change process should include implementation & training to be cascade to all stakeholders.

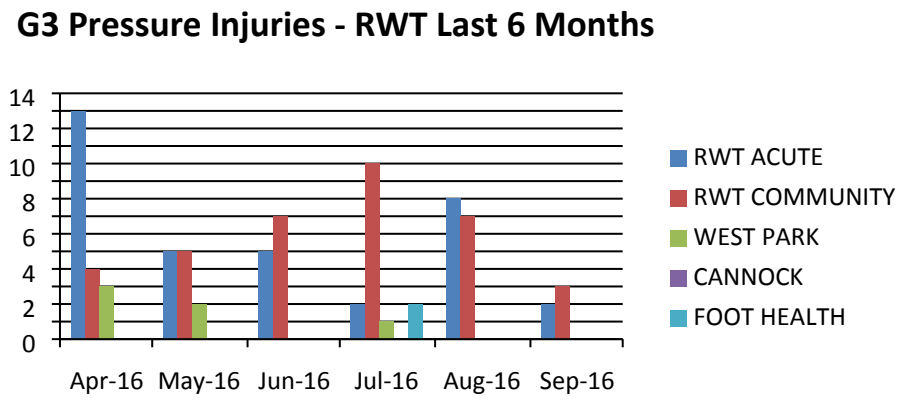
This work is currently underway and being driven by the group.

In September, 5 Grade 3 Pressure Injury incidents were reported by RWT; 2 at RWT site and 3 in the Community. This is a very encouraging improvement and continues to be on the downward trend in the monthly incidents reported over the last 9 months. All incidents are

discussed at the bi weekly scrutiny meetings which the CCG attend and are graded as avoidable or unavoidable following a comprehensive RCA. These meetings are chaired by the Trusts' Chief Nurse and the head nurses from each area affected attend with their RCA findings and action plans.

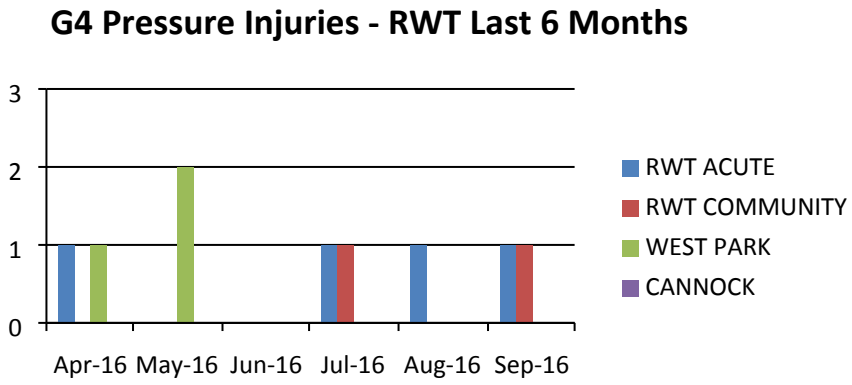
Across the region, this is held up as a best practice and demonstrates ownership of the issue at executive director level.

Future reporting of these will include the avoidable and unavoidable data. (Due to the time lag for the final RCA scrutiny meeting and the decision on whether an injury is avoidable or not, this piece of work cannot be actioned until the December report).



4.6 Pressure Injury Grade 4

Two Grade 4 Pressure Injury incidents were reported by RWT in September. This has remained the same since April.



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

At present the greatest concern for the Trust is for C-Difficile. The Trust have reported over trajectory for the year with only 2 more cases before the Trust will reached its yearly ceiling. This is a reported improvement on last year for the same period but still not at the levels that are required. The Trust has decreased its tolerance in a 28 day period from 3 cases to 2 cases before executive led intervention is undertaken. The result of this action has led to the Trust being under trajectory for the past few months.
The Trust has provided assurance that the following actions have been undertaken:

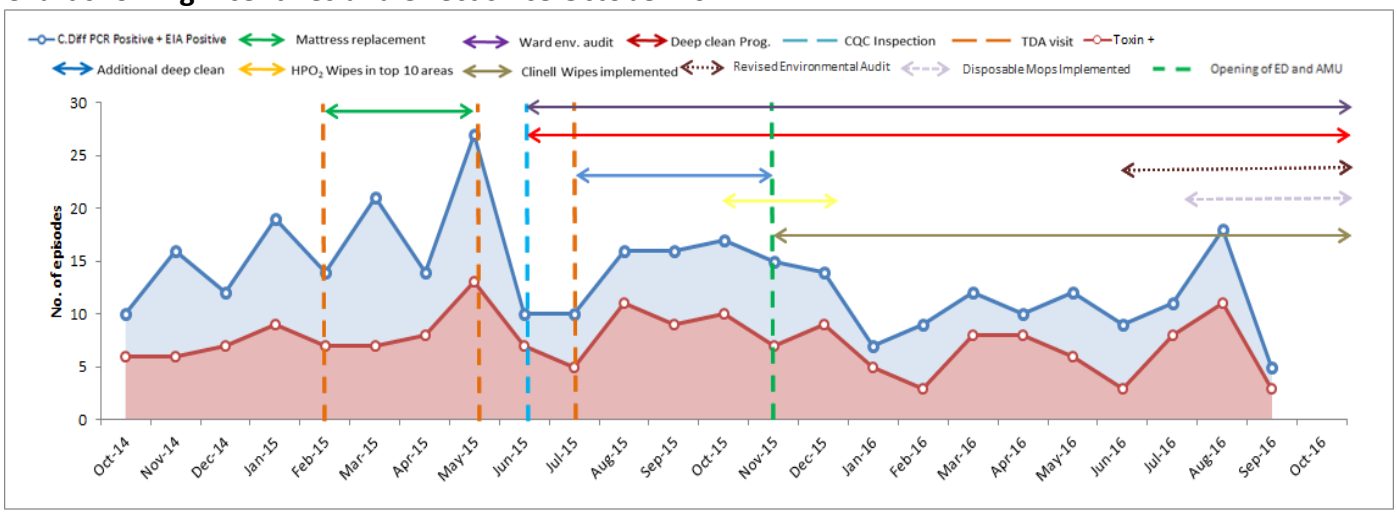
- Ward/divisions of concern are being monitored more vigilantly.
- Lesson learnt from wards showing improvement have been shared.
- Actions have been taken where treatment delays and time to isolate are not at optimum rates.
- Disposable mops have been introduced since July 2016 and from September there is scrutiny with the clinical teams following every case with the tolerance for an incident meeting lowered to 2 cases in 28 days linked to any area.
- Chart of full activity showing incentives and effect to reduce CDiff are shown on table below.

MRSA bacteraemia has remained at nil since February 2015. CPE remained a challenge for the Trust however the Trust continued to monitor the most resistant cases.
As would be expected through the summer period, cases of Noro-Virus have remained very low.
European Point Prevalence Survey commenced in September 2016; all wards will be audited for HCAI. The information collated will inform and improve the understanding of local, national and Europe wide issues on the following:

- Occurrence of HCAIs
- Quality of antimicrobial prescribing
- Quality of antimicrobial stewardship

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

Chart showing incentives and effect since October 2014



4.8 West Midlands Quality Review Service

The draft report for the review of imaging services which took place on September 21st 2016 at RWT has been received by the Trust and CCG. Immediate risks were notified to the Trust at the time of the review and a letter of assurance has been received by WMQRS and CCG from the Chief Executive that these issues have been addressed. The Trust now has until 4th November to review the report and make any comments/submit any additional information. Once the final report has been received the CCG will formally include the action plan to be added to the CQRM agenda for monitoring and assurance.

4.9 Performance

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

Quality issues related to poor performance are routinely addressed under the Serious Incident reporting mechanism. In addition RWT are undertaking a review of all RTT breaches to monitor any harm which has resulted as a result of delay for treatment. This is being led by NHSE for a specific Specialised Commissioned Service at present but once a model has been agreed, it will be utilised for all harm reviews.

4.12 Regulator concerns

4.12.1 CQC RWT

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.

In July the CQC carried out an announced review of safeguarding children and Looked after Children across the acute, CCG and LA pathways. Verbal feedback was received at the end of the review and the written report is expected by end of August. A Strategic Stakeholder Group has been agreed and the first meeting was held on 25th August 2016. The function of this group is to seek demonstrable assurance that the actions are being progressed and how they are being embedded. Exceptions will be reported to the Local Children's Safeguarding Board. With the second meeting held on October 7th the action plan is being progressed by all stakeholders and no areas of concern have been raised.

RWT safeguarding team structure has been reviewed by RWT and a business case was presented to the October Commissioning Committee for funding to support. A verbal update will be provided at the Governing Body meeting on the 8th November.

4.12.2 CQC General Practice

General Practice A previously rated as 'inadequate' has recently been rated as overall 'good'. Two other practices are being supported to improve from 'requires improvement'. The CCG meets with CQC area managers to share intelligence on a regular basis.

4.12.3 CQC BCPFT

BCPFT CQC Risk Summit was held in May 2016. A substantial action plan is in place and this is being monitored at CQRM and Contract Meetings. A further visit from CQC took place on 17th October and the final report is awaited.

4.12.4 Health and Safety Executive

RWT received a Notice of Contravention for Radiology Department, the Trust will respond within the required time frame and this will be monitored at CQRM and contract review meetings until satisfactory assurance is received. An update is expected in November 2016.

4.12.5 Healthwatch

Following discussions with RWT and Healthwatch, it has been agreed that where possible scheduled quality visits to the Trust will be joint with Healthwatch and CCG. Healthwatch colleagues are scheduled to accompany the CCG Quality Team at 3 visits in September and October and more will be planned in the New Year. Healthwatch have attended a joint visit to the A&E and UCC on 26th September 2016 and Maternity Unit on 31st October.

4.14 Mortality (RWT)

The published SHMI, released by the Health and Social Care Information Centre (HSCIC) for January - December 2015 is 1.04 and banded “as expected" with no significant variation from the bench mark (England average is 1). This represents a very slight increase of 0.02 when compared to previous publications.

The SHMI is a ratio between observed and expected death rates. The expected death rate is a number statistically derived from the analysis of all ordinary admissions (day cases and regular attenders are excluded). For the last 4 publications a slight increase is noted in crude mortality of up to 0.2%.

The charts below represent the SHMI trend for RWT showing the consistent performance in the last 3 years (Fig. 1) and RWT’s position in the national picture for the reporting period (Fig. 2).

Fig. 1 RWT’s SHMI by publication period

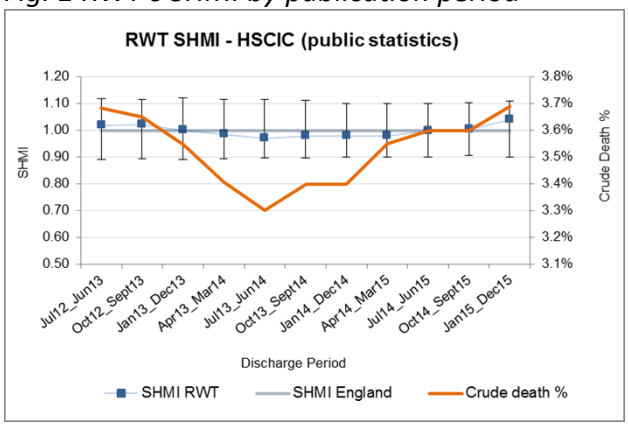
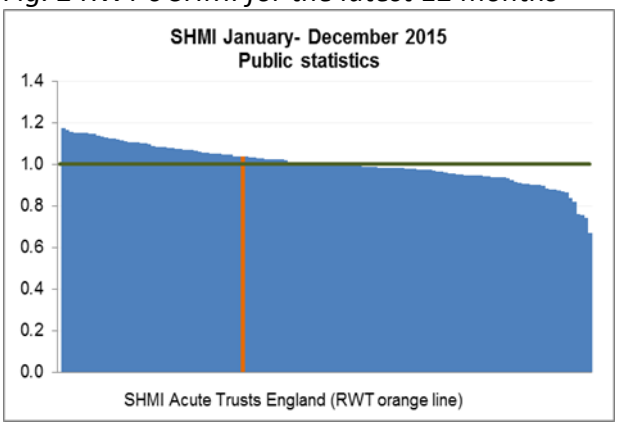


Fig. 2 RWT’s SHMI for the latest 12 months



(Source: HSCIC, figures released bi-monthly, next release at the end of September 2016).

The estimated SHMI (provided by Healthcare Evaluation Data – HED) for the latest 12 months, March 2015 - February 2016 is 104.7 and banded as higher than expected (95% CI). Whilst the mortality rates for the Trust have not increased following the latest data refresh, the expected death rate has decreased, which resulted in a higher standardised mortality rate. This is likely to be due to changes in the national dataset which would impact on an individual Trust’s data.

To note, this is not the final dataset for 2015-16; this was expected to be released in September 2016 and the analysis is being reviewed and shared at the next Trust MORAG meeting. (October meeting was cancelled by RWT).

A number of diagnoses groups have been showing a higher than expected SHMI at internal alert level. These were discussed at the Mortality Review Group (MRG) and a plan of action was agreed.

MRG has coordinating the coding and clinical reviews for the following diagnosis groups:

- Pneumonia – large clinical audit in progress. An audit conducted in 2015 by a Respiratory Consultant in collaboration with the Coding Department found that coding for Pneumonia was accurate. It is anticipated that the higher SHMI in recent months is attributed to the decrease in the overall number of admissions with Pneumonia. This hypothesis is being tested within the current audit and the evidence will be presented in the final report.

- Acute bronchitis – 51% of the sample reviewed (41 cases) for coding had the diagnosis amended; clinical audit is near completion (following data resubmission this diagnosis group is well within expected limits).

- Intestinal infection - 23% of the sample reviewed (26 cases) for coding had the diagnosis amended; clinical audit is in progress.

- Other liver diseases - 33% of the sample reviewed (15 cases) for coding had the diagnosis amended; clinical audit is to commence shortly.

- Acute myocardial infarction - 7% of the sample reviewed (27 cases) for coding had the diagnosis amended; clinical audit is completed and findings are presented to the MRG in September 16.

- Phlebitis; thrombophlebitis and thromboembolism – 2 out of 9 cases reviewed for coding had the diagnosis amended; clinical audit is in progress.

- Fluid and electrolyte disorders - 12% of the sample reviewed (41 cases) for coding had the diagnosis amended; clinical audit is to commence in August 16.

- Abdominal pain – clinical audit in progress.

- Coma, stupor and brain damage – 17% of the sample reviewed (12 cases) for coding had the diagnosis amended; clinical audit completed report to be presented at MRG in September 2016.
    - All audits are discussed at the MRG and at the Commissioner Mortality Oversight Group.

Lessons and actions from the audits

All cases coded on admission with pneumonia, bronchitis or chest sepsis are validated by a second coder prior to being input in the system.

A review of admissions recorded as elective found that in some areas some admissions should have been recorded as non-elective. The Head of Coding and Data Quality has been coordinating work to ensure that where local rules apply for direct admission portals, the rules are well documented and administrative staff receive the appropriate training.

Collaborative work between clinical coders and clinicians is on-going in order to improve quality of documentation and accuracy of coding. 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. A Memorandum of Understanding for sharing information across the health sector has been developed. The CCG is working with the Trusts to have a shared approach on sharing coroner concerns at CQRMs. Since the agreement, there have been no coroner recommendations discussed at CQRMs.

The CCG is also working with NSHE and RWT on how learning from avoidable deaths in primary care can be included in the Trust mortality review meetings.

4.15 Workforce

Further to an extraordinary 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: - (progress updates taken from the Chief Nurse Assurance Report to the Trust Governing Body on 25th July 2016 can be seen in brackets)

- Impact on quality on areas of low fill rates and how this is managed **(3 times a day assessment of patient acuity to ensure staff with the right skills are on the appropriate wards)**
- Early capture of new graduate **(see next point)**
- Local recruitment **(29 newly qualified from Sept 2016 cohort have secured staff nurse posts in the Trust)**
- Midwifery posts have been filled and there are no vacancies in this area at the time of writing this report. **(14 newly qualified midwives have commenced employment at the end of October)**
- Overseas recruitment (**Filipino nurses have joined the Trust, the numbers are small at the moment due to English competency testing)**
- Workforce strategy direction **(retention- 13 members of staff have been successful in accessing further training courses at University level.**
- **Return to Practice-3 currently employed on the course)**
- Risks and mitigations **–(management and leadership band 7 insights include conflict management, recruitment and retention and report writing)**
- Impact on recruitment following acquisitions of new site. Planning assumptions reflection and going forward to next planning round.
- Recruitment fairs- **(successful in Dublin and Edinburgh)**
- Ward 3 West Park **(closed)**
- Ward A5/6 **(12 beds closed to support the staffing deficit pending the on-going recruitment)**

- 2 longstanding consultant vacancies have been recruited to substantively

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 Ward 3 at West Park Hospital as a direct result of staffing issues impacting on quality of patient care. Ward 3 was staffed by an intensive support team of 6 senior nurses from RWT, this was not sustainable. Twelve further beds are closed on A5 and A6 to support the staffing deficit.

5.0 BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST
Level of Concern as of 30th September 2016

Black Country Partnership	
Month	**Concern Level and Actions**
September 2016	Level 2 –previous CQC inspection rated the Trust as Requiring Improvement. BCPFT action plan in place. Re inspection took place on October 17th 2016, awaiting report to review the current concern level

a) PREVENT Training

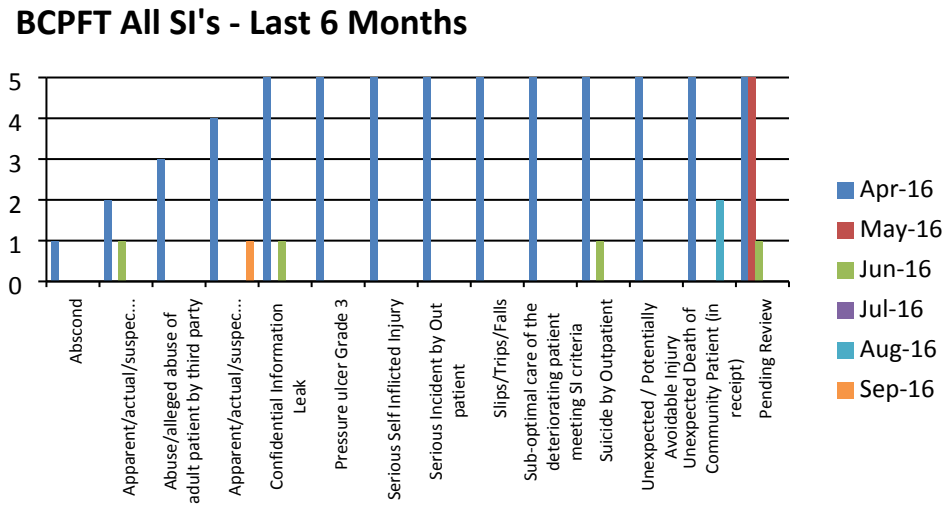
Remedial action plan agreed in June. This will be monitored via CQRM and Contract Review Meetings.

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.

5.1 Serious Incidents

In September, 1 SI of suspected self-harm at Penn Hospital was reported. Full investigation has been completed for how the blade was brought into the hospital following return from an approved leave of absence. The process for assessment of risk prior to each episode of leave from wards has been reviewed and strengthened.



The SIs which show 'pending review' are those that currently have a 'stop clock' applied due to third party involvement i.e. police, coroner, court case

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 at the time of writing this report.

5.6 **NHS Safety Thermometer**

BCPFT's harm free care rate for August 2016 was 95%. 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 September 2016 was Learning Disabilities. Key areas to note were:

- The largest number of incidents occurred in forensic services and included both physical and non-physical aggression. One incident involved a moderate degree of harm where a nurse was injured by a patient. There were five medication errors which are being managed by the Trust.
- There were five informal complaints, no formal complaints and three compliments.
- There was one prone restraint in month. This will be examined at the next CQRM.
- The sickness absence rate was 7.7% with the causes of sickness similar to previous months. Despite the high rate of sickness absence, it should be noted that the rate of incidents has not increased, showing that patient safety measures remain effective.

- The Autism Strategy has gone to Cabinet. A diagnostic pathway will be commissioned through Dudley and Walsall Trust.
- The consultation on Pond Lane has come to an end and the report will be shared once completed.
- The new Section 117 policy has gone through a Section 117 Working Group and is due to be shared with BCPFT's Mental Health Act Manager before it can be taken forward.
- A number of Syrian refugees are expected in Wolverhampton at the end of the year. WCCG has gone out to tender regarding primary care but needs to consult with BCPFT regarding CAMHs, LD and mental health provision.

RED Indicators - Month 5 (August 2016) BCPFT dashboard shows reporting on national and local quality requirements

PREVENT Contract Performance Notice – the contract performance notice has been agreed and the final version will be shared at October's CQRM and will continue to be monitored monthly.

Going forward the new Head of Quality and Risk is working with the BCPFT to strengthen the quality of data that the Trust shares. Currently there are weaknesses and also the process which examines the number of delayed transfers of care is being overhauled.

6.0 OTHER SECTORS

6.1 Compton Hospice – CQRM held, no issues of concern noted. A CQC inspection also took place in July 2016. Overall rating is 'good'.

6.2 Vocare - took over the Out of Hours Service at 8.00 am on 1st April 2016. The contract is now signed and conversations held re planning and agreeing TOR for CQRMs to commence in November 2016. The first meeting was held in October. One SI reported by Vocare is currently under review as the RCA did not meet the CCG expectation of completion and quality. Going forward expectations and time scales of quality and timescales will be agreed and monitored via the CQRMs.

7.0 CHILDREN'S SAFEGUARDING

7.1 Serious Case Reviews

On Monday 26th September Wolverhampton Safeguarding Children Board (WSCB) published the findings of a Serious Case Review into parental neglect. The SCR centres on the children of a Wolverhampton couple who were taken into care in 2014 after an emergency admission to hospital identified significant concerns regarding their supervision

and care. The father was jailed for two years for gross neglect following a subsequent child protection investigation. The mother has since passed away.

There was a wide range of services and practitioners supporting the family, and many displayed considerable commitment to improve the care the children were receiving. However, coordination of services was lacking resulting in the neglect the children were exposed to not effectively being addressed. Had this been better it may have made a difference – but equally it could also have been the case that the parents' resistance to help would have remained exactly the same.

The agencies involved in the review were Wolverhampton Safeguarding Children Board, City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, the Royal Wolverhampton Hospitals Trust, Black Country Partnership NHS Trust, Recovery Near You, Spurgeons Young Carers and Base 25, the children's schools and the family's GPs. The WCCG action plan developed as a result of the SCR was fully implemented prior to the publication.

In order to protect the children within the family, the publication was redacted and subject to a 'soft publish' agreement.

7.2 As reported in the previous Governing Body report in October, Section 11 Audits were completed by provider and the CCG as per the statutory requirements. The data is currently being analysed by the Local Safeguarding Children Board and the CCG will take action with any gaps in its internal or provider audit provision.

7.2.1 OFSTED Inspection

The 2016/17 OFSTED Inspection schedules require that Wolverhampton OFSTED inspection will be completed before May 2017. A multi disciplinary OFSTED team from all the key stakeholders have been deployed in Wolverhampton for several months now in preparing for the inspection. The next opportunity for the inspection will now be after November 14th. All stakeholders are currently ready in waiting for the formal notification and the mobilisation team will lead on informing and leading on the inspection.

7.3 Looked After Children

The number of children in care continues to slowly but steadily decrease, with the WCCG remaining active partners within multi-agencies arrangements and core corporate duties and responsibilities. Below are the figures as at the end of Sept 2016:

	Number	%age
Wolverhampton City Council	**271**	**43.2**
Dudley Metropolitan Borough Council	40	6.4
Sandwell Metropolitan Borough Council	29	4.6
Walsall Metropolitan Borough Council	60	9.6

South Staffordshire Council	35	5.6
All in Adjoining LAs	**164**	**26.2**
Anywhere Else - not in Wolverhampton or in Adjoining LAs	**192**	**30.6**
TOTAL LAC*	**627**	**100**

- as of September 30th 2016

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 incumbent commenced their new role 5th September 2016.

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	F
Parkfields	F

Assurance – there is a robust system in place whereby safety concerns such as safeguarding, care home acquired pressure injury, 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 1st February 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. Dashboards are being designed to monitor quality of care in these 9 homes using contractual levers to drive performance.

Out of area homes which have Wolverhampton health or social care funded patients and that are of concern are monitored jointly with CQC and City of Wolverhampton Council. NHSE have a wider remit to share this information at Quality Surveillance Group Meetings.

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 by 500 deliveries in 2016/17 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. A joint quality review visit is planned for 31st October 2016. A verbal update will be given at the Governing Body meeting on 8th November.

Assurances have been acquired regarding:

- Staffing on maternity
- Staffing and consultant cover for neo natal services
- Current vacancies and recruitment timelines
- Sonographer capacity
- Repatriation of babies back to Walsall in a timely manner

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

Chronology of actions to date includes:

June: Walsall maternity capping monitoring meetings now completed.

July: Commence Black Country data collection exercise for maternity services and commissioning semi structured interviews re: maternity services. This has now commenced.

End of July: Commissioning stakeholder event for maternity services. Share commissioning response, in consideration of agreeing scope for Business Case going forward. This event is delayed, currently waiting new date.

October: Joint Walsall and Wolverhampton CCGs (and Healthwatch) quality visit to RWT Maternity Unit. (31st October 2016).

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 October and information from Quality Review Meetings held during the month of September was 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

Failure to commission good quality and safe services would be a considerable reputational risk for the organisation.

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.

14.3 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.

14.4 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 reviewed and updated.

15.0 Recommendations

For **Assurance**

- **Note** the actions being taken.
- **Note** the actions in relation to the CQC Safeguarding and LAC Review in July 2016 and the preparedness for the pending OFSTED Inspection.
- **Note** the steps being taken regarding the 4th NE in Ophthalmology at RWT
- **Note** the steps being taken regarding BCPFT safeguarding/PREVENT training compliance
- **Note** the maternity review findings which will be reported verbally at the meeting
- **Continue** to receive monthly assurance reports

Name: Manjeet Garcha
Job Title: Director of Nursing and Quality
Date: 27th October 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**	**27/10/16**
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**	**Oct 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**	**27/10/2016**

(V1.0 final)

This page is intentionally left blank

WOLVERHAMPTON CCG

GOVERNING BODY
8th November 2016

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 25th October 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	£350.743m	£350.743m	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	313	77	(236)	G
Maximum closing cash balance %	1.25%	0.31%	0.80%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	93%	2%	A
QIPP	£4.93m	£4.52m	£0.41m	A
Programme Cost £'000*	165,997	166,488	491	G
Reserves £'000*	890	0	(890)	G
Running Cost £'000*	2,777	2,698	(79)	G

- The net effect of the three identified lines (*) is a small underspend and the green rating refers to the overall position.
- The CCG continues to exceed the BPPC target of paying 95% of its invoices within 30 days (figures are cumulative April16-September 16).
- QIPP is slightly below target for Month 6 albeit anticipating full delivery including the unallocated QIPP by year end.
- Cash balances have returned to levels within NHSE guidelines.

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

	Annual Plan £'000	YTD Performance M06			
		Plan £'000	Actual £'000	Variance £'000 o(u)	Var % o(u)
Acute Services	181,259	90,629	91,062	433	0.48%
Mental Health Services	34,307	17,153	17,112	(42)	(0.24%)
Community Services	37,645	18,843	18,445	(397)	(2.11%)
Continuing Care/FNC	12,259	6,129	6,636	506	8.26%
Prescribing & Quality	51,640	25,924	24,841	(1,083)	(4.18%)
Other Programme	16,752	7,318	8,392	1,074	14.67%
Total Programme	**333,862**	**165,997**	**166,488**	**491**	**0.30%**
Running Costs	5,555	2,777	2,698	(79)	(2.86%)
Reserves	5,154	890	0	(890)	(100.00%)
Total Mandate	**344,571**	**169,664**	**169,185**	**(478)**	(0.28%)
Target Surplus	6,172	2,723	0	(2,723)	(100.00%)
Total	**350,743**	**172,387**	**169,185**	**(3,201)**	(1.86%)

The table below details the forecast out turn by service line at Month 6.

	Annual Plan £'000	Forecast Outturn at M06			Forecast Outum at M05			In Month Movement £'000 o(u)
		Actual £'000	Variance £'000	Var %	Actual £'000	Variance o(u) £'000	Var %	
Acute Services	181,259	183,436	2,177	1.20%	182,312	1,839	1.02%	338
Mental Health Services	34,307	34,220	(87)	(0.25%)	34,298	(157)	(0.45%)	70
Community Services	37,645	36,291	(1,354)	(3.60%)	37,518	(214)	(0.57%)	(1,140)
Continuing Care/FNC	12,259	13,286	1,027	8.38%	13,704	1,445	11.79%	(418)
Prescribing & Quality	51,640	50,182	(1,459)	(2.82%)	50,854	(1,159)	(2.23%)	(300)
Other programme	16,752	18,226	1,474	8.80%	16,449	24	0.15%	1,450
Total Programme	**333,862**	**335,641**	**1,780**	**0.53%**	**335,135**	**1,780**	**0.53%**	**(0)**
Running Costs	5,555	5,555	0	0.00%	5,555	0	0.00%	0
Reserves	5,154	3,375	(1,780)	(34.53%)	3,375	(1,780)	(34.53%)	0
Target Surplus	6,172	6,172	0	0.00%	6,172	0	0.00%	0
Total Mandate Spend	**350,743**	**350,743**	**(0)**	(0.00%)	**350,237**	**0**	**0.00%**	**(0)**

- The Acute portfolio variance is due to adverse movements in Dudley Group of Hospitals Non Elective Vascular Activity, NHS 111 increased costs arising from step in provision and the Non Contract Activity portfolio which due to its nature is subject to fluctuations.

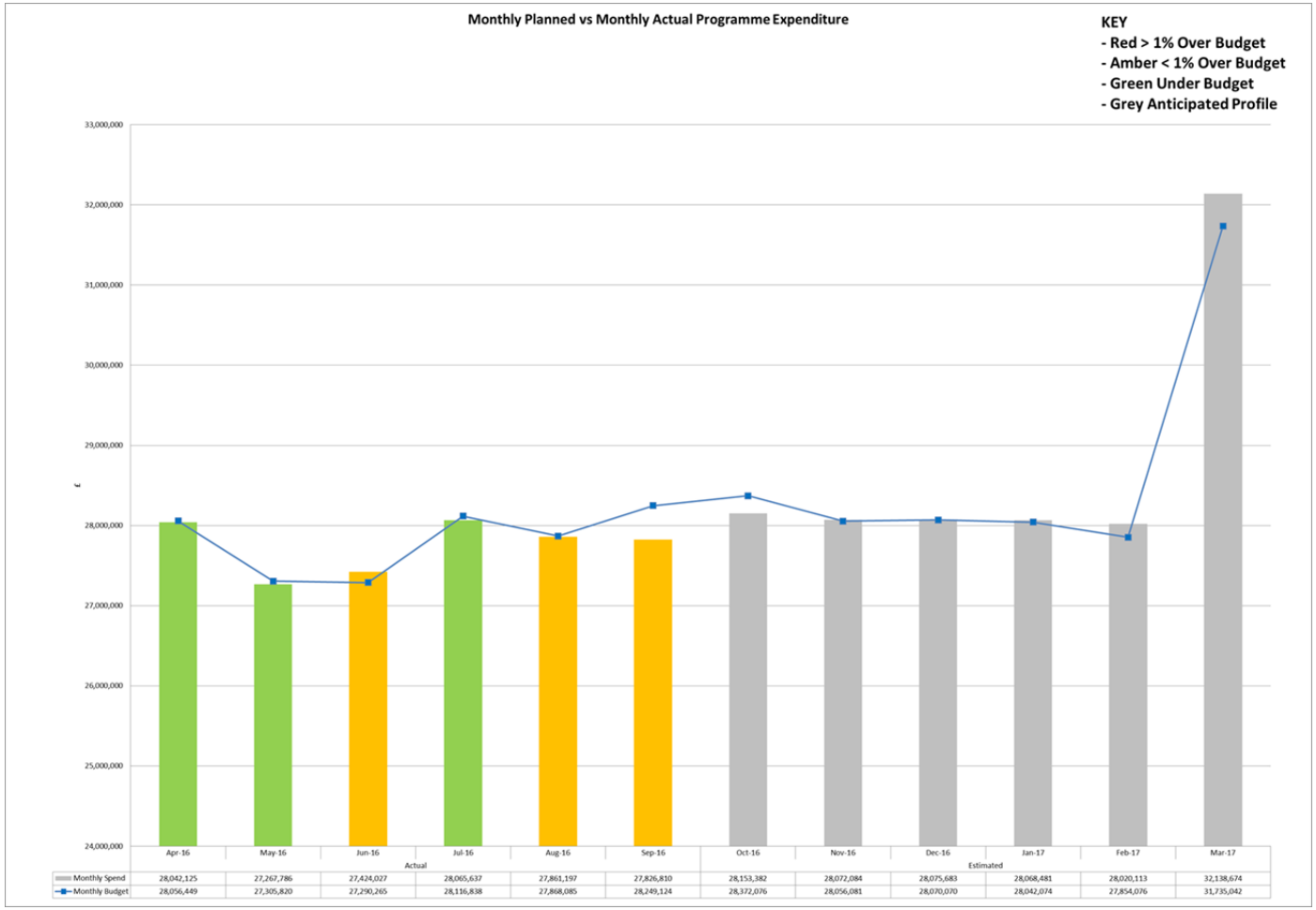
- The above table reflects the new FNC rates which have created a cost pressure of c £1.4m.

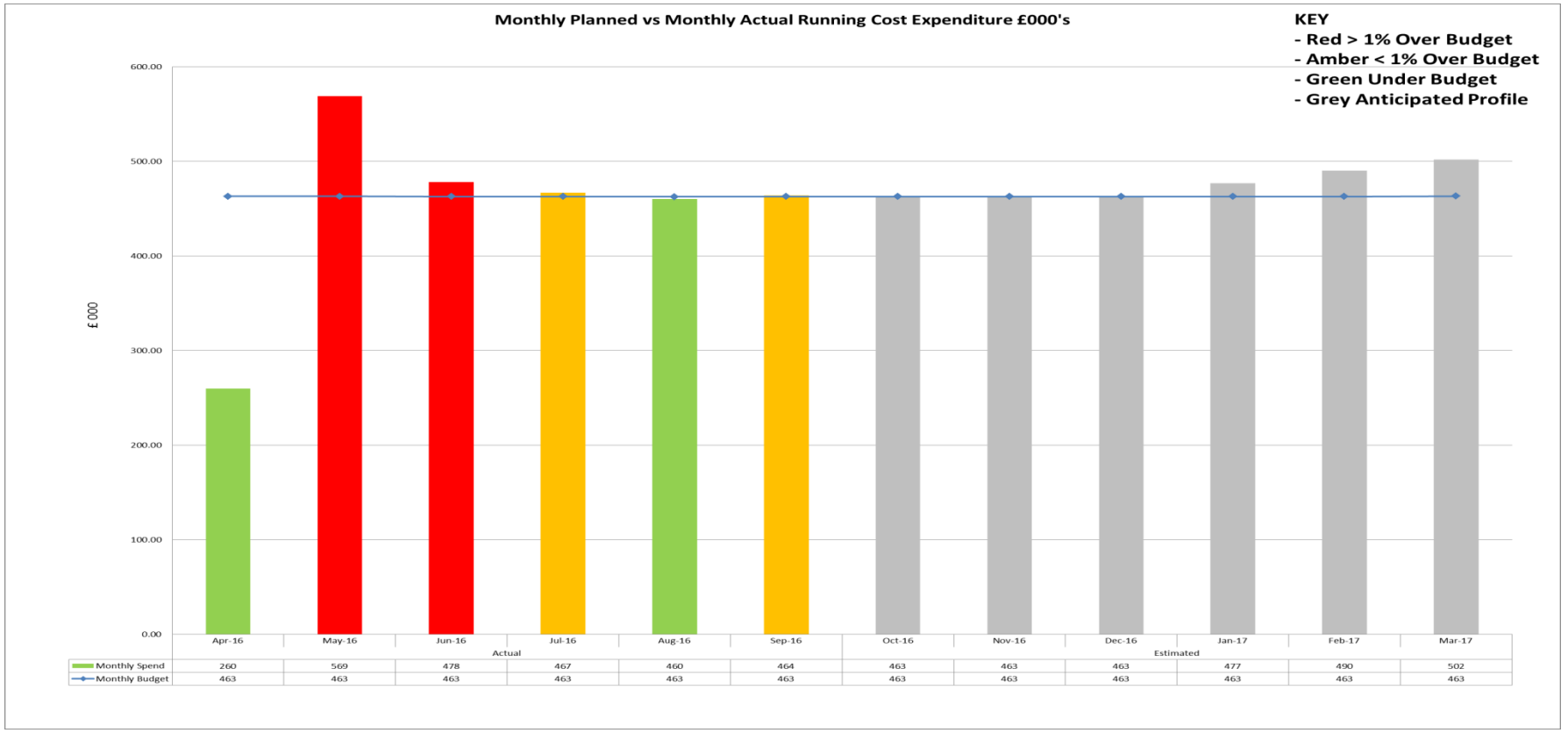
- Community Services under spend is due to the marginal threshold being invoked and assumptions regarding costs recovered for a ward closure in West Park and recruitment slippage in the Rapid Response Nursing Team.

- Prescribing is continuing to underspend and month 6 reflects an improving position with the forecast underspend being increased from M5.

- The variance on BCF is included within the Other Programme line and now reflects the revised forecast for WCC budgets within the BCF pool.

- The identification of schemes to reduce the unallocated QIPP are reflected in the Other Programme costs as well as improved FOTs for Reablement and Enhanced Services.




Monthly Planned vs Monthly Actual Running Cost Expenditure £000's
KEY
- Red > 1% Over Budget
- Amber < 1% Over Budget
- Green Under Budget
- Grey Anticipated Profile
£ 000
600.00
500.00
400.00
300.00
200.00
100.00
0.00
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 Spend 260 569 478 467 460 464 463 463 463 477 490 502
Monthly Budget 463 463 463 463 463 463 463 463 463 463 463 463

2. QIPP

The Committee noted the slight improvement in the QIPP Programme performance as at Month 6. The improvement in the forecast outturn is due to the identification of QIPP within Grants.

	YTD Plan £'m	YTD Actual £'m	YTD Var o(u) £m	An. Plan £'m	FOT £'m	Var o(u) £m
Transactional	1.13	1.50	0.37	2.21	3.34	1.13
Transformational	3.09	3.02	-0.07	6.93	6.56	-0.37
Unallocated	0.71	0.00	-0.71	2.12	0.00	-2.12
Total	**4.93**	**4.52**	**-0.41**	**11.26**	**9.90**	**-1.36**

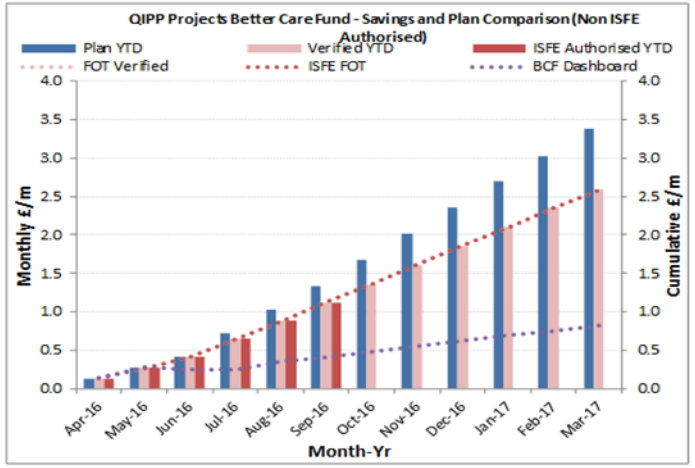
- Schemes have been identified for £9.90m (87.9%) and all but £107k is recurrent.
- QIPP Programme Board has identified the urgent need to replenish the Hopper and to move schemes that are currently in scoping or baselining to the implementation and delivery phases.
- Risk has been identified for 60% of the unallocated QIPP within the risk schedule.

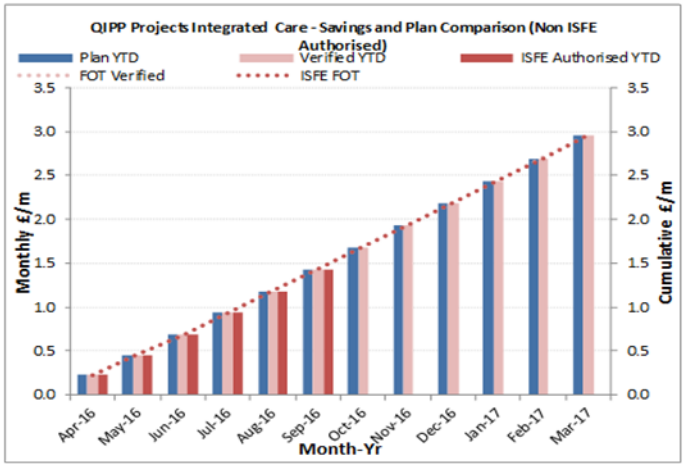
QIPP Programme Delivery Board - Validated Figures for Non ISFE

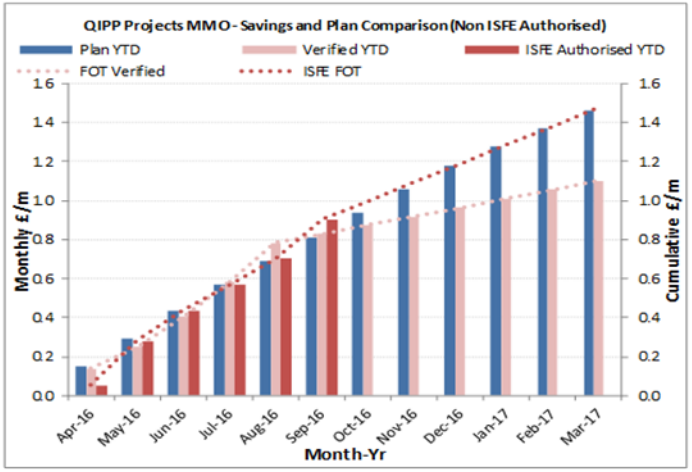
Reporting Period : Sep-16

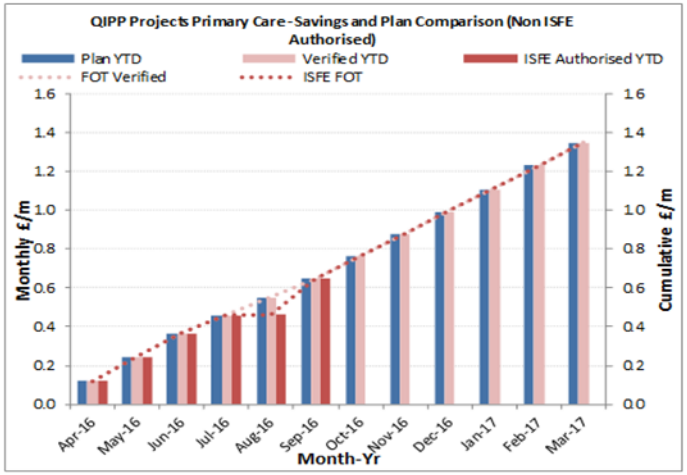
Financial Savings Projects within QIPP Programme Delivery Board and Annual Plan

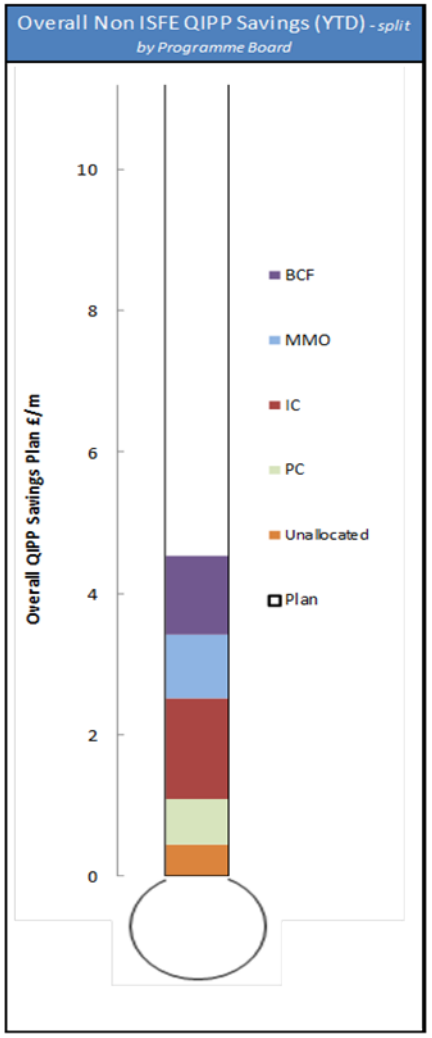
Source : Non ISFE Submission by Wolverhampton CCG - Financial Projects Only & BCF Dashboard











Note : Cumulative figures are based on a secondary axis

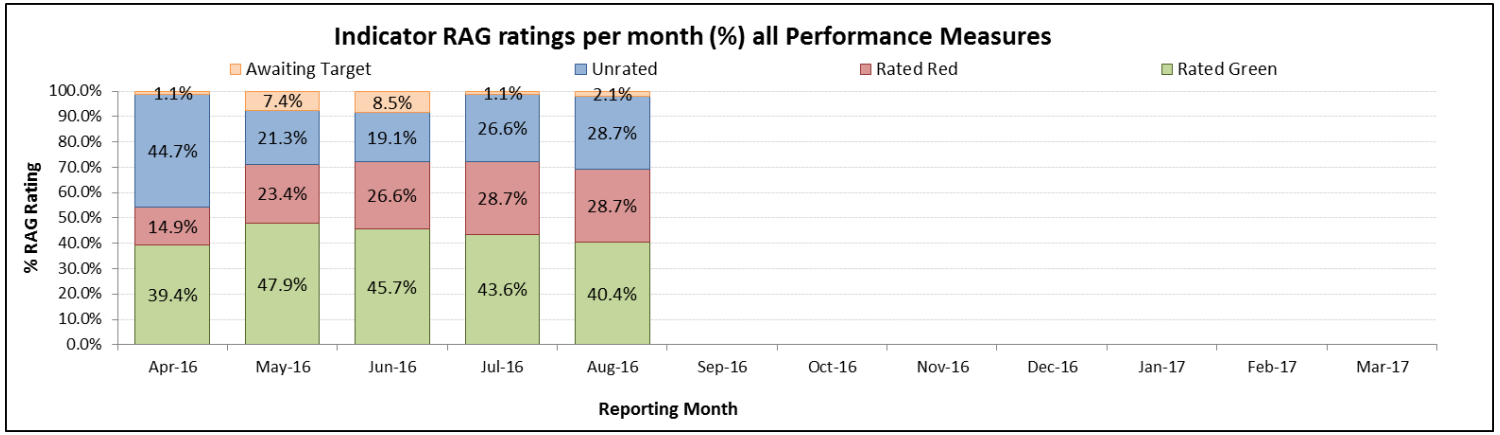
Note : Updates provided by Project Leads as verified figures on Project Highlight sheets may exclude data due to lags in data availability.

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)	Previous Mth	Awaiting Target	Total
NHS Constitution	13	11	11	11	0	2	0	0	**24**
Outcomes Framework	7	6	8	8	21	21	1	2	**37**
Mental Health	21	21	8	8	4	4	0	0	**33**
Totals	**41**	**38**	**27**	**27**	**25**	**27**	**1**	**2**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)	Previous Mth:	Awaiting Target
NHS Constitution	54%	46%	46%	46%	0%	8%	0%	0%
Outcomes Framework	19%	16%	22%	22%	57%	57%	3%	5%
Mental Health	64%	64%	24%	24%	12%	12%	0%	0%
Totals	**44%**	**40%**	**29%**	**29%**	**27%**	**29%**	**1%**	**2%**



Exception highlights were as follows;

RWT_EB3 - Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*

Monthly Performance *(Current month highlighted)*

	Apr	May	Jun	Jul	**Aug**	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
	91.50%	90.95%	91.04%	91.18%	-	-	-	-	-	-	-	-	91.17%
STF Trajectory:	92.03%	92.04%	92.04%	92.05%	92.05%	92.07%	92.15%	92.15%	92.15%	92.15%	92.15%	92.27%	

Section	Monthly Commentary
Situation	The performance data for headline level RTT (Incompletes) was not submitted by RWT on the SQPR at Month 5. At time of submission the Trust confirmed that this was due to "On-going validation" of waiting lists. The August performance has since been confirmed for the Royal Wolverhampton Trust via the National Unify 2 submission as 90.67% with 3,365 (out of 36,049) patients waiting more than 18 weeks. The Trust have confirmed that performance has seen a deterioration in August largely due to annual leave and bank holidays during the month which resulted in reduced capacity.
Action	Updated Recovery Action Plans (RAP) have been received from the Trust for General Surgery, Gynaecology, Orthopaedics, Plastic Surgery and Urology. Pro-active use of the Advice and Guidance functionality is being utilised by Wolverhampton GP's to seek advice on appropriateness of referrals and identify any alternatives, clinically developed templates/care plans have been embedded within GP clinical systems to ensure a consistent best practice approach. A Clinical Assessment Service (CAS) for specific specialties has been introduced to review each referral which can result in requests for further diagnostic tests prior to an outpatient appointment, decision to approve or discharge. These actions are being worked on as part of the CCG's development of a demand management plan to manage referral activity and provide best practice guidance. Significant efforts continue regarding pathway validation and diagnostic waiting times which have resulted in the decrease in Orthodontics long waiters to 53 patients waiting over 52 weeks which is ahead of the RWT internal recovery trajectory of 61.
Outcome/ Assurances	The CCG is coming under increased scrutiny from NHSE regarding over performing activity and CCG investigations into actual activity against plan have unearthed several coding issues which have been escalated to RWT via formal contract notices. This includes coding of diagnostic activity and consultant to consultant referrals. ***NHSE Updates:*** RTT performance continues to be a challenge nationally and is regularly discussed with NHS England as part of the performance and assurance process. Key Line of Enquiry updates requested from CCG (Aug16) to assess what systems and processes are in place related to specific areas (eg. alternatives to outpatient referrals, management of outpatient follow up appointments). Outsourcing Plan Update requested from the CCG (Sept16) split by specialty and actions. The CCG working with NHSE re the strategic demand management plan letter and developing a best practice case study which is to be shared across the region. ***Discussion Point :*** *Outsourcing of referral activity - alternative providers/alternative options?*

RWT_EBS4 - Zero tolerance RTT waits over 52 weeks for incomplete pathways*

Monthly Performance *(Current month highlighted)*

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
0.00	0.00	100.00	64.00	***53.00***	-	-	-	-	-	-	-	217.00

Section	Monthly Commentary
Situation	This indicator has breached the zero threshold for 52 week waiters for the third consecutive month with 53 patients recorded as waiting over 52 weeks at the end of August 2016. All breaches relate to Orthodontics. The Trust reported 100 waiters over 52 weeks in June which were identified following an in depth review of waiting list practices and have been working to reduce the numbers.
Action	Action plans have been developed and continue to be updated on a monthly basis for all specialties that are failing the individual targets.
Outcome/ Assurances	As Orthodontics is a specialised service commissioned by NHSE, sanctions cannot be enacted, however, the Trust have developed an action plan to review all affected patients. This indicator has breached the Year End target for 2016/17. **Additional Information :** *The National RTT data indicates that there was 1 x Non Admitted clock stop over 52 weeks at RWT in August for Rheumatology.*

RWT_EB5 - Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department*

Monthly Performance *(Current month highlighted)*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
	85.08%	88.03%	91.61%	88.63%	***90.32%***	-	-	-	-	-	-	-	88.73%
STF Trajectory:	90.47%	90.87%	91.78%	92.91%	93.81%	94.54%	95.01%	95.00%	95.01%	93.94%	93.92%	94.46%	

Section	Monthly Commentary
Situation	The A&E 4 Hour Wait performance has failed to meet the 95% national target since August 2015. The Month 5 performance has seen a small increase from previous months (90.32%) but has failed to achieve the STF recovery trajectory and both Type 1 and the combined All Types target for the month.
Action	An updated Remedial Action Plan (RAP) has been received for August 16 from the Trust with updates on actions including : 3 x Trust Fellows commenced the August rotation however, failed to recruit to an additional B7 Senior Sisters post (for 24/7 cover), new Junior Doctors Rota has been established to provide enhanced coverage is on target, 3 additional ACPs (to supplement Middle Grades) are now in post with a new rota implemented from September (incorporating twilight shift). The Trust have confirmed that combined reporting with Vocare/UCC and dual triage commenced 1st September 2016. Issues affecting performance included : Patient flow first assessment delays and "Other ED" delays which could all relate to operational issues within the A&E department and high numbers of attendances, increasing ambulance conveyances and recently bed capacity issues. Human Factors Training recommendations continue to be embedded across the Emergency Department (ED).
Outcome/ Assurances	The Trust carried out an unannounced visit to the Emergency Department out during a weekend in August and noted several issues which they are working on to resolve. The Trust are aware of issues regarding delays in first assessments and are working closely with Vocare to improve the patient flow in ED and this will be supplimented when the dual triage is fully embedded (from 1st September). The Trust are confident that as a result of joint reporting and dual triage, that performance will improve from September. Early indications are that the September SQPR reported performance has seen an improvement to 93.86%, however is still below the 95% target. ***NHSE Updates:*** A&E performance continues to be a challenge nationally and is regularly discussed with NHS England as part of the performance and assurance process. Requests for additional assurances and verification regarding year on year variances against plan for both Urgent and Elective Care have been requested which the CCG have responded with a breakdown of issues, actions and confirmation of Activity Data (SLAM).

RWT_EB8 - Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers*

Monthly Performance *(Current month highlighted)*

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
93.30%	97.00%	96.41%	95.36%	***95.63%***	-	-	-	-	-	-	-	95.54%

Section	Monthly Commentary
Situation	Performance for Month 5 has breached both in-month (95.63% against a target of 96%) and YTD (95.54%). Performance for this indicator had previously seen improvement since the April submission, but since Quarter 1 has seen a decline in performance with August reporting 9 patient breaches in month (8 of which where due to capacity issues within the specialties and 1 patient inititated delay). Analysis of the Year on Year performance shows performance is above that of 2015/16 for the same month (15/16 - 93.85%).
Action	Performance for this indicator had previously seen significant improvements since the April submission which failed to achieve standard due primarily to capacity issues. The capacity issues primarily relate to issues with Urology and the breaches here are related to the 62 day cancer wait performance. An updated Remedial Action Plan has been received for 62 Day waits which has confirmed the re-advertisement for 2 vacant middle grade posts in Urology had commenced which should have a positive impact all cancer wait indicators. Active recruitment is underway, also waiting list initiatives and Saturday clinics are being made available to recover performance.
Outcome/ Assurances	Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end, however the validated figures for August confirm that the Trust achieved 95.8% (relating to 9 breaches out of 214 patients seen) and therefore is rated as RED. The position for Quarter 1 has been confirmed as 96.4% and within target. Early indications are that the September performance has seen an improvement and has achieved target with 96.37% and is therefore GREEN.

RWT_EB9 - Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*

Monthly Performance *(Current month highlighted)*

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
97.37%	91.11%	75.76%	89.47%	***87.27%***	-	-	-	-	-	-	-	88.20%

Section	Monthly Commentary
Situation	The performance for Month 5 has seen a slight decrease in performance since the previous month and remains under the 94% target at 87.27% which relates to 7 patients breaching the standard, the Trust have confirmed breaches were due to capacity issues. The YTD performance (88.20%) has also breached target. Performance for the previous 4 months has been significantly below that achieved for the same months in 2015/16.
Action	This indicator is affected by small cohorts of patients with a total of 55 patients seen in August (7 of which breached target). There have been a number of vacancies across several specialties including Head and Neck, Gynaecology and Urology which are affecting capacity and workforce issues to deliver against targets. Lack of consultant cover in Head & Neck, Urology and Gynaecology is compounding the issue. An updated Remedial Action Plan has been received for 62 Day waits which has confirmed the re-advertisement for 2 vacant middle grade posts in Urology had commenced which should have a positive impact all cancer wait indicators. Active recruitment is underway, also waiting list initiatives and Saturday clinics are being made available to recover performance.
Outcome/ Assurances	Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end. The validated figures for Q1 have now been confirmed as April - 100% (GREEN), May - 91.8% (4 breaches RED), June - 77.8% (8 breaches RED), July 92.1% (3 breaches RED) and August 88.7% (7 breaches out of 62 patients and therefore RED). The total position for Quarter 1 has been confirmed as 90.4% and breaches target. Early indications are that the September performance has seen an improvement to 89.36%, however is still below target.

RWT_EB12 - Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer*

Monthly Performance *(Current month highlighted)*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
	79.88%	72.02%	81.36%	79.77%	***75.63%***	-	-	-	-	-	-	-	77.73%
STF Trajectory:	83.91%	84.02%	85.00%	85.20%	85.12%	85.16%	85.38%	85.00%	85.47%	85.00%	85.07%	85.15%	

Section	Monthly Commentary
Situation	The performance in Month 5 has seen a reduction in performance and breached the 85% target achieving 75.63% in month and 77.73% year to date. The Trust have confirmed that there were 30 patient breaches in August (21 x tertiary referrals, 4 x capacity issues, 1 x patient initiated and 4 x complex pathways). Performance has failed to meet the STF Trajectory of 85.12% for the month. Analysis by Cancer site confirms the breaches are relating to : Gynaecology (30.00%), Urology (63.83%), Head & Neck (66.67%), Upper GI (83.33%), Colorectal (80.00%) and Lung (86.67%).
Action	An updated Remedial Action Plan (RAP) has been received (August 16) with the following updated actions : The review of the Russell's Hall to New Cross pathway for Head & Neck patients has been completed with the aim to improve late tertiary referrals, an action plan has been agreed and the Trust are awaiting feedback from Russell's Hall. The appointment of a fourth Gynae Oncology Consultant has been completed (from September16). Re-advertisement for 2 vacant middle grade posts in Urology has commenced. Protocol updates for the Fast Track Team has been completed (to change practice to ensure that referrals are managed in line with national rules which are clear and that a referral can only be withdrawn by the GP not declined by the Trust, review of practice with regards to management of inappropriate referrals etc.) with implementation in August.
Outcome/ Assurances	Tertiary referrals remain a significant factor on the performance of this indicator with 66.7% of tertiary referrals received after day 42 of the pathway and of those, 28.6% were received after day 62 of the pathway. The validated performance figures have now been confirmed as : April - 80.95% (16 breaches RED), May - 71.75% (25 breaches RED), June - 83.16% (16 breaches RED), July - 82.2% (10.5 breaches RED) and August - 74.2% (21 breaches out of 81.5 patients RED). Early indications are that the September performance has seen an improvement (80.13%), however is still below target. **Discussion Points :** Performance for 62 Day Cancer waits by CCG has been highlighted in the National News ***(4th Oct - http://www.bbc.co.uk/news/health-37553078)*** reporting that findings show that two-thirds of areas are failing to achieve the target of ensuring 85% of cancer patients start treatment within 62 days of an urgent referral. National data ranking for both CCGs and Provider Trusts is available overleaf.

RWT_EB13 - Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers*

Monthly Performance *(Current month highlighted)*

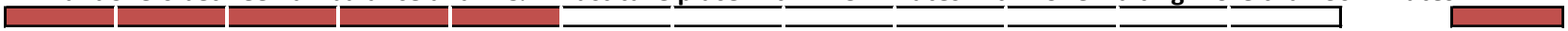
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD/Cum
80.77%	96.88%	82.35%	84.00%	***95.83%***	-	-	-	-	-	-	-	87.97%

Section	Monthly Commentary
Situation	Performance in Month 5 has seen a signifcant improvement from the previous month achieving the 90% target in month (95.83%), however is still below year to date (87.97%). The Trust have confirmed that there was a shared breach (0.5) which has affected the August performance.
Action	An updated Remedial Action Plan (RAP) has been received (August 16) with the following updated actions : The review of the Russell's Hall to New Cross pathway for Head & Neck patients has been completed with the aim to improve late tertiary referrals, an action plan has been agreed and the Trust are awaiting feedback from Russell's Hall. The appointment of a fourth Gynae Oncology Consultant has been completed (from September16). Re-advertisement for 2 vacant middle grade posts in Urology has commenced. Updates to Protocol (Fast Track Team) have been completed with implementation in August. Active recruitment is underway, also waiting list initiatives and Saturday clinics are being made available to recover performance.
Outcome/ Assurances	This indicator performance is affected by small number variations (August data refers to 12 patients overall). The validated performance figures have now been confirmed as : April - 80.8% (2.5 breaches RED), May - 96.9% (0.5 breaches GREEN), June - 82.4% (1.5 breaches RED), July - 92.3% (1 breach GREEN) and August 95.7% with 0.5 breaches (GREEN). Early indications are that the September performance has seen a decline to 76.92% and is therefore RED.

Hot Topics for Discussion were as follows;

Indicator Ref:	Title and Narrative
RWT_EAS5	**Minimise rates of Clostridium difficile***  Performance in Month 5 breached the monthly threshold of 2.9 with 8 cases of C.Diff. The YTD performance also exceeds the cumulative threshold of 15 with a total of 28 cases. The Trust have confirmed that there were 16 positive cases (by toxin test), 8 of which were attributable to RWT using the external definition of attribution. Focussed work is currently being undertaken with specific wards (C41, C18, C25, ICCU and CHU). Treatment delays and time to isolate are improving with HPV compliance remaining good. The Trust have confirmed that they remain above the regional average although the margin is considerably reduced in the last 2 quarters. **Discussion Point :** ***Has the anti-microbial prescribing post funding been approved?***

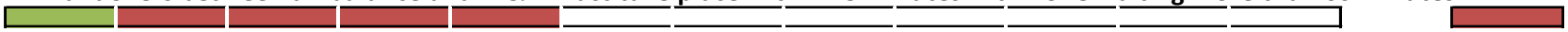
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes*



RWT_EBS7a

Performance in Month 5 saw a decrease in handover delays to 50 (the lowest number of breaches in month so far this year). Compared to the same month in 15/16, there has been a 100% increase in breach numbers (15/16 - 25 in month, 88 YTD and 16/17 - 50 in month, 303 YTD). The Trust have confirmed that the number of ambulance conveyances to New Cross have increased again, and at a rate above the national trend. Performance is being closely monitored by the CCG and performance is discussed at CQRM and CRM every month. Contractual sanctions are enforced based on the numbers of breaches each month, with fines for Month 5 estimated at £16,000 (based on 50 breaches 30-60mins £10,000 and 6 breaches 60mins £6,000). There were no patients breaching the 12 hour threshold during August.

All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes*



RWT_EBS7b

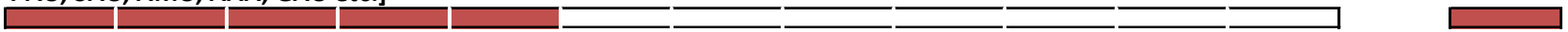
Performance in Month 5 saw an increase in handover delays to 6 breaches. Compared to the same month in 15/16, there where no reported breaches in the same reporting month (15/16 - 0 in month, 0 YTD and 16/17 - 6 in month, 19 YTD). The Trust have confirmed that the number of ambulance conveyances to New Cross have increased again and at a rate above the national trend. Performance is being closely monitored by the CCG and performance is discussed at CQRM and CRM every month. Contractual sanctions are enforced based on the numbers of breaches each month, with fines for Month 5 estimated at £16,000 (based on 50 breaches 30-60mins £10,000 and 6 breaches 60mins £6,000). There were no patients breaching the 12 hour threshold during August.

Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.

RWT_LQR1

Performance for this indicator saw a 2.21% decrease from the previous month. It is the lowest performance since May 2015 and has failed to achieve the 95% target and Recovery Trajectory for August. The YTD performance also remains below the 95% target (93.44%). New Junior Doctors at the Trust are completing e-discharge training and the Trust have developed a new report to enable them to monitor usage and performance. The Trust continue to target areas of poor compliance and issues around base ward performance are being highlighted with Divisional Medical Directors and flagged for follow up with relevant Operational Teams. The e-discharge training package will be prioritised for September 2016. The fine for not achieving this target in August is estimated to be £5,000 (£10,000 in total when combined with assessment unit breaches).

Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all assessment units [e.g. PAU, SAU, AMU, AAA, GAU etc.]



RWT_LQR2

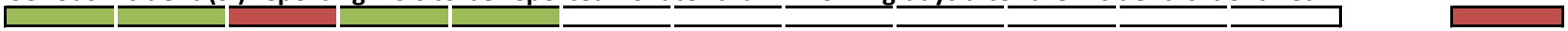
Performance for this indicator has seen a 2.02% decrease from the previous month (a decrease in performance for the 3rd consecutive month) and remains below the 95% target both in-month (80.92%) and YTD (84.06%). Performance is 2.72% higher compared to the same month in 15/16, however remains below the recovery trajectory which required 95% achievement by August 2016. The performance by assessment unit for August has been confirmed as follows:

AMU - 94.70% (Increase), MATY - 83.33% (decrease), GAU - 52.50% (significant decrease from 86.67% in July), PAU - 81.01% (decrease) and SEU - 67.70% (decrease). New Junior Doctors at the Trust are completing e-discharge training and the Trust have developed a new report to enable them to monitor usage and performance. The Trust continue to target areas of poor compliance and the PAU assessment unit have confirmed that there is a new process in place for ensuring patients are added to the PAS System in a timely fashion with additional admin support provided between 22:00 - 08:00 hours. The Remedial Action Plan (RAP) received in September 2016 indicated that functionality issues in GAU had been identified and changes implemented, however GAU have seen a significant drop in performance from the previous month. The CCG raised concerns regarding the draft discharge notifications that were previously agreed with the Trust. This has been discussed at CRM and CQRM and the CCG has discussed the issue internal and has confirmed to cease the draft discharge notification process.

The development of the e-discharge training package has now been confirmed as prioritised for September 2016 and will require 4-6 weeks development time once resource has been identified. The fine for not achieving this target in August is estimated to be £5,000 (£10,000 in total when combined with wards excluding assessment unit breaches).

Discussion Point : ***RAP update required to reflect continuing issues with GAU performance/review of functionality and usage.***

Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the incident is identified.



RWT_LQR4

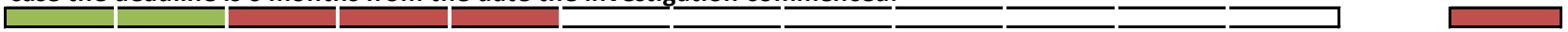
This indicator breached for the first time in June with 2 serious incidents failing to meet the 2 working days threshold. There were no breaches reported for August, however, this indicator has breached the Year End threshold of zero breaches.
The Quality team have confirmed the breaches as follows :
2016/16553 - Slip/Trip/Fall
2016/17008 - Slip/Trip/Fall A programme of work has been developed by the WCCG led Health Economy Pressure Ulcer Prevention Steering Group, this details the work streams, objectives and proposed solution to the issues identified. The Trusts Falls Policy is under review and is expected to be ratified in October 2016. This has been shared with members of the Falls Group for comment. Early indications are that there are no further breaches reported for September.

Serious incident (SI) reporting – 72 hour review to be undertaken and uploaded onto the STEIS system by the provider (offline submission may be required where online submission is not possible).

RWT_LQR5

This indicator breached for the first time in Q1 with 4 serious incidents failing to meet the 72 hour review threshold. There were no breaches reported for August, however, this indicator has breached the Year End threshold of zero breaches.
Breaches have been categorised as follows :
2016/12746 - Slip/Trip/Fall
2016/14543 - Pressure Ulcer Grade 3
2016/14657 - Pressure Ulcer Grade 3
2016/14938 - Pressure Ulcer Grade 3
A programme of work has been developed by the WCCG led Health Economy Pressure Ulcer Prevention Steering Group, this details the work streams, objectives and proposed solution to the issues identified. The Trusts Falls Policy is under review and is expected to be ratified in October 2016. This has been shared with members of the Falls Group for comment. Early indications are that September has also breached and we are awaiting further information regarding the incident.

Serious incident reporting - Share investigation report and action plan, all grades within timescales set out in NHS Serious Incident Framework. 60 working days of the incident being identified unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.



RWT_LQR6

This indicator breached for the first time in June with 6 serious incidents failing to meet the 60 working days review threshold and has breached every month since. The M5 SQPR submission reported 1 breach (2016/12378 - Treatment Delay), however the CCG Quality Team have identified and agreed 1 further breach during the month (2016/13501 - Diagnostic incident including delay in meeting SI criteria). This indicator has breached the Year End threshold of zero breaches.

Previous breaches have been categorised as follows :

1 x Slip/Trip/Fall (12746)

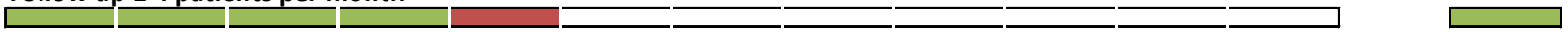
3 x Pressure Ulcer Grade 3 (14543/146557/14938)

1 x Confidential Information Leak (9407)

Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. Management of any serious incident is in line with the Serious Incident Framework (2015) which requires a Root Cause Analysis (RCA) and agreement of closure by the CCG once satisfied that the RCA investigation report and action plan meets required standards. A programme of work has been developed by the WCCG led Health Economy Pressure Ulcer Prevention Steering Group, this details the work streams, objectives and proposed solution to the issues identified. The Trusts Falls Policy is under review and is expected to be ratified in October 2016. This has been shared with members of the Falls Group for comment. Early indications are that there are no further breaches to report in September.

Additional Information : 1 breach has been reported for Vocare (Out of Hours GP Service) during August (2016/12796 - Treatment Delay)

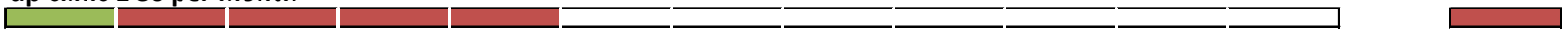
Optimising Outpatient Follow-Ups - 2015/16 - Prostate cancer patients receiving telephone follow up clinic: Prostate Biopsy Follow up ≥ 4 patients per month



RWT_LQR18ai

This indicator has failed to achieve target for the first time this year with only 3 patients receiving a prostate biopsy telephone follow up in August against a target of 4 per month, however is currently achieving YTD (42 with a target of 20 patients by Month 5). The CCG have queried peformance with the Trust due to the decline in performance, however we are still awaiting a response. The CCG are expected a detailed response regarding performance at the next CQRM, if not received a formal update request will be issued.

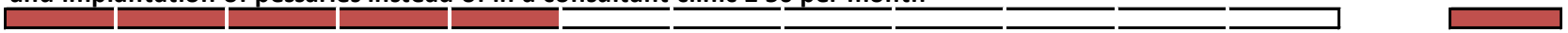
Optimising Outpatient Follow-Ups - Paediatric Rheumatology and Paediatric Endocrinology patients receiving telephone follow up clinic ≥ 30 per month



RWT_LQR18b

This was a new indicator for 2016/17 and has failed to achieve the 30 target for August with only 11 patients receiving telephone follow up (the lowest level so far this year). The target of 30 telephone follow ups was agreed following the Q3 2015/16 CQUIN (6b) Project Managers report on Planned Care (Optimising Outpatient Follow-Up). The service did not commence until January 2016 and therefore the indicator was carried over to 2016/17 to assess progress. Current performance has been raised with the Trust and the CCG are awaiting feedback from the operational teams.

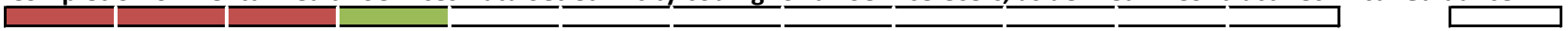
Optimising Outpatient Follow-Ups - Gynaecology Nurse Led Clinic – patients followed up in nurse led clinics for the management and implantation of pessaries instead of in a consultant clinic ≥ 50 per month



RWT_LQR18c

This was a new indicator for 2016/17 and has failed to achieve the 50 threshold for August with 2 patients receiving pessary implants. The year to date total is 17 against a target of 250 implants. The target of 50 nurse led follow ups was agreed following the Q3 2015/16 CQUIN (6b) Project Managers report on Planned Care (Optimising Outpatient Follow-Up) which predicted activity levels of 40 patients per month for Quarter 4 2015/16. The service did not commence until January 2016 and therefore the indicator was carried over to 2016/17 to assess progress. Current performance has been raised with the Trust and the CCG are awaiting feedback from the operational teams.

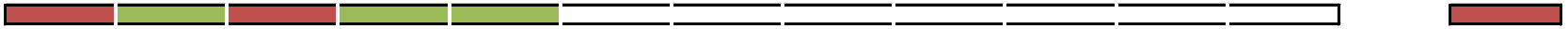
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance



BCPFT_MHSDS1

No data has been received for the August performance for this indicator. The SQPR submission comments indicated that data is subject to a one month data lag due to the HSCIC submission deadlines. Following discussion at CQRM, the Trust have confirmed that Ethnicity is part of the GP Referral template and have requested CCG support to reinforce the coding requirement for each referral from GPs.

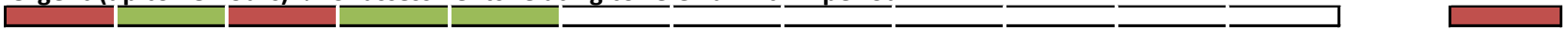
More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral



BCPFT_LQGE04

This indicator has achieved the 50% target for August with 62.50% of service users commencing a NICE-concordant package of care within 2 weeks of referrals (numerator = 5, denominator =8), however the Year End performance remains below target at 45.17%. An Action Plan has been received from the Trust which incorporates new National guidance regarding packages of care which have a delayed agreement. A CVO is in preparation for the indicator to reflect a change to patients age span (14-65). Exception reporting, risk mitigation and remedial actions are to continue to be discussed at CQRM and CRM to ensure that process and actions are in place to monitor and address the number of incomplete pathways. Small number variations and high levels of DNA continue to effect performance for this indicator. 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.

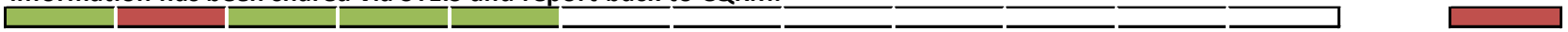
Urgent (up to 48 hours). % of assessments relating to referral within period



BCPFT_LQGE13

This indicator has achieved the 85% target in-month, however is close to target (85.00%) and the YTD remains below target at 83.05%. Performance has been raised and discussed at the CQRM and continues to be monitored.

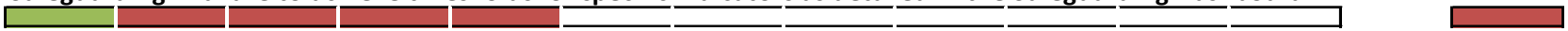
Update of STEIS at 3 working days of the report. The provider will keep the CCG informed by updating STEIS following completion of 48 hour report (within 72 hours of reporting incident on STEIS). CCG will do monthly data checks to ensure sufficient information has been shared via STEIS and report back to CQRM.



BCPFT_LQGE16

This indicator achieved the 100% target for August, however due to the breaches reported in May (85.71%) performance for this indicator has breached year end (96.43%) and will remain RED.

Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Safeguarding Dashboard.



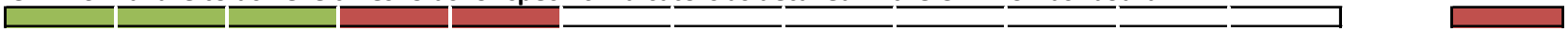
It has been confirmed with the CQRM board that this indicator relates to if all indicators on the dashboard are green, if any breach this should be reported as NO with an exception report and comments regarding actions and assurances provided. Following this confirmation, data for May and June has since been amended to "No".

August breaches reported on the Safeguarding Dashboard include:

LQSG03 - Level 3 for Safeguarding Children (in month - 80.5%, YTD - 81.53% against 85% target)

BCPFT_DB01 All Safeguarding breaches have been raised at the September CQRM and the Trust have confirmed that breaches occurred due to staff non attendance and the Trust have confirmed they are addressing the non-attendance issues with individual staff and are monitoring DNA reasons to establish trends (eg staff unable to attend face to face training due to staff capacity issues). Levels 1 and 2 are currently face to face training, however an e-learning tood is due to be available from October. Level 3 training however, requires face to face attendance and additional sessions have been identified with a plan through to March 2017. A Remedial Action Plan (V1.1) includes recovery trajectories as follows : 45% achievment by Aug16, 65% by Oct16 and 85% by Dec16.

CAMHS - failure to achieve thresholds for specific indicators as detailed in the CAMHS Dashboard.



This indicator relates to if all indicators on the dashboard are green, if any breach this should be reported as NO with an exception report and comments regarding actions and assurances provided.

August breaches reported on the CAMHS Dashboard are:

LCA01 - % of children referred who have initial assessments within 18 weeks (in month - 65.8%, YTD - 73.03% against a Q2 target of 75%). The

BCPFT_DB02 Trust have confirmed that there were 13 breaches during August, primarily as a result of a high number of patient cancellations and non attendance during August which is not unusual during the summer holiday period. 4 patients who breached had previously DNA'd or cancelled appointments which if they had attended would have increased the performance to 76.3% and above target. The Trust have a Remedial Action Plan in place and is successfully reducing waiting times (current waiting times is 5 weeks).

4. 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.

5. FINANCIAL CONTROL ENVIRONMENT ASSESSMENT (FCEA)

The Committee received the latest CCG self assessment undertaken in September 16 which was submitted to NHSE. The CCG is awaiting comments from NHSE on progress made.

6. PLANNING ROUND 17/18 – 18/19

The Committee received a position statement in relation to the overall financial planning assumptions, QIPP and compliance with the business as outlined in the Operating Plan guidance. A report will be brought to the December Governing Body meeting outlining the CCG's 5 year finance plan which is aligned to the Operating Plan.

7. RISK and MITIGATION

Risks	Potential Risk Value Mth04	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %
CCGs					
Acute SLAs	1.13	1.50	75.00%	1.13	44.24%
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	0.63	0.79	60.00%	0.47	18.55%
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	0.80	1.18	80.00%	0.95	37.22%
TOTAL RISKS	2.56	3.47		2.54	100.00%

- Risk associated with Acute over performance and BCF is the CCG's biggest risk being £1.5m gross but probability rated to £1.13m.
- 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 reduction in risk is associated with the identification of £764k against the unallocated QIPP plan.
- Other risks are in the main associated with NHS Property Services moving to charging market rents

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

Mitigations	Expected Mitigation Value Mth04	Full Mitigation Value £m	Probability of success of mitigating action %	Expected Mitigation Value £m	Proportion of Total %
Uncommitted Funds (Excl 1% 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	1.38	1.25	100.00%	1.25	49.21%
Delay/ Reduce Investment Plans	0.40	0.40	100.00%	0.40	15.75%
Other Mitigations	0.47	0.50	100.00%	0.50	19.69%
Mitigations relying on potential funding	0.31	0.39		0.39	15.35%
Actions to Implement Sub-Total	2.56	2.54		2.54	100.00%
TOTAL MITIGATION	2.56	2.54		2.54	100.00%

- Non Recurrent measures relate to the diversion of 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 M5 the CCG has already committed its Contingency reserve of £1.78m therefore this cannot be considered as mitigation.

Other Risk

Breaches in performance and increases in activity will result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and national agreed targets

and are being managed to operate within the CCG's financial constraints. Activity and Finance performance is discussed monthly through the Finance and Performance Committee Meetings to provide members with updates and assurance of delivery against plans.

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

8. RECOMMENDATIONS

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

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **19th October 2016**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
8 NOVEMBER 2016

Agenda item 14

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 4 October 2016**
Report of:	Pat Roberts, Primary Care Joint Commissioning Committee Chair
Contact:	Pat Roberts, Primary Care Joint Commissioning Committee Chair Jane Worton, Primary Care Liaison Manager
(add board/ committee) Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide the Governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee on 4 October 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 4 October 2016. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

The Committee received the following update reports:-

2.1 **NHS England**
The Committee were updated on the NHS England GP Resilience Programme which has replaced the Vulnerable Practice Programme and is part of the 83 national projects which are being captured in the GP 5 Year Forward View. Local teams have been asked to confirm practice selections by 18 October 2016 and it was noted that this included practices that have self-referred as well as ones identified by CCGs.

2.2 **Wolverhampton CCG**
An update was provided on the new models of care and it was noted that there are currently 5 groups with 90% of practices aligned to Primary Care Home / Vertical Integration models. Discussion took place around the Vertical Integration evaluation process which is in the early stages and the key performance indicators which are being developed.

2.3 **Primary Care Programme Board**
The Committee were informed that the interpreting procurement review of bidders is currently in progress with a new contract commencing in December 2016.

2.4 **Primary Care Operations Management Group (PCOMG)**
An overview of the key areas covered at the PCOMG Meeting was provided. Discussion took place around the level of patient engagement which is required when a practice is merging / closing.

3. OTHER ISSUES CONSIDERED

3.1 Workforce Strategy Update
The Committee were provided with an update on the primary care workforce analysis and the draft Strategy which is currently being consulted on with members of the Workforce Task and Finish Group. Discussion also took place around the inclusion of the Wolverhampton vertical integration practices and how their data should be represented.

3.2 Social Prescribing
A proposal of Social Prescribing to be delivered as a 12 month pilot was presented to the Committee which would be delivered during the pilot by Wolverhampton Voluntary Sector Council.

3.3 The Committee met in private session to discuss the service level agreement and specification for the Zero Tolerance Scheme and future proposals.

4. CLINICAL VIEW

4.1. Not applicable.

5. PATIENT AND PUBLIC VIEW

5.1. Not applicable.

6. RISKS AND IMPLICATIONS

6.1. None arising from this update.

7. RECOMMENDATIONS

That the Governing Body Note the Report

Name Pat Roberts
Job Title Lay Member for Public and Patient Involvement, Committee Chair
Date: 18 October 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**	**18/10/16**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body – November 2016

Agenda item 15

Title of Report:	**Report of the Primary Care Strategy Committee**
Report of:	Steven Marshall
Contact:	Sarah Southall
Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	Provide assurance on progress made towards implementation of the CCGs Primary Care Strategy:- • Program of Work Delivery & Governance Arrangements • New Models of Care Reports from the committee are provided at monthly intervals to ensure the Governing Body are kept appraised the extent of implementation of the CCGs Primary Care Strategy.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	
Relevance to Board Assurance Framework (BAF):	Better Care – Primary Medical Care including access to services

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCGs Primary Care Strategy was ratified by the Governing Body in January 2016 in recognition of the changing demands in primary care. The CCGs vision seeks to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities.

2. PRIMARY CARE STRATEGY COMMITTEE

2.1. In September 2016 the Primary Care Strategy Committee met to review progress in respect of three key areas of delivery:-

- Program of Work Delivery
- Governance Arrangements
- New Models of Care

2.2. The Program Management Office supports all seven task and finish groups attached to this program of work. The Primary Care Strategy Committee received highlight reports from the following groups in September 2016, summarised in the table below:-

Task & Finish Group	Highlights
Practices as Providers	• Group met in September 2016 • Gap analysis received from the Project Manager supporting Primary Care Home. • Preparations were underway for a forthcoming visit from the National Association of Primary Care to Primary Care Home. • The visit from the National Association of Primary Care was well attended by a range of stakeholders within primary care as well as the CCG and Public Health. • Peer Review continues to be undertaken at quarterly intervals. The latest outcomes have been reviewed & shared with locality meetings & have influenced the commissioning intentions process.
Localities as Commissioners	• Practices have expressed an interest in which groups they wish to align with e.g. Primary Care Home or Royal Wolverhampton Trust. • The members meeting in October was largely dedicated to the new contracting & commissioning landscape due to be implemented April 2017. • Existing locality structures are subsequently under review as a result of the formation of practice groups given that they are not necessarily aligned with the

	existing locality structure
Workforce Development	• Primary Care Workforce Strategy had been prepared & consultation was underway. • Particular attention is being given to the vision for the workforce at group level as practices begin to work together and respond to commissioning at scale. • Preparations for a Primary Care Recruitment Fair are underway. The event is expected to take place in February/March 2017 in partnership with stakeholders from the Local Medical Council, University, Health Education West Midlands and the Deanery, with a focus on recruitment and retention to roles in the primary care setting. • Focus on training opportunities, stronger allegiance with Health Education West Midlands & NHS England to develop our primary care workforce.
Clinical Pharmacists in Primary Care	• Professional indemnity attached to this role continues to be discussed at national level. • National funding has been delayed. Further updates on the area of work will be provided in December. • A needs analysis & options for introducing this role are currently being explored.
General Practice Contract Management	• Preparation for full delegation is now underway. The application is due to be submitted to NHS England early December. • The CCG continues to ensure that all reasonable preparatory work is underway to enable a smooth transition. • Discussions are due to commence with NHS England regarding contracting support provided by the Primary Care Hub. • MCP Contracts had been delayed and unlikely to be available until January 2017. • The program of work for this work stream is currently on track
Estates Development	• Outcome of Estates Transformation Fund bids was still awaited • The program of work for this work stream is currently on track
IM&T	• Discussions with the CCGs Mental Health provider have commenced to enable information to be included in the shared care record. • Rollout plan for patient/public wifi has commenced. • A review of the DXS Service was concluded. The outcome of the review was is planned to be shared with the Primary Care Program Board.

2.3. The Programme Management Structure has been established. The committee receive highlight reports from each task and finish group following their meetings covering: summary of discussions that have taken place activity that was planned and not achieved; key actions for the group in the coming weeks/month; any risks to escalate for discussion at the committee. There were no significant risks escalated although there are risks attached to some of the work streams. Further profiling continues to take place to ensure risks are duly mitigated and recorded accordingly.

2.4. Whilst this program of work is in its infancy there are a series of items that have been achieved many of which were reported to Governing Body in October. The committee are satisfied with the extent of mobilisation that has occurred to date and has no concerns to share with the Governing Body at this stage.

3.0 NEW MODELS OF CARE

3.1 In order to sustain primary medical services in Wolverhampton and in line with the General Practice Five Year Forward View the shape of collaboration among practices in Wolverhampton has concluded with practices aligning themselves with their preferred practice grouping with a view to signing memorandum(s) of understanding by the end of October 2016.

3.2 The Primary Care Home model has been championed at national level by the National Association of Primary Care and NHS Confederation and is based on care provided with a hub/neighbourhood approach. There are currently two formal Primary Care Home Hubs, (a third hub is being explored). Each constitute in the region 30 – 50,000 patients and are intended to function with an integrated workforce, with a strong focus on partnerships spanning primary/secondary/social care. To achieve this, they will be required to work closely with Community Neighbourhood Teams. A combined focus on the personalisation of care and improvements in population health are outcomes each hub will be committed to. Each hub is embracing the opportunity to respond to NHS England's ten high impact actions exploring the health needs of their registered population. The priorities are predominantly to improve access in the primary care setting, provide greater continuity of care through working in partnership with community services (that will enable patient centred co-ordinated care among professionals and intended to demonstrate improved clinical effectiveness and quality of care).

3.3 The Medical Chamber, the largest group, comprises of in excess of 100,000 patients and similarly seeks to achieve signed memorandum(s) of understanding among interested practices, who will similarly receive sufficient support from the CCG to mobilise working at scale. This group will adopt a similar approach - their focus and priorities are the same, the only difference being that this grouping prefers to function currently as a federated model, while retaining existing contractual arrangements. Further alternatives might include the formation of a body recognised in law in which the clinicians become Directors (organisational form to be detemined), but with a social enterprise commitment.

3.4 The Ten High Impact Actions our groups are being supported to tackle are categorised as follows:-

1. Active Signposing
2. New Consultation Types
3. Reduce Did Not Attend (DNAs)
4. Develop the Team
5. Productive Work Flows
6. Personal Productivity
7. Partnership Working
8. Social Prescribing
9. Support Self Care
10. Develop Quality Improvement Expertise

The CCGs response to the General Practice Five Year Forward View is also actively monitored via the Primary Care Strategy Committee. NHS England have commenced the rollout of a series of projects (83 in total). These include support for vulnerable practices; practice resilience; funding to support training for reception & administrative staff; training programmes to improve productivity within practices. A detailed tracker will be introduced to the committee in November capturing the status of each project. This will also capture the benefits realisation and impact each project is having for practices/groups.

3.5 The vertical integration/primary and acute care system model (PACs) is a collaboration between the Royal Wolverhampton Trust and a cohort of general practices (see Appendix 1) again focussing on the needs of the registered population. This is an opportunity for trusts to reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. There are currently three practices involved in this model, a further two practices have confirmed their intention to sub-contract their General Medical Services Contract to Royal Wolverhampton Trust. The CCG are currently supporting this model and in the final stages of agreeing the measurement and governance arrangements that will enable the CCG and trust to measure the effectiveness and impact of the model.
Both MCP and VI models will be judged on their performance and outcomes using the same criteria

4 CLINICAL VIEW

There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven.

5 PATIENT AND PUBLIC VIEW

Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.

6 RISKS AND IMPLICATIONS

Key Risks

6.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

6.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications

6.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

6.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

6.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

6.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

7 **RECOMMENDATIONS**

The recommendations made to governing body regarding the content of this report are as follows:-

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

Name Sarah Southall
Job Title Head of Primary Care
Date October 2016

Enclosures:-

Appendix 1 New Models of Care Graphic

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	Manjeet Garcha	27.10.16
Public/ Patient View	Pat Roberts	27.10.16
Finance Implications discussed with Finance Team	Claire Skidmore	27.10.16
Quality Implications discussed with Quality and Risk Team	Manjeet Garcha	27.10.16
Medicines Management Implications discussed with Medicines Management team	David Birch	27.10.16
Equality Implications discussed with CSU Equality and Inclusion Service	Juliet Herbert	27.10.16
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	Steven Marshall	27.10.16
Signed off by Report Owner (Must be completed)	Steven Marshall	27.10.16

V6.1 20.10.16

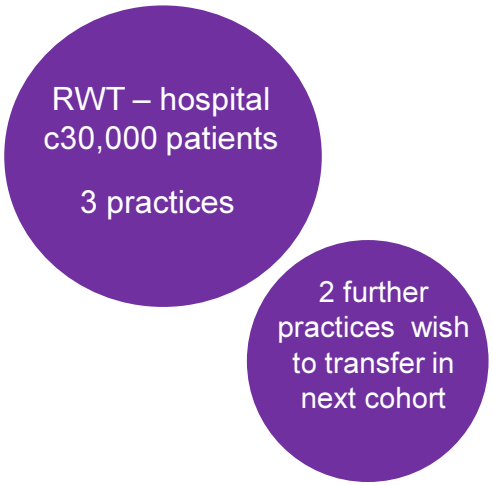
New Models of Care (Wolverhampton)

NHS
Wolverhampton
Clinical Commissioning Group

Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

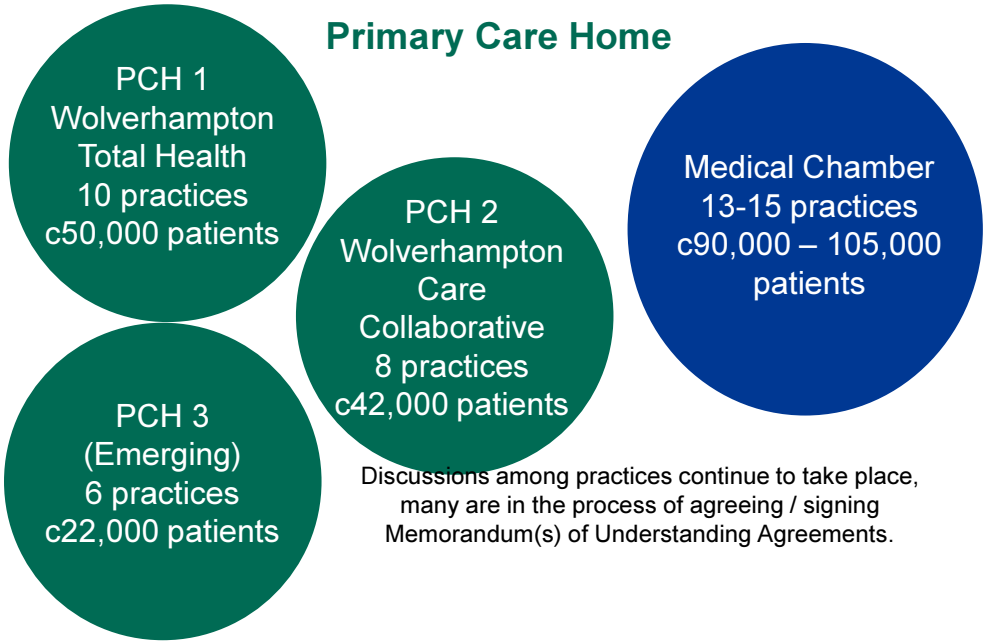
Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. Part of Vertical Integration is a greater level of back office support which will care of the business element of General Practice.

Vertical Integration (VI)



Primary Care Home is a joint NAPC and NHS confederation programme. Primary Care Home Model is based on care hubs/neighbourhood approach. Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people, function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care, a combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Primary Care Home



Discussions among practices continue to take place, many are in the process of agreeing / signing Memorandum(s) of Understanding Agreements.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
8 NOVEMBER 2016

Agenda item 14

Title of Report:	**Summary – Primary Care Joint Commissioning Committee 4 October 2016**
Report of:	Pat Roberts, Primary Care Joint Commissioning Committee Chair
Contact:	Pat Roberts, Primary Care Joint Commissioning Committee Chair Jane Worton, Primary Care Liaison Manager
(add board/ committee) Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide the Governing Body with an update from the meeting of the Primary Care Joint Commissioning Committee on 4 October 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 4 October 2016. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

The Committee received the following update reports:-

2.1 **NHS England**
The Committee were updated on the NHS England GP Resilience Programme which has replaced the Vulnerable Practice Programme and is part of the 83 national projects which are being captured in the GP 5 Year Forward View. Local teams have been asked to confirm practice selections by 18 October 2016 and it was noted that this included practices that have self-referred as well as ones identified by CCGs.

2.2 **Wolverhampton CCG**
An update was provided on the new models of care and it was noted that there are currently 5 groups with 90% of practices aligned to Primary Care Home / Vertical Integration models. Discussion took place around the Vertical Integration evaluation process which is in the early stages and the key performance indicators which are being developed.

2.3 **Primary Care Programme Board**
The Committee were informed that the interpreting procurement review of bidders is currently in progress with a new contract commencing in December 2016.

2.4 **Primary Care Operations Management Group (PCOMG)**
An overview of the key areas covered at the PCOMG Meeting was provided. Discussion took place around the level of patient engagement which is required when a practice is merging / closing.

3. OTHER ISSUES CONSIDERED

3.1 Workforce Strategy Update
The Committee were provided with an update on the primary care workforce analysis and the draft Strategy which is currently being consulted on with members of the Workforce Task and Finish Group. Discussion also took place around the inclusion of the Wolverhampton vertical integration practices and how their data should be represented.

3.2 Social Prescribing
A proposal of Social Prescribing to be delivered as a 12 month pilot was presented to the Committee which would be delivered during the pilot by Wolverhampton Voluntary Sector Council.

3.3 The Committee met in private session to discuss the service level agreement and specification for the Zero Tolerance Scheme and future proposals.

4. CLINICAL VIEW

4.1. Not applicable.

5. PATIENT AND PUBLIC VIEW

5.1. Not applicable.

6. RISKS AND IMPLICATIONS

6.1. None arising from this update.

7. RECOMMENDATIONS

That the Governing Body Note the Report

Name Pat Roberts
Job Title Lay Member for Public and Patient Involvement, Committee Chair
Date: 18 October 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**	**18/10/16**

NHS
Wolverhampton
Clinical Commissioning Group

MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 13TH SEPTEMBER 2016, COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON SCIENCE PARK.

PRESENT:	Manjeet Garcha	-	Executive Director of Nursing & Quality
	Nicola Ensor	-	Interim Head of Quality & Risk
	Jim Oatridge	-	Lay Member, WCCG
	Kerry Walters	-	Governance Lead Nurse, Public Health
	Marlene Lambeth	-	Patient Representative
	Pat Roberts	-	Lay Member Patient & Public Involvement
	Philip Strickland	-	Administrative Officer
APOLOGIES:	Dr R Rajcholan	-	WCCG Board Member (Chair)

1. APOLOGIES & INTRODUCTIONS

Introductions were made and the above apologies were noted by members. MG wished it be noted that a replacement for Tony Fox was currently being looked into following his resignation from the Committee.

2. MINUTES & ACTIONS OF THE LAST MEETING

2.1 Minutes of the 9th August 2016

The minutes of the meeting held on the 9th August 2016 were approved as an accurate record.

2.2 Action Log from meeting held on the 9th August 2016

The Action Log from the Quality & Safety Committee held on the 9th August 2016 was discussed, agreed and an updated version would be distributed with the minutes of this meeting.

3. DECLARATIONS OF INTEREST

No declarations of interest were raised.

4. MATTERS ARISING

No matters were raised by members.

5. FEEDBACK FROM ASSOCIATED FORUMS

5.1 Draft CCG Governing Body Minutes

The minutes of the 12th July 2016 were noted by members

5.2 Health and Wellbeing Board Minutes

The minutes of the 20th July 2016 were noted by members.

5.3 Quality Surveillance Group Minutes

Minutes of the 1st June 2016 were noted by members. MG confirmed that at present the CCG is not under surveillance and therefore is not currently presenting any reports at this group. MG confirmed she would be in attendance at the next QSG.

5.4 Primary Care Operational Management Group

The minutes of the 23rd July 2016 were noted by committee members.

5.5 Clinical Commissioning Committee Minutes

The minutes of the 28th July 2016 were noted by the committee.

5.6 Pressure Ulcer Steering Group

The minutes of the 19th July 2016 were noted by members.

5.7 Area Prescribing Minutes

NE raised a suggestion regarding trails of patients with asthma and the trail of using Vitamin D following national guidance. MG enquired if there were any research money to study this? DB stated that he would look into this and consider it going forward.

The minutes were noted by committee members.

6. ASSURANCE REPORTS

.

6.1 Monthly Quality Report

NE reported that Treatment delays are still currently being reviewed with Royal Wolverhampton Trust (RWT) and they have appointed a national ED expert to undertake a review of all SI's from 2016/16. A report in relation to this is due to be published around November 2016.

NE reported a reduction in Grade 4 pressure injuries, there were 15 grade 3's reported of which 10 were deemed avoidable and 5 were unavoidable. MG believed it would be useful to identify how many of the 10 avoidable were made from the Community or the Acute Trust. NE confirmed that as part of the Pressure Ulcer Scrutiny Group the template that is used has now taken into account the need to identify what avoidable pressure ulcers were indeed hospital acquired. JO stated that the statistics and databases don't help to solve the gaps in care that cause these pressure injuries. JO added that if the gaps in care are the

result of staffing issues then the cause is then down to management. MG agreed that the issue could indeed be staffing in terms of number or in terms of staff conducting correct practice. MG stated that towards the start of the year RWT were beginning to report an increased number of Grade 4 Pressure injuries however it was added as the year has progressed the numbers had begun to fall.

MG highlighted a rise in falls through August at RWT and enquired if there had been a particular trend that had led to this rise? NE stated that the full information on those specific falls had not fully been fed through but from the basic information that had been received all necessary precautions including suitable footwear had been worn.

ML enquired that issues in relation to Slips and falls and confidentiality breaches for this reporting period both have involvement from Ward C15 and questioned whether that could have some kind of link in terms of the management of the ward. MG stated that this was the reason that all the data that is submitted was triangulated to identify and specific trends. MG explained that these trends are then discussed through the ward dashboard at the Clinical Quality Review meeting at RWT. Staffing was identified as one of the main contributing factors to the occurrence of issues on specific wards. It was highlighted that recruitment of nurses continues to be a national issue.

With regard to Overdue SI's PR raised a concern regarding the length of time it appeared to be taking to get outstanding Si's closed off due to the unavailability of senior members of the team. MG confirmed that a response in relation to the overdue SI's would be picked up at the next CQRM.

NE reported that there was current dialogue between RWT and Dudley CCG in relation to some issues with tertiary referrals contributing to breaches of the 62 day target.

MG reported that following the A&E performance call on Friday 9th September 2016 there had been 95 beds in the system that were free however by the end of the weekend the performance had been very poor. MG confirmed that the figures produced around 15 varying reasons as to why the performance had breached. The main reason had been identified as patients requiring 1st assessment. MG confirmed that a quality visit to ED and the Urgent Care Centre was arranged for the 26th September 2016. NE believed that the visit would help to identify some of the triaging issues.

NE report that there had been an increase in numbers seen through maternity and NE had enquired whether this would have impacted on the quality of the service. The initial feedback suggested that the maternity department were handling the additional numbers really well. MG confirmed that the additional numbers are being monitored across the health economy. MG stated that the ratio at RWT for births per midwife was currently at 1:30 against a national average of 1:28 and this would be monitored.

NE stated that the numbers of complaints at RWT had begun to fall however it was noted that a large number of complaints is not always negative as this can show a positive engagement with patients. NE stated that the important part was to identify the key themes from the complaints and implement learning. PR confirmed that since the implementation of the complaints policy, good strong communications have been distributed explaining the best ways to make a complaint. PR also added that Alison Dowling the new Patient Experience manager at RWT is attempting to improve the general culture around dealing with complaints.

PR stated that it would be beneficial for the Friends and Family Data to include additional information and themes, as data alone does not always provide the whole picture. NE confirmed that this extra information has been requested and information should start to appear in the coming months.

NE confirmed that CQUIN submissions had been made for quarter 1 and all evidence had been checked and the majority of targets for quarter 1 had been met. The CQUIN yet to be finalised was around Paediatric asthma.

With regard to the Black Country Partnership, NE raised that there had been 2 serious incidents for the reporting period. It was noted that both deaths were unexpected deaths and full RCAs were in progress. JO highlighted that the 2 deaths were not obviously displayed on the Serious Incidents chart on page 68 of the meeting pack. Indeed JO added that the Serious Incidents marked down as 'Pending Review' did not then get reallocated following review.

ACTION: ***JO & PR requested that the Serious Incidents recorded as 'Pending Review' needed to be allocated a specific category following review. So that the SI's can be tracked and closed off.***

It was noted that the BCPFT were behind in terms of delivery of their PREVENT training.

From page 72 and 73 of the meeting pack JO raised an issue with regard to the two safeguarding referrals noted under the Safeguarding Adults section of the report. One was pertaining to physical abuse and the second was related to organisational abuse. JO wished to understand more clearly the process for investigation and resolution in these instances. MG clarified that adult referrals are dealt with via the local safeguarding adult authority which is then investigated immediately with Police involvement if required and a team is dispatched to the location of the stated concern to undertake a risk assessment to see if the patient is safe to remain. It was noted that the majority of referrals do come from a care home environment. All the identified shortfalls would then be placed into an action plan that is then monitored at a weekly meeting along with regular follow up visits. MG continued that if improvement were not made over a period of time the service can be suspended of all new admissions. It was noted that DIP Sampling would see some reporting on closure and assurance in this area.

It was noted that there were no new formal complaints for the month of August and 2 outstanding complaints would be closed by the end of the reported week.

MG confirmed that 'Healthwatch' would now be joining the CCG as part of the Quality Visit timetable to help minimise disruption.

JO raised a concern in terms of timing the agenda for the Quality & Safety Committee. It was felt that timing were a useful guide for the chair however it was agreed that timings do detract from giving specific item the in depth review they deserve. The case in point was that of the Monthly Quality Report.

ACTION: ***Timings for agendas to be used specifically for the chairs use and not to be present on future agendas.***

6.2 Infection Prevention Service Report

The report was submitted for assurance and was noted by committee members.

6.3 Safeguarding Children and LAC Quarterly Report.

LM began by extending apologies for the deferral of the submitted report from previous meetings due to the unexpected and recent CQC visit. The report was then accepted to be a retrospective look for the period of the 1st April 2016 – 30th June 2016. Just for understanding LM confirmed that the WCCG self-assessment contained 13 standards relating to Safeguarding Children which is taken from the accountability and assurance framework and also from the section 11 audit and therefore the organisation was following a very thorough self-assessment process. LM confirmed that very recently this had been combined with safeguarding adults. At present 5 standards were rated as amber. LM re-assured the committee that this reflected more additional work that had been undertaken as opposed to outstanding work that has not been completed particularly regarding policies to with West Midlands standards. Those policies were confirmed as out for consultation at present.

LM stated that a lot of the work that is undertaken is around partnership working of which this could be noted throughout the submitted report for instance the Goddard report which had been raised as part of the Quality Report.

LM confirmed that a number of post have been funded from the CCG to work as part of the MASH. It was confirmed that 2 admin roles were appointed to however due to the long vetting process the candidates then withdrew their interest in the post. LM added that a second round of interviews had now been undertaken with one position appointed to and one still outstanding subject to further interviews.

LM confirmed that a Serious Case review had been completed on family E and advice was being sought from the national panel on limited publication.

The report also highlighted the on-going programme of training delivered by the team part funded by NHS England. Evaluation forms of the training have been changed to include what 2 things would a practice implement as a result of the training they had received.

It was noted that apologies had been forwarded by Fiona Brennan due to a clinic however LM reported on her behalf that the numbers of Looked after children did continue to fall.

The remainder of the report was noted by the committee.

6.4 Safeguarding Children Section 11 Audit

LM confirmed that the submitted report provided assurance that WCCG was compliant with Section 11 of the Children Act 2004 and has effective arrangements to safeguard and promote the welfare of children. LM confirmed that all evidence for the audit had now been submitted via the online facility as a statutory responsibility. It was confirmed that this had been signed off by Manjeet Garcha and Trisha Curran. LM confirmed that any areas that are felt there would be areas of improvement an action plan had been developed to address these particular areas. LM confirmed that 2 years previously when this audit was

last completed the CCG had just formed from the old PCT and the position had was not as strong as it was deemed at present. LM confirmed that this was confirmed by a recent safeguarding audit that deemed the CCG was 'substantial'.
JO enquired which internal audit team had conducted the audit? LM stated that this was conducted by our previous internal audit team but is now monitored by the new internal audit team who LM believed were very strong and robust.

6.5 Health & Safety Performance Report

The report was submitted for assurance and was noted by committee members.

6.6 Quality Assurance in CHC Quarterly Report

The report was submitted for assurance and was noted by committee members.

7. ITEMS FOR CONSIDERATION

7.1 Regional Medicines Optimisation Committees – Proposals for Establishment

DB confirmed that the submitted was a consultation document regarding medicines that are not covered by NICE guidance. Those drugs outside of NICE guidance are reliant on a local champion. DB did add however that some drugs are 'left on the shelf' until someone agrees to commence their use. DB noted that NHS England were aware of this and are now looking to introduce regional medicines committees to take away from the work that is currently undertaken locally. DBN stated therefore that there would be 4 regional committees in place to give recommendations to CCGs on a wider range of drugs. It was noted that this would be a more efficient way of looking at new medicines as knowledge at regional level would be greater than the knowledge locally. DB stated that his only concern was in tying this alongside CCG annual planning, for instance if a drug was introduced mid-way through a financial year and there was not enough provision for the new drug. DB welcomed any comments from Committee members. It was suggested that non-voting rights for the pharmaceutical industry should be advised.

8. POLICIES FOR CONSIDERATION

8.1 Volunteer Policy

NE confirmed that the policy had been 'Savilled' and all volunteers would have an enhanced DBS and conduct safeguarding training. The policy also included a section on social media behaviour. The volunteer policy had been amended to include as part of the policy a workbook for any volunteers commencing as Patient Reviewers.

PR requested that references to Patient Council needed to be removed as we the CCG does not have a patient council.

ACTION: ***PR & NE to meet to make amendments to be made to the policy and the policy is to be distributed following completion for formal agreement and an update given at the October meeting.***

9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

No items were highlighted for escalation

10. ANY OTHER BUSINESS

11. DATE AND TIME OF NEXT MEETING

- ***Tuesday 11th October 2016, 10.30am – 12.30pm; CCG Main Meeting Room.***

This page is intentionally left blank

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Wednesday 28th September 2016
Commencing at 1.30 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 (Chair)	Yes
Claire Skidmore (CS)	Chief Financial Officer	No
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 ~

Lesley Sawrey	CCG Deputy Chief Finance Officer	Yes
Mursheda Nessa	WCC Public Health	Yes
Liz Hull (LH)	CCG Admin Officer	Yes

Apologies for absence

Apologies were submitted on behalf of Claire Skidmore, Cyril Randles, Viv Griffin, Juliet Grainger and Vic Middlemiss.

Declarations of Interest

CCM526 Dr Morgans declared a clinical interest in Item CCM532 – Atrial Fibrillation.

RESOLVED: That the above is noted.

Minutes

CCM527 The minutes of the last Committee, which took place on Thursday 25th August 2016 were approved as true and accurate.

RESOLVED: That the above is noted.

Matters Arising

CCM528 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

CCM529 (CCM514) Contracting & Procurement Update – Nuffield: Services commissioned from Nuffield include a range of elective / planned care in the following specialities:

- General Surgery
- Ophthalmology
- Pain Management
- Musculoskeletal / Orthopaedic, including joints
- Physiotherapy

The services will include, where appropriate:

- Pre-treatment
- Treatment
- Recovery
- Discharge

Level of physiotherapy provided and why this may differ from RWT to Acute Trusts – A contributing factor is complexity of the patient as this impacts upon the post-op care/phsyio. Nuffield only accept non-complex low level patients whereas RWT accept all patients with varying complexity. This is why the level of physiotherapy input may appear different when making comparisons.

(CCM514) Contracting & Procurement Update – STF Query: It has been confirmed that STF money will be retained by NHSI/NHSE if RWT do not meet targets.

RESOLVED: That the above is noted.

Contracting & Procurement Update

CCM530 Members of the Committee were provided with an overview and update of key contractual issues, predominantly relating to Month 4 (July) activity and finance performance. The report also included key actions from the Clinical Quality Review and Contract Review meetings held in September 2016.

Royal Wolverhampton NHS Trust

Performance issues

Remedial Action Plans remain in place for:

- A&E
- E-discharge
- Cancer 62 days

A&E year to date performance is as follows:

A&E	April	May	June	July
Actual	85.08%	88.03%	91.61%	88.63%
STF Trajectory	90.00%	91.00%	92.00%	95.00%

Key points from the A&E Remedial Action Plan:

- Joint triage arrangements with Vocare due to commence on 1 September which should facilitate more effective triage and ultimately move patients through faster
- Fulltime Flow Coordinator now allocated to ED.
- Mixed success with recent recruitment:
  - Additional nurses will start in September although 5 vacancies remain.
  - Only three Trust Fellows commenced in August (leaving 4 short)
  - Three Advanced Care Practitioners in post to supplement middle grade rota.
  - On target with new junior doctors rota
  - Failed to recruit additional senior sister for 24/7 cover.

<u>E-discharge</u>

E-discharge (assessment)	April	May	June	July
Actual	84.59%	87.38%	84.48%	82.94%
Target	95%	95%	95%	95%

E-discharge (ward areas)	April	May	June	July
Actual	92.84%	93.40%	94.59%	94.29%
Target	95%	95%	95%	95%

Key points from the E-Discharge Remedial Action Plan – Covering Wards and assessment areas:

- Clinicians have identified a lack of IT hardware in ward areas as one of the key reasons why discharges are not being actioned in a timely fashion. Additional equipment may be required to address this concern before performance achieves standard on a consistent basis.
- Junior doctors strike will impact on the delivery of e-discharge, whilst the September strike has been stood down, others strike dates are still planned

Cancer 62 day target

Cancer	April	May	June	July
Actual	79.88%	72.02%	81.36%	84.00%
STF Trajectory	84.00%	84.00%	85.00%	85.00%

Key points from the Cancer Remedial Action Plan

- Main reasons identified for non-compliance identified as follows:
  - Urology capacity
  - Late tertiary referrals
  - Radiology capacity (increased demand has put pressure on the service to deliver reports and scans in a timely manner).
  - Capacity in Gynaecology services
  - Referrals for Head & Neck have significantly increased

Referral to Treatment

RTT (headline)	April	May	June	July
Actual	84.59%	87.38%	84.48%	91.18%
STF Trajectory	92%	92%	92%	94.2%

Recovery plans are in place for the five main challenged speciality areas.

Performance Sanctions

The year to date total as at Month 4 is £122,850. This excludes any sanctions pertaining to A&E, Cancer 62 day waits and RTT, which are subject to the Sustainability and Transformation Fund (STF) process.

Other RWT contractual issues

- A&E Coding issues
  - Activity impacting on HRGs (VB09Z and VB11Z)
  - Potential duplicate patients on the system
  - The CCG Continue to pursue these issues

Black Country Partnership Foundation Trust

Performance issues

Non-achievement of CQUIN target (Quitiapene) – Discussions have taken place with the Trust and actions are being put in place to address this.

SQPR - Most indicators are on target YTD. The Early Intervention Service had been an area of concern. However, this has been 100% for the last 2 months.

Remedial Action Plan (PREVENT) – The Trust has agreed to provide monthly updates on the milestones in the trajectory. At present they are on target for all indicators and likely to meet the end of year milestones if performance continues as it is.

Contract Activity (BCPFT)

BCPFT are over-performing and over-spending against the block contract on a number of lines; high level observations is a particular area of concern raised by the Trust. Whilst this does not impact on the CCG directly (because of the protection afforded by the block), it is being closely monitored. We anticipate that the Trust will be seeking to raise these issues during contract negotiations as part of their strategy to move to cost and volume, for activity lines where costs outweigh income.

Other Contracts/ Significant Contract issues

Urgent Care Centre - The contract for the Urgent Care Centre has finally been signed by Vocare, which enables the CCG to undertake more robust contract management of key issues, in particular activity performance.

The CCG has undertaken an analysis of activity and identified that Vocare is significantly under plan for activity YTD, particularly for face to face contacts. The CCG will therefore be seeking to claim money back, as per the wording of the contract which states that a 40% marginal rate will apply to activity below a 10% tolerance. A further update will be provided to the committee in October.

RESOLVED: That the above is noted.

Social Prescribing Business Case

CCM531 Mr Marshall presented a report in relation to the Social Prescribing Business Case.

The CCG previously explored a model of Social Prescribing through a Social Impact Bond financial model. The financial model proposed was deemed to result in a level of risk to the CCG that meant the proposal was not viable. The operational model of Social Prescribing however is a model that we would wish to pilot, as evidence shows that it improves patients wellbeing and reduces social isolation.

A 12 month pilot for social prescribing is proposed, to be delivered by the Wolverhampton Voluntary Sector Council. The model proposed would see 3 trained "link workers" across the City working with and supporting individuals that require low level, non-clinical support but whom access Health and Social Care services regularly.

The outcomes of Social Prescribing are expected to be:

- A reduction in social isolation
- Improved health and well being
- A reduction in demand on primary care and secondary care activity

Finances:

- The anticipated cost of delivering the model as a 12 month pilot is £148,316.
- For Financial Year 2016/17 there is a part year effect equivalent to (148.316/12) x3 = £37,079.
- Confirmation of costs to be provided.

RESOLVED: The Committee supported the proposal of the 12 month pilot subject to:

1) The Business Case wording is modified to strengthen the fact that the link workers will forward and support case management.
2) It is made explicit that the funding route is the GP development reserve we hold
3) It is costed for 3 months of service (from January 17) which reflects the front loading of the admin costs (i.e. buying of computers etc.) and thereafter annually.
4) Equality / Quality Impact Assessment to be completed.

Atrial Fibrillation

CCM532 Mr Love presented a Business Case to the Committee, which sought to introduce a project to improve diagnosis and treatment of Atrial Fibrillation (AF) in Primary Care. The Business Case for a 12 month pilot in the South West was approved by the Primary Care Programme Board on 14th September 2016.

RESOLVED: The Committee did not approve the pilot and requested that:

- The Primary Care Board proposes the way forward to the Committee.
- Further work is completed around pathways and scaling the risk.
- Work with Finance in order to demonstrate cash flow

Nuffield Health Ltd Business Case for a Spinal Service

CCM533 Nuffield Health Limited (the Nuffield) is currently commissioned to provide a range of elective services including pain management, orthopaedics and general surgery. At present, this does not include spinal surgery and it is NHS Trusts, in the main, that provide this surgery for our patients.

The Nuffield has submitted a business case to extend the current directory of services commissioned to include spinal services. The rationale provided states that, should this service be commissioned, it would form part of the commissioned pain management pathway and provide a seamless patient journey.

RESOLVED: The Committee approved the Business Case.

Any Other Business

CCM534 None.

Date, Time & Venue of Next Committee Meeting

CCM535 Thursday 27th October 2016 at 1pm in the CCG Main Meeting Room.

This page is intentionally left blank

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 27 September 2016
Science Park, Wolverhampton

Present:

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

In regular attendance:

Mr G Bahia	Business and Operations Manager
Mrs L Sawrey	Deputy Chief Finance Officer

In attendance

Mr A Sharma	Senior Contracts Manager
Miss M Patel	Administrative Officer

1. Apologies

Apologies were submitted by Mr Middlemiss and Mrs Pidoux

2. Declarations of Interest

FP.16.92 There was no declarations of interest.

3. Minutes of the last meeting held on 30 August 2016

FP.16.93 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.16.94

- Item 90 (FP.16.78) – Update regarding the process and governance relating to the waiving of fines to be brought to the next meeting – Mrs Skidmore presented a briefing paper. Item closed.
- Item 91 (FP.16.88) - Performance Report to be revised to highlight important areas for discussion – Information had been revised and was presented in the report at the meeting today. Item closed.

5. Matters Arising from the minutes of the meeting held on 30 August 2016

FP.16.95 Mr Bahia advised that under FP.16.88 that under the section 62 day Cancer Wait Tertiary Referrals. The sentence should be amended to - **A meeting had been set up for the 8 September with Dudley CCG's Head of Quality and steps are being taken to resolve this issue.**

6. Finance Report

FP.16.96 Mrs Sawrey reported on the Month 5 financial position, stating that it had proven to be a very difficult month to close down. The financial target had been hard to achieve.

- The acute portfolio has deteriorated in month, in particular for Dudley Group of Hospitals. There has also been more activity within the smaller contract hospitals but there does not seem to be a reduction in the numbers attending at RWT. The Dudley Group of Hospitals overspend is mainly due to emergency vascular work.
- CHC costs have increased and the under spend had been reduced. The length of stay in terminal phase was increasing (10 weeks instead of 6) and CHC packages were very expensive.
- RWT – There has been no real change in the main hotspots. Electives are underspent and non-electives and outpatients are overspent. Queries remain with A&E with particular regard to the double counting of people attending A&E. The Committee discussed this in depth.
- Diagnostic Consultant to Consultant referrals are being looked into. The majority of referrals are mostly related to scans and MRI scans.
- The other two key areas discussed were BCF and QIPP. QIPP savings have deteriorated. Following a BCF Deep Dive in month 5 (conducted by all leads), the main area of concern in slippage in recruitment to the community team.
- The Committee discussed the issues around the Rapid Response Team including recruitment.

Mrs Skidmore advised that the Finance position had been discussed in depth at a recent Senior Management Team meeting and options, ideas and practical actions have been identified. There would be a further meeting taking place the following week to discuss forward planning.

Mrs Sawrey gave a QIPP Board update:

- Currently there were limited QIPP schemes in the pipeline, delivery boards have been asked to address this via development of commissioning intentions.
- Mrs S Southall would be attending future QIPP Board to give an overview of feedback from practice visits.
- The effect of new tariff changes could increase the QIPP from £14million to as much as £20million in 2017/18.
- Mr Price recognised the QIPP position but asked that a fuller update on the reasons for the slippage against targets to be included in next month's report, together with an update on progress against future QIPP plans.

Mrs Skidmore had attended the Accountable Officers Meeting in the morning and shared with the group a document on 2017-2019 Operational Planning and Contracting. This item was not for circulation and was discussed in the group.

Resolved: The Committee;

- Noted the contents of the report and the current position, particularly with regard to the risks inherent in the finance position.

6. Performance Report

FP.16.97 Mr Bahia highlighted that of the indicators for Month 4, 41 are green rated, 26 are red rated and 26 are unrated. Following discussions at the last Finance and Performance Committee meeting, the Monthly Performance Exception Report had been revised to highlight key areas.

The following key points from the report were discussed;

- Handover between ambulance and A&E – There were 87 handover delays for patients waiting over 30 minutes in July 16/17 plus 5 handover delays for patients waiting over 60 minutes. Contractual sanctions were enforced based on the numbers of breaches each month, with fines for Month 4 estimated at £22,400.

- E-discharge – There continues to be issues with achievement of the e-discharge target. E-discharge for performance for all wards and assessment units is failing. New Junior Doctors arriving at the Trust were completing e-discharge training. The fine for not achieving this target is estimated to be £10,000 in total.

- Serious Incident (SI) reporting – A programme of work is ongoing through the Pressure Ulcer Prevention Steering Group and the Trusts Falls Policy is under review.

- Stroke – The indicator had failed to meet the 60% target for the first time in July reporting 58.82% in month. The trust had confirmed that there has been an issue with a number of patients that had been incorrectly flagged as 'high risk'. Training has been provided to remedy this.

- Mixed Sex Accommodation – Early indications in August reported multiple mixed sex accommodation breaches. The CCG are awaiting updates from the Trust.

- DToCs – Performance for July achieved the Q2 stretch target of 3.20% for delays (excluded Social Care (1.29%)). 4.43% had been confirmed as the overall delays position.

- RTT – Delivery was under the STF trajectory. There remains a problem with capacity issues including recruitment.

- A&E – This has failed the target and STF trajectory. Human Factors training has taken place. The SRG Meeting has now been replaced by the A&E Delivery Board.

- 62 day Cancer Waits Tertiary Referrals – Mr Bahia, Ms N Ensor and Mr V Middlemiss took part in a teleconference with Ms M Minott - Head of Quality and Risk at Dudley. Miss Minott had not been aware of the late tertiary referrals sent from Dudley. She committed to look into this.

- C.Diff – There have been fewer breaches reported.

- RTT Waits over 52 weeks for incomplete pathways – There are 64 patients that had breached the 52 weeks relating to Orthodontics remaining to be seen. Work to see all patients affected by this issue is ahead of target.

- IAPT measures – There has been significant improvements in this area. DNA's however continue to affect performance figures.

Following discussions at the last Finance and Performance Committee meeting, the Monthly Performance Exception Report had been revised to highlight key areas. Mr Price thanked Mr Bahia for the revisions to the document.

Resolved: The Committee

- Noted the content of the report and the updates given.

7. Monthly Contract and Procurement Report

FP. 16.98 Mr Sharma presented the Monthly Contract and Procurement Report on behalf of Mr Middlemiss. The report focused primarily on Month 4 (July).

Areas highlighted in the report were:

- Remedial Action Plans
  - A&E RAP – Joint triage arrangements with Vocare commenced from the 1 September 2016. Vocare have seen increases in activity.
  - E-discharge – This covers ward and assessment areas.
  - Cancer RAP – The 62 day wait target is being missed because of the delay in receiving patients from Dudley Group of Hospitals. A clinical audit is taking place.

- Performance Sanctions
  - There have been a number of breaches where financial sanctions had been applied.

- Other RWT Contractual Issues
  - There have been issues with coding and duplication. This is being looked at and reimbursements have been sought where there has been overcharging.

- BCPFT
  - A RCA had taken place regarding the prescribing and monitoring of Quetiapine which was a drug used for patients with psychosis.

Resolved – The Committee:

- noted the contents of the report

8. Any Other Business

FP.16.99 There were no items raised under any other business.

9. Date and time of next meeting

FP.16.100 Tuesday 25 October 2016 at 3.15pm, CCG Main Meeting Room

Signed:

Dated:

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE JOINT COMMISSIONING COMMITTEE

Minutes of the Primary Care Joint Commissioning Committee Meeting
Held on Tuesday 6th September 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
Dr Salma Reehana	Locality Chair / GP	No
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
Emma Cox	Senior Finance Manager	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	Yes
Sarah Gaytten	Independent Patient Representative	Yes
Peter Price	Vice Chair	No

Non-Voting Observers ~

Katie Spence	Consultant in Public Health	Yes
Donald McIntosh	Chief Officer – Wolverhampton Healthwatch	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
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) (Minute Taker)	Yes
Trisha Curran	Interim Accountable Officer (WCCG)	Yes
Claire Skidmore	Chief Finance and Operating Officer (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator	Yes

Welcome and Introductions

PCC180 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

PCC181 Apologies were submitted on behalf of Dr Helen Hibbs, Peter Price, Ros Jervis, and Anna Nicholls.

Declarations of Interest

PCC182 Dr Kainth and Dr Bush 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 2nd August 2016

PCC183 RESOLVED:

That the minutes of the previous meeting held on 2nd August 2016 were approved as an accurate record.

Matters arising from the minutes

PCC184 **GP Peer Review Terms of Reference**
It was noted the Terms of Reference were shared with the Committee for information.

RESOLVED: That the above is noted

Committee Action Points

PCC185 **Minute Number PCC121 - Primary Care Joint Commissioning Committee Terms Of Reference**
It was noted this item was on the meeting agenda.

Minute Number PCC174 – Wolverhampton CCG Update
Mr Hastings confirmed he had responded to Wolverhampton LMC queries within in the 7 day deadline.

Minute Number PCC174 – Primary Care Support England (PCSE)
Ms Worton confirmed an e-mail went out to all Practice Managers on the 11th August requesting PCSE feedback. All the responses had been collated and sent to NHS England where the information will be discussed in a forum meeting between Capita Services and NHS England. It was confirmed any feedback would be escalated back to the CCGs this could be fed back to the GP Practices.

Minute Number PCC175 – GP Peer Review
It was noted this item was on the meeting agenda.

Minute Number PCC176 – Acute Discharge Process
Mr Blankley confirmed he had met with Dee Harris and discussions have commenced regarding prescribing within the acute discharge process.

Minute Number PCC176 – Premises Charges
Mr Hastings agreed to chase Anna Nicholls regarding this action.

Minute Number PCC177 – Workforce Strategy
This item is due to be presented at the October meeting.

RESOLVED: That the above is noted.

NHS England Update – Primary Care Update

PCC186 Mr McIntyre presented the NHS England update to the Committee outlining the latest developments in primary care nationally and locally. Mr McIntyre highlighted to the Committee the deadline for delegated applications for full delegation is the 5th December 2016. The outcomes of the approval process will be communicated in January 2017 with the go live date for new delegated arrangements on the 1st April 2017.

Mr McIntyre stated the application documents will be published within the next month and asked for the CCG to ensure they are prepared in order to meet this deadline. Mr McKenzie confirmed that the CCG will be provided a report on this process to the Wolverhampton CCG Governing Body Meeting next month.

Ms Roberts queried the Primary Care Commissioning Activity Report and who would be submitted the return to UNIFY. It was confirmed that NHS England would complete this return on behalf the CCG. Mr McIntosh asked if the completed return would be shared with the Committee, Ms Shelley agreed this would be shared at the October meeting.

Ms Roberts queried in relation to the GP Resilience Programme it notes that comments are invited on this document by 2nd September 2016 and asked if the CCG have/or needed to make a response. Mr Hastings confirmed there is a programme of work on the GP Forward view, which NHS England has held a workshop that the CCGs were in attendance. Mr Hastings agreed to confirm and report back.

RESOLUTION: Primary Care Commissioning Activity return to be shared with the Committee in October 2016.

Mr Hastings agreed to report back if the CCG had/or needed to make a response on the GP Resilience Programme document.

NHS England Finance Update

PCC187 Ms Cox presented the Wolverhampton CCG's (2016/217) GP Services month 4 finance position report to the Committee. The forecast outturn is £33.1m delivering a breakeven position. The allocation has reduced by £881k, in relation to month 2 transfer of budget allocations from NHS England to the CCG due to contracts now being held by the CCG.

A number of reviews have been carried in month 4 in relation to GP forecasts including;

- Recalculation of Global Sum Payments, PMS and APMS Contract payments based on the July 2016 updated list sizes
- Review of QOF outturn for practices who had not received their 2015/16 finalised position in month 2
- Review of DES Forecasts based on practice sign up

A drawdown of £45k against the 0.5% contingency was required to deliver a breakeven position, with a balance of £125k remaining for further in year cost pressures. Ms Curran queried whether any unspent contingency reserves would roll over to 2017/2018. It was noted that it was not possible to roll over the contingency reserve however, at month 10 discussions take place around how any remaining money could be allocated, which the CCG will start to forecast and plan for in advance.

RESOLVED: That the above is noted.

Wolverhampton CCG Update

PCC188 Mr Hastings provided the following update to the Committee in relation to Wolverhampton CCG Primary Care:

Estates and Technology Transformation Fund (ETTF) – The outcome of all bid applications will be received by November 2016, therefore no commitments can be made until the outcomes are received.

Estates – A lot of progress has been achieved in relation to the Locality Hubs for the better care fund.

Digital Road Map – Positive feedback has been received in relation to the plans that have been submitted. There have been good stakeholder relationships and the plan is making good progress and the plan continues to be refined which will be submitted as a final submission within the next few weeks.

Capita / Primary Care Support England - Feedback is awaited via the Primary Care Operational Group Meeting in respect of outcome/concerns from the forum meeting held with NHS England and Capita, where GP responses are discussed.

Vertical Integration – There are three GP Practices currently integrated with RWT with another two waiting expressing an interest.

RESOLVED: That the above is noted.

Primary Care Programme Board Update July 2016

PCC189 Ms Garcha presented an update on the delivery of the work being undertaken by the Primary Care Programme Board. The Interpreting Procurement closing date had been extended until the 30th August 2016 and a review of the bidders will take place during September. The new contract will start on the 1st December 2016.

In relation to the Community Equipment Procurement a paper had been presented to the Commissioning Committee in August with a view of taking a joint procurement process with Wolverhampton City Council. The assurance provided at the Commissioning Committee is that Wolverhampton City Council will procure a like for like service. The Commissioning Committee have rejected this proposal and agreed for the Wolverhampton CCG to go ahead and procure their own services. It was confirmed the joint discussions with Wolverhampton City Council has delayed the process by six months.

A paper was presented to the meeting in August on Choose and Book, Advice and Guidance, where it was confirmed that advice and guidance services are not available for Neurology and Geriatric Medicine. After a number of escalations it has been highlighted there are vacant posts within these specialties. Further work is being undertaken to understand if GPs are using the service overall and the system correctly. These discussions will take place at the next Clinical Reference Group in September.

A new proposal for Atrial Fibrillation had been presented to the Commissioning Committee, where the Committee reviewed the options available. It was agreed to introduce a scheme as a pilot within one Locality for a 12 month period, with a view to start in line with the flu vaccination process. Discussions took place around when the pilot should be undertaken and around the targeted age group for Atrial Fibrillation.

Ms Garcha provided an update on the timeline for Primary Care Review (Basket and Minor Injuries) which was as follows:

- Sign off of the costing template at the July 2016 Finance and Performance Committee.
- Review of specifications with revised tariffs at the August 2016 Clinical Reference Group.
- Proposal to be shared for support at the Septembers LMC Officers Meeting.

An A&E chest pain audit had been undertaken and indicated out of the 21 patients reviewed only one patient was deemed suitable for CDU. This is now being addressed through contact discussions with The Royal Wolverhampton Trust.

RESOLVED: That the above is noted

Primary Care Operations Management Group Update

PCC190 Mr Hastings provided an overview of the key areas covered at the Primary Care Operational Management Group Meeting which took place on the 23rd August 2016.

Ms Roberts asked if the Primary Care Operational Management Group were happy with the percentage of returns and the comments received in relation the Friends and Family Test results. Mr Hastings confirmed that the responses are reviewed, however there are two GP Practices who fail to submit data even after support has been given. The Primary Care Operational Management Group have agreed to give the GP Practices a month to improve performance and if no improvement has been made this will be brought to the Committee recommending a breach notice.

RESOLVED: That the above is noted

Mr Marshall left the meeting

Terms of Reference

PCC191 Mr McKenzie informed the Committee the Terms of Reference were reported upon in June 2016. It was noted at the June meeting further changes would

need to be undertaken, following publication of an updated Guidance on Managing Conflict of Interest for CCGs by NHS England.

The amended Terms of Reference were shared with the Committee highlighting the changes, the main changes are the inclusion of the Lay Member for Finance and Performance within the Committee Membership (as a Deputy Chair) and GP members no longer having formal voting rights. It has also included clarification that CCG's requirements around registration of interest apply to NHS West Midland Representatives.

Mr McKenzie highlighted at this point no changes have been made to the Committee's remit and responsibilities. As part of the process for applying for full delegation of Primary Care, the CCG will need to establish a Primary Care Committee and have discussions on whether any additional functions will be delegated to the Committee by the CCG.

It was noted that the two independent patient representatives needed to be added to the membership of the committee.

RESOLVED: That subject to the amendment to the membership to include the patient representatives, the Terms of Reference be approved.

Any Other Business

PCC192 **Primary Care Full Delegation**

It was confirmed the application needs to be submitted by the 5th December 2016 and full delegation of Primary Care will commence as of the 1st April 2016.

RESOLVED: That the above is noted.

Date, Time & Venue of Next Committee Meeting

PCC193 Tuesday 4th October 2016 at 2.00pm in PC108, Wolverhampton Science Park

This page is intentionally left blank

Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
Primary Care Strategy Committee

Minutes of the Primary Care Health Strategy Implementation Programme Board
Held on Wednesday 7th September 2016
Commencing at 1.00pm in the CCG Mina Meeting Room, Wolverhampton Science Park, Glaisher Drive, Wolverhampton

Present:

Sarah Southall (Chair)	Head of Primary Care, Wolverhampton CCG
Trisha Curran	Interim Accountable Officer
Andrea Smith	Head of Integrated Commissioning, Wolverhampton CCG
Mike Hastings	Associate Director of Operations, Wolverhampton CCG
David Birch	Head of Medicines Optimisation, WCCG
Samina Arshad	Primary Care Lead, Wolverhampton CCG
Dr Mehta	GP, Local Medical Committee Chair
Ranjit Khular	Primary Care Transformation Manager, WCCG
Vic Middlemiss	Head of Contracting and Procurement, Wolverhampton CCG
Barry White	Project Manager – New Models of Care
Laura Russell (minutes)	Primary Care PMO Administrator, Wolverhampton CCG

Apologies for absence

PCSC09 Apologies were submitted on behalf of Steven Marshall, Dr Helen Hibbs, Dr Dan DeRosa, Manjeet Garcha, Steven Marshall and Claire Skidmore.

Actions

PCSC10

PCHSIPB01 – Terms of Reference
Mr Hastings feedback this was to ensure the roles and accountability are represented at the appropriate meetings and this has taken place through the revision of the terms of references. It was agreed to close this action.

PCHSIPB02 – Terms of Reference
Mrs Southall confirmed that she had met with Trisha Curran and Claire Skidmore and amendments had been made to Committees terms of reference. The amended version is an agenda item for approval. Action Closed,

PCHSIPB03 – Risk Register Report Datix
Ms Russell amended the highlighted the report to include a section on risk and e-mailed this to all the Task and Finish Group leads on 19th August 2016. Action Closed.

PCHSIPB04 – Implementation Plan
This has been completed and a revised programme was issued along with the August minutes. – Action closed.

PCHSIPB05 – T&FG 1 – GP Contract Management
The terms of reference will be formally agreed at the next Task and Finish Group being held on the 14th September 2016. Action Closed.

PCHSIPB06 – T&FG 1 GP Contract Management
Mrs Southall had met with Ms Smith to finalise costs for GP attendance to the Task and Finish Group meetings in order to determine the impact on the budget. Action Closed.

PCHSIPB07 – T&FG2 – Workforce Development
Amendments made to the terms of reference – Action Closed.

PCHSIPB08 – T&FG3 – Developing Practices as Providers
Amendments made to the terms of reference – Action Closed.

PCHSIPB09 – T&FG5 – Clinical Pharmacists in Primary Care
Amendments made to the terms of reference – Action Closed.

PCHSIPB10 – T&FG6 – Estates Development
Amendments made to the terms of reference – Action Closed.

PCHSIPB11 – T&FG7 – Localities as Commissioners
Amendments made to the terms of reference – Action Closed**.**

PCHSIPB12 – Any Other Business
Discussion Items included as a standard agenda Item– Action Closed.

RESOLVED: That the above was noted.

Matters Arising

PCSC11 **a) Terms of Reference for Approval**

Mrs Southall presented the revised terms of reference to the Committee and highlighted the main changes these are:

- A name change from the Primary Care Health Strategy Implementation Programme Board to the Primary Care Strategy Committee.
- The membership has been split into members and in attendance.
- Chair of future meetings will be the Director of Strategy and Transformation.
- Quoracy now includes at least two Executives and representation from each Task and Finish Group

The Committee reviewed the terms of reference in relation to the membership it was agreed to change the Local Medical Council to Local Medical Committee and include the New Models of Care Project Manager to the in attendance section. It was also highlighted the Task and Finish Group Work Streams Leads needed to be defined.

The Committee formally approved and signed off the Terms of Reference subject to amendments highlighted as above.

RESOLUTION:
Ms Russell agreed to make final amendments to the Terms of Reference and circulate with the minutes.

Risk Register

PCSC12 **a) Risk Register Report Datix - Primary Care and Primary Care Strategy**

Mrs Southall presented risks associated with Primary Care and to the Primary Care Strategy currently on Datix register. There have been two risks added to the register via the Clinical Pharmacists in Primary Care Task and Finish Group these were:

Risk ID 439: GP employed clinical pharmacist network.
Risk ID 440: Unattractive employment of clinical pharmacists by GP Practices.

Both of the above risks are recorded as Moderate and have reasonable levels of control in place. There are currently no red risks on the risk register.

Risks pertaining to the other Task and Finish Groups were yet to be entered on Datix by the work stream leads. As a minimum a portfolio risks for each should be entered by the next meeting.

RESOLUTION: All work force lead to ensure that risks pertaining to their task and finish groups should be entered onto Datix by the next meeting.

Performance

PCSC13 **a) Implementation Plan**

Mrs Southall presented the Primary Care Strategy Committee's implementation plan which has been altered to reflect the changes discussed at the previous meeting. The strategic objectives for the Committee are now clearly defined for the Committee and Task and Finish Groups.

The Committee discussed those areas with an action status as not started or slipped (red) and the following was highlighted:

Reference number PCSC009 (Identify appropriate areas for development of extended services in line with population needs) – Confirmed this will commence toward the end of September, through until the end of the contract year.

Reference Number 1.9 Continue to embed and evaluate the Primary Care In reach Team (PITs)/Resource Centre's (Practices as Providers) – Mrs Southall advised that the project group were due to meet to review progress, clarification was sought from Ms Arshad regarding project timescales these were confirmed as follows:

- February 2016 – 3 month mobilisation period.
- May 2016 – service go live date
- August 2016 – project Review Group cancelled
- September 2016 revised project review group meeting
- December 2016 evaluation report to be taken to PITS Meeting.

It was agreed the action noted from the meeting will be shared with the Committee.

RESOLUTION: Notes of PITS Project Review Group to be shared with Committee.

Reference Number 2.0 (Localities as Commissioners) – Following their Task and Finish Group it was agreed the tasks needed to be aligned more appropriately and cohesively and this will be updated for the next meeting.

RESOLUTION: Mrs Southall and Mr Khular to review Localities as Commissioners tasks and be aligned more appropriately and cohesively and this will be updated for the next meeting.

Reference Number 2.5 End of Life (Localities as Commissioners) - this was discussed at the Task and Finish Group on how this should be assembled into a programme of work and objectives for this Group. It was agreed this will be taken forward as a group of activities in order to improve long terms conditions and care in the community.

Reference Number 2.7 Commission self-care initiatives from a range of Voluntary sector organisations in 17/18(Localities as Commissioners) - It was a highlighted this area of work has commenced and aligns to the Better Care Fund and will be reflected in alignment of tasks.

Reference Number 2.23 Improvement in Practice response rates and ratings in NHSE 360 Stakeholder Feedback Member Practice (Localities as Commissioners) - The Committee agreed the wording for this task needed to be reviewed as they felt it needed to relate more to stakeholder engagement.

RESOLUTION: Mrs Southall and Mr Khular to review the wording on reference number 2.23 Improvement in Practice response rates and ratings in NHSE 360 Stakeholder Feedback Member Practice.

Reference Number 3.0 (Workforce Development) - There were some gaps with timescales this will be picked up between Ms Russell and Ms Garcha and an updated version will be provided for the next meeting.

RESOLUTION: An updated version for Workforce and Development tasks/timescales will be provided for the next meeting.

Reference Number 4.0 (Clinical Pharmacist) – Mr Birch confirmed the content and the timescales will be updated and populated with Ms Russell and will be ready for the next meeting.

RESOLUTION: Mr Birch and Ms Russell to complete contact and timescales for the next meeting.

Reference Number 5.1 Review MOU between NHS E/CCG to understand the future relationship between the hub and CCG and to scope future resource requirements for Primary Care contracting. (Primary Care Contract Meeting) – Mr Middlemiss noted this correlates with the terms of reference. The next task and finish group will be discussing the need to review the MOU (Primary Care Hub) between NHSE and CCG, it was agreed the timescale would be more reflective of a October start timescale.

RESOLUTION: Timescale to be amended to October 2016.

Reference Number 5.5 Implementation of MCP/PACs emerging care model and contract framework, working in conjunction with NHS (Primary Care Contracting) – This will be reflected in further national guidance anticipated at the end of September 2016.

Reference Number 6.11 Estates Strategy to be Implemented (Estates Development) - This will be reliant on the ETFF bid outcomes, 13 bids were submitted and support from regional to national level.

Reference Number 7.5 Work with PCH test site to investigate technological solutions (IM&T and Business Intelligence) – It was highlighted this area of work had commenced Mr Hastings agreed to confirm.

RESOLUTION: Mr Hastings agreed to confirm if this area of work has started.

The status and timescales for all entries will be reviewed with each work stream lead before the next meeting.

Task and Finish Group Highlight Report Including Terms of Reference

PCSC14

a) T&FG1 – Practice as Providers

Ms Arshad informed the Committee the Task and Finish Group had met on the 25th August 2016, a summary of their discussions were also discussed were the Terms of Reference including, Quoracy, Voting, Back office Functions and Forming of Networks/new models of care and linking to the Better care Fund work streams. Discussions took place regarding the proposal of amending the terms of reference to include LMC representation and they were exploring the feasibility of a Primary Care Nurse Lead for the group. The Committee agreed the role of the LMC would be beneficial for the group, however adding the Primary Care Nurse Lead they were unsure whether this should be included.

Ms Curran raised her concern that across all the terms of reference for the Task and Finish Group the first paragraph did not reflect the purpose and the link between the different groups. It was agreed this would needed to be reviewed.

RESOLUTION: Mrs Southall agreed to review the terms of reference first paragraph to ensure they are more reflective of the purpose of the group.

b) T&FG 2 – Localities as Commissioners

Ms Arshad confirmed the meeting took place on the 6th September in which the terms of reference were discussed. The terms of reference where shared and the highlighted changes were around membership and governance.

Mr Khular feedback that discussions were regarding the CCG moving towards new models of care and ensuring this aligned to locality structure in terms of grouping. The group also discussed the need for GPs and Practices taking a role of being involved within the commissioning process and it was agreed the aim of the Task and Finish Group is to develop processes in order to enable GPs to undertake their commissioning.

It was highlighted once the confirmation of the groupings for new models of care have been finalised the group may need to review/change the name and membership of the group.

RESOLVED: That the above is noted.

c) T&FG 3 – Workforce and Development

Ms Arshad present on behalf of Manjeet Garcha the highlight report and terms of reference and highlighted the following points;

- Terms of Reference to be amended and confirmed.
- GP lead to be confirmed as Dr Salma Reehana.
- Various areas of representation to be confirmed.
- 12 months' worth of monthly meeting dates to be confirmed and distributed.

- Recommendations from the Workforce report were discussed at the Walsall CEPN meeting on the 27th July 2016.
- Draft Project Plan to be on the Agenda for the 30th August 2016

It was requested by the Committee if the report could include more details around the key actions taken as the Committee are not sighted on their meeting papers.

The terms of reference have been revised and shared with the Committee and it was highlighted that additional information under section 7.2 has been included in reference to the Primary Care Strategy.

RESOLVED: that the above is noted

d) T&FG 4 – Clinical Pharmacists in Primary Care

Mr Birch presented the highlight report to the group and the terms of Reference to the Committee.

Mr Birch highlighted he had made contact with the CPPE to confirm training and development arrangements for the role of Clinical Pharmacist , up until now this has been restricted to those involved within the national pilot. This is now opening up to those pharmacists employed by practices outside of the national pilot. A slide pack has been developed and Mr Birch is currently visiting the localities to introduce the idea and explaining the differences between CCG optimisation role and the GP Employed Clinical Pharmacist role.

Discussions took place around the engagement with GP Practices and how to highlight the benefits. As there is no funding available from the CCG, it was suggested in developing a package. This can be advertised to the GP Practices to highlight the services and benefits from employing a clinical pharmacist within their practice.

RESOLUTION: Mr Birch agreed to review and take forward the option of developing a package that can be advertised to the GP Practices to highlight the services and benefits from employing a clinical pharmacist within their practice.

e) T&FG 5 – Primary Care Contract Management

Mr Middlemiss confirmed the next meeting of the Task and Finish Group will be taking place on the 14th September 2016. The Terms of Reference has been amended to reflect name and membership changes and will be presented at the meeting next week.

Mr Middlesmiss highlighted the areas of work and aims the group are taking forward these include;

- Collaborative Working between NHSE, CCG and Public Health
- Progression to Fully Delegated Commissioning
- Development of New Models of Care

RESOLVED: That the above is noted.

f) T&FG 6 – Estates Development

Mr Hastings provided an update to the group regarding the Estates being undertaken with Primary Care. The main key areas included discussion with NHS property services regarding the Bilston Urban Village Site, reviewing sites that RWT are pulling services from to determine void costs and the work around Black County STP model.

RESOLVED: That the above is noted.

g) T&FG 7 – IM&T and Business Intelligence

Mr Hastings informed the Committee of the work being delivered by IM&T and provided an update on the progress around the digital road map, mental health shared records and patient WIFI. It was noted as the group is an enabler and already has an existing working group in which the work for the Primary Care Strategy IM&T and Business Intelligence will be picked up.

RESOLVED: that the above is noted.

GP 5 Year Forward View Report and Action Plan

PCSC15 **a)** Mrs Southall shared with the Committee a report and action plan that was presented to the Primary Care Joint Commissioning Committee in August 2016. The action plan has been compiled to capture what is happening locally and outlines the responsible leads. It also correlates with the NHS England projects, the CCG have asked NHS England if the CCG could be given as much notice as possible in relation to any funding and relevance of projects to allow enough communication with GPs.

RESOLVED: That the above is noted.

b) The MCP Guidance has been shared with the Committee for information. There were no queries, colleagues should liaise with Mrs Southall or Mr Middlemiss.

RESOLVED: That the above is noted.

c) Indemnity Letter had been shared with the Committee, the review is currently underway and the Committee will be informed of any future developments.

RESOLVED: That the above is noted.

d) NHS Confederation Letter

Mrs Southall confirmed the summary model shared was relevant at the time of sharing the meeting papers, new formations are taking place among practices a revised model will be provided at the next meeting. Mrs Southall confirmed that the letter had been Shared with Practice Manager an application was being supported for Wolverhampton Core Collaborative.

RESOLUTION: Mrs Southall to Provide an updated models of care summary to the next meeting.

STP Update

PCSC16 Mrs Southall presented the report to Committee which was highly sensitive and asked the Committee not share this information. The Committee members are to provide Mrs Southall with any issues or queries they may have in relation to this report.

RESOLUTION: Any queries to be shared with Mrs Southall.

Discussion Items

PCSC17 **a) Hospital and General Practice interface Improvement Plan**

Mrs Southall informed the group within the NHS contract for providers was required to adopt a series of requirements from April 2016. The CCG have learnt this has not been implemented fully by the providers and there is an audit taking place which will be completed at the end of September 2016.

The CCG have developed a responsive action plan which provided detail on actions that are taking place/planned following intelligence gathering and audit findings. The CCG are trying to determine the cost of the activity to determine what the financial consequences will be if clinical practice does not change. Dr Mehta raised concerns that the audit may under estimate the level of work, this was recognized by other colleagues too.

RESOLVED: that the also is noted

b) CCG Seven Day Services Action Plan

Mrs Southall shared with the Committee the CCGs 7 day services action plan which provides an oversight of the clinical standards and the requirements/ actions taken in order to achieve them. The CCG are currently working jointly with RWT towards 10 Clinical standards. There will be an engagement event in October 2016, which GPs will be encouraged to attend and invites will be sent out later in September.

RESOLVED: that the also is noted

Any Other Business

PCSC18 Mrs Southall thanked Ms Arshad for all her contributions and work towards the launch of the Primary Care Strategy implementation and associate piece of work.

Date, Time & Venue of Next Committee Meeting

PCHSIPB08 Wednesday 12th October 2016 at 12.30pm, CCG Main Meeting Room Wolverhampton Science Park.